The first line of treatment for PTSD should be an individual, manualized trauma-focused psychotherapy. Trauma-focused psychotherapies impart greater change and longer lasting improvements in the core symptoms of PTSD when compared to pharmacotherapies. However, when unavailable or not preferred by the patient, pharmacotherapy or individual trauma-focused psychotherapy are still recommended as viable alternatives.

### GENERAL GUIDELINES AND PREVENTION

#### GENERAL CLINICAL MANAGEMENT
1. Engage patients in shared decision making (SDM), which includes educating patients about effective treatment options.
2. For patients with PTSD who are treated in primary care, use collaborative care interventions that facilitate active engagement in evidence-based treatments.

#### PREVENTION OF PTSD
- Insufficient evidence to recommend trauma-focused psychotherapies in the immediate post-trauma period
- Patients with acute stress disorder (ASD): Use an individual trauma-focused psychotherapy that includes a primary component of exposure and/or stimulus restructuring
- Insufficient evidence to recommend pharmacotherapy

#### DIAGNOSIS AND ASSESSMENT OF PTSD
- Perform periodic screening for PTSD using validated measures such as Primary Care PTSD Screen (PC-PTSD) or the PTSD Checklist (PCL)
- Patients with suspected PTSD: Diagnostic evaluation should include determination of DSM criteria, acute risk of harm to self or others, functional status, medical history and treatment history, and relevant family history
- Patients with a diagnosis of PTSD: Use a quantitative self-report measure of PTSD severity, such as the PCL-5, in initial treatment planning and to monitor treatment progress

### TREATMENT OF PTSD

#### PTSD and co-occurring conditions: Presence of co-occurring disorders:
- Insufficient evidence to recommend for or against:
- The first-line of treatment for PTSD should be an individual, manualized trauma-focused psychotherapy. Trauma-focused psychotherapies impart greater change and longer lasting improvements in the core symptoms of PTSD when compared to pharmacotherapies. However, when unavailable or not preferred by the patient, pharmacotherapy or individual trauma-focused psychotherapy are still recommended as viable alternatives.

#### OTHER TREATMENT FOR PTSD?
- Insufficient evidence to recommend for or against:
  - Psychosocial treatments (PSY) should not prevent patients from receiving PTSD treatment
  - Patients with sleep problems: undergo independent sleep assessment, particularly after patients pre-date PTSD onset or remain following successful completion of a course of treatment

### PHARMACOTHERAPY
- No evidence to recommend use of medication in the early period following trauma to prevent development of PTSD
- Initial pharmaceutical approach should include a first-line monotherapy trial of sufficient time for response
- Providers should monitor patients for outcomes and side effects
- Providers should consider patient’s response or side effect history, and comorbidities, when choosing medication and dosage
- Selective serotonin reuptake inhibitors (SSRIs) and serotonin noradrenaline reuptake inhibitors (SNRIs) are the only medication classes strongly recommended
- Recommended SSRIs include Fluoxetine, Paroxetine, or Sertraline
- Recommended SNRI is Venlafaxine
- Medications not suggested/recommended:
  - Anticonvulsants or atypical antipsychotics as a monotherapy
  - Divalproex
  - Oxybutynin
  - Haloperidol
  - Benzodiazepines
  - Ketamine
  - Hypoglycemics
  - D-cycloserine
- CBD is not recommended given lack of evidence, known adverse effects, and associated risks

### PSYCHOTHERAPY
- Empirically supported trauma-focused psychotherapies use cognitive, emotional, or behavioral techniques to facilitate processing a traumatic experience
- Include 8-16 sessions with the following core techniques:
  - Exposure to traumatic images or memories through narrative or internet-based cognitive behavioral therapy (iCBT)
  - Exposure to avoided or triggering cues in vivo or through imaginal reexposure
- Effective trauma-focused approaches for treatment of PTSD:
  - Prolonged Exposure (PE)
  - Cognitive Processing Therapy (CPT)
  - Eye Movement Desensitization and Reprocessing (EMDR)
  - Brief Eclectic Psychotherapy (BEP)
  - Narrative Exposure Therapy (NFT)
- Less evidence to support, but better than receiving no treatment:
  - Stress Inoculation Training (SIT)
  - Present-Centered Therapy (PCT)
  - Interpersonal Psychotherapy (IPT)
  - Group therapy
  - Internet-based cognitive behavioral therapy (CBT)

### CLINICAL SUPPORT TOOLS FOR PROVIDERS AND PATIENTS

#### Patient Guide
- A quick reference for providers that summarizes the CPG
- Pocket Card
- Manual guide to help providers access and diagnose PTSD
- Online resources and tools to treat PTSD in-viva, in-vitro, and online

#### Family Guide
- Provides detailed information about PTSD
- Brochure that describes symptoms and treatment options and offers healthy coping strategies and resources for family members of those diagnosed with PTSD

#### Pocket Guide
- A quick reference for providers that summarizes the CPG
- Patient Summary
- Clinician Summary
- System-wide goal of developing evidence-based guidelines is to improve the patient’s health
- Current PTSD CPG updated in 2017 by the VA/DoD Evidence-Based Practice Work Group
- A revised Framework to Assess and Treat Patients with Acute Stress Disorder/Posttraumatic Stress Disorder (ASD and PTSD)
- The first line of treatment for PTSD should be an individual, manualized trauma-focused psychotherapy. Trauma-focused psychotherapies impart greater change and longer lasting improvements in the core symptoms of PTSD when compared to pharmacotherapies. However, when unavailable or not preferred by the patient, pharmacotherapy or individual trauma-focused psychotherapy are still recommended as viable alternatives.

#### CLINICAL SUPPORT TOOLS FOR PROVIDERS

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- Pocket card
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- Clinician summary
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#### FOR MORE INFORMATION

- Download the clinical practice guideline and clinical support tools

#### ALTERNATIVE TREATMENTS

- Insufficient evidence to recommend for or against:
  - Repetitive transcranial magnetic stimulation (rTMS)
  - Electroconvulsive therapy (ECT)
  - Hyperbaric oxygen therapy (HBOT)
  - Vagal nerve stimulation (VNS)
- Insufficient evidence to recommend as primary treatment:
  - Acupuncture
  - Meditation/yoga
  - Yoga
  - Mindfulness meditation

#### WHAT ABOUT PRAZOSIN?
- Prazosin is not recommended given lack of evidence, known adverse effects, and associated risks

### IN THE U.S. ADULT POPULATION

#### PTSD prevalence rates of 6.1% (lifetime prevalence) and 4.7% (current prevalence) per findings from Wave 3 of National Epidemiologic Survey on Alcohol and Related Conditions to assist health care providers of algorithms and recommendations for treating patients diagnosed with PTSD

#### In Department of Defense (DoD)
- Similar prevalences found by service, branch, or rank adjusted for combat exposure (Ramchand et al., 2015)
- Combat exposure is the strongest predictor of mental health problems among those deployed to Iraq and Afghanistan

#### In Department of Veterans Affairs (VA)
- Precise PTSD prevalence estimates in the current population of U.S. Veterans overall have yet to be established
- A recent survey of a nationally representative U.S. Veteran sample found lifetime 6.1% and 5% current PTSD prevalence rates (Kikel et al., 2014)

#### PREVENTION OF PTSD

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