# An algorithm for medication in the treatment of Complex PTSD

## (DID and BPD are variants of Complex PTSD)

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# The purpose for the presentation

- ***Algorithm for medication:***
  My stepwise reasoning about the order in which I choose kinds of medication to test.
- My reasoning for this simple algorithm is based on the following three assumptions:
  1. ***Medication facilitates psychotherapy.***
  2. ***Need for medication changes from the acute phases to the intervals between crises.***
  3. ***All psychiatric drugs mitigate irrational emotions of Complex PTSD despite their names as antianxiety, antidepressant, antipsychotic or mood stabilizer.***

# Medication facilitates psychotherapy.

- Medication facilitates re-exposure to events that resemble past traumatic ones.  Medication mitigates the intensity of unstoppable negative emotions (fear, anger and aggression, anxiety) for the purpose of learning ways to cope with such danger.
- Only novel learning experiences, usually with psychotherapy, may eventually remove the reasons for emotions of that intensity and tenacity.

# The typical life course of Complex PTSD

***Engagement in experiments with intimacy*** in existing or new relationships (e.g., between parents and children, between best friends, lovers and lifemates).

Intimacy consists of making ***commitments to jointly pursue each partner's long-term goals***. Partners keep their commitment regardless of how each partner's needs may vary and even if one partner becomes unable to contribute.

## *Disengagement*

Enduring personality changes

- Fear of closeness
- Cynicism about others' benevolence or their own worth
- Certainty about others' love is an illusion

→ ***Engagement*** →

↓↑

***Crisis of trust***

Disorder

## *Disengagement*

Enduring personality changes become consolidated

# Two kinds of disorder

***Crisis of trust***

Anxious and depressive, intrusive rumination about others' intentions and expectations

→

←

Relentlessly testing others' intentions.

Flashbacks, depersonalization, hallucinations

# Two kinds of moods

***Engagement → Disengagement***

***Lingering moods from having lost hope and faith in the world's benevolence***

***Crisis of trust***

***Extreme and lasting moods during frustration with current crisis***

Similar emotions (fear, anger, anxiety, depression) arise from different experiences and reasons in the two phases of Complex PTSD's life course

# All psychiatric drugs mitigate irrational emotions

- ***All of them mitigate negative emotions*** of Complex PTSD (fear, anger and aggression, anxiety)
- There is ***no good medication for depression.*** All psychiatric drugs may lessen depression indirectly, by reducing irrational anxiety and the failure to function that it causes.
- In addition to their antianxiety action, antipsychotics and mood stabilizers repair the biochemistry of schizophrenia and manic-depressive illness.

# Step 1

- ***Use a quick acting antianxiety drug*** in repeated doses
- ***Benzodiazepine***s are most reliable.
  - Clonazepam (Klonopin)
  - Alprazolam (Xanax)
  - Lorazepam (Ativan)
- Alternatives are hydroxyzine, clonidine.
- ***Antipsychotics are safer***, if large doses are required.
  - Quetiapine/Seroquel,
  - Risperidone/Risperdal,
  - Olanzapine/Zyprexa,
  - Haloperidol/Haldol

# Step 2

At the same time, during the acute phase,

- ***Initiate buspirone (Buspar) or an antidepressant.*** These take 1-4 weeks to become effective they are only modestly effective in only two thirds of cases they often have side-effects
- ***Gabapentin*** (Neurontin) is effective as a long-term antianxiety drug for a few patients.
- If and when they take effect, they are useful as ***persistently active*** medication, ***without the risk*** of habituation and addiction.
- They usually are ***insufficient*** for prevention of relapse to ***acute symptoms.*** It is necessary then to supplement them with quick-acting drugs.
- Often, it is necessary to add a sleeper

# Step 3 and Step 4

- If buspirone or the antidepressant prescribed at Step 2 fail to provide their modest effect without side-effects, it is indicated to ***try alternative antidepressants, one at a time***, with good documentation of efficacy (take advantage of side-effects)
- In the intervals between crises, transition from giving ***quick-acting antianxiety drugs*** (especially benzodiazepines) routinely to giving them

  ***only "as necessary."***

# Step 5

- Finally, if Buspar and antidepressants fail, ***give consideration*** to routine, long-term use of ***antipsychotics and mood stabilizers.***
- Antipsychotics are modestly effective, but their long-term toxicity makes them a last resort option.
- There is little evidence that mood stabilizers are useful for reduction of emotional intensity or impulsivity. Gabapentin may be an exception.
- Antipsychotics and mood stabilizers ***should not be continued without proof of measurable efficacy.***

# Clinicians may suffer illusions of medication's efficacy

- ***"Medication was working but then it lost its efficacy."***
  The medication effect is limited. The effect varies with  good or bad turns of social events
- ***"The patient stopped taking his medicine and got worse."***
  He got worse and then neglected medication

  or threw it away

# Hypnotics

**Addictive**

***Non- benzodiazepine* |**
Zaleplon (Sonata)
Zolpidem (Ambien)
Eszopiclone (Lunesta)

***Benzodiazepine***
Quazepam (Doral)
Flurazepam (Dalmane)

Estazolam (ProSom)

Temazepam (Restoril)
Triazolam (Halcion)

**Not addictive**

***Antipsychotic***
Quetiapine (Seroquel)

***Antidepressant***
Amitriptyline (Elavil)
Trazodone (Oleptro)
Ramelteon (Rozerem)
Mirtazapine (Remeron)
Doxepin (Silenor)

# The algorithm