

Posttraumatic Stress Disorder: VA/DOD Guideline for the Treatment of Posttraumatic Stress Disorder and Acute Stress Disorder (2017)

About the Guideline

- The guideline committee consisted of 41 individuals with expertise in the field of study.
- The committee provided 40 recommendations, based on a systematic review, for the management of patients with posttraumatic stress disorder (PTSD) and acute stress disorder (ASD).
- This clinical practice guideline (CPG) is intended to provide healthcare practitioners with a framework by which to evaluate, treat, and manage the individual needs and preferences of patients with PTSD and ASD.
- The patient population of interest for this CPG is adults who are eligible for care in the Department of Veterans Affairs (VA) and the Department of Defense (DoD) healthcare delivery systems. It includes veterans as well as deployed and nondeployed active duty service personnel, National Guard, and Reserves.

Key Clinical Considerations

Become familiar with the recommendations and best-practice statements provided in this guideline.

Definitions

Traumatic Events

- A traumatic event is defined in the Diagnostic and Statistical Manual of Mental Disorders fifth edition (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.
- There is a wide spectrum of psychological responses to traumatic events, ranging from nondebilitating symptoms to a transient acute stress reaction (ASR), to an acute, time-limited and clinically significant clinical acute stress disorder (ASD) to a persistent posttraumatic stress disorder (PTSD) that may become chronic, if untreated.
- The DSM-5 definition of traumatic events is the same for both ASD and PTSD.

Acute Stress Reaction (ASR)

- ASR is defined as a normal, transient reaction to trauma and is not a DSM-5 diagnosis, although symptoms can be temporarily debilitating.
- Combat and operational stress reaction (COSR) is the military equivalent of ASR and reflects a normal, transient, acute reaction to a high-stress operational or combat-related traumatic event in a military occupational setting.
- ASR/COSR can present with a broad group of physical, mental, behavioral, and emotional symptoms and signs such as depression, fatigue, anxiety, and panic.

Acute Stress Disorder (ASD)

- ASD, a diagnosis defined by DSM-5, can also occur after exposure to a traumatic event. Symptoms for ASD must last at least 3 days but less than 1 month after exposure to the traumatic event to be considered ASD.
- The symptoms of ASD cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, and are not attributable to the side effects of a substance, such as alcohol or medications, or a medical condition, such as a traumatic brain injury.
- There are two diagnostic criteria that need to be met for a diagnosis of ASD to be given:
 - Criteria A: Exposure to actual or threatened death, serious injury, or sexual violence by one or more of the following:
 - Direct experience
 - Witnessing the event in person
 - Learning the event occurred and involved a close friend or family member
 - Experiencing repeated first-hand exposure to traumatizing events, such as a first responder might experience
 - Criteria B: Presence of 9 or more of the following symptoms:
 - Intrusion symptoms
 - Distressing memories of the event
 - Recurrent distressing dreams
 - Dissociative reactions (flashbacks)
 - Intense prolonged psychological stress in response to cues of the event
 - Negative mood
 - Persistent inability to experience happiness, loving, positive emotions
 - Dissociative symptoms
 - Altered sense of reality
 - Inability to remember an important aspect of the traumatic event
 - Avoidance symptoms
 - Efforts to avoid distressing memories, thoughts, feelings of the event
 - Efforts to avoid external reminders (people, places, conversations, etc.), that arouse distressing memories of the traumatic event
 - Arousal symptoms
 - Sleep disturbance
 - Irritable behavior, angry outbursts (verbal or physical aggression)
 - Hypervigilance
 - Problems with concentration
 - Exaggerated startle response

Posttraumatic Stress Disorder (PTSD)

- PTSD is a clinically significant condition with symptoms that have persisted for more than one month after exposure to a traumatic event.
- The symptoms of PTSD cause clinically significant distress or impairment in social, occupational, or other important areas of functioning, and are not attributable to the side effects of a

substance, such as alcohol or medications, or a medical condition, such as a traumatic brain injury.

PTSD Diagnosis

- 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.
- A specific number of the following symptoms must be present:
 - Presence of one or more of intrusion symptoms associated with the traumatic event:
 - Intrusion symptoms
 - Distressing memories of the event
 - Recurrent distressing dreams
 - Dissociative reactions (flashbacks)
 - Intense prolonged psychological stress in response to cues of the event.
 - Persistent avoidance of stimuli associated with the traumatic event, as evidenced by one or both of the following:
 - Avoidance of distressing memories, thoughts, and feelings about the traumatic event.
 - Avoidance of external reminders (people, places, conversations, activities, objects, and situations) that arouse distressing memories, thoughts, or feelings of the traumatic event.
 - Negative alterations in cognitions and mood associated with the event, as evidenced by two or more of the following:
 - Inability to recall important aspect of the event
 - Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world
 - Persistent distorted cognitions about the cause or consequence of the event that lead to blaming self/others
 - Persistent negative emotional state (fear, horror, anger, guilt, or shame)
 - Diminished interest/participation in important activities
 - Feeling of detachment or estrangement from others
 - Persistent inability to experience positive emotions
 - Marked alterations in arousal and reactivity with the traumatic event, as evidenced by two or more of the following:
 - Irritable behavior or angry outbursts expressed as verbal or physical aggression
 - Reckless or self-destructive behavior
 - Hypervigilance
 - Exaggerated startle response
 - Problems with concentration
 - Sleep disturbance
- The PTSD diagnosis should specify whether the dissociative symptoms of depersonalization or derealization are present.

PTSD General Management

- Engage patients in shared decision making, which includes educating patients about effective treatment options.
- For patients with PTSD who are treated in primary care, collaborative care interventions that facilitate active engagement in evidence-based treatments is suggested.

Assessment of PTSD

- Periodic screening for PTSD using validated measures such as the Primary Care PTSD Screen (PC-PTSD) or the PTSD Checklist (PCL) is suggested.
- 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 recommended. A structured diagnostic interview may be considered.
- 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.

Prevention of PTSD

- 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 posttrauma period.
- Indicated prevention of PTSD and treatment of ASD
 - For the indicated prevention of PTSD in patients with acute stress disorder (ASD), individual trauma-focused psychotherapy that includes a primary component of exposure and/or cognitive restructuring is recommended.
 - For the prevention of PTSD in patients with ASD, there is insufficient evidence to recommend the use of pharmacotherapy.

Treatment of PTSD

- Treatment Selection
 - Individual, manualized trauma-focused psychotherapy is recommended over other pharmacologic and nonpharmacologic interventions for the primary treatment of PTSD.
 - When individual trauma-focused psychotherapy is not readily available or not preferred, pharmacotherapy or individual non-trauma-focused psychotherapy is recommended.
- Psychotherapy
 - For patients with PTSD, individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring and 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 recommended.

- For individual, manualized non-trauma-focused therapies for patients diagnosed with PTSD, Stress Inoculation Training (SIT), Present-Centered Therapy (PCT), and Interpersonal Psychotherapy (IPT) are suggested.
- 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 (SS), and supportive counseling.
- There is insufficient evidence to recommend using individual components of manualized psychotherapy protocols over or in addition to the full therapy protocol.
- Manualized group therapy is suggested over no treatment at all.
- There is insufficient evidence to recommend for or against trauma-focused or non-trauma-focused couples therapy for the primary treatment of PTSD.
- Pharmacotherapy
 - Sertraline, PARoxetine, FLUoxetine, or venlafaxine are recommended as monotherapy for PTSD, for patients diagnosed with PTSD who choose not to engage in or who are unable to access trauma-focused psychotherapy.
 - Nefazodone, imipramine, or phenelzine are suggested as monotherapy for the treatment of PTSD if the recommended pharmacotherapy (sertraline, PARoxetine, FLUoxetine, or venlafaxine), trauma-focused psychotherapy, or non-trauma-focused psychotherapy are ineffective, unavailable, or not in accordance with patient preference and tolerance.
 - The treatment of PTSD with QUetiapine, OLANzapine, and other atypical antipsychotics (except for risperiDONE), citalopram, amitriptyline, lamoTRigine, or topiramate as monotherapy is not suggested due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks.
 - Treating PTSD with divalproex, tiaGABine, guanFACINE, risperidone, benzodiazepines, ketamine, hydrocortisone, or D-cycloSERINE as monotherapy is not recommended due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks.
 - Treating PTSD with cannabis or cannabis derivatives is not recommended due to the lack of evidence for their efficacy, known adverse effects, and associated risks.
 - 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, hydroXYzine, cyproheptadine, zaleplon, and zolpidem.
- Augmentation Therapy
 - The use of topiramate, baclofen, or pregabalin as augmentation treatment of PTSD is not suggested due to insufficient data and/or known adverse effect profiles and associated risks.
 - Combining exposure therapy with D-cycloSERINE in the treatment of PTSD is not suggested outside of the research setting.

- Using atypical antipsychotics, benzodiazepines, and divalproex as augmentation therapy for the treatment of PTSD is not recommended due to low-quality evidence or the absence of studies and their association with known adverse effects.
- There is insufficient evidence to recommend the combination of exposure therapy with hydrocortisone outside of the research setting.
- There is insufficient evidence to recommend for or against the use of mirtazapine in combination with sertraline for the treatment of PTSD.
- Prazosin
 - For global symptoms of PTSD, and for nightmares associated with PTSD, the use of prazosin as monotherapy or augmentation therapy is not recommended.
- Combination therapy
 - For partial- or non-responders to psychotherapy, there is insufficient evidence to recommend for or against augmentation with pharmacotherapy.
 - For partial- or non-responders to pharmacotherapy, there is insufficient evidence to recommend for or against augmentation with psychotherapy.
 - There is insufficient evidence to recommend for or against starting patients with PTSD on combination pharmacotherapy and psychotherapy.
- Nonpharmacologic 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)
 - Vagal nerve stimulation (VNS)
- Complementary and integrative treatments
 - There is insufficient evidence to recommend acupuncture or any complimentary and integrative health (CIH) practice as a primary treatment for 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.
 - Using trauma-focused psychotherapies that have demonstrated efficacy using secure video conferencing (VTC) modality is recommended when PTSD treatment is delivered via VTC.
- Treatment of PTSD with co-occurring conditions
 - Patients with PTSD should be assessed for high-risk behaviors (smoking, alcohol/drug use, unsafe weapon storage, unprotected sex, needle sharing, human immunodeficiency virus [HIV] and hepatitis C risks). Any high-risk behaviors noted should be addressed in the treatment plan.
 - The presence of co-occurring disorder(s) should not prevent patients from receiving other VA/DoD guideline-recommended treatments for PTSD.
 - VA/DoD guideline-recommended treatments for PTSD in the presence of co-occurring substance use disorder (SUD) are recommended.

- An independent assessment of co-occurring sleep disturbances in patients with PTSD is recommended, particularly when sleep problems predate PTSD onset or remain following successful completion of a course of treatment.
- Cognitive Behavioral Therapy for Insomnia (CBT-I) for insomnia in patients with PTSD is recommended, unless an underlying medical or environmental etiology is identified, or severe sleep deprivation warrants the immediate use of medication to prevent harm.

Topics for Knowledge Gaps and Recommended Research

- Shared decision making and collaborative care
- Treatments for acute stress disorder and preventing PTSD
- Treatments for PTSD
- Nonpharmacologic biological treatments for PTSD
- Technology-based treatments for PTSD
- Treatments for PTSD with comorbidities and co-occurring conditions

Reference:

U.S. Department of Veterans Affairs & U.S. Department of Defense. (2017). VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder. Washington, DC: Veterans Health Administration and U.S. Army Medical Command. <https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf>