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The Nuanced Nature of PTSD Treatment: CBT, Pharmacotherapy, Or A Balance of Both?

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ABSTRACT

Post-Traumatic Stress Disorder (PTSD) is a multifaceted psychiatric condition that necessitates tailored treatment approaches. This paper examines the effectiveness of Cognitive Behavioural Therapy (CBT) and pharmacotherapy in addressing various PTSD manifestations. CBT, through structured techniques like Prolonged Exposure (PE) therapy and Cognitive Processing Therapy (CPT), demonstrates long-term efficacy by fostering coping mechanisms and addressing cognitive distortions. Pharmacotherapy, including SSRIs, SNRIs, and prazosin, provides immediate symptom relief, especially for acute cases. However, the limitations of both methods underscore the importance of an integrated treatment approach. This paper concludes that combining CBT and pharmacotherapy offers the most effective strategy, addressing both immediate and long-term psychological needs while accommodating the diverse experiences of PTSD patients.

Key Words: PTSD, Treatment, Cognitive Behavioural Therapy, Pharmacotherapy

INTRODUCTION

According to APA (2022), Post-Traumatic Stress Disorder (PTSD) is a type of psychiatric disorder affecting individuals who have experienced or witnessed a traumatic event. It can significantly impact one's social, physical, mental, and spiritual well-being. These events, which can be emotionally and physically damaging, include warfare, acts of terrorism, sexual assault, natural disasters, intimate partner violence, and bullying. The main symptoms of PTSD include intrusive thoughts, such as flashbacks, hallucinations, and nightmares. The individual may also exhibit avoidance behaviour and experience changes in their physical and emotional state, which include irritability, trouble sleeping, outbursts of anger, and difficulty concentrating. Another key symptom is the shift in thinking and mood, i.e., self-doubting, hopelessness, etc. (WebMD, 2022). According to the National Center for PTSD, approximately 7–8% of individuals will develop PTSD in their lifetime. Certain groups are more susceptible to PTSD. For instance, research indicates a higher prevalence of PTSD among veterans compared to civilians. Women and minority groups also show increased vulnerability to the disorder (Golden Steps ABA, 2023). In fact, studies reveal that women are twice as likely as men to develop PTSD. Moreover, a significant rise in PTSD cases was observed during the COVID-19 pandemic across different populations: 15.45% among COVID-19 patients, 17.23% among healthcare professionals, and 17.34% among the general population (Yunitri et al., 2022). Facing PTSD can bring a multitude of challenges that affect various aspects of an individual's life. PTSD often exists alongside other mental health issues like anxiety, depression, substance abuse, etc. Each individual response to trauma is unique,

and recovery from it can be lengthy. Therefore, overcoming the complexities faced by PTSD requires professional help. Cognitive Behavioural Therapy (CBT) and pharmacotherapy are two distinct yet impactful strategies used for the treatment of PTSD. CBT assists individuals in understanding unhealthy thought processes and emotions that arise from experiencing trauma by exploring the underlying causes behind actions. CBT consequently helps minimize the intensity of these reactions (Skedel, 2021). On the other hand, pharmacotherapy involves the use of medication to mitigate symptoms of PTSD. In line with the aforementioned, this paper seeks to explore and address the following research question: To what extent do Cognitive Behavioural Therapy (CBT) and pharmacotherapy demonstrate effectiveness in treating various forms of PTSD?

The paper argues that while both CBT and pharmacotherapy have demonstrated effectiveness in treating PTSD, their relative suitability varies depending on the type of PTSD and individual patient needs, necessitating a nuanced, personalised approach to treatment.

Background and Problem Statement

As mentioned above, PTSD is a type of psychiatric disorder that occurs in people who have experienced or witnessed a traumatic event. Trauma or traumatic event refers to anything that can be emotionally or physically harmful or can even be life-threatening. It can manifest as a single event or as a chain of events, such as survival in a war zone or experiencing persistent abuse. It is essential to know that it is not necessary to experience the traumatic event directly; observing a traumatic incident can also lead to psychological consequences (Cleveland Clinic, 2023). PTSD is listed under the category of "Trauma and Stressor-Related Disorder" in DSM-5. To be formally diagnosed with PTSD, the individual must see a mental health professional who can diagnose the condition. The DSM-5 criteria specify that the symptoms must persist for more than a month and cause significant distress in daily functioning to receive a diagnosis (U.S. Department of Veterans Affairs, 2023).

PTSD can be further classified into different sub-groups. These classifications help in identifying the nature of PTSD in detail, as each individual experiences and reacts to trauma differently. Each type reflects a different duration, onset, and complexity of symptoms. The various types of PTSD are:

Acute PTSD (ASD): According to Fanai and Khan (2023), Acute Stress Disorder (ASD) was initially created to address acute stress reactions (ASRs) as they were often overlooked or wrongly labelled. The DSM-5 made suitable changes and then categorised ASD as a "Trauma and Stressor-related Disorder". ASD refers to a range of acute stress reactions that occur within three days to four weeks following the incident. If these symptoms persist beyond four weeks, then they are categorised as PTSD. Symptoms of ASD are psychological and behavioural stress responses, which include recurring nightmares, uncontrollable and distressing memories, irritability or anger outbursts, difficulty in concentration, and exaggerated response to loud noises, sudden movements or other stimuli (startle reflex), etc. The primary issue associated with ASD is the potential development of PTSD if it is left untreated (Cleveland Clinic, 2023a).

Chronic PTSD: Chronic PTSD is a type of PTSD where an individual experiences symptoms for a longer duration, usually exceeding three months following the traumatic event. The primary factor that helps in distinguishing chronic PTSD from other PTSDs is its long-lasting nature. Unlike ASD, chronic PTSD requires more extensive and therapeutic approaches for its treatment. Chronic PTSD can have a significant impact on one's life. One of its main symptoms is repeated reliving of the traumatic incident. This happens through upsetting memories, nightmares, or flashbacks. People with chronic PTSD often try to avoid reminders of their traumas and, therefore, stay away from certain people, situations, places, etc. This

avoidance and isolation lead to the development of loneliness and depression. Emotional numbing is another symptom of chronic PTSD, where the individual might struggle to feel or show emotions. This can impact their relations with their close ones and can create a sense of distance from others. Hyperarousal can also be seen as a symptom; people experiencing chronic PTSD may feel constantly on edge, which shows irritability, trouble focusing, and sleep issues. Physical problems like muscle tension and involuntary spasms due to a heightened state are also likely.

Complex PTSD: As defined by Psychology Today (2024), Complex PTSD is a type of stress disorder that includes symptoms that develop after experiencing severe and often repeated trauma. These types of traumatic events usually stem from a damaging relationship with caregivers or other adults during the childhood period, which can affect their ability to function as adults. It can also arise from situations like experiencing torture, being a refugee or an asylum seeker, being held in a concentration camp, or being a victim of slavery. Individuals who are experiencing complex PTSD find it hard to manage their anger and often make choices that result in harming themselves, struggle with low self-esteem, have trust issues, and face challenges in forming meaningful relationships. People with complex PTSD experience 'emotional flashbacks' in which the individual experiences intense feelings that they felt initially during the time of the traumatic incident. Dissociative symptoms like depersonalisation and physical symptoms like headaches, dizziness, and chest pains are also experienced, along with regular suicidal feelings (Mind, 2021).

Delayed-Onset PTSD: Delayed-onset PTSD is a type of PTSD where an individual does not develop symptoms for about six months after the traumatic event. In some cases, symptoms may develop after years or decades. It is estimated that almost a quarter of cases of PTSD might be delayed-onset (Tull, 2020). Cases of delayed-onset PTSD were found in a large number of soldiers during the 1980s, over a year after they had been home. It was reported that 39% of those who developed delayed-onset PTSD did not start showing symptoms until almost a year after combat. The most common incidents that result in developing delayed-onset PTSD are the loss of a loved one, being in a major accident, sexual, physical, or emotional abuse, and experiencing a natural disaster, a terrorist attack, or war. In contrast to other types of PTSD, delayed-onset PTSD is harder to diagnose (Brown, 2020).

PTSD is a multifaceted condition that requires tailored approaches for effective management, as its manifestations depend significantly on the trauma an individual has experienced. The disorder casts a long shadow over personal relationships, professional lives, and broader social dynamics. Symptoms such as hypervigilance, nightmares, and social withdrawal can strain even the most supportive family relationships, disrupting trust, intimacy, communication, and problem-solving within close circles. Professionally, individuals with PTSD often struggle with concentration and face significant challenges in maintaining productivity, impacting not only their own work performance but also their teams and workplaces.

The complexity of PTSD further extends to its treatment, as a one-size-fits-all approach fails to address the diverse needs of those affected. Cognitive Behavioral Therapy (CBT) is widely recognized as an effective intervention for many individuals, emphasizing the relationship between thoughts, feelings, and behaviors to develop effective coping strategies. However, not all patients respond equally to CBT, particularly those requiring more immediate relief from acute symptoms, who may benefit from pharmacotherapy. This duality in treatment approaches underscores the necessity of a nuanced and personalized understanding of PTSD management. Analyzing the relative efficacy of CBT and pharmacotherapy is crucial to identifying the most suitable pathways for different forms of PTSD,

paving the way for improved outcomes and recovery.

Analysis of Cognitive Behavioural Therapy (CBT) for PTSD

CBT is a well-known and effective treatment for various mental health issues like depression, anxiety disorders, eating disorders, PTSD, and substance abuse. Apart from that, CBT can also be used to treat physical conditions such as chronic pain, tinnitus, and rheumatism. It is recognised as a form of psychotherapy that emphasises tailored conversations between the patient and the mental health professional to help individuals achieve a deeper understanding of their thoughts, emotions, and behavioural patterns. In most cases, CBT might be the only form of treatment, but in some cases, it may be used alongside other therapies or medications. Many studies show that techniques used in CBT can bring about lasting changes. It serves as a powerful method for enhancing one's ability to manage stressful life circumstances (Mayo Clinic, 2025).

The foundations of CBT were laid in the 1950s and 1960s. During this period, behavior therapy emerged, which used exposure techniques based on classical and operant conditioning. Later, psychologists began to merge cognitive treatments with behaviour therapy to address negative thought patterns. Influential psychologists like Aaron Beck and Albert Ellis made significant contributions, creating rational emotive therapy and concentrating on cognitive therapy. In the 1980s, researchers started to develop methods that combined both approaches for effective results.

According to McLeod (2023), the CBT triangle, also referred to as the 'cognitive triangle', serves as a valuable structure or framework that provides us with the complex relationship between our thoughts, emotions, and behaviour. In this type of framework, one aspect influences the other, creating a dynamic interplay that shapes our mental health. Thoughts, situated at the top of the triangle, serve as the cognitive foundation. Cognitive distortions, also known as flawed thinking patterns, can significantly affect how individuals perceive and interpret their surroundings. These distortions include, all-or-nothing thinking (viewing situations in binary terms), catastrophizing (expecting the worst outcomes without evidence), mind reading (assuming to know other's thoughts without proof), emotional reasoning (making conclusion based on feelings not facts), labelling (defining oneself or others by a single trait or event), and personalization (blaming oneself for external events without a clear link). Based on our thoughts, we experience emotions (feelings), which are emotional responses that influence communication, reactions, and decision-making processes. While emotions can motivate positive actions, they may also lead to negative behaviors if not appropriately addressed. Recognizing and expressing feelings is essential for emotional well-being, as suppressing them can have counterproductive effects. Behaviors, on the other hand, are responses to internal or external stimuli. They are influenced by both thoughts and feelings, often serving as outward indicators of an individual's emotional state, especially when emotions are not verbally expressed. CBT seeks to modify maladaptive behaviors through techniques like behavioral activation, which encourages engagement in positive and rewarding activities, and gradual exposure, which helps individuals confront feared situations or behaviors in a controlled and systematic manner (Locker, 2023).

As briefly mentioned before, CBT combines two psychotherapeutic approaches, i.e., cognitive therapy and behavioural therapy.

- **Cognitive therapy** revolves around comprehending one's thoughts, beliefs, and expectations. Its objective is to identify and modify harmful and misleading beliefs. Cognitive therapy provides ways to replace negative thoughts with more realistic and positive ones, helping people think more clearly and manage their thoughts better.

- **Behavioural therapy** originates from the idea of "behaviourism." It examines the impact of specific behaviours and how these behaviours affect an individual's life. This approach aims to change these behaviours to create better outcomes.

CBT has emerged as a highly effective treatment approach for individuals struggling with PTSD. By employing various techniques, CBT aims to address the underlying thought patterns and behaviours associated with the trauma. There are specific CBT techniques tailored to treat PTSD, offering strategies that can facilitate healing and recovery. Such techniques are:

Prolonged Exposure Therapy (PE): According to the American Psychological Association (2017), PE is a form of CBT that encourages patients to encounter their trauma-related thoughts, feelings, and situations in a safe and controlled environment. The goal of PE therapy is to reduce avoidance behaviour by gradually facing feared memories and triggers. The potential risk in participating in PE includes mild unease when trying new activities and discussing memories related to the traumatic incident. This unease is typically for a shorter duration, and over time, patients feel better with continuous engagement in PE. The treatment typically lasts for about 3 months, with weekly sessions. The therapist starts with an overview of the treatment and the patient's history, followed by psychoeducation and anxiety management techniques. After the initial assessment, exposure begins with using techniques like imaginal and vivo methods, with the pace set by the patient to ensure a safe therapeutic environment. One early study from 2018 investigates the effects of PE therapy in adults with chronic complex PTSD who had not responded to other treatments. The findings indicated that PE therapy reduces PTSD symptoms in 71% of the participants. Another study published in 2019 showed that PE therapy led to a rapid decrease in suicidal ideations among adolescents suffering from PTSD related to sexual assault (Lockett, 2024).

Cognitive processing therapy (CPT): CPT focuses on identifying and challenging distorted beliefs and thought patterns related to trauma. It helps individuals understand how the trauma has impacted their feelings and thoughts. Like PE therapy, CPT provides information about PTSD and helps patients confront unpleasant memories and thoughts associated with the traumatic event. However, unlike CPT, PE therapy does not explicitly focus on addressing distorted thought patterns or cognitive errors. CPT can be helpful for people who have experienced trauma in various situations, including combat veterans, survivors of sexual assault, and childhood abuse. Research has shown that CPT is effective in reducing negative cognitions related to PTSD. It may even create positive impacts in areas not specially targeted during therapy. For instance, one study suggested that adults engaged in CPT had a greater reduction in heavy drinking than those opting for a different type of CBT. This makes CPT useful when trauma co-occurs with substance abuse issues (Cherry, 2024).

Dialectical behavioural therapy (DBT): As per Laub (2022), while DBT is traditionally used for borderline personality disorder (BPD), it has also been helpful for people diagnosed with PTSD and experiencing severe emotional dysregulation. It is an evidence-based therapy that uses dialectics (or opposites) to target and replace maladaptive behaviour and thought patterns. DBT combines cognitive behavioural techniques like mindfulness, distress tolerance, emotional regulation, interpersonal effectiveness, exposure and response prevention, opposite action, validation, and self-acceptance to treat PTSD.

Acceptance and commitment therapy (ACT): ACT aims to help individuals confront and manage emotions, thoughts, and bodily sensations that are negative and unwanted (Glasofer, 2024). It's common for

both the patient and the therapist to feel the urge to avoid such unwanted emotions. However, ACT considers avoidance to be problematic because trying to escape difficult situations can lead to an increase in a sense of failure; avoidance doesn't help in overcoming such negative emotion, and this can result in tampering with an individual's ability to fully engage in meaningful activities and relationships. ACT does not aim at reducing unwanted thoughts, but rather it aims at making individuals accept their past traumas and acknowledging negative thoughts while still pursuing a fulfilling life (Lupcho & Crosby, 2023). This is accomplished through different processes like mindfulness, willingness, connection to personal value, committed action, diffusion, and observing self.

Despite the many benefits of CBT, it is not without challenges. One significant drawback is the reliance on patient commitment. Individuals who exhibit avoidance behaviours may find it difficult to engage in CBT fully. Building trust and establishing therapeutic alliances is crucial. The structured nature of CBT is also not suitable for patients who prefer a more open-ended conversation. Additionally, CBT may not be equally effective for all types of PTSD, particularly complex PTSD. Individuals who are experiencing complex PTSD may present with a range of symptoms and complications that require more nuanced approaches that are beyond CBT. For such patients, other methods are more effective, including Schema Therapy or Eye Movement Desensitization and Reprocessing (EMDR) (Higuero, 2019).

While CBT techniques like Prolonged Exposure Therapy (PE), Cognitive Processing Therapy (CPT), dialectical behaviour therapy (DBT), and acceptance and commitment therapy (ACT) offer powerful tools for treating PTSD, therapists must alter the approaches to meet the requirements of each patient. By analysing the strengths and weaknesses of each technique, professionals can create more effective treatments.

The Role of Pharmacotherapy in PTSD - Insights and Comparisons with CBT

Pharmacotherapy is an essential approach in the treatment of mental health disorders that entails the use of a variety of medications to reduce symptoms, improve daily functioning, and support long-term recovery (World Health Organization, 2009). Over the years, pharmacotherapy has evolved through various and extensive research and clinical experiences to effectively address chemical imbalances in the brain that contribute to the disorders. Medications can include antidepressants, antipsychotics, mood stabilizers, etc., depending upon the diagnosis. The goal of pharmacotherapy is not only to reduce the intensity of the symptoms but also to enhance the patient's ability to engage in therapeutic processes, such as psychotherapy. It allows patients to benefit fully from therapy and other modes of treatment.

The common categories of pharmacotherapy for PTSD include the following:

Selective Serotonin Reuptake Inhibitors (SSRIs): According to Healthwise (2014), SSRIs are considered first-line interventions for PTSD. The chemicals in our brain play a crucial role in controlling our emotions and overall well-being. In conditions like PTSD, individuals often experience an imbalance in neurotransmitters, specifically serotonin. Serotonin contributes to feelings of happiness, stability, and emotional resilience. Healthcare professionals usually prescribe SSRIs to combat these low levels of neurotransmitters. Several studies have shown positive results of SSRIs in improving symptoms of non-combat related PTSD.

Serotonin-Norepinephrine Reuptake Inhibitors (SNRIs): SNRIs are used to reduce depressive symptoms. They block the reabsorption of the neurotransmitters serotonin and norepinephrine in the brain, making more of these chemicals available to ease depressive symptoms (Mayo Clinic,

2024). SSRIs and SNRIs are similar in functioning, but neither is inherently better than the other. SSRIs are usually prescribed first since they tend to have fewer side effects, but this varies from individual to individual (Jones, 2025).

Prazosin: Prazosin is an alpha-1 antagonist (also called minipress) approved initially for treating high blood pressure, but has been effective in treating PTSD. It manages sleep disturbances and nightmares by blocking responsiveness to norepinephrine, a chemical that affects the 'fight or flight' response to real and perceived threats. It is only effective in individuals experiencing PTSD, it does not reduce nightmares otherwise. As per research, it can improve sleep quality and reduce the severity of PTSD within eight weeks (Peters, 2025).

Benzodiazepines: Benzodiazepines are considered a common yet controversial treatment for PTSD. Some mental health professionals argue that it can help in reducing insomnia, anxiety, and irritability associated with PTSD, while others say that it may worsen or prolong the condition (GUINA et al., 2015). Scientifically, Benzodiazepines act on the brain's gamma-aminobutyric acid (GABA), which regulates nervous system activities. Increasing GABA produces a calming effect (Griffin et al., 2013). They can be a short-term tool for managing PTSD as they offer quick relief from anxiety and sleep disturbances. However, individuals who rely on benzodiazepines can experience memory problems and cognitive decline, get addicted to them, and experience a paradoxical effect. Pharmacotherapy can indeed be effective for treating specific types of PTSD. Medications can provide immediate symptom relief, helping patients who experience intense distress. However, it does not address the underlying cognitive dysfunction and thought patterns that contribute to PTSD. One of the main advantages of CBT over pharmacotherapy is that it focuses on long-term pain management. Studies have shown that patients who undergo CBT for PTSD are less likely to experience the symptoms again as they acquire the ability to manage them. CBT also targets the root cause of the disorder by addressing thought patterns and behaviours. This approach helps patients in acknowledging their symptoms and gaining greater control over their pain. Medication, on the other hand, manages surface-level symptoms without addressing cognitive and emotional factors.

That being said, CBT is not always as effective, especially for patients who are experiencing severe symptoms and are facing difficulties in engaging in therapies in the initial stages of recovery. Such severe symptoms of PTSD can lead to avoidance behaviours, making it difficult for individuals to participate in therapeutic processes fully. This highlights the need for a balanced approach. In such cases, pharmacotherapy can be utilised to provide immediate symptom relief, helping individuals manage their symptoms and engage in subsequent CBT plans. Therefore, combining both pharmacotherapy and CBT can enhance effectiveness and address both the symptoms and the cognitive processes, and therefore, professionals can tailor treatment plans to meet both long-term and short-term needs of PTSD patients.

CONCLUSION

PTSD is a complex psychiatric disorder arising from traumatic experience, which significantly impacts an individual's social, emotional, and psychological well-being. The complex nature of PTSD requires various personalised treatment approaches to deal with it effectively. Both CBT and pharmacotherapy emerge as significant treatment options, each offering distinct limitations and advantages.

CBT serves as an effective therapeutic tool to deal with PTSD. It emphasises a relation between thoughts, emotions, and behaviours. It also creates awareness of distorted thought patterns and avoidance behaviours, and further helps individuals to modify their reactions to trauma depending upon the type of PTSD they are experiencing. Techniques like PE therapy and CPT focus on common

symptoms of PTSD, allowing patients to confront their traumas in a safe environment. Due to its structured approach, CBT is effective in long-lasting improvement and helps establish coping strategies that mitigate symptoms. However, its reliance on sustained commitment can pose challenges for individuals with avoidance behaviors or complex PTSD, necessitating further personalization.

Pharmacotherapy, on the other hand, provides immediate relief from acute symptoms, making it invaluable in the early stages of treatment. Medications like SSRIs and SNRIs address distressing symptoms, while prazosin offers targeted relief for sleep disturbances. Yet, pharmacotherapy often lacks the capacity to address the underlying cognitive distortions central to PTSD, underscoring the need for integration with therapeutic interventions like CBT.

In conclusion, the effectiveness of PTSD treatment lies in recognizing the unique needs of each individual. A combination of CBT and pharmacotherapy represents the most comprehensive approach, effectively addressing both immediate symptom relief and long-term psychological resilience. This tailored strategy is particularly effective for individuals with severe trauma or complex symptomology.

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