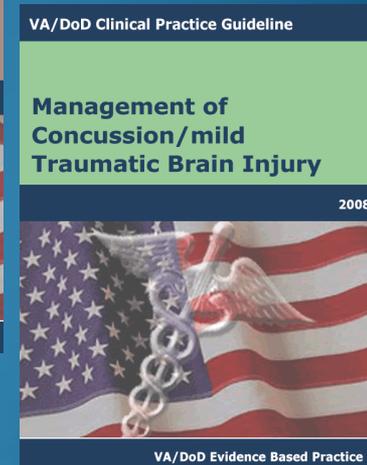
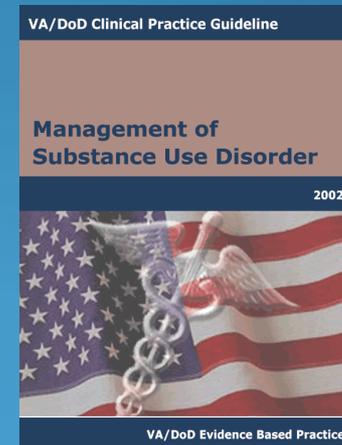
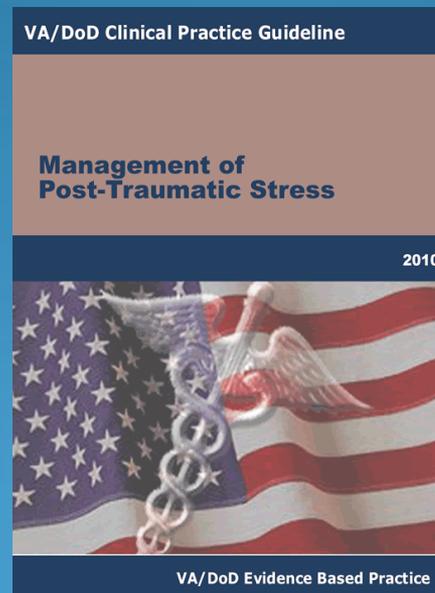
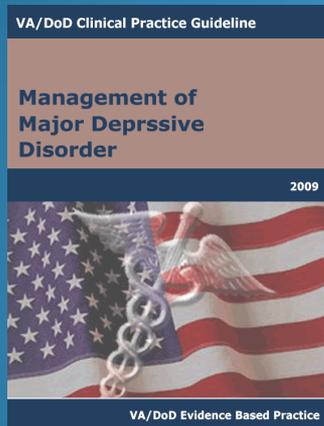
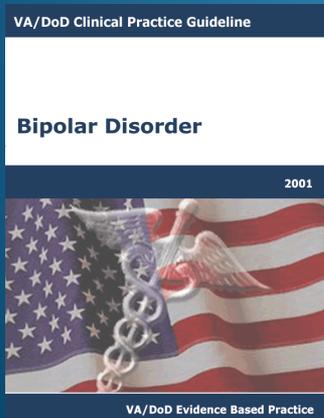


# VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress Update- 2010

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

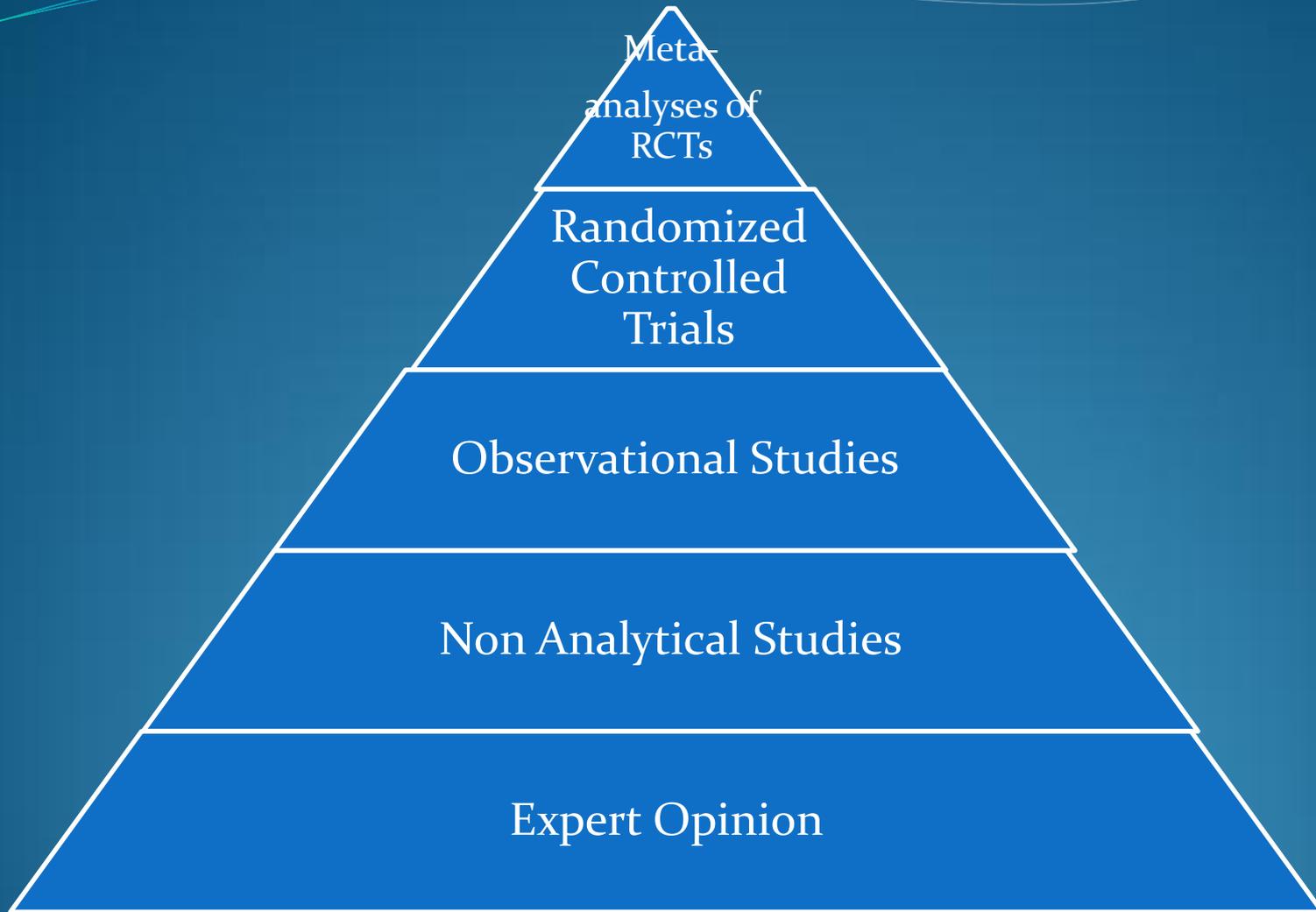
# Clinical Practice Guidelines

- Systematically developed statements to assist practitioner and patient in choosing appropriate healthcare for specific clinical conditions
- Seek to generate actionable recommendations
- Attempt to incorporate all issues relevant to a clinical question
- Include value judgments when weighting different outcomes, burdens, and costs
- Need to provide guidance for areas where evidence is lacking
- In VA, driven by clinical algorithms

# Assumptions

- a) Guidelines are developed by multidisciplinary groups
- b) They are based on a systematic review of the scientific evidence
- c) Recommendations are explicitly linked to the supporting evidence and graded according to the strength of that evidence

# LEVEL OF THE EVIDENCE



**EVIDENCE HIERARCHY**

# Strength of Recommendation

- A Strongly Recommend to offer or provide ...**  
*There is good evidence that the intervention improves important health outcomes -- benefits substantially outweigh harm.*
- B Recommend to offer or provide ...**  
*There is fair evidence that the intervention improves health outcomes -- that benefits outweigh harm.*
- C Consider offering or providing ....**  
*There is poor evidence that the intervention can improve health outcomes -- balance of benefit and harm is too close to justify a general recommendation.*
- I Insufficient Evidence is to recommend for or against providing ...**  
*Evidence that the intervention is effective is lacking or of poor quality, or conflicting, - balance of benefits and harms cannot be determined.*

# The PTSD Working Group

VHA	DoD
<p><b>Matt Friedman, MD</b>  <b>Josef Ruzek, PhD</b></p>	<p><b>Robert Koffman, MD [BUMED]</b>  <b>Patrick Lowry, MD [Army]</b>  <b>Charles Engel, MD [Army]</b></p>
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**Guideline Facilitator:** Oded Susskind, MPH

# Development Process

## 1. Scope

- Update any recommendations from the original guideline likely to be effected by new research findings;
- Address content areas and models of treatment for which little data existed during the development of the original guideline; and
- Review the performance and lessons learned since the implementation of the original guideline

# Development Process

## Search Key Questions

What interventions are effective in treatment of PTSD? -  
Resolution of symptoms and functional outcomes

### 1. Psychotherapy techniques?

Cognitive Processing Therapy

Exposure Therapy

Anxiety Management

EMDR

Family Therapy

DBT, CBCT, ACT or mindfulness

Psychoeducation

# Development Process

## Search Key Questions

What interventions are effective in treatment of PTSD? -  
Resolution of symptoms and functional outcomes

3. Are any Complementary Alternative Medicine (CAM) approaches more effective than no intervention?

Acupuncture

Body-mind

Meditation (Yoga)

Herbal, food supplements

Energy (Reiki)

Tai Chi

# Development Process

## Search Key Questions

What intervention are effective in management of co-occurring disorders with PTSD? - Resolution of symptoms, prevention of complications, Improvement in Quality of Life

MDD

SUD

mTBI

Sleep disturbance

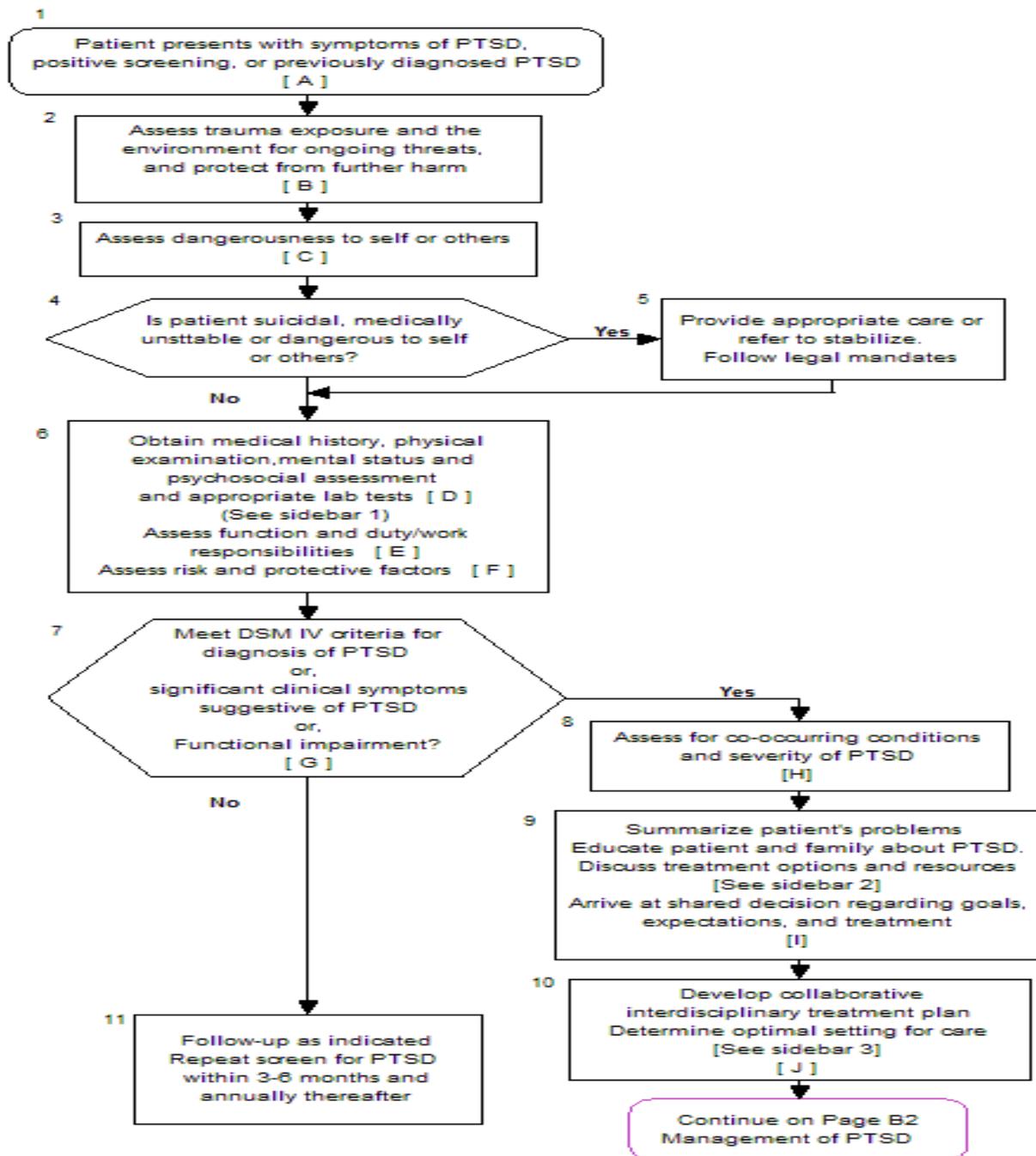
Pain

Hyperarousal

# Development Process

Overarching (global) questions:

1. Is individual therapy more effective than group therapy?
2. Is inpatient therapy more effective than outpatient therapy?
3. Is single component more effective than multiple components of psychotherapy?
4. Is single therapy more effective than multiple therapies?
5. Is initial pharmacotherapy more effective than initial psychotherapy?
6. Is early intervention more effective than later intervention?
7. Is augmenting of treatment strategies more effective than switching to another?
8. Is technology-based delivery more effective than provider based delivery?



**Sidebar 1: ASSESSMENT**

- History: psychiatric, medical, military, marital, family, past physical or sexual abuse, medication or substance use, social, and spiritual life
- Identify trauma history and duration
- Drug inventory (including over-the-counter drugs and herbals)
- Corroborate evaluation with family/significant other
- Physical exam and laboratory tests - **evidence of trauma**
- Assess for signs of trauma, substance use or comorbidity
- Assess and assure safety of self and other [ D ]

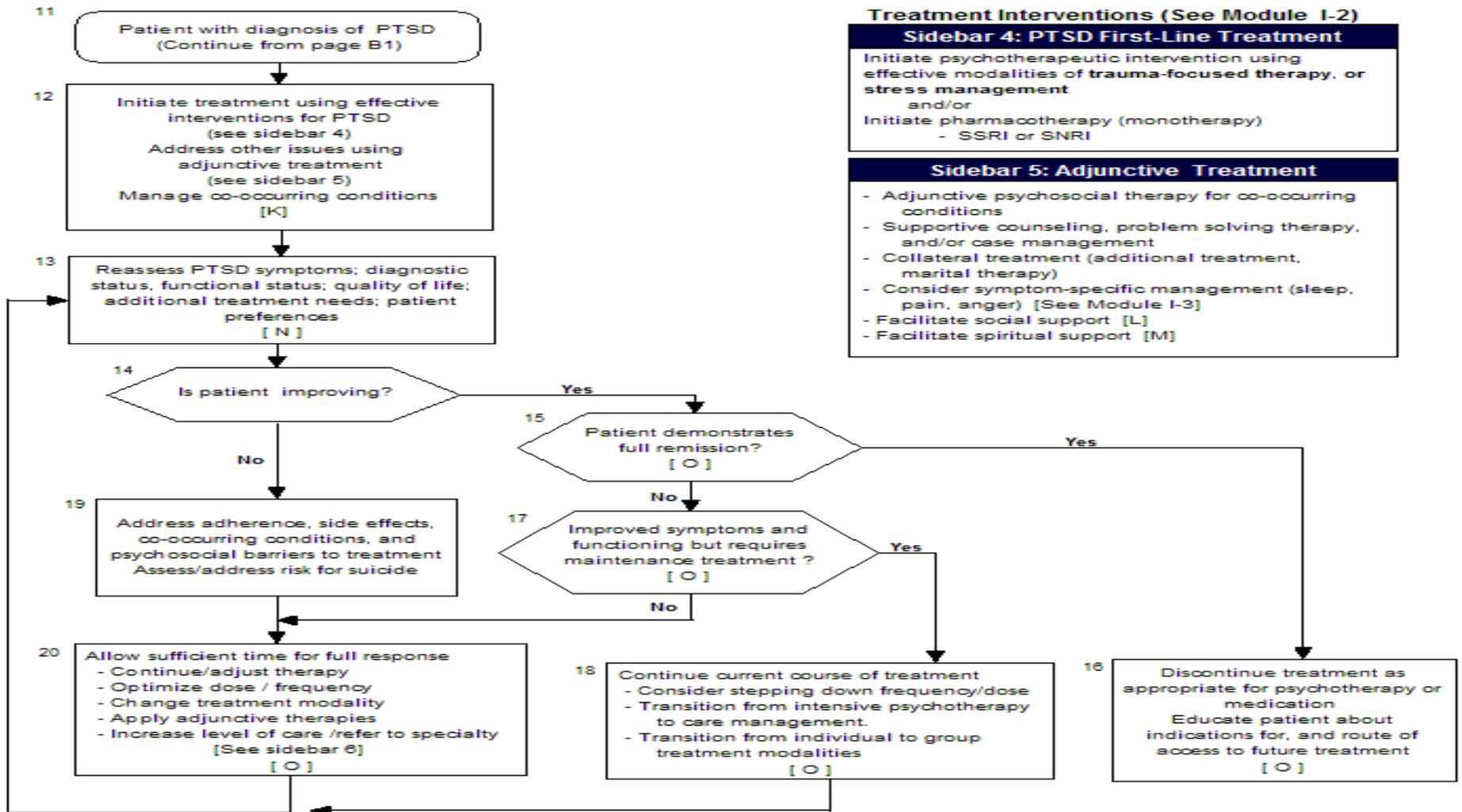
**Sidebar 2: Treatment Setting Considerations**

- Existence of co-occurring disorders
- Severity of comorbid conditions
- Severity of PTSD symptoms
- Expertise of the provider
- Patient preferences
- Continuity of care (mental health, primary care, integrated care, vet centers, other)
- Resource availability (e.g. transportation) [ J ]

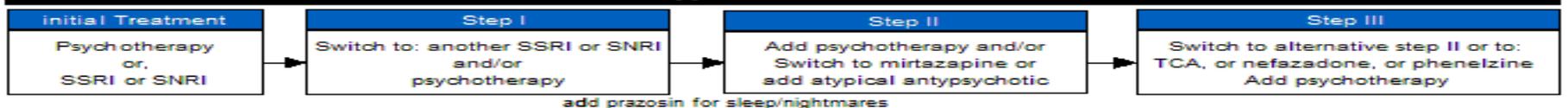
**Sidebar 3: indication for Referral to Specialty Care**

- Severe or unstable co-occurring conditions
- Severe or unstable PTSD
- Patient prefers referral to specialty [ J ]

Primary care clinicians may decide to refer for specialized psychiatric care at any point, depending on comfort and experience in treating PTSD



**Sidebar 6: Stepped Care Treatment of PTSD**



add prazosin for sleep/nightmares

# Assessment of Symptoms

- Patients presumed to have symptoms of PTSD or who are positive for PTSD on initial screening should receive a thorough assessment of their symptoms
- Consider use of a validated, self-administered checklist
  - Routine ongoing use of these checklists may allow assessment of treatment response and patient progress
- Diagnosis of PTSD should be obtained based on a comprehensive clinical interview that assesses all the symptoms that characterize PTSD
  - Structured diagnostic interviews, such as the Clinician-Administered PTSD scale (CAPS), may be considered

# Assessment of Trauma Exposure

- Assessment of the trauma exposure experience should include:
  - History of exposure to traumatic event(s)
  - Nature of the trauma
  - Severity of the trauma
  - Duration and frequency of the trauma
  - Age at time of trauma
  - Patient's reactions during and immediately following trauma exposure (e.g., helplessness, horror, and fear)
  - Existence of multiple traumas
- Clinician must consider ability to tolerate the recounting of traumatic material

# Assessment of Functioning

- Assessment of function should be obtained through a comprehensive narrative assessment, and the use of standardized, targeted, and validated instruments designed to assess family/relationship, work/school, and/or social functioning
- Determination of when to return to work/duty should take into consideration the complexity and importance of the patient's job role
- Continuing presence of PTSD symptoms should not be considered in itself as sufficient justification for preventing a return to work/duty

# Selection of Treatment for PTSD

- A supportive and collaborative treatment relationship or therapeutic alliance should be developed and maintained
- Providers should explain to all patients with PTSD the range of available and effective therapeutic options for PTSD
- Choice of a specific approach should be based on:
  - Severity of symptoms
  - Clinician expertise
  - Patient preference

# What Happens in PTSD?

- Trauma exposure causes extreme emotion
- Formerly neutral cues elicit similar emotional reactions
  - E.g., feeling unsafe, panic sensations
- Survivors form negative judgments about themselves and the world around them (e.g., guilt and self-blame)
- Stress leads to anger, depression
- Survivors cannot regulate their emotional roller-coaster
- Continuing sense of threat
- Ordinary coping does not work (helplessness)
- Survivors turn to maladaptive coping (withdrawal, drinking)
- PTSD symptoms interfere with family, work-school functioning

# Some Potential Treatment Goals

- Changing the way the memories are processed/reducing reactivity to reminders
- Restructuring negative appraisals
- Managing symptoms
- Reducing problems associated with PTSD (e.g., family difficulties)
- Engaging the Veteran in treatment

# Cognitive Theory of PTSD (Ehlers and Clark)

- Individuals with PTSD have “idiosyncratic negative appraisals of the traumatic event and/or its sequelae that have the common effect of creating a sense of serious current threat”
- (Ehlers & Clark, 2000, p. 320)

# Cognitive Theory of PTSD

- Two key processes lead to sense of threat
  - Differences in appraisal of trauma and sequelae (e.g., intrusive symptoms)
  - Differences in nature of memory and link to other memories
- Perceived threat also motivates behavioral and cognitive responses that prevent cognitive change and therefore maintain the disorder

# Cognitive Theory of PTSD

- Memories characterized by
  - Mainly sensory impressions
  - Sense that “happening right now”
  - Original emotions and sensory impressions are reexperienced
  - Affect without recollection
  - Involuntary reexperiencing triggered by wide range of stimuli and situations

# Treatment Implications Of Cognitive Theory of PTSD

- Trauma memory needs to be elaborated and integrated into context of individual's preceding and subsequent experience
- Problematic appraisals that maintain sense of threat need to be modified
- Dysfunctional coping strategies that prevent recovery need to be dropped

# Trauma-Focused Treatments for PTSD

- Strongly recommend:
- Patients diagnosed with PTSD should be offered one of the **evidence-based trauma-focused psychotherapeutic interventions** that include components of exposure and/or cognitive restructuring; **or stress inoculation training [A]**
- Examples:
  - Prolonged Exposure
  - Eye Movement Desensitization Reprocessing (EMDR)
  - Cognitive Processing Therapy

# Rationale for Exposure

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- Revisiting memory and avoided situations will reduce reactivity and engender new learning
- Will also facilitate review of inaccurate and unhelpful trauma-related beliefs and thoughts

# Cognitive Therapy

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- Identifying dysfunctional, erroneous thoughts and beliefs (cognitions)
- Challenging these cognitions
- Replacing these cognitions with functional, realistic cognitions

# Dysfunctional Negative Cognitions Underlying PTSD

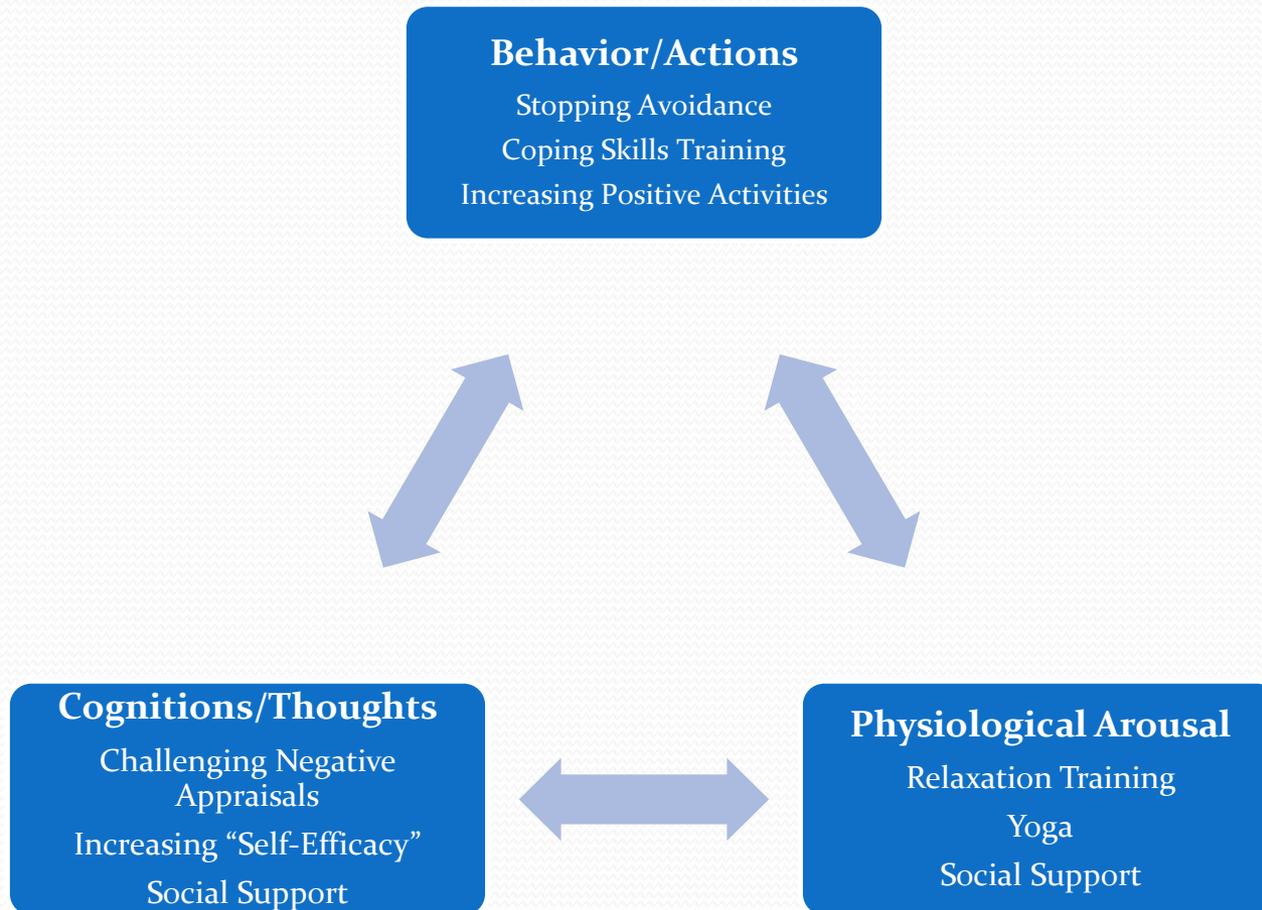
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- The world is extremely dangerous
  - People are untrustworthy
  - No place is safe
- I (the victim) am extremely incompetent
  - PTSD symptoms are a sign of weakness
  - Other people would have prevented the trauma

# Q: How Should Treatment Work?

- Reframe negative cognitions
- Increase therapeutic exposure/ Facilitate emotional processing
- Reduce high arousal
- Increase social support
- Increase adaptive coping
- Prevent maladaptive coping
  - Avoidance, rumination, substance abuse, isolation
- Decrease fear of symptoms

# Interacting Systems



# SIT: Anxiety Management Treatment

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- Relaxation Training
- Controlled Breathing
- Positive Self-talk and Imagery
- Social Skills Training
- Distraction Techniques  
(e.g., thought stopping)

# Psychoeducation

- Psychoeducation is recommended as a component of PTSD treatment [C]
  - Nature of PTSD symptoms
  - Practical steps to cope with trauma-related problems
  - Nature of the recovery process and PTSD treatment

# Family/Couples Treatment for PTSD

- There is insufficient evidence to recommend for or against Family or Couples Therapy as first-line treatment for PTSD
- Family or Couples therapy may be considered in
  - Managing PTSD-related family disruption or conflict
  - Increasing support
  - Improving communication [1]
- Significant others should also be advised to consider assistance to address problems related to patient's PTSD

# Group Treatment for PTSD

- Group Therapy may be considered for treatment of PTSD [C]
- Insufficient evidence for any particular type of group therapy

# Supportive Psychotherapy

- Supportive psychotherapy is not considered to be effective for the treatment of PTSD
- Supportive psychotherapy may be helpful in preventing relapse in patients who have reasonable control over their symptoms and are not in severe and acute distress

# Other Treatments for PTSD

- **Brief Psychodynamic Therapy** can be considered for patients with PTSD [C]
- **Hypnotic techniques** can be considered, especially for symptoms associated with PTSD, such as...
  - Pain, anxiety, dissociation, and nightmares, for which hypnosis has been successfully used [C]
- Insufficient evidence to recommend for or against **Dialectical Behavioral Therapy** (DBT) as first-line treatment for PTSD [I]
  - DBT can be considered for patients with a borderline personality disorder typified by parasuicidal behaviors [B]

# Other Treatments for PTSD

- **Relaxation techniques** should be considered as a component of treatment approaches for ASD or PTSD in alleviating symptoms associated with physiological hyper-reactivity [C]
- **Imagery Rehearsal Therapy (IRT)** can be considered for treatment of nightmares and sleep disruption [C]

# Spiritual Support

- Assess for spiritual needs and facilitate access to spiritual/religious care when sought [I]

# Acupuncture

- Acupuncture may be considered as treatment for patients with PTSD [B]

# Complementary and Alternative Medicine

- There is insufficient evidence to recommend CAM approaches as first line treatments for PTSD [I]
- CAM approaches that facilitate a relaxation response (e.g. mindfulness, yoga, massage) may be considered for adjunctive treatment of hyperarousal symptoms, although there is no evidence that these are more effective than standard stress inoculation techniques [I]
- May be considered as adjunctive approaches to address some co-morbid conditions (e.g. acupuncture for pain) [C]

# CAM (Cont)

- May facilitate engagement in care
- May be considered for some patients who refuse evidence-based treatments
- Providers should discuss the evidence for effectiveness and risk-benefits of different options, and ensure that the patient is appropriately informed

# Adjunctive Services: Psychosocial Rehabilitation

- Consider psychosocial rehabilitation techniques related to
  - Persistent high-risk behaviors
  - Lack of self-care/independent living skills
  - Homelessness
  - Interactions with a family that does not understand PTSD
  - Social isolation or inactivity
  - Unemployment
- Rehabilitation techniques can serve as a contextual vehicle for alleviating PTSD symptoms
- Psychosocial rehabilitation should occur concurrently or shortly after a course of treatment for PTSD

# PTSD-SUD Comorbidity

- All patients diagnosed with PTSD should receive comprehensive assessment for SUD, including nicotine dependence
- Recommend and offer cessation treatment to patients with nicotine dependence [A]
- Educate them about the relationships between PTSD and substance abuse
- Treat other concurrent Substance Use Disorders consistent with VA/DoD clinical practice guidelines
- Provide multiple services in the most accessible setting [I]
- Insufficient evidence to recommend for or against any specific psychosocial approach [I]

# Delivery of Care: Telemedicine

- Telemedicine interventions that involve person-to-person individual treatment sessions appear to have similar efficacy and satisfaction, though data are limited [C]
- Telemedicine interventions recommended
  - Geographic distance between patient and provider or other barriers to patient access (e.g., agoraphobia, physical disability)
  - Patient would benefit from more frequent face-to-face contact than is feasible
  - Patient declines more traditional mental health interventions

# Telemedicine (Cont)

- Providers should endeavor to
  - Maintain and strengthen the therapeutic relationship
  - Build patient rapport
  - Stress practice and assignment completion
  - Ensure adequacy of safety protocols
  - Ensure compliance with regulations, procedures, ethical standards of the organization in which they are employed
  - Patient confidentiality and safety should be monitored closely

# Web-Based Interventions

- Insufficient evidence to recommend for or against Web-based interventions as a stand-alone intervention or as an alternative to standard mental health treatment for PTSD [I]
- If used, clinicians should carefully review content for accuracy and ethical application
- May be used where face-to-face interventions are not feasible
- Providers should regularly encourage patients to complete the intervention

# Role of Primary Care Provider

- Provide education about the disorder
- Ensure provision of evidence-based treatment within the primary care or through referral
- Regular follow-up and monitoring of symptoms and co-morbid health concerns
- Consider consultation with mental health providers for patients with PTSD who seem reluctant to talk to a mental health provider
- Take leadership in providing a collaborative multi-disciplinary treatment approach
- Continue to be involved in the treatment of patients with acute or chronic stress disorders

# Optimal Setting for Care

- Factors to consider when determining the optimal setting for treatment include:
  - Severity of the PTSD or co-occurring disorders
  - Local availability of service options (specialized PTSD programs, evidence-based treatments)
  - Level of provider comfort and experience in treating psychiatric co-morbidities
  - Patient preferences
  - The need to maintain a coordinated continuum of care for chronic co-morbidities
  - Availability of resources and time to offer treatment

# Management of Specific Symptoms

- Sleep disturbance
- Pain
- Irritability, severe agitation, and/or anger

# Sleep Disturbance

- Sleep disturbance
  - Encourage patients to practice good sleep hygiene
  - Offer Cognitive Behavioral Therapy for Insomnia, which may include:
    - Educating about proper sleep habits and sleep needs
    - Correcting false and unrealistic beliefs/concerns about sleep
    - Identifying and addressing anxious, automatic thoughts which disrupt sleep

# Insomnia

- Monitor symptoms to assess improvement/deterioration and reassess accordingly
- Explore cause(s) for insomnia, including co-morbid conditions
- Begin treatment for insomnia with non-pharmacological treatments, including sleep hygiene and cognitive behavioral treatment
- If symptoms persist or worsen, refer for evaluation and treatment of insomnia

# Pain

- Management should be multidisciplinary, addressing physical, social, psychological, and spiritual components in an individualized treatment plan [C]
- Balance the benefits of pain control with possible adverse effects (especially sedating medications) on the individual's ability to participate in, and benefit from, PTSD treatment [I]
- Consider offering Cognitive Behavioral Therapy, which may include:
  - Encouraging increasing activity by setting goals
  - Correcting unrealistic beliefs/concerns about pain
  - Teaching cognitive and behavioral coping skills
  - Practicing coping skills and reinforcement of use

# Irritability, Severe Agitation, or Anger

- Assess the nature, severity, and dangerousness of symptoms
- Offer referral for:
  - Anger Management therapy
  - Training in exercise and relaxation techniques
- Promote participation in enjoyable activities - especially with family/ loved ones
- Promote sleep and relaxation
- Avoid stimulants and other substances (caffeine, alcohol)
- Address pain

# SR = Strength of Recommendation (see Appendix A)

Balance of Benefit and Harm				
SR	Significant Benefit	Some Benefit	Unknown Benefit	None
A	Trauma-focused psychotherapy that includes components of exposure and/or cognitive restructuring; or, Stress inoculation training			
C		Patient Education Imagery Rehearsal Therapy Psychodynamic Therapy Hypnosis Relaxation Techniques Group Therapy		
I		Family Therapy	WEB-Based CBT Acceptance and Commitment Therapy Dialectical Behavioral Therapy	