

Addressing Sleep Impairment in Treatment Guidelines for PTSD

TO THE EDITOR: We reviewed Dr. Germain's article (1) in the April issue with much interest. We would like to kindly correct Dr. Germain's statement that no treatment guidelines have proposed that the initial treatment for posttraumatic stress disorder (PTSD) should focus on sleep impairment. The PTSD algorithm of the Psychopharmacology Algorithm Project at the Harvard South Shore Program (2), published in 2011, provides treatment guidelines that support exactly the idea that sleep evaluation and treatment should be the first step in assessing and treating PTSD. Notably, the first reference in the Psychopharmacology Algorithm Project article is to previous research by Dr. Germain and colleagues (3).

From a psychopharmacological perspective, the availability of prazosin (4), which has demonstrated a much larger effect size than the selective serotonin reuptake inhibitors (SSRIs), a greater tolerability profile, and a shorter time to response, makes this approach possible. Many experts continue to promote SSRIs as a first-line treatment for this disorder, but the evidence—despite U.S. Food and Drug Administration approval of two SSRIs—remains not at all impressive (5, 6). SSRIs have a small effect size in ameliorating the range of PTSD symptoms, and they frequently exacerbate insomnia and nightmares. Furthermore, they often produce disabling sexual side effects.

For many patients, sleep fragmentation may exacerbate daytime PTSD symptoms (hypervigilance, avoidance, and reexperiencing), and these symptoms may improve when sleep improves (7). The importance of sleep in regulating trauma-related memories and emotions has significant clinical implications, suggesting that prioritized interventions to correct sleep disturbances may facilitate the psychotherapeutic processing of traumatic events.

References

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Response to Ticlea et al.

TO THE EDITOR: I wish to thank Ticlea et al. for correcting the statement that there was no available guideline for the treatment of sleep disturbances comorbid with posttraumatic stress disorder (PTSD). Drs. Bajor, Ticlea, and Osser (1) have indeed suggested sensible and evidence-based guidelines for the management of nightmares and insomnia as the first decision point in the pharmacological treatment of PTSD in adults. Specifically, they recommend the use of prazosin and trazodone for nightmares and insomnia, respectively. They also offer additional recommendations in case of nonresponse.

Similar efforts to guide the management of sleep disturbances comorbid with PTSD using cognitive-behavioral strategies, or with the combination of pharmacological and psychological treatments, are lacking. As noted in the original article (2) and by Ticlea et al., the restoration of consolidated sleep, through pharmacological or psychological treatments, is likely to play a critical role in providing the neural milieu necessary to facilitate sleep-dependent learning processes involved in PTSD recovery.

References

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Concomitant Use of Maintenance ECT and Vagus Nerve Stimulation for More Than 10 Years in Treatment-Resistant Depression

TO THE EDITOR: Vagus nerve stimulation (VNS) has been approved by the U.S. Food and Drug Administration as an adjunctive treatment for certain types of intractable epilepsy and treatment-resistant depression. Maintenance ECT is used for