



# Posttraumatic Stress Disorder and Acute Stress Disorder Pocket Guide



Department of Veterans Affairs and Department of Defense employees who use this information are responsible for considering all applicable regulations and policies throughout the course of care. Every health care professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation.



## Pocket Guide Tabs

This pocket guide references content and considerations from sections and algorithms within the 2017 Department of Veterans Affairs (VA)/Department of Defense (DoD) Clinical Practice Guideline (CPG) for the Management of Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) – hereby referred to as the 2017 PTSD CPG – which is designed to assist providers in managing or co-managing patients with PTSD and related conditions such as acute stress reaction (ASR) and combat and operational stress reaction (COSR).

<b>Tab 1</b>	<b>Clinical Algorithms</b>
<b>Tab 2</b>	<b>General Clinical Management</b>
<b>Tab 3</b>	<b>ASR/COSR and ASD</b>
<b>Tab 4</b>	<b>Assessment and Diagnosis of PTSD</b>
<b>Tab 5</b>	<b>Prevention of PTSD</b>
<b>Tab 6</b>	<b>Treatment of PTSD</b>
<b>Tab 7</b>	<b>Treatment of PTSD with Co-occurring Conditions</b>
<b>Tab 8</b>	<b>Medication Tables</b>
<b>Tab 9</b>	<b>References and Resources</b>

NOTE: The recommendations in the 2017 PTSD CPG and this pocket guide are intended to provide information and assist in decision making. They are not intended to define a standard of care and should not be construed as one. Additionally, they should not be interpreted as prescribing an exclusive course of treatment.

# Introduction

Since the release of the 2010 VA/DoD CPG for the Management of Post-Traumatic Stress, a growing body of research has expanded the general knowledge and understanding of PTSD and other stress-related disorders, such as ASD and other acute reactions to trauma. Improved recognition of the complex nature of ASR, ASD and PTSD has led to the adoption of new or refined strategies to manage and treat patients with these conditions.

Consequently, a recommendation to update the 2010 PTSD CPG was initiated in 2015. The updated 2017 PTSD CPG is based on evidence published between March 2009 and March 2016 and includes objective, evidence-based information on the management of PTSD and related conditions. It is intended to assist health care providers in all aspects of patient care, including, but not limited to, diagnosis, treatment and follow-up.

## Overview

This pocket guide is a quick reference tool created for general and specialty health care providers who manage treatment services for patients with PTSD or ASD in VA or DoD health care settings. The pocket guide was developed directly from the 2017 VA/DoD CPG for the Management of PTSD and ASD. The CPG and associated pocket guide are not intended as a standard of care and should not be used as such. Standards of care are determined on the basis of all clinical data available for an individual case and are subject to change as scientific knowledge and technology advances and patterns evolve. There is variation among state regulations and the guideline does not cover the variety of ever-changing state regulations that may be pertinent. The ultimate judgment regarding a particular clinical procedure or treatment course must be made by the individual clinician in light of the patient's clinical presentation, patient preferences and the available diagnostic and treatment options. VA and DoD employees who use this information are responsible for considering all applicable regulations and policies throughout the course of care and patient education.

**For more comprehensive information, please refer to the full-length CPG, available at: <https://www.healthquality.va.gov/guidelines/MH/ptsd/> and <https://www.qmo.amedd.army.mil/pguide.htm>**

## Target audience

The target audience is VA and DoD health care practitioners, including primary care physicians, nurse practitioners, physician assistants, psychiatrists, psychologists, social workers, nurses, pharmacists, chaplains, addiction counselors and others involved in the care of service members or veterans with PTSD or ASD.

## Target patient population

The target population includes adults (18 or older) with PTSD or ASD who are treated in any VA or DoD clinical setting.

## Contraindications

This CPG is not intended for and does not provide recommendations for the management of PTSD or ASD in children or adolescents.

## Goals

The CPG and accompanying pocket guide are intended to provide health care providers with a framework by which to evaluate, treat and manage the individual needs and preferences of patients with PTSD and ASD, thereby leading to improved clinical outcomes.

Goals are to:

- Enhance assessment of the patient's condition and determine the best treatment method in collaboration with the patient and, when possible and desired, the patient's family and caregivers
- Optimize the patient's health outcomes and improve quality of life
- Minimize preventable complications and morbidity
- Emphasize the use of patient-centered care

## CPG Recommendations

The following recommendations were made using a systematic approach per the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach (see 2017 PTSD CPG Appendix A for complete explanation of the evidence review methodology).

Recommendations were scaled as follows: strong for, weak for, not applicable (N/A), strong against or weak against. Recommendations were also categorized to account for the various ways in which they could have been updated from the 2010 PTSD CPG. **Amended** (7 total) refers to recommendations from the 2010 PTSD CPG that were carried forward to the updated 2017 PTSD CPG where the evidence has been reviewed and a minor amendment has been made. **New – added** (8 total) refers to new recommendations following review of the evidence. **New – replaced** (26 total) refers to recommendations from the 2010 PTSD CPG that have been carried over to the updated 2017 PTSD CPG and changed following review of the evidence.

#	Recommendation	Strength	Category
<b>A. General Clinical Management</b>			
1.	We recommend engaging patients in shared decision making (SDM), which includes educating patients about effective treatment options.	Strong For	Amended
2.	For patients with PTSD who are treated in primary care, we suggest collaborative care interventions that facilitate active engagement in evidence-based treatments.	Weak For	<b>New</b> (replaced)
<b>B. Diagnosis and Assessment of PTSD</b>			
3.	We suggest periodic screening for PTSD using validated measures such as the Primary Care PTSD Screen (PC-PTSD) or the PTSD Checklist (PCL).	Weak For	Amended

#	Recommendation	Strength	Category
4.	For patients with suspected PTSD, we recommend an appropriate diagnostic evaluation that includes determination of Diagnostic and Statistical Manual of Mental Disorders (DSM-5) criteria, acute risk of harm to self or others, functional status, medical history, past treatment history and relevant family history. A structured diagnostic interview may be considered.	Strong For	Amended
5.	For patients with a diagnosis of PTSD, we suggest using a quantitative self-report measure of PTSD severity, such as the PTSD Checklist for DSM-5 (PCL-5), in the initial treatment planning and to monitor treatment progress.	Weak For	Amended

### C. Prevention of PTSD

#### a. Selective Prevention of PTSD

6.	For the selective prevention of PTSD, there is insufficient evidence to recommend the use of trauma-focused psychotherapy or pharmacotherapy in the immediate post-trauma period.	N/A	<b>New</b> (replaced)
----	---	-----	--------------------------

#### b. Indicated Prevention of PTSD and Treatment of ASD

7.	For the indicated prevention of PTSD in patients with ASD, we recommend an individual trauma-focused psychotherapy that includes a primary component of exposure and/or cognitive restructuring.	Strong For	<b>New</b> (replaced)
----	--	------------	--------------------------

#	Recommendation	Strength	Category
8.	For the indicated prevention of PTSD in patients with ASD, there is insufficient evidence to recommend the use of pharmacotherapy.	N/A	<b>New</b> (replaced)

## D. Treatment of PTSD

### a. Treatment Selection

9.	We recommend individual, manualized trauma-focused psychotherapy (see Recommendation 11) over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD.	Strong For	<b>New</b> (added)
10.	When individual trauma-focused psychotherapy is not readily available or not preferred, we recommend pharmacotherapy (see Recommendation 17) or individual non-trauma-focused psychotherapy (see Recommendation 12). With respect to pharmacotherapy and non-trauma-focused psychotherapy, there is insufficient evidence to recommend one over the other.	Strong For	<b>New</b> (added)

#	Recommendation	Strength	Category
<b>b. Psychotherapy</b>			
11.	For patients with PTSD, we recommend individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include prolonged exposure (PE), cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, brief eclectic psychotherapy (BEP), narrative exposure therapy (NET) and written narrative exposure.	Strong For	<b>New</b> (replaced)
12.	We suggest the following individual, manualized non-trauma-focused therapies for patients diagnosed with PTSD: stress inoculation training (SIT), present-centered therapy (PCT) and interpersonal psychotherapy (IPT).	Weak For	<b>New</b> (replaced)
13.	There is insufficient evidence to recommend for or against psychotherapies that are not specified in other recommendations, such as dialectical behavior therapy (DBT), skills training in affect and interpersonal regulation (STAIR), acceptance and commitment therapy (ACT), seeking safety and supportive counseling.	N/A	<b>New</b> (replaced)
14.	There is insufficient evidence to recommend using individual components of manualized psychotherapy protocols over or in addition to the full therapy protocol.	N/A	<b>New</b> (added)

#	Recommendation	Strength	Category
15.	We suggest manualized group therapy over no treatment. There is insufficient evidence to recommend using one type of group therapy over any other.	Weak For	<b>New</b> (replaced)
16.	There is insufficient evidence to recommend for or against trauma-focused or non-trauma-focused couples therapy for the primary treatment of PTSD.	N/A	Amended

### c. Pharmacotherapy

17.	We recommend sertraline, paroxetine, fluoxetine or venlafaxine as monotherapy for PTSD for patients diagnosed with PTSD who choose not to engage in or are unable to access trauma-focused psychotherapy.	Strong For	<b>New</b> (replaced)
18.	We suggest nefazodone, imipramine or phenelzine as monotherapy for the treatment of PTSD if recommended pharmacotherapy (see Recommendation 17), trauma-focused psychotherapy (see Recommendation 11) or non-trauma-focused psychotherapy (see Recommendation 12) are ineffective, unavailable or not in accordance with patient preference and tolerance.  NOTE: Nefazodone and phenelzine have potentially serious toxicities and should be managed carefully.	Weak For	<b>New</b> (replaced)

#	Recommendation	Strength	Category
19.	We suggest against treatment of PTSD with quetiapine, olanzapine and other atypical antipsychotics (except for risperidone, which is a Strong Against, see Recommendation 20), citalopram, amitriptyline, lamotrigine or topiramate as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks.	Weak Against	<b>New</b> (replaced)
20.	We recommend against treating PTSD with divalproex, tiagabine, guanfacine, risperidone, benzodiazepines, ketamine, hydrocortisone or D-cycloserine as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks.	Strong Against	<b>New</b> (replaced)
21.	We recommend against treating PTSD with cannabis or cannabis derivatives due to the lack of evidence for their efficacy, known adverse effects and associated risks.	Strong Against	<b>New</b> (added)
22.	There is insufficient evidence to recommend for or against monotherapy or augmentation therapy for the treatment of PTSD with eszopiclone, escitalopram, bupropion, desipramine, doxepin, D-serine, duloxetine, desvenlafaxine, fluvoxamine, levomilnacipran, mirtazapine, nortriptyline, trazodone, vilazodone, vortioxetine, buspirone, hydroxyzine, cyproheptadine, zaleplon and zolpidem.	N/A	<b>New</b> (replaced)

#	Recommendation	Strength	Category
<b>d. Augmentation Therapy</b>			
23.	We suggest against the use of topiramate, baclofen or pregabalin as augmentation treatment of PTSD due to insufficient data and/or known adverse effect profiles and associated risks.	Weak Against	<b>New</b> (replaced)
24.	We suggest against combining exposure therapy with D-cycloserine in the treatment of PTSD outside of the research setting.	Weak Against	<b>New</b> (added)
25.	We recommend against using atypical antipsychotics, benzodiazepines and divalproex as augmentation therapy for the treatment of PTSD due to low quality evidence or the absence of studies and their association with known adverse effects.	Strong Against	<b>New</b> (replaced)
26.	There is insufficient evidence to recommend the combination of exposure therapy with hydrocortisone outside of the research setting.	N/A	<b>New</b> (added)
27.	There is insufficient evidence to recommend for or against the use of mirtazapine in combination with sertraline for the treatment of PTSD.	N/A	<b>New</b> (replaced)
<b>e. Prazosin</b>			
28a.	For global symptoms of PTSD, we suggest against the use of prazosin as mono- or augmentation therapy.	Weak Against	<b>New</b> (replaced)

#	Recommendation	Strength	Category
28b.	For nightmares associated with PTSD, there is insufficient evidence to recommend for or against the use of prazosin as mono- or augmentation therapy.	N/A	<b>New</b> (replaced)

#### f. Combination Therapy

29.	In partial- or non-responders to psychotherapy, there is insufficient evidence to recommend for or against augmentation with pharmacotherapy.	N/A	<b>New</b> (replaced)
30.	In partial- or non-responders to pharmacotherapy, there is insufficient evidence to recommend for or against augmentation with psychotherapy.	N/A	<b>New</b> (replaced)
31.	There is insufficient evidence to recommend for or against starting patients with PTSD on combination pharmacotherapy and psychotherapy.	N/A	<b>New</b> (added)

#### g. Non-pharmacologic Biological Treatments

32.	There is insufficient evidence to recommend for or against the following somatic therapies: repetitive transcranial magnetic stimulation (rTMS), electroconvulsive therapy (ECT), hyperbaric oxygen therapy (HBOT), stellate ganglion block (SGB) or vagal nerve stimulation (VNS).	N/A	<b>New</b> (replaced)
-----	---	-----	--------------------------

#	Recommendation	Strength	Category
<b>h. Complementary and Integrative Treatments</b>			
33.	There is insufficient evidence to recommend acupuncture as a primary treatment for PTSD.	N/A	<b>New</b> (replaced)
34.	There is insufficient evidence to recommend any complementary and integrative health (CIH) practice, such as meditation (including mindfulness), yoga and mantram meditation, as a primary treatment for PTSD.	N/A	<b>New</b> (replaced)
<b>i. Technology-based Treatment Modalities</b>			
35.	We suggest internet-based cognitive behavioral therapy (iCBT) with feedback provided by a qualified facilitator as an alternative to no treatment.	Weak For	<b>New</b> (replaced)
36.	We recommend using trauma-focused psychotherapies that have demonstrated efficacy using secure video conferencing (VTC) modality when PTSD treatment is delivered via VTC.	Strong For	Amended
<b>E. Treatment of PTSD with Co-occurring Conditions</b>			
37.	We recommend that the presence of co-occurring disorder(s) not prevent patients from receiving other VA/DoD guideline-recommended treatments for PTSD.	Strong For	<b>New</b> (added)

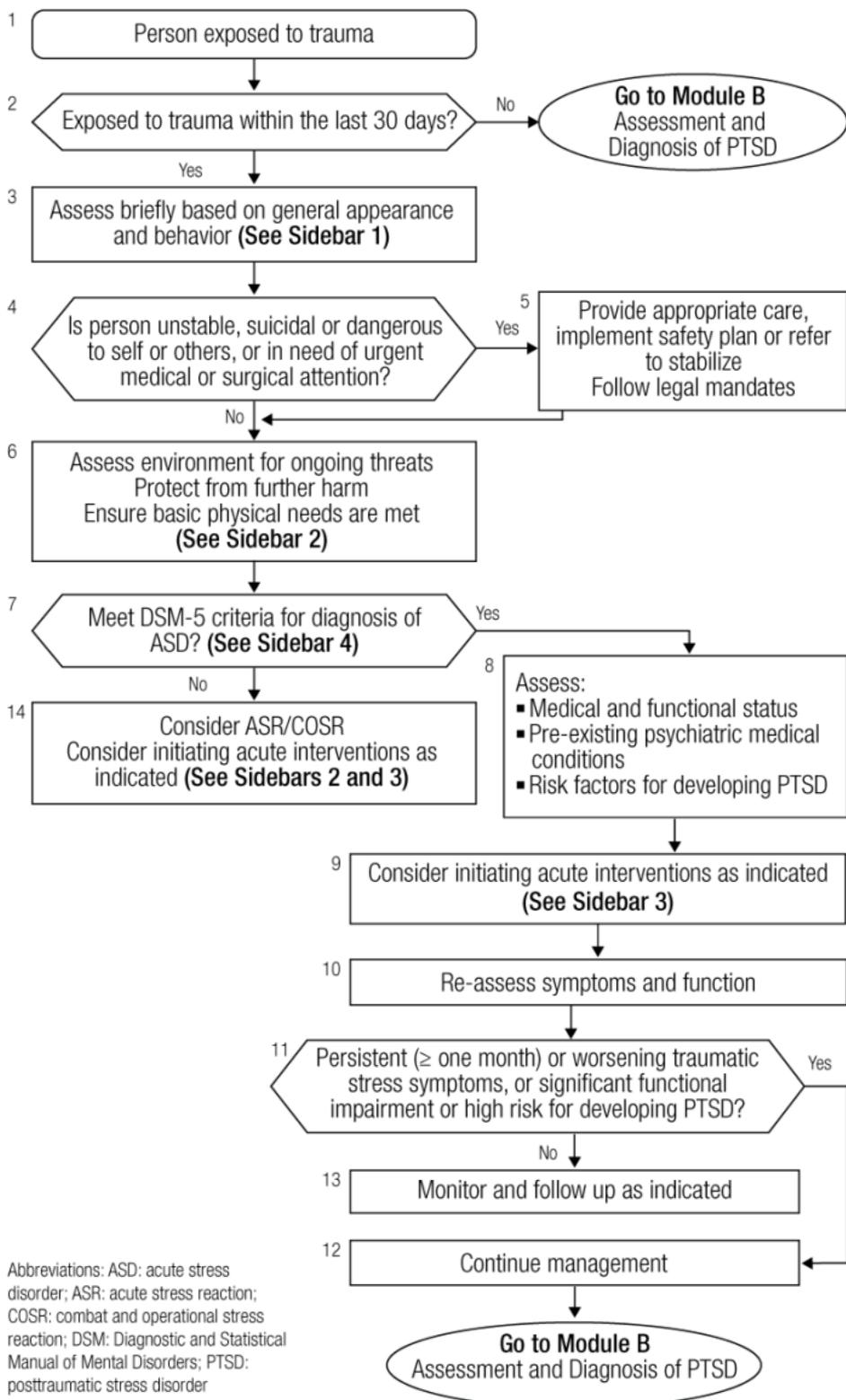
#	Recommendation	Strength	Category
38.	We recommend VA/DoD guideline-recommended treatments for PTSD in the presence of co-occurring substance use disorder (SUD).	Strong For	<b>New</b> (replaced)
39.	We recommend an independent assessment of co-occurring sleep disturbances in patients with PTSD, particularly when sleep problems pre-date PTSD onset or remain following successful completion of a course of treatment.	Strong For	<b>New</b> (replaced)
40.	We recommend cognitive behavioral therapy for insomnia (CBT-I) for insomnia in patients with PTSD unless an underlying medical or environmental etiology is identified or severe sleep deprivation warrants the immediate use of medication to prevent harm.	Strong For	Amended

Page intentionally left blank

# Clinical Algorithms

# Tab 1 - CLINICAL ALGORITHMS

## Module A: Acute Stress Reaction/Disorder



Abbreviations: ASD: acute stress disorder; ASR: acute stress reaction; COSR: combat and operational stress reaction; DSM: Diagnostic and Statistical Manual of Mental Disorders; PTSD: posttraumatic stress disorder

## Module A

### Sidebar 1: Assessment

- Symptoms
- History of trauma
- Medical status
- Mental status
- Functional status
- Psychosocial status
- Occupational performance

### Sidebar 2: Immediate Needs

- Survival, safety and security
- Food, hydration, shelter and clothing
- Sleep
- Medical care (first aid)
- Stabilization (if needed)
- Orientation
- Communication with unit/family, friends and community
- Education and normalization

### Sidebar 3: Acute Interventions

#### Provide:

- Education and normalization
- Acute symptom management
- Social support
- For ASD only: Brief sessions of individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring

#### Avoid:

- Psychological debriefing

### Sidebar 4: Diagnostic Criteria for Acute Stress Disorder Based on DSM-5

#### Criterion A required

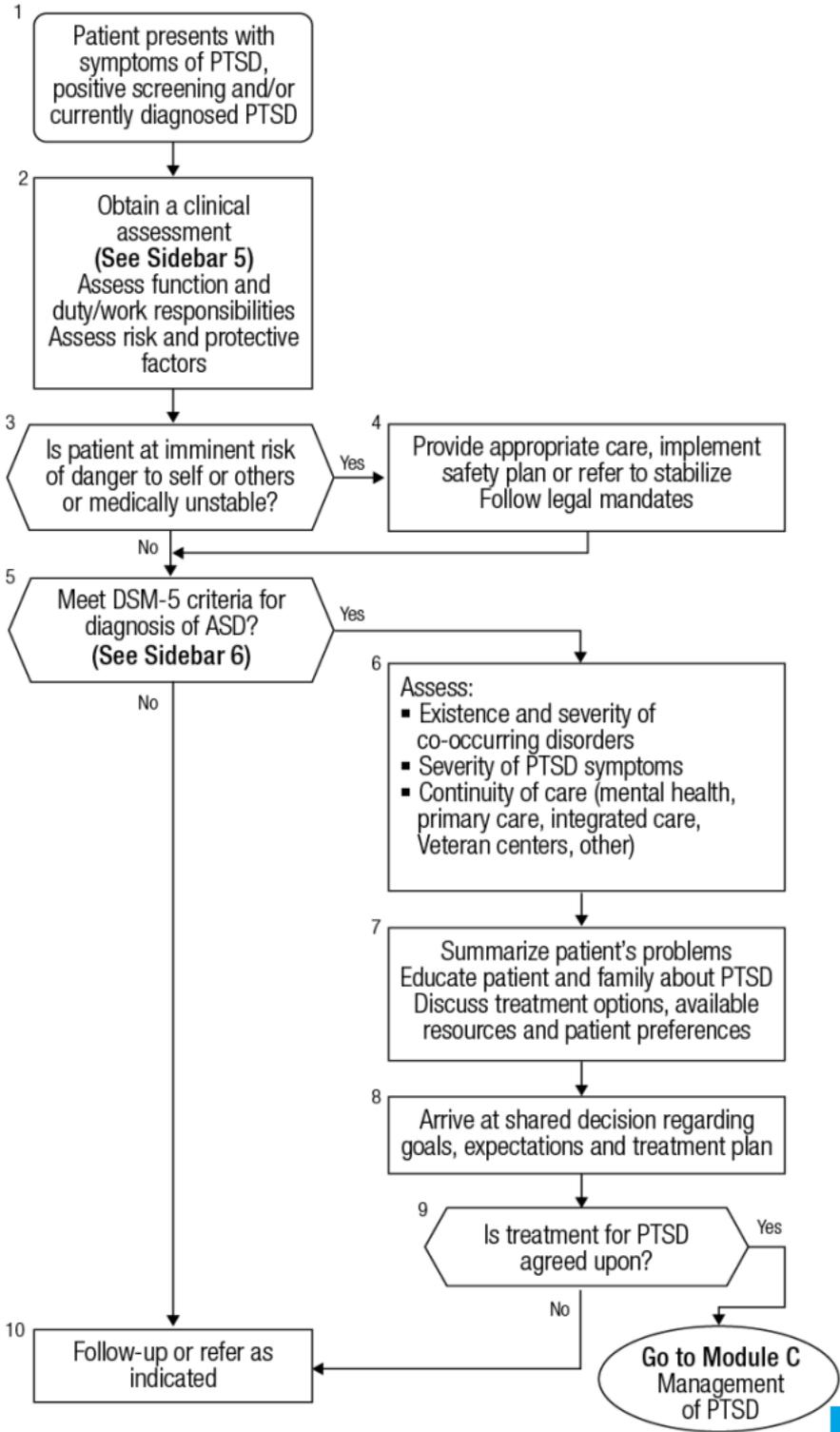
Exposure to actual or threatened death, serious injury or sexual violation in one (or more) of the following way(s):

1. Direct exposure
2. Witnessing the event
3. Learning that a close family member or close friend was exposed to a trauma
4. Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

### Sidebar 4: Diagnostic Criteria for Acute Stress Disorder Based on DSM-5, continued

<p><b>Criterion B</b> <b>9 required</b></p>	<p>Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance and arousal, beginning or worsening after the traumatic event(s) occurred:</p> <p><b>The traumatic event is persistently re-experienced, in the following way(s):</b></p> <ol style="list-style-type: none"> <li>1. Intrusive thoughts</li> <li>2. Nightmares</li> <li>3. Flashbacks</li> <li>4. Emotional distress or physical reactivity after exposure to traumatic reminders</li> </ol> <p><b>Negative mood</b></p> <ol style="list-style-type: none"> <li>5. Difficulty experiencing positive affect</li> </ol> <p><b>Dissociative symptoms</b></p> <ol style="list-style-type: none"> <li>6. Altered sense of reality</li> <li>7. Inability to recall key aspects of the trauma</li> </ol> <p><b>Avoidance of trauma-related stimuli after the trauma, in the following way(s):</b></p> <ol style="list-style-type: none"> <li>8. Trauma-related thoughts or feelings</li> <li>9. Trauma-related reminders</li> </ol> <p><b>Arousal symptoms</b></p> <ol style="list-style-type: none"> <li>10. Difficulty sleeping</li> <li>11. Irritability or aggression</li> <li>12. Hypervigilance</li> <li>13. Difficulty concentrating</li> <li>14. Heightened startle reaction</li> </ol>
<p><b>Criterion C</b></p>	<p>Symptoms last three days to one month after trauma exposure</p>
<p><b>Criterion D</b></p>	<p>Symptoms cause significant distress or functional impairment</p>
<p><b>Criterion E</b></p>	<p>Symptoms are not due to medication, substance use or other illness</p>

# Module B: Assessment and Diagnosis of Posttraumatic Stress Disorder



**Sidebar 5: General Assessment**

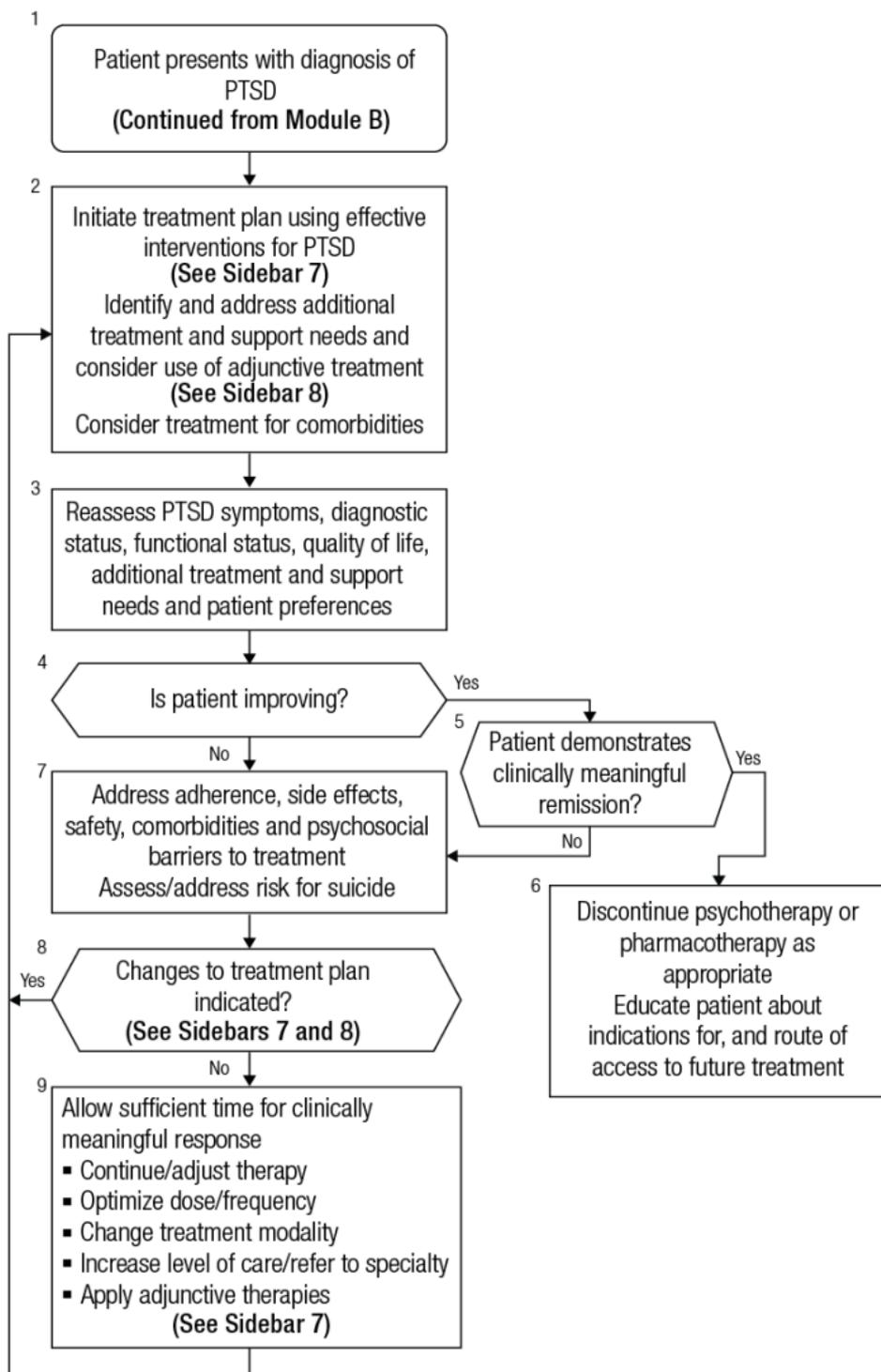
- Safety assessment
- History: psychiatric, medical, military, marital, family, past physical or sexual abuse, medication or substance use, social and spiritual life, functional status
- Identify trauma history and duration
- Current medications (including over-the-counter drugs and herbals)
- With patient consent, consider obtaining additional history from family/significant other
- Mental status exam
- Physical exam and laboratory tests – evidence of trauma
- Assess for signs of trauma, substance use or co-occurring disorders

**Sidebar 6: Diagnostic Criteria for Posttraumatic Stress Disorder Based on DSM-5**

<b>Criterion A required</b>	<p>The person was exposed to: death, threatened death, actual or threatened serious injury or actual or threatened sexual violence, in the following way(s):</p> <ol style="list-style-type: none"> <li>1. Direct exposure</li> <li>2. Witnessing the trauma</li> <li>3. Learning that a relative or close friend was exposed to a trauma</li> <li>4. Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)</li> </ol>
<b>Criterion B 1 required</b>	<p>The traumatic event is persistently re-experienced, in the following way(s):</p> <ol style="list-style-type: none"> <li>1. Intrusive thoughts</li> <li>2. Nightmares</li> <li>3. Flashbacks</li> <li>4. Emotional distress after exposure to traumatic reminders</li> <li>5. Physical reactivity after exposure to traumatic reminders</li> </ol>
<b>Criterion C 1 required</b>	<p>Avoidance of trauma-related stimuli after the trauma, in the following way(s):</p> <ol style="list-style-type: none"> <li>1. Trauma-related thoughts or feelings</li> <li>2. Trauma-related reminders</li> </ol>

### Sidebar 6: Diagnostic Criteria for Posttraumatic Stress Disorder Based on DSM-5, continued

<p><b>Criterion D</b> 2 required</p>	<p>Negative thoughts or feelings that began or worsened after the trauma, in the following way(s):</p> <ol style="list-style-type: none"> <li>1. Inability to recall key features of the trauma</li> <li>2. Overly negative thoughts and assumptions about oneself or the world</li> <li>3. Exaggerated blame of self or others for causing the trauma</li> <li>4. Negative affect</li> <li>5. Decreased interest in activities</li> <li>6. Feeling isolated</li> <li>7. Difficulty experiencing positive affect</li> </ol>
<p><b>Criterion E</b> 2 required</p>	<p>Trauma-related arousal and reactivity that began or worsened after the trauma, in the following way(s):</p> <ol style="list-style-type: none"> <li>1. Irritability or aggression</li> <li>2. Risky or destructive behavior</li> <li>3. Hypervigilance</li> <li>4. Heightened startle reaction</li> <li>5. Difficulty concentrating</li> <li>6. Difficulty sleeping</li> </ol>
<p><b>Criterion F</b> required</p>	<p>Symptoms last for more than one month</p>
<p><b>Criterion G</b> required</p>	<p>Symptoms cause significant distress or functional impairment</p>
<p><b>Criterion H</b> required</p>	<p>Symptoms are not due to medication, substance use or other illness</p>



### Sidebar 7: Initiating Treatment

1. Initiate individual, manualized trauma-focused psychotherapy (See Recommendation 11) according to patient preference
2. If individual trauma-focused psychotherapy is not readily available or not preferred, initiate pharmacotherapy (See Recommendation 17) or non-trauma-focused psychotherapy (See Recommendation 12) according to patient preference
3. If options 1 and 2 are not feasible or have been exhausted, offer other psychotherapies (See Recommendations 13 and 15) or other pharmacotherapy (See Recommendation 18)

### Sidebar 8: Additional Treatment and Support Needs

- Consider treatment for comorbidities (See Recommendations 37-40, as well as other relevant VA/DoD CPGs\*)
- Consider symptom-specific management (e.g., sleep, pain)
- Facilitate social support

\*VA/DoD CPGs can be found at the following link: <https://www.healthquality.va.gov/index.asp>. Relevant VA/DoD CPGs to consult may include CPGs for the Management of Major Depressive Disorder, Substance Use Disorder, Suicide, Chronic Multisymptom Illness, Concussion-mild Traumatic Brain Injury and others.

Page intentionally left blank

# **General Clinical Management**

## Tab 2 – GENERAL CLINICAL MANAGEMENT

### Patient-centered Care, Shared Decision Making and Collaborative Care

*Engaging patients in shared decision making (SDM), which includes educating patients about effective treatment options, is strongly recommended (Recommendation 1, Strong For, Amended). For patients with PTSD who are treated in primary care, collaborative care interventions that facilitate active engagement in evidence-based treatments are suggested (Recommendation 2, Weak For, New-replaced).*

#### Patient-centered care

VA/DoD CPGs encourage clinicians to use a patient-centered care approach that is tailored to the patient's capabilities, needs, goals, prior treatment experience and preferences. When properly executed, patient-centered care may decrease patient anxiety, increase trust in a clinician and improve knowledge and treatment adherence.

- Good communication between health care professionals and the patient is essential and should be supported by evidence-based information tailored to the patient's needs
- Use of an empathetic and non-judgmental approach facilitates discussions sensitive to gender, culture, ethnic and other differences
- The information that patients are given about treatment and care should be culturally appropriate and available to people with limited literacy skills – it should also be accessible to people with additional needs such as physical, sensory or learning disabilities
- Family involvement should be considered, if appropriate
- Improved patient-clinician communication through patient-centered care can be used to convey openness to discuss any future concerns
- As part of the patient-centered care approach, clinicians should:
  - Review the outcomes of previous self-change efforts, past treatment experiences and outcomes (including reasons for treatment dropout) with the patient
  - Explain treatment options to patients, including the benefits of accepting a referral to a mental health specialist
  - Discuss any concerns the patient has and explore any identified treatment barriers
  - Involve the patient in prioritizing problems to be addressed and in setting specific goals regardless of the selected setting or level of care

## Shared decision making

The SDM process has the goal of considering patient preference in treatment decisions to improve patient-centered care, decision quality and treatment outcomes.

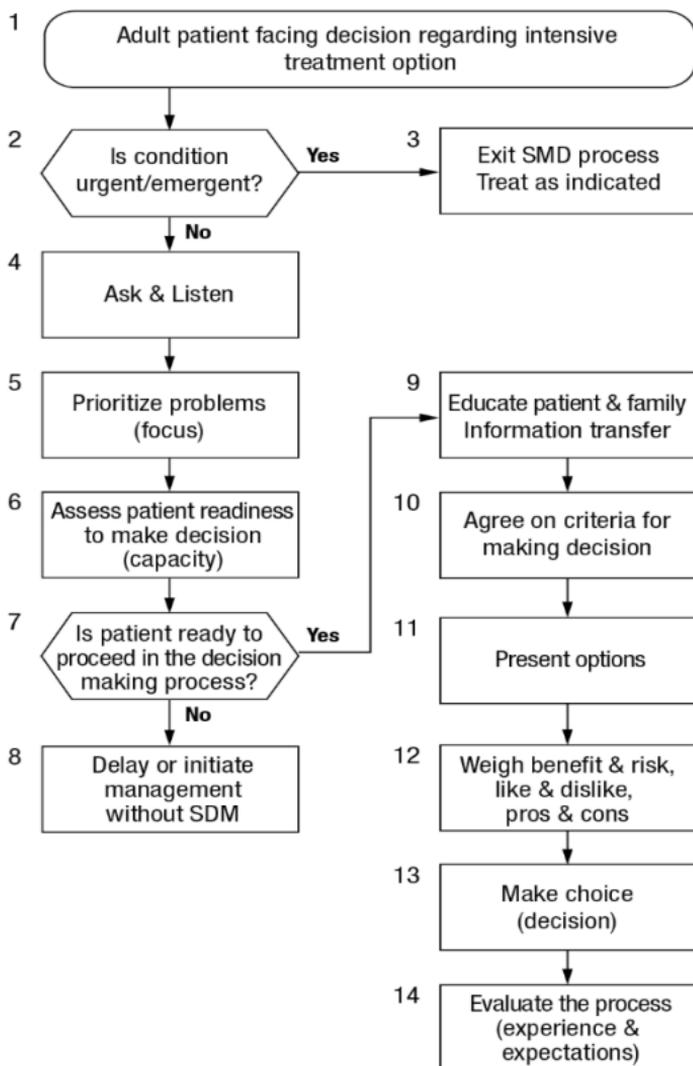
- In SDM, the patient and provider together review treatment options and compare the benefits, harms and risks of each with the goal of selecting the option that best meets the patient's needs
- The process of SDM maximizes the likelihood that patient preference is taken into account and the benefits outweigh any potential harms
- For additional information on shared decision making, please see Module D on page 28, which is drawn from Shared Decision Making: A Guide for Busy Clinicians<sup>1</sup> (<https://www.healthquality.va.gov/> and <https://www.qmo.amedd.army.mil>)

## Collaborative care

The collaborative care model is an evidence-based approach to integrating physical and behavioral health services that is usually provided within the primary care setting. Care coordination is an integral component of most collaborative care models.

- Many collaborative care models generally involve a stepped-care approach to symptom management, using a predetermined treatment sequence that starts with simple, low-intensity interventions first – subsequent treatment steps involving increased complexity and intensity are attempted only after initial treatment is unsuccessful
- The use of collaborative care interventions that employ or facilitate active engagement in evidence-based PTSD treatments in the primary care setting appears to increase patient compliance with treatment, improve patient satisfaction and potentially reduce premature termination of treatment when delivered in the primary care setting
- Some models also offer telehealth or additional care delivery modalities
- Collaborative care typically includes:
  - Care coordination and care management
  - Regular/proactive monitoring and treatment to achieve outcomes measured using validated clinical rating scales
  - Regular consultation or referral to appropriate specialists for patients who do not show clinical improvement

## Shared Decision Making Algorithm



Abbreviations: SDM: Shared Decision Making

The above algorithm is drawn from Shared Decision Making: A Guide for Busy Clinicians<sup>1</sup> available at <https://www.healthquality.va.gov/> and <https://www.qmo.amedd.army.mil>.

# ASR/COSR and ASD

## Tab 3 – ASR/COSR AND ASD

### What is a Traumatic Event?

- A traumatic event is defined in the DSM-5 as “an event (or series of events) in which an individual has been personally or indirectly exposed to actual or threatened death, serious injury or sexual violence”<sup>2</sup>
- There is a wide spectrum of psychological responses to traumatic events, ranging from normal, transient, non-debilitating symptoms to a transient stress reaction to an acute, time-limited and clinically-significant clinical disorder (i.e., ASD) to a persistent disorder (i.e., PTSD) that may become chronic, if untreated
- The DSM-5 definition of traumatic events is the same for both ASD and PTSD, and one can meet the trauma definition with any one of four criteria (A1 – A4 shown below)

Criterion	Characteristics
A1	<ul style="list-style-type: none"> <li>▪ Direct exposure to traumatic event(s)</li> <li>▪ Events may include actual or threatened death, serious injury (e.g., military combat, physical attack, torture, man-made/natural disasters, accidents, incarceration, and exposure to war zone/urban/domestic violence) or sexual violence or assault</li> </ul>
A2	<ul style="list-style-type: none"> <li>▪ Witnessing such traumatic event(s)</li> <li>▪ Includes people who directly observed such events, but were not harmed themselves</li> </ul>
A3	<ul style="list-style-type: none"> <li>▪ Indirect exposure such as learning that a loved one was exposed to a traumatic event; if the loved one died during such an event</li> <li>▪ In cases of actual or threatened death to a loved one, the event(s) must have been violent or accidental</li> </ul>
A4	<ul style="list-style-type: none"> <li>▪ Exposure to repeated or extreme details of trauma</li> <li>▪ Details may include seeing dead body parts or severely injured people as part of one’s professional duties (e.g., medical, law enforcement, mortuary affairs, journalism personnel)</li> </ul>

# Acute Stress Reaction, Combat and Operational Stress Reaction and Acute Stress Disorder

Acute stress reaction (ASR) and the military analog, combat and operational stress reaction (COSR), can present with a broad group of physical, mental, behavioral and emotional symptoms and signs (e.g., depression, fatigue, anxiety, panic, decreased concentration/memory, hyperarousal, dissociation). Identification of a patient with ASR/COSR symptoms is based on observation of behavior and function as well as clinical assessments since there is insufficient evidence to recommend a specific screening tool.

Individuals who experience ASR or COSR should receive a comprehensive assessment of their symptoms or behavioral signs to include details about the time of onset, frequency, course, severity, level of distress, work performance, functional impairment and other relevant information. Additionally, the individual should be assessed for medical causes of acute changes in behavior.

## Acute stress reaction:

- ASR is defined as a transient normal reaction to traumatic stress and is not a DSM-5 diagnosis, although symptoms may be temporarily debilitating
- Onset of stress-related signs and symptoms may be simultaneous or within minutes of the traumatic event or may follow the trauma after an interval of hours or several days
- In most cases, symptoms will resolve rapidly with simple measures, such as reassurance, rest and ensuring safety

## Combat and operational stress reaction:

- COSR is the military analog of ASR and reflects a normal, transient, acute reaction to a high-stress operational or combat-related traumatic event in a military occupational setting
- Military policy indicates that service members with COSR who do not respond to initial supportive interventions may warrant referral or evacuation, though the general principle of care is to provide treatment as close to the service member's unit/team as possible

If COSR continues beyond three days with persistent limitations of functioning, it is necessary to monitor service members for the possible development of ASD.

## Acute stress disorder:

- ASD is a diagnosis defined by DSM-5 (see following table for full criteria) that can also occur after exposure to a traumatic event

- Symptoms must last at least three days but less than one month after exposure to the traumatic event for an individual to be eligible for this diagnosis
- Individuals with ASD must have been exposed to a traumatic stressor (Criteria A1 – A4 given on page 30) and they must exhibit at least nine out of 14 possible symptoms that are nested within five diagnostic clusters
- Symptoms need to cause significant distress or functional impairment

## DSM-5 Diagnostic Criteria for ASD

### **Criterion A. Exposure to actual or threatened death, serious injury or sexual violence in one (or more) of the following ways:**

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others
3. Learning that the event(s) occurred to a close family member or close friend

Note: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse)

Note: This does not apply to exposure through electronic media, television, movies or pictures, unless this exposure is work related.

### **Criterion B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance and arousal, beginning or worsening after the traumatic event(s) occurred:**

#### **Intrusion Symptoms**

1. Recurrent, involuntary and intrusive distressing memories of the traumatic event(s)
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings)
4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

## DSM-5 Diagnostic Criteria for ASD

### Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, loving feelings)

### Dissociative Symptoms

6. An altered sense of reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing)
7. Inability to remember an important aspect of the event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs)

### Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event(s)
9. Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts or feelings about or closely associated with the traumatic event(s)

### Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep)
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects
12. Hypervigilance
13. Problems with concentration
14. Exaggerated startle response

**Criterion C. Duration of the disturbance (symptoms in Criterion B) is three days to one month after trauma exposure.**

Note: Symptoms typically begin immediately after the trauma, but persistence for at least three days and up to a month is needed to meet disorder criteria.

**Criterion D. The disturbance causes clinically significant distress or impairment in social, occupational or other important areas of functioning.**

**Criterion E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by brief psychotic disorder.**

## Evaluation and Management of ASR/COSR and ASD

The steps below are drawn from the 2017 PTSD CPG recommendations as well as the Module A algorithm, which includes: an ordered sequence of steps of care; recommended observations and examinations; decisions to be considered; and actions to be taken by health care providers evaluating and managing patients with ASR/COSR and ASD.

### Conduct Brief Assessment

- For individuals exposed to trauma within the last 30 days, complete a brief assessment based on general appearance and behavior comprising the following:
  - Symptoms
  - History of trauma
  - Medical status
  - Mental status
  - Functional status
  - Psychosocial status
  - Occupational performance
- If the individual is unstable, suicidal or dangerous to self or others, or in need of urgent medical or surgical attention:
  - Provide appropriate care
  - Implement a safety plan
  - Refer to stabilize
  - Follow legal mandates



### Continued Monitoring and Assessment

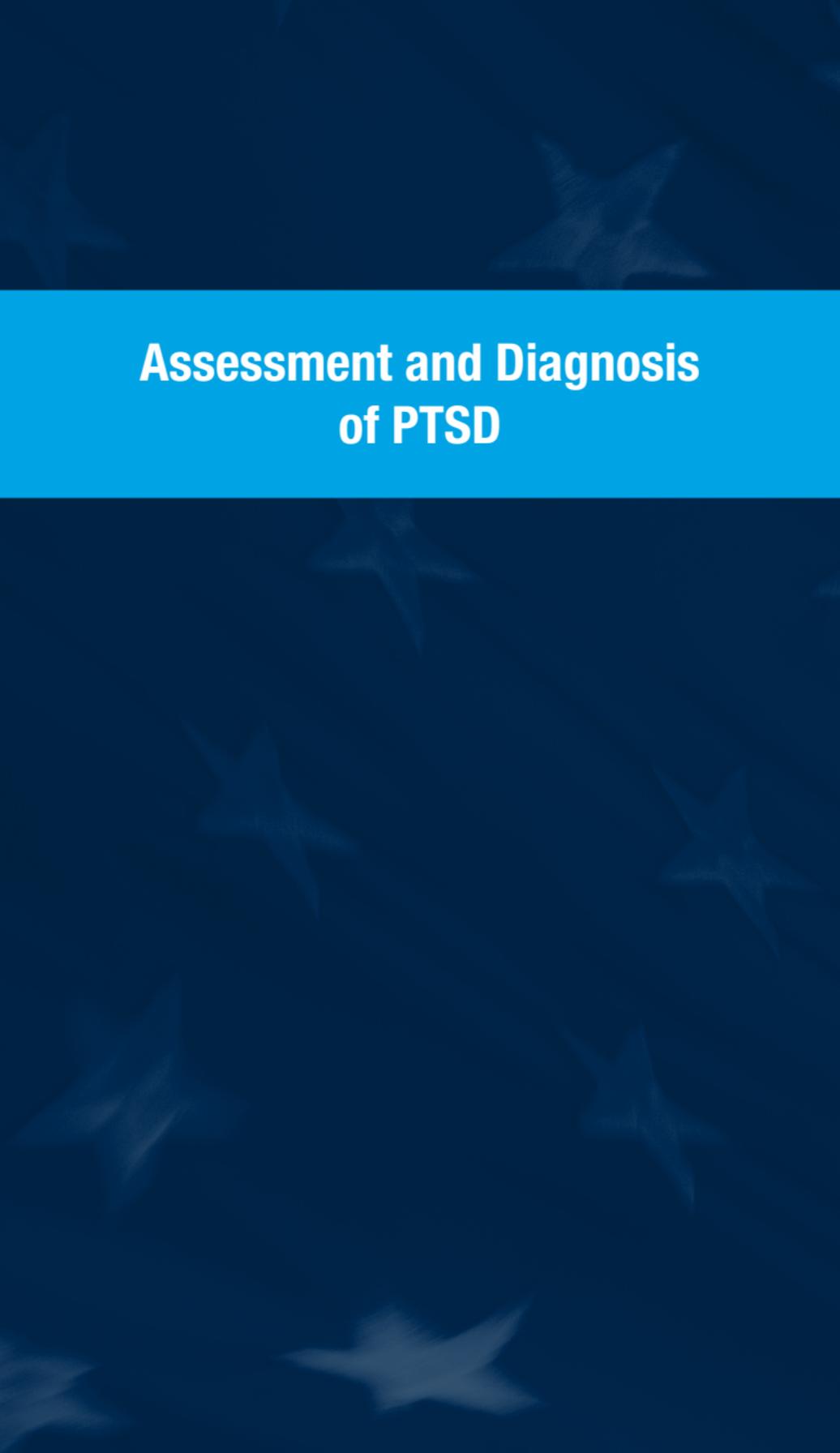
- Assess the environment for ongoing threats
- Protect from further harm
- Ensure basic physical needs are met:
  - Survival
  - Food, hydration, shelter and clothing
  - Sleep
  - Medical care (first aid)
  - Stabilization (if needed)
  - Orientation
  - Communication with unit/family, friends and community
  - Education and normalization
- Assess for diagnosis of ASD (see DSM-5 criteria on pages 32-33)
- If DSM-5 criteria for ASD is met, assess:
  - Medical and functional status
  - Pre-existing psychiatric medical conditions
  - Risk factors for developing PTSD
- Initiate acute interventions for ASR/COSR and ASD as indicated by providing:
  - Education and normalization
  - Acute symptom management
  - Social support
  - **For ASD only:** Brief sessions of individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring
- Avoid psychological debriefing



### Reassess Symptoms and Function

- If symptoms do not persist or worsen, monitor the individual and follow up as indicated
- If symptoms persist for more than one month, worsen or there is significant functional impairment or high risk for developing PTSD:
  - Continue management
  - Evaluate for a diagnosis of PTSD

Page intentionally left blank



# **Assessment and Diagnosis of PTSD**

# Tab 4 – ASSESSMENT AND DIAGNOSIS OF PTSD

## What is PTSD?

PTSD is a clinically-significant condition with symptoms that have persisted for more than one month after exposure to a traumatic event and caused significant distress or impairment in social, occupational or other important areas of functioning (see pages 39-42 for full criteria).

- Criterion A for PTSD is the same as criterion A for ASD; however ASD can only be within the first month after the traumatic event
- After one month, the diagnostic question is whether PTSD is present — individuals with PTSD must exhibit a specific number of symptoms from each symptom cluster (Criteria B – E)
- PTSD symptoms must persist for at least one month after the traumatic event (Criterion F) and result in significant distress or functional impairment (Criterion G)
- PTSD can also have a delayed expression, when full diagnostic criteria are not met until at least six months after exposure to the traumatic event
- PTSD can appear alone as the only diagnosis, or more commonly, with another co-occurring DSM-5 disorder, such as a substance use disorder (SUD), mood disorder or anxiety disorder
- PTSD is also strongly associated with functional difficulties, reduced quality of life and adverse physical health outcomes

### Impact of PTSD:

- PTSD can affect all aspects of a person's functioning and well-being
- PTSD is associated with nearly all assessed Axis 1 disorders and lifetime suicide attempts
- There are specific increased risks of co-occurring depression and SUD
- PTSD is also associated with impairments in social and occupational functioning and overall quality of life
- In addition, PTSD is associated with poorer perceived physical health, increased morbidity and greater health care utilization for physical problems
- Findings on mortality are mixed, but generally show that PTSD is associated with increased overall mortality and mortality due to accidental causes

## DSM-5 Diagnostic Criteria for PTSD

### **Criterion A. Exposure to actual or threatened death, serious injury or sexual violence in one (or more) of the following ways:**

1. Directly experiencing the traumatic event(s)
2. Witnessing, in person, the event(s) as it occurred to others
3. Learning that the event(s) occurred to a close family member or close friend

Note: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse)

Note: This does not apply to exposure through electronic media, television, movies or pictures, unless this exposure is work-related.

### **Criterion B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred.**

1. Recurrent, involuntary and intrusive distressing memories of the traumatic event(s)
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s)
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings)
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s)

## DSM-5 Diagnostic Criteria for PTSD

**Criterion C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:**

1. Avoidance of or efforts to avoid distressing memories, thoughts or feelings about or closely associated with the traumatic event(s)
2. Avoidance or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts or feelings about or closely associated with the traumatic event(s)

**Criterion D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred as evidenced by two or more of the following:**

1. Inability to recall an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol or drugs)
2. Persistent and exaggerated negative beliefs or expectations about oneself, others or the world (e.g., "I am bad," "no one can be trusted," "the world is completely dangerous," "my whole nervous system is permanently ruined")
3. Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, shame)
5. Markedly diminished interest or participation in significant activities
6. Feeling of detachment or estrangement from others
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, loving feelings)

## DSM-5 Diagnostic Criteria for PTSD

**Criterion E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:**

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression towards people or objects
2. Reckless or self-destructive behavior
3. Hypervigilance
4. Exaggerated startle response
5. Problems with concentration
6. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep)

**Criterion F. Duration of the disturbance (symptoms in Criteria B, C, D and E) is more than one month.**

**Criterion G. The disturbance causes clinically significant distress or impairment in social, occupation or other important areas of functioning.**

## DSM-5 Diagnostic Criteria for PTSD

**Criterion H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.**

Specify whether:

**With dissociative symptoms:** The individual's symptoms must meet the criteria for PTSD and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream, feeling a sense of unreality of self or body, time moving slowly)
2. Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant or distorted)

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

*Specify if:*

**With delayed expression:** If the full diagnostic criteria are not met until at least six months after the event (although the onset and expression of some symptoms may be immediate).

### PTSD subtypes

Subtype	Characteristics
Dissociative PTSD	<ul style="list-style-type: none"> <li>Diagnosed when an individual meets all diagnostic criteria for PTSD</li> <li>Also exhibits depersonalization or derealization</li> </ul>
PTSD with Delayed Expression	<ul style="list-style-type: none"> <li>Diagnosed if full diagnostic criteria are not met until at least six months after exposure to the traumatic event (although the onset and expression of some symptoms may be immediate)</li> </ul>

Subtype	Characteristics
Subthreshold PTSD	<ul style="list-style-type: none"> <li>▪ Sometimes designated as partial PTSD or sub-syndromal PTSD</li> <li>▪ Diagnosis used by clinicians to characterize individuals with clinically significant posttraumatic reactions who fail to meet full PTSD criteria (often for lack of one or two symptoms)</li> <li>▪ The DSM-5 diagnosis for such individuals is Other Specified Trauma and Stress-Related Disorder (309.89)</li> </ul>
Complex PTSD	<ul style="list-style-type: none"> <li>▪ Used to characterize traumatized individuals who, in addition to usually meeting full PTSD diagnostic criteria, also exhibit prominent behavioral difficulties (such as impulsivity and self-destructive actions), emotional difficulties (such as affect lability), cognitive difficulties (such as dissociation), interpersonal difficulties and somatization</li> <li>▪ The DSM-5 does not recognize complex PTSD as a distinct, valid and empirically-based diagnosis</li> </ul>

## Screen for PTSD

*Periodic screening for PTSD using validated measures such as the Primary Care PTSD Screen (PC-PTSD) or the PTSD Checklist (PCL) is suggested (Recommendation 3, Weak for, Amended).*

- Identification of individuals with PTSD is essential to ensure that they receive appropriate treatment and screening is often considered a key step in the diagnostic process
- Screening for PTSD can be performed in primary and specialty care settings, and both VA and DoD mandate screening either in context with combat deployments or in primary care settings
- Primary care is considered to be an important context for screening because many people with PTSD and other mental disorders first present in primary care and not in specialty mental health care settings
- VA recommends annual screening for the first five years following separation and then every five years thereafter and DoD recommends routine screening throughout deployment cycles

**CAUTION**

One time screening is not recommended because PTSD is a disorder with a fluctuation course for many people. Onset may be delayed and symptoms may reoccur even after a long period of remission. An individual who is symptom-free at one point may be symptomatic at another.

- A variety of measures are available for PTSD screening – both VA and DoD have relied most heavily on the PC-PTSD and PCL for various screening purposes
- The PC-PTSD, a four-item questionnaire that is generally scored positive if at least three of the four items are endorsed, performs well against both DSM-IV and DSM-5 PTSD diagnoses

## Diagnosis of PTSD

The steps below are drawn from the 2017 PTSD CPG recommendations as well as the Module B algorithm, which includes: an ordered sequence of steps of care; recommended observations and examinations; decisions to be considered; and actions to be taken by health care providers for the assessment and diagnosis of PTSD.

### Obtain Clinical Assessment

- Complete a comprehensive clinical assessment (see page 45)
- Assess function and duty/work responsibilities
- Assess risk and protective factors
- Determine whether patient is at imminent risk of danger to self or others or is medically unstable; if yes:
  - Provide appropriate care
  - Implement safety plan or refer to stabilize
  - Follow legal mandates

### Conduct Diagnostic Evaluation

- Conduct a clinical interview or a structured diagnostic interview:
  - Clinician-Administered PTSD Scale (CAPS)
  - Posttraumatic Stress Disorder Symptom Scale Interview for DSM-5 (PSSI-I)
  - Structured Clinical Interview for DSM-5 (SCID-5)
- Determine whether patient meets DSM-5 diagnostic criteria (Criterion A – H) for PTSD (see pages 39-42)

### Assess for Severity and Comorbidities

- Assess for existence and severity of co-occurring disorders
- Assess severity of PTSD symptoms using a quantitative self-report measure of PTSD severity
- Assess for continuity of care (e.g., mental health, primary care, integrated care, veteran centers, other)

### Educate Patient/Family About PTSD and Treatment Options

- Summarize the patient's problems
- Educate the patient and family about PTSD
- Discuss treatment options, available resources and patient preferences



### Develop and Initiate Treatment Plan

- Arrive at a shared decision regarding goals, expectations and treatment plan
- Initiate mutually agreed-upon treatment plan

*For patients with suspected PTSD, an appropriate diagnostic evaluation that includes determination of DSM criteria, acute risk of harm to self or others, functional status, medical history, past treatment history and relevant family history is strongly recommended. A structured diagnostic interview may be considered*  
**(Recommendation 4, Strong For Amended).**

- PTSD is associated with a range of comorbid psychological conditions, poorer physical health, increased treatment utilization, impaired functioning and reduced quality of life – a comprehensive diagnostic evaluation should include all of these factors
- Diagnosis can be made on the basis of a clinical interview or a structured diagnostic interview such as the CAPS, PSSI-I or SCID-5
- Structured diagnostic interviews can help to enhance the accuracy and completeness of diagnosis – the time required for structured interviewing may not be available in primary care and routine specialty mental health care settings
- If diagnosis is based on a clinical interview in any setting, it can be helpful to administer a self-report questionnaire such as the PCL-5 along with other routine self-report screening tools, such as the Patient Health Questionnaire-9 (PHQ-9) and Alcohol Use Disorders Identification Test-Consumption (AUDIT-C)

The table below includes the general components included in a clinical assessment for PTSD.

## Components of a Clinical Assessment for PTSD

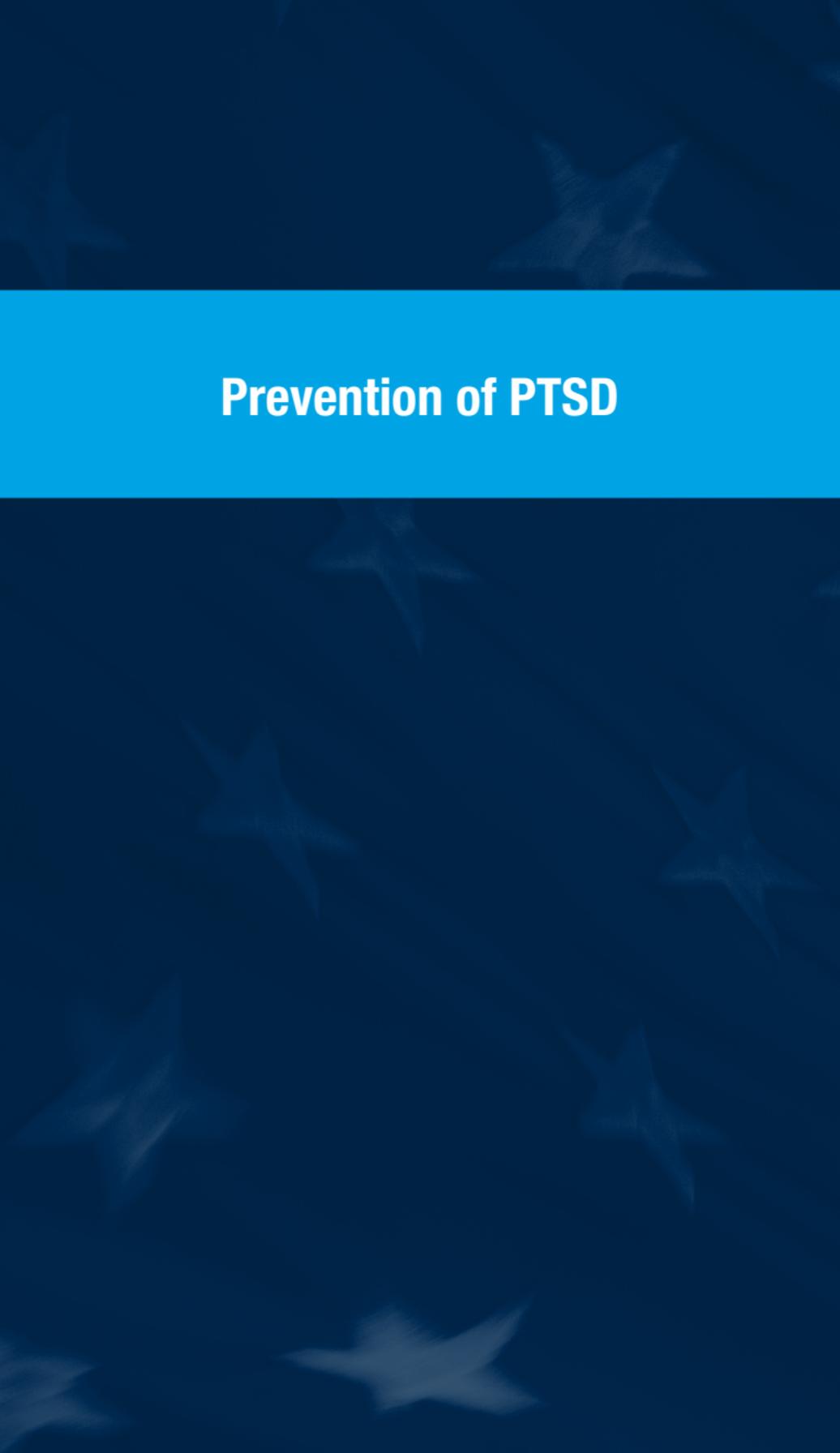
- Safety assessment
- History:
  - Psychiatric
  - Medical
  - Military
  - Marital
  - Family
  - Past physical or sexual abuse
  - Medication or substance use
  - Social, spiritual and functional status
- Trauma history and duration
- Current medications (including over-the-counter drugs and herbals)
- Additional history from family/significant other (with patient consent to obtain)
- Mental status exam
- Physical exam and laboratory tests
- Assess for signs of trauma, substance use or co-occurring disorders

## Determination of Symptom Severity

*For patients with a diagnosis of PTSD, using a quantitative self-report measure of PTSD severity, such as the PTSD Checklist for DSM-5 (PCL-5), in the initial treatment planning and to monitor treatment progress is suggested (Recommendation 5, Weak For, Amended).*

- In addition to their utility in screening and diagnosis, brief questionnaires such as the PCL-5 can be used to assess symptom severity
- Giving providers frequent and timely information about patients' symptom severity during medication and psychotherapy treatment may be associated with better patient outcomes

While there is potential harm in not screening, which could prevent individuals with PTSD from being detected and receiving the care they need, inaccurately diagnosing PTSD in a patient who does not have PTSD could result in unintended harms to the patient from being labeled with a mental disorder and from side effects of treatment.



# Prevention of PTSD

## Tab 5 – PREVENTION OF PTSD

### Selective and Indicated Prevention of PTSD

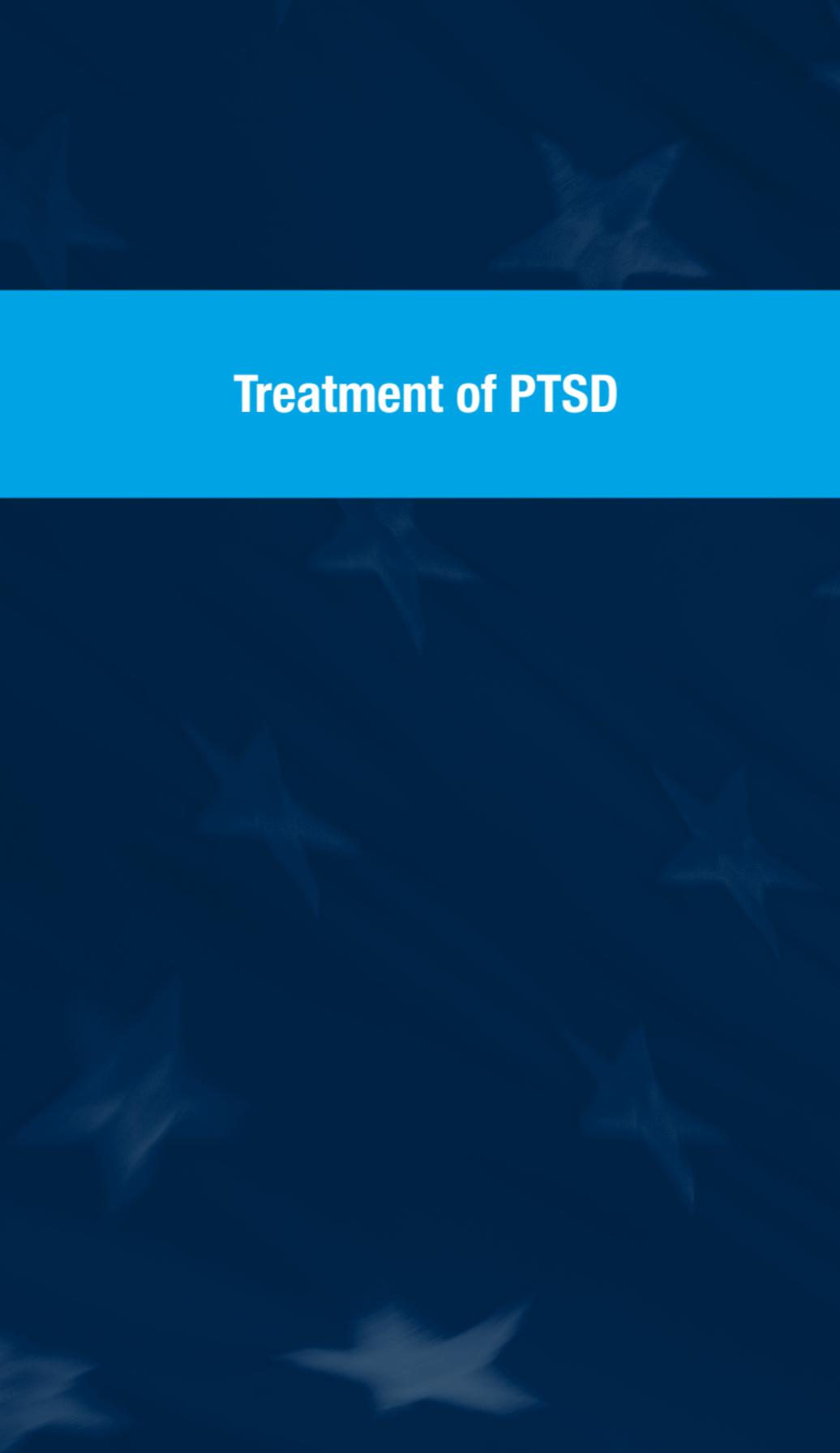
- Universal prevention strategies target the general population and are not directed at a specific at-risk group – there are currently no recommended strategies for universal prevention of PTSD
- Selective prevention targets individuals who are at higher than average risk for developing PTSD and includes strategies delivered to trauma-exposed individuals who have not yet developed symptoms or met criteria for ASD or PTSD
- Indicated prevention includes strategies to prevent PTSD in individuals with symptoms of ASD or who meet criteria for ASD

#### Selective prevention of PTSD

*For the selective prevention of PTSD, there is insufficient evidence to recommend the use of trauma-focused psychotherapy or pharmacotherapy in the immediate post-trauma period (Recommendation 6, Insufficient Evidence, New-replaced).*

#### Indicated prevention of PTSD

*For the indicated prevention of PTSD in patients with ASD, an individual trauma-focused psychotherapy that includes a primary component of exposure and/or cognitive restructuring is strongly recommended (Recommendation 7, Strong For, New-replaced). For the indicated prevention of PTSD in patients with ASD, there is insufficient evidence to recommend the use of pharmacotherapy (Recommendation 8, Insufficient Evidence, New-replaced).*



# Treatment of PTSD

## Tab 6 – TREATMENT OF PTSD

The steps below are drawn from the 2017 PTSD CPG recommendations as well as the Module C algorithm, which includes: an ordered sequence of steps of care; recommended observations and examinations; decisions to be considered; and actions to be taken by health care providers managing treatment of patients with ASR/COSR and ASD.

### Initiate Treatment Plan and Identify Additional Treatment Needs

- Initiate individual, manualized trauma-focused psychotherapy according to patient preference
- If individual trauma-focused psychotherapy is not readily available or not preferred, initiate pharmacotherapy or non-trauma-focused psychotherapy according to patient preference
- If individual trauma-focused psychotherapy, non-trauma-focused psychotherapy or pharmacotherapy are not feasible or have been exhausted, offer other psychotherapies or other pharmacotherapy
- Identify and address additional treatment and support needs
- Consider use of adjunctive treatment:
  - Consider treatment for comorbidities
  - Consider symptoms-specific management
  - Facilitate social support

### Reassess the Patient

- Reassess the patient for the following:
  - PTSD symptoms
  - Diagnostic status
  - Functional status
  - Quality of life
  - Additional treatment and support needs
  - Patient preferences
- Determine whether or not the patient is improving

## Adjust the Treatment Plan

- If patient demonstrates clinically meaningful remission:
  - Discontinue treatment (psychotherapy, pharmacotherapy) as appropriate
  - Educate patient about indications for and route of access to future treatment
- If patient does not demonstrate clinically meaningful remission, address the following:
  - Adherence
  - Side effects
  - Safety
  - Comorbidities
  - Psychosocial barriers to treatment
  - Risk for suicide
- Allow sufficient time for clinically meaningful response:
  - Continue/adjust therapy
  - Optimize dose/frequency
  - Change treatment modality
  - Increase level of care/refer to specialty
  - Apply adjunctive therapies

## Treatment Selection

*Individual, manualized trauma-focused psychotherapy (see Recommendation 11) over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD is strongly recommended (Recommendation 9, Strong For, New-added).*

- Use of individual trauma-focused psychotherapy over pharmacotherapy reflects the current state of the research into PTSD treatment
- Trauma-focused psychotherapies impart greater change with regard to core PTSD symptoms than pharmacotherapies, and these improvements persist for longer time periods
- The risks for negative side effects or negative reactions to the treatment are generally greater with pharmacologic treatments than with psychotherapies
- The positive effects of medication treatment diminish over time and are lost when medications are stopped
- A growing body of literature indicates a patient preference for psychotherapy over pharmacotherapy

*When individual trauma-focused psychotherapy is not readily available or not preferred, pharmacotherapy (see Recommendation 17) or individual non-trauma-focused psychotherapy (see Recommendation 12) are strongly recommended. With respect to pharmacotherapy and non-trauma-focused psychotherapy, there is insufficient evidence to recommend one over the other (Recommendation 10, Strong For, New-added).*

- Individual trauma-focused psychotherapies may not be readily available in all settings and not all patients elect to engage in such treatment
- Offering treatment using pharmacologic agents or individual, manualized psychotherapy that is not trauma-focused (such as stress inoculation training [SIT], present-centered therapy [PCT] and interpersonal psychotherapy [IPT]) (see Recommendation 12) is recommended
- Pharmacotherapy or individual non-trauma-focused psychotherapy can help reduce PTSD symptoms when used as the primary treatment modality
- Therefore, these treatment modalities should be considered when individual trauma-focused psychotherapy is not available or when a patient declines trauma-focused psychotherapy

## Psychotherapy

*For patients with PTSD, individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include prolonged exposure (PE), cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, brief eclectic psychotherapy (BEP), narrative exposure therapy (NET) and written narrative exposure are strongly recommended (Recommendation 11, Strong For, New-replaced).*

- Trauma-focused psychotherapy is defined as any therapy that uses cognitive, emotional or behavioral techniques to facilitate processing a traumatic experience and in which the trauma focus is a central component of the therapeutic process
- Although a number of theoretical frameworks have been cited in support of these treatments, extinction learning and cognitive-behavioral models provide the strongest empirical foundation
- While trauma-focused psychotherapies differ considerably in their approaches and protocols, most often they involve eight to 16 sessions with varying combinations of the following core techniques:
  - Exposure to traumatic images or memories through narrative or imaginal exposure
  - Exposure to avoided or triggering cues in vivo or through visualization
  - Cognitive restructuring techniques focused on enhancing meaning and shifting problematic appraisals stemming from the traumatic experience(s)

- There are other psychotherapies that meet the definition of trauma-focused treatment for which there is currently insufficient evidence to recommend for or against their use – future research is needed to explore the efficacy of novel, emerging treatments

*For patients diagnosed with PTSD, individual, manualized non-trauma-focused therapies: stress inoculation training (SIT), present-centered therapy (PCT) and interpersonal psychotherapy (IPT) are suggested (Recommendation 12, Weak For, New-replaced).*

- Although evidence supports the use of trauma-focused psychotherapies for the treatment of PTSD, access to these treatments is not uniform across clinics
- In addition, not all patients are willing to participate in treatments that may focus on their trauma to any extent
- As a result, some practitioners utilize non-trauma-focused therapies
- SIT, PCT and IPT are the non-trauma-focused therapies with the most evidence derived from clinical trials that have involved direct comparisons with first-line trauma-focused therapies
- These treatments differ in their focus and techniques, but are similar in that none of them include a direct exposure to, or cognitive focus on, the traumatic event(s)

*There is insufficient evidence to recommend for or against psychotherapies that are not specified in other recommendations, such as dialectical behavior therapy (DBT), skills training in affect and interpersonal regulation (STAIR), acceptance and commitment therapy (ACT), seeking safety and supportive counseling (Recommendation 13, Insufficient Evidence, New-replaced).*

- A wide variety of manualized protocols, including DBT, STAIR, ACT, seeking safety, hypnosis, brief psychodynamic therapy and supportive counseling, have all been used in the treatment of PTSD – however, further research is needed in order to make a recommendation for or against their routine use in patients with PTSD
- Some of these treatments have been found to be effective for the treatment of other disorders (e.g., ACT for major depressive disorder [MDD]), but do not have evidence of efficacy in patients with PTSD

Psychotherapy	Characteristics
<b>Trauma-focused Therapies</b>	
<b>Prolonged Exposure</b>	<ul style="list-style-type: none"> <li>▪ Emphasizes imaginal exposure through repeatedly recounting the traumatic narrative out loud</li> <li>▪ Recounting is often in present tense, eyes closed, reinforced by being asked to listen to an audio recording of the narrative process between treatment sessions</li> <li>▪ This is combined with in vivo exposure and emotional processing of the narrative experience</li> </ul>
<b>Cognitive Processing Therapy and Other Trauma-focused Cognitive Therapies</b>	<ul style="list-style-type: none"> <li>▪ Emphasize cognitive restructuring through Socratic dialogue</li> <li>▪ Goal is to examine problematic beliefs, emotions and negative appraisals stemming from the event, such as self-blame or mistrust</li> </ul>
<b>Eye Movement Desensitization and Reprocessing</b>	<ul style="list-style-type: none"> <li>▪ Incorporates imaginal exposure through narration and visualization to process the worst image, emotion and negative cognition associated with the traumatic event, along with a more healthy cognitive reappraisal, with bilateral eye movements or other form of bilateral stimulation</li> <li>▪ Intended to create a dual awareness environment to facilitate processing and relaxation</li> </ul>
<b>Brief Eclectic Therapy</b>	<ul style="list-style-type: none"> <li>▪ Has a strong psychodynamic perspective</li> <li>▪ Also incorporates imaginal exposure, written narrative processes, cognitive restructuring through attention to meaning and integration of the experience, relaxation techniques, and a metaphorical ritual closing to leave the traumatic event in the past and foster a sense of control</li> </ul>
<b>Narrative Exposure Therapy</b>	<ul style="list-style-type: none"> <li>▪ Relies on imaginal exposure through a structured oral life-narrative process that helps patients integrate and find meaning in multiple traumatic experiences across their lifespan</li> <li>▪ Written narrative exposure alone has been shown to be effective as a stand-alone and simple way to deliver exposure therapy</li> </ul>

Psychotherapy	Characteristics
Non-trauma-focused Therapies	
Stress Inoculation Training	<ul style="list-style-type: none"> <li>Does not include a direct exposure to, or cognitive focus on, the traumatic event</li> <li>A form of cognitive restructuring</li> <li>Targets individual thinking patterns that lead to stress responses in everyday life</li> </ul>
Present-Centered Therapy	<ul style="list-style-type: none"> <li>Does not include a direct exposure to, or cognitive focus on, the traumatic event</li> <li>Focuses on current problems in a patient's life that are related to PTSD</li> </ul>
Interpersonal Psychotherapy	<ul style="list-style-type: none"> <li>Does not include a direct exposure to, or cognitive focus on, the traumatic event</li> <li>Focuses on the impact that trauma has had on an individual's interpersonal relationships</li> </ul>

*There is insufficient evidence to recommend using individual components of manualized psychotherapy protocols over or in addition to the full therapy protocol* **(Recommendation 14, Insufficient Evidence, New-added).**

- Relatively few studies have examined whether modifying psychotherapy protocols by adding components of other effective psychotherapies is beneficial, or conversely, whether the components of a multi-component protocol are as effective as the complete protocol
- The evidence shows inconsistent results and does not support any strong conclusions and there is insufficient evidence to determine whether the harms and benefits differ for combined or separated treatments relative to the original protocols
- The primary focus of research in this area has been on adding different components to exposure therapy – several studies have examined the potential benefits of adding cognitive restructuring to exposure
- If modifications to an established protocol (e.g., PE, CPT, EMDR) are clinically necessary, the modifications should be empirically and theoretically guided, and with understanding of the core components of trauma-focused psychotherapies considered most therapeutically active

*Manualized group therapy over no treatment is suggested. There is insufficient evidence to recommend using one type of group therapy over any other* **(Recommendation 15, Weak For, New-replaced).**

- The limited data on the efficacy of group therapy for PTSD indicates that it is not as effective as individual therapy
- Some patients with PTSD may prefer manualized group psychotherapy over other treatment formats
- The research has not shown any particular model of manualized trauma-focused or non-trauma-focused group psychotherapy for PTSD to be superior to other active interventions, such as PCT, psychoeducation or treatment as usual
- However, group psychotherapy is better than no treatment in reducing PTSD symptoms
- A trade-off to taking part in group psychotherapy may be that individuals do so at the expense of taking part in individual trauma-focused therapy or other treatments that have greater empirical support
- Patient factors that may warrant consideration include a preference for individual trauma-focused psychotherapy, willingness to disclose personal information in a group, and potential value of group approaches such as the comradery, milieu and social support

Clinical programming that offers group treatment instead of individual treatment may seem like a cost-efficient way to treat more patients more quickly. However, given the absence of evidence that group treatment is as effective as individual trauma-focused psychotherapy, it is not advisable to conclude that group treatment is sufficiently cost-effective.

*There is insufficient evidence to recommend for or against trauma-focused or non-trauma-focused couples therapy for the primary treatment of PTSD (Recommendation 16, Insufficient Evidence, Amended).*

- In some cases, veterans may prefer PTSD treatment that includes attention focused on their intimate relationships
- There are no studies that compare individual trauma-focused treatment for PTSD to a couples-based approach
- Overall, there is promising but limited evidence in support of trauma-focused couples therapy for PTSD

## Pharmacotherapy

The table below shows medication monotherapy for the treatment of PTSD according to their recommendation and evidence.

Medication monotherapy for the treatment of PTSD by recommendation and strength of evidence

Quality of Evidence*	Recommend For	Suggest For	Suggest Against	Recommend Against	No Recommendation For or Against
Moderate	Sertraline^ Paroxetine^ Fluoxetine Venlafaxine		Prazosin (excluding the treatment of PTSD associated nightmares)		Prazosin for the treatment of PTSD associated nightmares
Low		Nefazodone±	Quetiapine Olanzapine Citalopram Amitriptyline	Divalproex Tiagabine Guanfacine	Eszopiclone
Very Low		Imipramine Phenelzine±	Lamotrigine Topiramate	Risperidone Benzodiazepines D-cycloserine Hydrocortisone Ketamine	Bupropion Desipramine D-serine Escitalopram Mirtazapine

Quality of Evidence*	Recommend For	Suggest For	Suggest Against	Recommend Against	No Recommendation For or Against
No Data					<u>Antidepressants:</u> Doxepin Duloxetine‡ Desvenlafaxine Fluvoxamine‡ Levomilnacipran Nortriptyline Trazodone Vilazodone Vortioxetine <u>Anxiolytic/Hypnotics:</u> Buspirone‡ Cyproheptadine Hydroxyzine Zaleplon Zolpidem

\* The Work Group determined there was no high quality evidence regarding medication monotherapy

^ FDA approved for PTSD

± Serious potential toxicity, should be managed carefully

† No data were captured in the evidence review and were not considered in the development of this table

‡ Studies of these drugs did not meet the inclusion criteria for the systematic evidence review due to poor quality

Sertraline, paroxetine, fluoxetine or venlafaxine are strongly recommended as monotherapy for PTSD for patients diagnosed with PTSD who choose not to engage in or are unable to access trauma-focused psychotherapy (**Recommendation 17, Strong For, New-replaced**).

- The benefits of these medications outweigh the potential harms
- The most frequent adverse effects of selective serotonin reuptake inhibitors (SSRIs) include sexual dysfunction, increased sweating, gastrointestinal upset and drowsiness/fatigue
- In 2004, the Food and Drug Administration (FDA) issued a black box warning stating that, compared to placebo, antidepressants increase the risk of suicidal thinking and behavior (suicidality) in children, adolescents and young adults; however, there does not appear to be an increase in the risk of suicidality in adults beyond age 24 and there may be a reduced risk in adults age 65 and older
- Venlafaxine shares these potential harms and can increase blood pressure at higher dosages
- Patient preferences and comorbidities should be considered when deciding between these agents



Patients taking selective serotonin reuptake inhibitors (SSRIs) and norepinephrine reuptake inhibitors (SNRIs) should have their dose tapered in order to reduce the chances of precipitating a discontinuation reaction, with the exception of fluoxetine (due to its long half-life).

*Nefazodone, imipramine or phenelzine are suggested as monotherapy for the treatment of PTSD if recommended pharmacotherapy (see Recommendation 17), trauma-focused psychotherapy (see Recommendation 11) or non-trauma-focused psychotherapy (see Recommendation 12) are ineffective, unavailable or not in accordance with patient preference and tolerance (NOTE: Nefazodone and phenelzine have potentially serious toxicities and should be managed carefully) (Recommendation 18, Weak For, New-replaced).*

- Although additional research on nefazodone, imipramine and phenelzine has been lacking over the past decade, the few previously published placebo-controlled studies demonstrated modest therapeutic effects of these medications for the treatment of PTSD
- These medications have fallen out of use by most clinicians due to their unwanted side effect profile, that includes, for example, rare cases of liver toxicity caused by nefazodone, anticholinergic, cardiac, and sedative effects of imipramine, and risk of hypertensive crisis with phenelzine if the patient does not follow a low tyramine diet and avoid contraindicated medications when using monoamine oxidase inhibitors (MAOIs)
- With careful monitoring, these medications can be used safely

- Patients may prefer one of these medications due to their sleep-enhancing effects and reduced sexual side effects, but may feel burdened by the need for periodic liver function testing (nefazodone), electrocardiograms (imipramine) or dietary/medication restrictions (phenelzine)

*Treatment of PTSD with quetiapine, olanzapine and other atypical antipsychotics (except for risperidone, which is a Strong Against, see Recommendation 20), citalopram, amitriptyline, lamotrigine or topiramate as monotherapy is suggested against due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks (Recommendation 19, Weak Against, New-replaced).*

- Antipsychotics can produce metabolic adverse effects (harms) that may exacerbate a patient's comorbidities or result in new medical problems
- Metabolic effects, including hyperglycemia, new onset diabetes, weight gain and increased lipid concentrations, can occur with all of the atypical antipsychotics
- Higher potency second generation antipsychotics also have a higher incidence of producing extrapyramidal effects, including akathisia and pseudo-parkinsonism, as well as hyperprolactinemia, which can result in sexual dysfunction and gynecomastia
- Antiepileptic drugs, including topiramate and lamotrigine, have a FDA warning of an increased risk of suicidal thoughts or behaviors:
  - Topiramate is known to cause paresthesias, hyperammonemia, kidney stones and cognitive side effects, including transient impaired learning and memory
  - Lamotrigine must be titrated very slowly and carries a risk of serious rash if dose titration recommendations are not followed carefully, especially in combination with valproate

**CAUTION** All antipsychotics are associated with an increased risk of stroke in elderly patients and death in elderly patients with dementia.

*Treating PTSD with divalproex, tiagabine, guanfacine, risperidone, benzodiazepines, ketamine, hydrocortisone or D-cycloserine as monotherapy is strongly recommended against due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks (Recommendation 20, Strong Against, New-replaced).*

- Antiepileptic drugs, including divalproex and tiagabine, have a FDA black box warning for an increased risk of suicidal thoughts or behaviors – therefore, divalproex or tiagabine for the treatment of PTSD are recommended against due to the lack of efficacy in the context of significant side effects
- Divalproex requires periodic laboratory testing of liver enzymes and platelets and has significant risks of weight gain, hirsutism, polycystic ovarian syndrome and teratogenicity, which may negatively impact patient acceptability and preferences, especially in women of childbearing potential

- The use of risperidone and benzodiazepines as monotherapy for the primary treatment of PTSD is recommended against due to very low quality of evidence and because the potential harms outweigh the benefits
- Because benzodiazepine use is associated with tolerance and dependence, it can be very difficult to discontinue these medications due to significant withdrawal symptoms
- Furthermore, preclinical evidence suggests that benzodiazepines may actually interfere with the extinction of fear conditioning and/or potentiate the acquisition of fear responses and worsen recovery from trauma
- In the context of limited information on the efficacy of ketamine in PTSD combined with its significant side effects and potential for abuse, the use of ketamine for the primary treatment of PTSD in a clinical setting is recommended against
- There is no evidence for the efficacy of hydrocortisone in the primary treatment of PTSD

*Treating PTSD with cannabis or cannabis derivatives is strongly recommended against due to the lack of evidence for their efficacy, known adverse effects, and associated risks (Recommendation 21, Strong Against, New-added).*

- Preliminary evidence that natural and synthetic cannabinoids could improve PTSD symptoms, particularly nightmares, is offset by the significant side effects, including tolerance, dependence, withdrawal syndrome, psychosis, cognitive deficits and respiratory symptoms if smoked
- The lack of well-designed randomized controlled trials (RCTs) evaluating the efficacy of cannabinoids in large samples of patients with PTSD, together with its serious side effects, does not support the use of natural or synthetic cannabinoids as a treatment for PTSD

*There is insufficient evidence to recommend for or against monotherapy or augmentation therapy for the treatment of PTSD with eszopiclone, escitalopram, bupropion, desipramine, doxepin, D-serine, duloxetine, desvenlafaxine, fluvoxamine, levomilnacipran, mirtazapine, nortriptyline, trazodone, vilazodone, vortioxetine, buspirone, hydroxyzine, cyproheptadine, zaleplon and zolpidem (Recommendation 22, Insufficient Evidence, New-replaced).*

- Medications listed in this recommendation are based on the following criteria:
  - Absence of studies
  - Studies reported conflicting results
  - Studies reported inconclusive results



Benzodiazepines are also relatively contraindicated in patients with history of traumatic brain injury (TBI), sleep apnea, chronic obstructive pulmonary disorder (COPD) or who have high rates of comorbid alcohol misuse and SUD, particularly veterans with combat-related PTSD.

- As of yet, there are no RCTs that would support the use of any of these agents as monotherapy
- Escitalopram, duloxetine, desvenlafaxine, levomilnacipran, vilazodone, vortioxetine and fluvoxamine have not been studied sufficiently to warrant a recommendation
- Currently, there is no evidence for the efficacy of bupropion in the treatment of core symptoms of PTSD – however, it is recognized that bupropion may be prescribed to manage antidepressant-induced sexual dysfunction, concurrent attention deficit disorder or smoking cessation in patients with a diagnosis of PTSD
- There is insufficient evidence to recommend for or against mirtazapine and eszopiclone as monotherapy for PTSD
- There is no evidence for the efficacy of D-serine in the primary treatment of PTSD

## Augmentation Therapy

The table below shows medication augmentation and combination pharmacotherapy for the treatment of PTSD according to their recommendation and evidence.

**Medication augmentation and combination\* pharmacotherapy for the treatment of PTSD by recommendation and strength of evidence**

Quality of Evidence±	Recommend For	Suggest For	Suggest Against	Recommend Against	No Recommendation For or Against
Moderate			Prazosin (excluding the treatment of PTSD associated nightmares)	Risperidone	Prazosin for the treatment of PTSD associated nightmares
Low			Topiramate	Divalproex Olanzapine	Hydrocortisone
Very Low			Baclofen Pregabalin D-cycloserine†		Mirtazapine and Sertraline^
No Data‡				Other atypical antipsychotics	Any drug not listed

\*Combination means treatments are started simultaneously; augmentation means one treatment is started after another treatment (all treatments are augmentation unless otherwise noted)

±The Work Group determined there was no high quality evidence regarding medication augmentation and combination therapy

†Outside of a research setting

^Combination treatment

‡No data were captured in the evidence review and were not considered in development of this table

*The use of topiramate, baclofen or pregabalin as augmentation treatment of PTSD is suggested against due to insufficient data and/or known adverse effect profiles and associated risks (Recommendation 23, Weak Against, New-replaced). Combining exposure therapy with D-cycloserine in the treatment of PTSD outside of the research setting is suggested against (Recommendation 24, Weak Against, New-added). Using atypical antipsychotics, benzodiazepines and divalproex as augmentation therapy for the treatment of PTSD is strongly recommended against due to low quality evidence or the absence of studies and their association with known adverse effects (Recommendation 25, Strong Against, New-replaced).*

- Risperidone and olanzapine are the only atypical antipsychotics to have been studied as augmentation treatment for PTSD
- Atypical antipsychotics, other than risperidone and olanzapine, have not been studied as augmentation therapy for PTSD – since the risks of these medications outweigh the unknown benefits, recommendation is against augmentation using atypical antipsychotics
- The use of benzodiazepines as augmentation therapy is recommended against due to the lack of evidence for effectiveness and because the risks outweigh potential benefits:
  - Historically, benzodiazepines, particularly alprazolam and clonazepam, were frequently used as a primary agent or “as needed” for the treatment of PTSD despite the lack of evidence of efficacy in RCTs
  - Because benzodiazepine use is associated with tolerance and dependence, it can be very difficult to discontinue these medications due to significant withdrawal symptoms
  - Benzodiazepines are also relatively contraindicated in patients with a history of TBI, sleep apnea, COPD or who have high rates of comorbid alcohol misuse and SUD, particularly veterans with combat-related PTSD

*There is insufficient evidence to recommend the combination of exposure therapy with hydrocortisone outside of the research setting (Recommendation 26, Insufficient Evidence, New-added). There is insufficient evidence to recommend for or against the use of mirtazapine in combination with sertraline for the treatment of PTSD (Recommendation 27, Insufficient Evidence, New-replaced).*

- Barriers to implementation include the requirement for a clinician trained in exposure therapy and a prescribing provider to synchronize their efforts
- Additional research into identification of certain subtypes of patients, proper hydrocortisone dose, timing of administration and other factors is warranted
- Additional research regarding the combination of sertraline with mirtazapine for PTSD treatment is required

## Prazosin

*For global symptoms of PTSD, the use of prazosin as mono- or augmentation therapy is suggested against (Recommendation 28a, Weak Against, New-replaced). For nightmares associated with PTSD, there is insufficient evidence to recommend for or against the use of prazosin as mono- or augmentation therapy (Recommendation 28b, Insufficient Evidence, New-replaced).*

- Despite the fact that prazosin has been used for managing PTSD-associated nightmares in recent years, there is insufficient evidence to recommend for or against the use of prazosin as mono- or augmentation therapy for nightmares or sleep disturbance associated with PTSD
- It is recognized that these recommendations constitute a significant reversal of prazosin's role in the current management of PTSD
- In patients who believe it to be beneficial, the continuation of prazosin is neither recommended for or against; the decision to stop or continue prazosin should be individualized and made using SDM — prazosin may need to be continued or restarted in some patients



### CAUTION

If patients and/or providers decide to discontinue prazosin, a slow taper of the dose is suggested, while monitoring for symptom worsening or reappearance.

## Combination Therapy

*In partial- or non-responders to psychotherapy, there is insufficient evidence to recommend for or against augmentation with pharmacotherapy (Recommendation 29, Insufficient Evidence, New-replaced). In partial- or non-responders to pharmacotherapy, there is insufficient evidence to recommend for or against augmentation with psychotherapy (Recommendation 30, Insufficient Evidence, New-replaced). There is insufficient evidence to recommend for or against starting patients with PTSD on combination pharmacotherapy and psychotherapy (Recommendation 31, Insufficient Evidence, New-added).*

- Although many patients show clinical improvement in response to recommended evidence-based psychotherapies and/or pharmacotherapies, a sizable proportion of patients are partial- or non-responders
- Determining what to do for these patients is a clinically important question, yet the limited evidence available is insufficient to guide clinical decision making
- Limited studies have examined the benefits of administering medication and psychotherapy to either augment a single initial modality following inadequate response, or as a combination at the outset of therapy

## Non-pharmacological Biological Treatments

*There is insufficient evidence to recommend for or against the following somatic therapies: repetitive transcranial magnetic stimulation (rTMS), electroconvulsive therapy (ECT), hyperbaric oxygen therapy (HBOT), stellate ganglion block (SGB) or vagal nerve stimulation (VNS) (Recommendation 32, Insufficient Evidence, New-replaced).*

- Although there is a great deal of interest in rTMS for the treatment of PTSD, data supporting its use is not robust – there is a limited number of trials and a lack of uniformity among studies in terms of location, frequency and intensity of treatment
- There is considerable interest in alternatives to either psychotherapy or pharmacology for the primary treatment of PTSD; however, there is currently insufficient evidence to recommend the majority of somatic therapies, including ECT, HBOT, SGB or VNS
- There is no conclusive evidence that HBOT is effective for treating PTSD – there have been no RCTs or uncontrolled trials specifically focused on patients with PTSD, and there is disagreement about what constitutes an adequate sham treatment
- Based on the evidence to date, and the practical and cost concerns, it does not appear that HBOT is a promising treatment for further study

## Complementary and Integrative Treatments

*There is insufficient evidence to recommend acupuncture as a primary treatment for PTSD (Recommendation 33, Insufficient Evidence, New-replaced). There is insufficient evidence to recommend any complementary and integrative health (CIH) practice, such as meditation (including mindfulness), yoga and mantram meditation, as a primary treatment for PTSD (Recommendation 34, Insufficient Evidence, New-replaced).*

- Overall, it is recognized that CIH practices are increasingly offered as part of the treatment of PTSD and that these practices hold promise as interventions to improve wellness and promote recovery
- Practitioners should consider factors such as patient preference and treatment availability when determining CIH treatment options
- Safety data suggest that acupuncture is not associated with any serious adverse events, but some participants report minor/moderate needle pain, superficial bleeding and hematoma
- There is an insufficient number of staff trained in acupuncture within the VA and DoD health care systems to be able to offer it widely

Meditation is promising and may provide a safe, self-administered and inexpensive intervention for PTSD – unfortunately, the current research clearly does not establish its efficacy.

- Meditation interventions, in particular, offered as augmentation treatments to treatment as usual – including yoga, mindfulness-based stress reduction (MBSR) and mantram repetition – statistically significantly reduced PTSD symptoms compared with all comparators across all sources of trauma; however, at this time there are methodologic concerns that make it difficult to recommend any specific type of meditation
- Research is needed to provide more information not only about meditation but other types of CIH as well for the primary and augmentation treatment of PTSD

## Technology-based Treatment Modalities

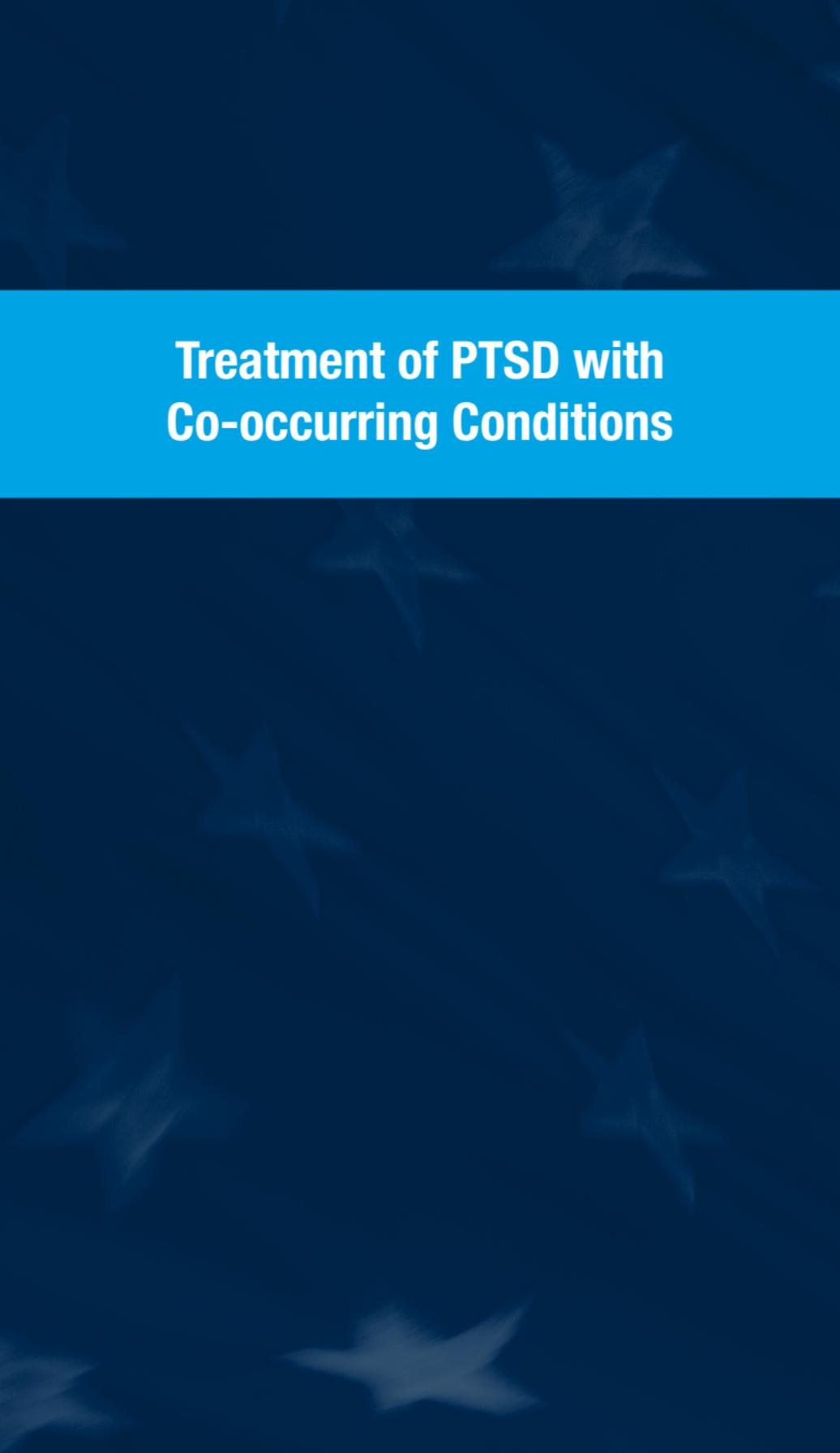
*Internet-based cognitive behavioral therapy (iCBT) with feedback provided by a qualified facilitator is suggested as an alternative to no treatment (Recommendation 35, Weak For, New-replaced).*

- These interventions may be suggested for patients who refuse other treatment interventions
- Several studies have shown beneficial effects of supported iCBT for PTSD symptoms when support is provided by a qualified facilitator (e.g., care manager, trained peer, therapist)
- There are many potential advantages of iCBT, including:
  - Increased access to services
  - Reduced stigma in seeking services
  - Convenience
  - Interventions can be completed on the patient's own schedule
  - Participation in supervised iCBT programs could be potentially very helpful to those in remote areas, locations where other services are not readily available or when irregular hours preclude conventional clinical care
- There are concerns that unsupervised iCBT or supervision by a peer not adequately trained to deal with a mental health crisis could be a potential harm
- Potential barriers, including knowledge and/or availability of technology, technical support and cost may prevent some individuals from using these approaches
- The use of supported iCBT is suggested with the following considerations:
  - Clinicians should carefully review the content of any web-based materials to ensure their accuracy and ethical application before recommending their use to patients
  - Web-based approaches may be used when face-to-face interventions are not feasible (e.g., geography limits access to other forms of treatment) or when patients decline more traditional mental health interventions

- Providers should regularly encourage patients to complete the intervention and endeavor to maintain and strengthen the therapeutic relationship, build patient rapport, stress practice and assignment completion and ensure adequacy of safety protocols
- Providers should be available for telephone contact for initial assessment or other reasons (e.g., emergencies, suicidality/homicidality or follow-up of specific problems)
- Providers using technology-assisted interventions should take steps to ensure that their work complies with the regulations and procedures of the organization in which they are employed, legal standards and the ethical standards of their professions
- Patient confidentiality and safety should be monitored closely

*Trauma-focused psychotherapies that have demonstrated efficacy using secure video teleconferencing (VTC) modality is strongly recommended when PTSD treatment is delivered via VTC (Recommendation 36, Strong For, Amended).*

- Although there are fewer studies examining the delivery of evidence-based treatments through VTC than those delivered in-person, there appears to be similar efficacy for VTC interventions as compared to the in-person delivery of services
- VTC interventions are encouraged when:
  - In-person interventions are not feasible due to geographic distance between patient and provider or other barriers to patient access (e.g., agoraphobia, physical disability)
  - The patient would benefit from more frequent contact than is feasible with face-to-face sessions
  - The patient declines in-person treatment
- Providers using VTC interventions should endeavor to maintain and strengthen the therapeutic relationship, build patient rapport, stress practice and assignment completion, and ensure adequacy of safety protocols using similar techniques as they do in-person
- Providers using VTC should take steps to ensure that their work complies with the regulations and procedures of the organization in which they are employed, legal standards and the ethical standards of their professions
- Patient confidentiality and safety should be monitored closely



# Treatment of PTSD with Co-occurring Conditions

## Tab 7 – TREATMENT OF PTSD WITH CO-OCCURRING CONDITIONS

*It is strongly recommended that the presence of co-occurring disorder(s) not prevent patients from receiving other VA/DoD guideline-recommended treatments for PTSD (Recommendation 37, Strong For, New-added). VA/DoD guideline-recommended treatments for PTSD in the presence of co-occurring SUD are strongly recommended. (Recommendation 38, Strong For, New-replaced).*

- The vast majority of patients with PTSD will have one or more co-occurring mental health disorders
- Comorbid medical and psychiatric conditions are important to recognize because they can modify clinical determinations of prognosis, patient or provider treatment priorities, selection of interventions and the setting where PTSD care will be provided
- Some comorbid medical or psychiatric conditions may require early specialist mental health consultation in order to assist in determining treatment priorities
- Treatment studies of PTSD with various co-occurring disorders have shown that individuals with comorbid conditions can tolerate and benefit from evidence-based individual trauma-focused PTSD treatment, such as PE and CPT
- Concurrent treatment of PTSD and SUDs also presumes that sufficient resources (e.g., programs, therapists) exist to treat both simultaneously and that providers are skilled in the management of co-occurring disorders
- Patient factors related to SUD that may warrant consideration include:
  - Possible denial of their SUD
  - Reluctance to stop using a substance perceived as beneficial for coping with PTSD symptoms
  - Ambivalence about engaging in treatment for either PTSD or SUDs



Suicidality in particular should be assessed early on and carefully monitored.

Because of the many potential etiologies of co-occurring conditions, it is generally best to develop a collaborative care treatment strategy to address these health concerns simultaneously with PTSD symptoms.

- To improve management of PTSD symptoms when they are complicated by the presence of a medical or psychiatric comorbidity, providers may consider the following:
  - Recognize that medical disorders/symptoms, mental health disorders and psychosocial problems commonly coexist with PTSD and that they should assess for them during the evaluation and treatment of PTSD

- Because of the high prevalence of psychiatric comorbidities in the PTSD population, screening for depression and other psychiatric disorders is warranted (see also the VA/DoD CPGs for the Management of Major Depressive Disorder [MDD] and the Management of Bipolar Disorder)
- Providers should assess and carefully monitor suicide risk (see the VA/DoD CPG for Assessment and Management of Patients at Risk for Suicide)
- Patterns of current and past use of substances by persons with trauma histories or PTSD should be routinely assessed to identify substance misuse or dependency (alcohol, nicotine, prescribed drugs, and illicit drugs) (see also Recommendation 38 on the management of PTSD in the presence of co-occurring SUD and the VA/DoD CPG for SUD)
- Pain (acute and chronic) and sleep disturbances should be assessed in all patients with PTSD (see Recommendation 39 regarding management of PTSD in the presence of co-occurring sleep disorders)
- Generalized physical and cognitive health symptoms, also attributed to mild traumatic brain injury (mTBI) and many other causes, should be assessed and managed in patients with PTSD and co-occurring diagnoses (see VA/DoD CPG for the Management of Concussion/mTBI and VA/DoD CPG for the Management of Chronic Multisymptom Illness)
- Associated high-risk behaviors (e.g., smoking, alcohol/drug use, unsafe weapon storage, dangerous driving, unprotected sex, needle sharing, human immunodeficiency virus, hepatitis risks) should be assessed in patients with PTSD and addressed in the treatment plan
- Providers should consider the existence of comorbid conditions when deciding whether to treat patients in the primary care or general mental health setting, or refer them for specialty mental health care
- Patients with complicated comorbidity may be referred to mental health or PTSD specialty care for evaluation and diagnosis

## PTSD and comorbid sleep disturbances

*An independent assessment of co-occurring sleep disturbances in patients with PTSD, particularly when sleep problems pre-date PTSD onset or remain following successful completion of a course of treatment, is strongly recommended (Recommendation 39, Strong For, New-replaced). Cognitive behavioral therapy for insomnia (CBT-I) for insomnia in patients with PTSD is strongly recommended unless an underlying medical or environmental etiology is identified or severe sleep deprivation warrants the immediate use of medication to prevent harm (Recommendation 40, Strong For, Amended).*

- Sleep disturbance is found in 90 – 100 percent of veterans with PTSD
- Some types of sleep disturbance, such as anxiety about falling asleep due to nightmares, are fairly unique to PTSD
- Others, including obstructive sleep apnea, restless leg syndrome and early morning awakening may occur in patients with PTSD, but are likely to have an alternative etiology and should be considered as co-occurring disorders

- Sleep disturbances often do not improve after otherwise effective first-line PTSD treatments – it is thus important to examine potential causes of sleep disturbance independently of PTSD, particularly with respect to underlying medical, dietary and environmental etiologies
- Treating nightmares is an integral part of treating sleep disturbance in PTSD; however, the data are somewhat inconclusive regarding the best choice of intervention
- CBT-I continues to offer the strongest evidence and greatest promise – it is a particularly attractive modality because:
  - Training is widely available in the VA and DoD
  - It can be delivered in individual or group format
  - It requires only a few sessions

# Medication Tables

## Tab 8 – MEDICATION TABLES

The following tables include dosing guidance and clinical considerations for selected monotherapy treatments for PTSD. Refer to the pharmaceutical manufacturer's literature for full prescribing information. The tables list commonly prescribed medications for PTSD. The decision to use one medication over another should be based on individual patient factors, symptom complaints and potential side effects as well as evidence from research.

### **SUICIDALITY AND ANTIDEPRESSANTS BLACK BOX WARNING:**

**Antidepressants increased the risk compared to placebo of suicidal thinking and behavior (suicidality) in children, adolescents and young adults in short-term studies of major depressive disorder (MDD) and other psychiatric disorders. Depression and certain other psychiatric disorders are themselves associated with increases in the risk of suicide. Patients of all ages who are started on antidepressant therapy should be monitored appropriately and observed closely for clinical worsening, suicidality or unusual changes in behavior. Families and caregivers should be advised of the need for close observation and communication with the prescriber.**

## Selective Serotonin Reuptake Inhibitors (SSRIs)

Drug	Initial Dose	Dose Range	Black Box Warning
<b>Fluoxetine</b> <i>Strong For recommendation</i>	10 – 20 mg daily	20 – 80 mg daily	Yes

**Contraindications:** The use of fluoxetine is contraindicated with the following medications – monoamine oxidase inhibitors (MAOIs), pimozide and thioridazine.

### Clinical Considerations:

- When using fluoxetine and olanzapine in combination, also refer to Boxed Warning and Precautions sections of the package insert for olanzapine and fluoxetine hydrochloride capsules
- Avoid abrupt discontinuation; risk for withdrawal symptoms with sudden discontinuation of SSRIs and SNRIs
- Common adverse effects of the SSRIs include nausea, headache, diarrhea, anxiety, nervousness, sexual dysfunction, agitation, dizziness, hyponatremia or syndrome of inappropriate anti-diuretic (SIADH) and serotonin syndrome
- Food and Drug Administration (FDA) pregnancy category: C
- If fluoxetine is required by the mother, it is not a reason to discontinue breastfeeding; agents (e.g., paroxetine, sertraline) with lower excretion into breast milk may be preferred

Drug	Initial Dose	Dose Range	Black Box Warning
<b>Paroxetine</b> <i>Strong For recommendation</i>	10 – 20 mg daily	20 – 50 mg daily	Yes

**Contraindications:** The use of MAOIs intended to treat psychiatric disorders with paroxetine or within 14 days of stopping treatment with paroxetine is contraindicated because of an increased risk of serotonin syndrome. The use of paroxetine within 14 days of stopping an MAOI intended to treat psychiatric disorders is also contraindicated. Starting paroxetine in a patient who is being treated with MAOIs such as linezolid or intravenous methylene blue is also contraindicated because of an increased risk of serotonin syndrome. Concomitant use with thioridazine is contraindicated. Concomitant use in patients taking pimozide is contraindicated. Paroxetine is contraindicated in patients with a hypersensitivity to paroxetine or any of the inactive ingredients in paroxetine tablets.

**Clinical Considerations:**

- Paroxetine has FDA label indications for treating PTSD
- Avoid abrupt discontinuation; withdrawal symptoms with sudden discontinuation of SSRIs and SNRIs, paroxetine and venlafaxine in particular
- Common adverse effects of the SSRIs include nausea, headache, diarrhea, anxiety, nervousness, sexual dysfunction, agitation, dizziness, hyponatremia or SIADH and serotonin syndrome
- FDA pregnancy category: D
- Paroxetine is considered one of the preferred antidepressants during breastfeeding due to lower excretion into breast milk

Drug	Initial Dose	Dose Range	Black Box Warning
<b>Sertraline</b> <i>Strong For recommendation</i>	25 – 60 mg daily	50 – 200 mg daily	Yes

**Contraindications:** Concomitant use in patients taking MAOIs is contraindicated. Concomitant use in patients taking pimozide is contraindicated. Sertraline tablets are contraindicated in patients with a hypersensitivity to sertraline or with any of the inactive ingredients in sertraline tablets.

**Clinical Considerations:**

- Sertraline has FDA label indications for treating PTSD
- Avoid abrupt discontinuation; withdrawal symptoms with sudden discontinuation of SSRIs and SNRIs, paroxetine and venlafaxine in particular
- Common adverse effects of the SSRIs include nausea, headache, diarrhea, anxiety, nervousness, sexual dysfunction, agitation, dizziness, hyponatremia or SIADH and serotonin syndrome
- FDA pregnancy category: C
- Sertraline is considered one of the preferred antidepressants during breastfeeding due to lower excretion into breast milk

## Serotonin Norepinephrine Reuptake Inhibitors (SNRIs)

Drug	Initial Dose	Dose Range	Black Box Warning
Venlafaxine <i>Strong For recommendation</i>	IR: 25 mg 2 or 3 times a day XR: 37.5 mg once daily	75 – 375 mg in 2 – 3 divided doses 75 – 225 mg once daily	Yes

**Contraindications:** The use of MAOIs intended to treat psychiatric disorders with venlafaxine hydrochloride or within 7 days of stopping treatment with venlafaxine hydrochloride is contraindicated because of an increased risk of serotonin syndrome. The use of venlafaxine hydrochloride within 14 days of stopping an MAOI intended to treat psychiatric disorders is also contraindicated. Hypersensitivity to venlafaxine hydrochloride or to any excipients in the formulation.

### Clinical Considerations:

- Avoid abrupt discontinuation; withdrawal symptoms with sudden discontinuation of SSRIs and SNRIs, paroxetine and venlafaxine in particular
- Common adverse effects of the SNRIs include nausea, headache, diarrhea, anxiety, nervousness, sexual dysfunction, agitation, dizziness, hyponatremia or SIADH and serotonin syndrome
- Venlafaxine can elevate blood pressure; caution advised with patients with hypertension
- FDA pregnancy category: C
- If venlafaxine is required by the mother, it is not a reason to discontinue breastfeeding; agents (e.g., paroxetine, sertraline) with lower excretion into breast milk may be preferred

## Tricyclic Antidepressants (TCAs)

Drug	Initial Dose	Dose Range	Black Box Warning
Imipramine Weak For recommendation	25 – 75 mg daily	100 – 300 mg in 1 or 2 divided doses	Yes

**Contraindications:** The concomitant use of MAOIs is contraindicated; hyperpyretic crises or severe convulsive seizures may occur in patients receiving such combinations and the potentiation of adverse effects can be serious, or even fatal. The drug is contraindicated during the acute recovery period after a myocardial infarction (MI). Patients with a known hypersensitivity to this compound should not be given the drug.

### Clinical Considerations:

- Avoid TCAs within three months of an acute MI
- TCAs are relatively contraindicated in patients with coronary artery disease or prostatic enlargement
- TCAs side effects include dry mouth, dry eyes, constipation, orthostatic hypotension, tachycardia, ventricular arrhythmias, weight gain and drowsiness; photosensitivity may occur
- FDA pregnancy category: Not assigned
- Imipramine is considered one of the preferred antidepressants during breastfeeding due to lower excretion into breast milk

## Monoamine Oxidase Inhibitors (MAOIs)

Drug	Initial Dose	Dose Range	Black Box Warning
Phenelzine <i>Weak For recommendation</i>	15 mg 3 times daily	15 mg daily; 90 mg in divided doses	Yes

**Contraindications:** Concomitant use with meperidine is contraindicated. The concurrent administration of an MAOI and bupropion hydrochloride (Wellbutrin®) is contraindicated. Patients with a known hypersensitivity to this compound should not be given the drug. Patients with pheochromocytoma, congestive heart failure, severe renal impairment or renal disease, a history of liver disease or abnormal liver function tests should not be given the drug.

### Clinical Considerations:

- Phenelzine considerations include drug-drug and drug-food interactions, risk of hypertensive crisis, hypotension and anticholinergic effects
- FDA pregnancy category: C
- If phenelzine is required by the mother, it is not a reason to discontinue breastfeeding; agents with lower excretion into breast milk may be preferred

## Other Monotherapy

Drug	Initial Dose	Dose Range	Black Box Warning
Nefazodone <i>Weak For recommendation</i>	25 – 100 mg 2 times daily	150 – 600 mg in 2 divided doses	Yes

**Contraindications:** Co-administration of terfenadine, astemizole, cisapride, pimozide, or carbamazepine with nefazodone hydrochloride is contraindicated. Nefazodone tablets are contraindicated in patients who were withdrawn from nefazodone because of evidence of liver injury. Nefazodone tablets are also contraindicated in patients who have demonstrated hypersensitivity to nefazodone hydrochloride, its inactive ingredients or other phenylpiperazine antidepressants.

### Clinical Considerations:

- Nefazodone is associated with life-threatening hepatic failure; monitor for signs and symptoms including liver function tests (LFTs); avoid if active liver disease; do not re-challenge
- Nefazodone is subject to many drug interactions, particularly those involving CYP3A4 and glycoprotein
- The co-administration of triazolam and nefazodone causes a significant increase in the plasma level of triazolam and a 75% reduction in the initial triazolam dosage is recommended if the two drugs are to be given together; because not all commercially available dosage forms of triazolam permit a sufficient dosage reduction, the co-administration of triazolam and nefazodone should be avoided for most patients, including the elderly
- FDA pregnancy category: C
- If nefazodone is required by the mother, it is not a reason to discontinue breastfeeding; agents (e.g., paroxetine, sertraline) with lower excretion into breast milk may be preferred

Page intentionally left blank

## References and Resources

# Tab 9 – REFERENCES AND RESOURCES

## References

- 1 Shared Decision Making: A Guide for Busy Clinicians. Retrieved from: <https://www.healthquality.va.gov/> and <https://www.qmo.amedd.army.mil>
- 2 American Psychiatric Association. (2013). Diagnostic and Statistical Manual of Mental Disorders (5th Edition). Washington, D.C.: American Psychiatric Publishing

## VA/DoD Resources

**Clinical Practice Guidelines (CPGs) can be accessed at <https://www.healthquality.va.gov/healthquality/guidelines/index.asp> and <https://www.qmo.amedd.army.mil/pguide.htm>:**

- VA/DoD CPG for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder
- VA/DoD CPG for the Management of Major Depressive Disorder
- VA/DoD CPG for the Management of Concussion/Mild Traumatic Brain Injury
- VA/DoD CPG for the Management of Chronic Multisymptom Illness
- VA/DoD CPG for Assessment and Management of Patients at Risk for Suicide
- VA/DoD CPG for the Management of Substance Use Disorders
- VA/DoD CPG for Management of Opioid Therapy for Chronic Pain

### **Military OneSource**

*Provides 24/7 support and information on housing, financial, legal, medical and psychological services*

Stateside 800-342-9647

Overseas 800-3429-6477

or collect 484-530-5908

[www.militaryonesource.mil](http://www.militaryonesource.mil)

### **National Center for Posttraumatic Stress Disorder**

*Provides education on trauma and PTSD and where to get help*

[www.ptsd.va.gov](http://www.ptsd.va.gov)

### **Real Warriors**

*Provides information and testimonies to share personal experiences which encourage service members and veterans to seek professional help quickly when it will have the greatest impact*

[www.realwarriors.net](http://www.realwarriors.net)

### **My HealtheVet**

*An online system for veterans to manage and track their health care*

[www.myhealth.va.gov](http://www.myhealth.va.gov)

## Psychological Health Center of Excellence

*Provides policies and evidence-based information and resources on psychological health in the military*  
[www.pdhealth.mil](http://www.pdhealth.mil)

## Mobile Apps



### PTSD Coach

*Provides education on PTSD that can be used alone or with psychological treatment*  
<http://t2health.dcoe.mil/apps/ptsd-coach>



### PTSD Family

*Provides support for family members of those with PTSD*  
[www.ptsd.va.gov/public/materials/apps/PTSDFamilyCoach.asp](http://www.ptsd.va.gov/public/materials/apps/PTSDFamilyCoach.asp)



### Breathe2Relax

*Provides diaphragm breathing exercises*  
<http://t2health.dcoe.mil/apps/breathe2relax>



### Tactical Breather

*Helps you gain control over physical and psychological responses to stress*  
<http://t2health.dcoe.mil/apps/tactical-breather>

## External Resources

Many resources are available for patients, family members and caregivers. Internet sites from established health care agencies or patient advocacy organizations are recommended over chat rooms, non-specialist or commercial sites. Recommended resources include:

### The National Institute of Mental Health

*Provides information on trauma and PTSD not specific to service members or veterans*

<https://www.nimh.nih.gov/health/topics/post-traumatic-stress-disorder-ptsd/index.shtml>

### The Substance Abuse and Mental Health Services Administration

*Provides information on trauma and PTSD not specific to service members or veterans*

<https://www.samhsa.gov/treatment/mental-disorders/post-traumatic-stress-disorder>



Updated March 2018 by the Psychological Health Center of Excellence (PHCoE)