

Post-Traumatic Stress Disorder

A plain-English guide for you and your family

WHAT IS HAPPENING

When something terrifying happens — like a car crash, violence, war, or assault — most people feel shaken for a few days or weeks, then slowly get back to normal. But in PTSD, the brain cannot file the memory away as 'over.' Instead, the trauma memory gets stuck in the fear center of the brain (the amygdala, your brain's alarm bell), and it keeps ringing even when you are safe. So reminders — a sound, a smell, a place — trigger the same panic your body felt during the trauma, and it feels like it is happening all over again. You might have nightmares where your brain tries over and over to process what happened. You might avoid people, places, or even thoughts that remind you of the trauma because just thinking about it sets off the alarm. You might feel numb, guilty, or believe dark thoughts like 'I am broken' or 'the world is not safe,' because the thinking part of your brain (the prefrontal cortex, the front area that usually puts feelings in perspective) gets overwhelmed and cannot calm the fear center down. You stay on high alert — jumpy, tense, scanning for danger — because your body thinks the threat is still there. Sleep breaks because nightmares wake you up and the alarm never shuts off. None of this is weakness. It is your brain trying to protect you with a system that got stuck in overdrive. With the right therapy (especially trauma-focused talk therapy that helps your brain reprocess the memory) and sometimes medicine (like an SSRI antidepressant that steadies serotonin, a brain messenger that helps regulate mood and fear), the alarm can calm, the thinking brain can come back online, and the memory can finally become a memory instead of a constant threat.

What you might feel

- Intrusive memories or nightmares of the trauma
- Avoiding reminders of the trauma (people, places, conversations, or thoughts)
- Feeling constantly on edge or jumpy (hyperarousal)
- Trouble sleeping or staying asleep
- Feeling numb, detached, or cut off from others
- Negative thoughts about yourself or the world ('I'm broken,' 'nowhere is safe')
- Sudden anger or irritability

- Thoughts of harming yourself or ending your life

Call the doctor right away if...

- Thoughts of suicide or a plan to harm yourself
- Harming yourself or taking dangerous risks on purpose
- Hearing voices or seeing things that aren't there (psychosis)
- Unable to care for yourself (not eating, drinking, or leaving bed for days)
- Severe panic attacks that feel like a heart attack or make you pass out

What the care team will do

- Ask directly about suicidal thoughts using clear words ('Are you thinking of killing yourself?') and assess for a specific plan, means, and timeline at every visit
- Screen for alcohol and drug use with a validated tool like the AUDIT-C (Alcohol Use Disorders Identification Test) and connect patient to substance treatment before starting trauma therapy
- Teach the patient one grounding technique (like 5-4-3-2-1: name five things you see, four you touch, three you hear, two you smell, one you taste) to use during flashbacks
- Verify the patient has a safe, stable place to sleep tonight and every night; if homeless, contact social work for emergency shelter placement before discharge
- Educate that Post-Traumatic Stress Disorder is a brain injury (changes in the amygdala, hippocampus, and prefrontal cortex visible on brain scans), not weakness or being 'crazy,' and recovery takes 3 to 6 months of weekly therapy
- Review all current medications and ask specifically about nightmares; if nightmares occur more than twice weekly, notify provider to consider adding prazosin 1 mg at bedtime
- Schedule the first therapy appointment before the patient leaves and give a written card with the date, time, therapist name, and phone number; confirm the patient has transportation
- Teach family members that anger outbursts and emotional numbness are symptoms of brain changes, not personal rejection, and that recovery is possible with treatment

Medicines you may be given — and why

Sertraline (Zoloft)

Sertraline raises the level of serotonin (a brain messenger that steadies mood, sleep, and worry) by blocking the pump that normally sucks serotonin back out of the gap between nerve

cells. With more serotonin staying in the gap longer, the brain gradually calms overactive fear circuits and steadies emotional responses to reminders of the trauma.

Paroxetine (Paxil)

Paroxetine raises serotonin (a brain messenger that steadies mood and calms overactive fear) by blocking the pump that recycles serotonin back into nerve cells. More serotonin in the gap between brain cells gradually quiets the amygdala's alarm and helps the prefrontal cortex regain control over trauma responses.

Prazosin (Minipress)

Prazosin blocks alpha-1 receptors (docking sites for norepinephrine, the brain's main wake-up and alarm chemical) in the brain. Norepinephrine surges during REM sleep in PTSD and re-plays the trauma as vivid nightmares. By blocking these receptors, prazosin keeps the alarm chemical from hijacking dreams, so nightmares become less frequent and less terrifying.

Venlafaxine (Effexor XR)

Venlafaxine blocks the pumps that recycle both serotonin (a mood and sleep steadier) and norepinephrine (a focus and energy messenger) back into nerve cells. More of both chemicals stay in the gaps between brain cells, which calms overactive fear circuits and helps the prefrontal cortex regain control over trauma responses. It is used when an SSRI alone has not worked well enough.

****NOT recommended: Benzodiazepines (lorazepam, clonazepam, alprazolam)****

Benzodiazepines boost GABA (the brain's main brake pedal) to quiet anxiety fast. However, in PTSD they interfere with the brain's natural process of learning that a trigger is no longer dangerous. They also cause dependence, worsen depression, raise the risk of overdose (especially with opioids or alcohol), and make trauma therapy less effective. Current VA/DoD and APA guidelines say do NOT use them for PTSD.

Where this information comes from

- VA/DoD Clinical Practice Guideline for PTSD 2023
- American Psychiatric Association DSM-5-TR 2022
- Cochrane Review on PTSD treatments
- National Center for PTSD (U.S. Department of Veterans Affairs)

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