

PTSD and Trauma Symptoms

A plain-English guide for you and your family

WHAT IS HAPPENING

When someone lives through a terrifying event—combat, assault, a crash, or abuse—the brain can get stuck replaying that danger as if it is still happening right now. The amygdala (the brain's alarm bell) keeps ringing, the hippocampus (the part that time-stamps memories and files them away as 'past') stops working right, and the prefrontal cortex (the calm-down center that usually tells the alarm to stop) gets weaker. The result is intrusions: memories, nightmares, and flashbacks that crash in without warning. The person avoids anything that reminds them of the trauma—places, people, even thoughts—because avoidance feels safer. But avoidance actually teaches the brain the danger is still real, so dark thoughts, guilt, numbness, and mood swings set in. The body stays locked in red-alert mode: jumpy, tense, unable to relax or sleep. None of this is random or a character flaw; every symptom is the brain and body trying to survive a threat that is over. Trauma-focused therapy—like CBT for trauma, EMDR (a treatment that uses eye movements to reprocess stuck memories), or prolonged exposure (facing safe reminders until the fear fades)—helps the brain re-learn that the danger is past. Medication (often an SSRI like sertraline or paroxetine) can turn down the alarm volume. Social support, stable housing, and freedom from new trauma make healing possible; without them, even the best treatment struggles. PTSD is not weakness—it is a brain injury caused by overwhelming fear, and it can heal.

What you might feel

- Flashbacks or intrusive memories
- Nightmares or sleep problems
- Avoiding people, places, or things that remind you of the trauma
- Feeling numb, detached, or unable to enjoy things
- Being jumpy, easily startled, or always on edge
- Anger outbursts or irritability
- Trouble concentrating or remembering things
- Thoughts of hurting yourself or ending your life

Call the doctor right away if...

- Thoughts of suicide or plans to hurt yourself
- Severe dissociation (feeling completely disconnected from your body or reality)
- Psychotic symptoms like hearing voices or seeing things that are not there
- Inability to care for yourself (not eating, bathing, or getting out of bed)
- Violent behavior toward others

What the care team will do

- Complete suicide risk assessment using a validated tool like the Columbia Suicide Severity Rating Scale and create a written safety plan with the patient
- Establish a calm, predictable environment with controlled lighting, minimal noise, and clear explanations before any physical touch or procedures
- Screen for traumatic brain injury history, especially in patients with combat or assault trauma, using questions about loss of consciousness or confusion after head impact
- Assess current housing stability, food security, and safety from ongoing abuse or violence before focusing on trauma therapy
- Review all current medications and flag benzodiazepines like lorazepam or clonazepam for gradual discontinuation under provider supervision
- Document trauma nightmares separately from general insomnia, including frequency and content, to guide prazosin dosing
- Connect the patient with trauma-focused therapy resources and verify they understand PTSD is treatable with specific evidence-based therapies, not just medication
- Monitor blood pressure before and after prazosin doses, especially the first dose and any dose increases, as orthostatic low blood pressure (hypotension) can cause falls

Medicines you may be given — and why

Sertraline (Zoloft)

Sertraline raises serotonin—a brain messenger that steadies mood, sleep, and fear signals—by blocking the pump that normally sucks it back into the nerve ending. Over weeks, more serotonin sits in the gap between nerves, which slowly calms the amygdala (the brain's alarm center that flags danger) and strengthens the prefrontal cortex (the front of the brain that pumps the brakes on big feelings).

Paroxetine (Paxil)

Paroxetine raises serotonin—a brain messenger that steadies mood, sleep, and fear signals—by blocking the pump that normally sucks it back into the nerve ending. Over weeks, more serotonin sits in the gap between nerves, which slowly calms the amygdala (the brain's alarm center) and strengthens the prefrontal cortex (the part that puts the brakes on big feelings).

Prazosin (Minipress)

Prazosin blocks alpha-1 receptors—docking ports for norepinephrine (the brain's fight-or-flight chemical)—in the brain and blood vessels. By blocking these ports, prazosin turns down the surge of norepinephrine that triggers nightmares and night sweats, so you sleep through the night without terrifying dreams jolting you awake.

Venlafaxine (Effexor XR)

Venlafaxine raises both serotonin (a brain messenger that steadies mood and sleep) and norepinephrine (a messenger that sharpens focus and energy) by blocking the pumps that normally suck them back into the nerve ending. Over weeks, more of both messengers sit in the gap between nerves, which calms the amygdala's alarm and strengthens the prefrontal cortex's control over fear and flashback circuits.

Fluoxetine (Prozac)

Fluoxetine raises serotonin—a brain messenger that steadies mood, sleep, and fear signals—by blocking the pump that normally sucks it back into the nerve ending. Over weeks, more serotonin sits in the gap between nerves, which slowly calms the amygdala (the brain's alarm center) and strengthens the prefrontal cortex (the part that puts the brakes on big feelings).

Where this information comes from

- VA/DoD Clinical Practice Guideline for PTSD 2023
- American Psychiatric Association (DSM-5-TR)
- National Institute of Mental Health (NIMH)
- Cochrane Review on Psychological Therapies for PTSD

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