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Posttraumatic Stress Disorder: VA/DoD Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder (2023)

About the Guideline

- The VA Evidence-Based Practice, Office of Quality and Patient Safety, in collaboration with the Clinical Quality Improvement Program, Defense Health Agency, identified four champions to lead the development of this guideline.
- The work groups were composed of individuals with the following areas of expertise: internal medicine, neurology, nursing, pharmacy, psychiatry, psychology, social work, and surgery. The Lewin Team—including The Lewin Group, ECRI, Sigma Health Consulting, and Duty First Consulting—was contracted by VA to help develop this guideline.
- This clinical practice guideline is intended to provide healthcare practitioners with a framework by which to evaluate, treat, and manage the individual needs and preferences of patients with posttraumatic stress disorder (PTSD) and acute stress disorder (ASD).
- The patient population of interest for this guideline is adults who are eligible for care in the Department of Veterans Affairs and Department of Defense 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, especially if you work in an acute care setting.

Definition of Traumatic Events

- A traumatic event is defined in the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, text revision (DSM-5-TR), 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 non-debilitating symptoms to a transient acute stress reaction (ASR); to a time-limited and clinically significant acute stress disorder (ASD); to a persistent posttraumatic stress disorder (PTSD) that may become chronic, if untreated.
- The DSM-5-TR definition of traumatic events is the same for both ASD and PTSD; a person can meet the trauma definition with any one of the four criteria listed.

Acute Stress Reaction (ASR)

- Acute stress reaction (ASR) is defined by the World Health Organization and ICD-10 as a transient, normal reaction to traumatic stress. A 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.

Diagnosis of Acute Stress Disorder (ASD)

- When symptoms of ASR create social or occupational impairment for greater than 72 hours, a diagnosis of ASD is often warranted, along with evidence-based interventions for the disorder.
- Individuals with ASD must have been exposed to a traumatic stressor (criteria A1-A4). In addition, they must exhibit at least 9 of 14 possible symptoms nested within five diagnostic clusters. 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.
    - 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 **nine or more** of the following symptoms:
        - Intrusions 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, and 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.

Diagnosis of 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 can appear alone as the only diagnosis or, more commonly, with another, co-occurring DSM-5-TR disorder such as a substance use disorder, 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.
            - Marked physiological reactions to internal or external cues resembling 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 cognition 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 cognition about the cause or consequence of the event that leads 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.
- The PTSD diagnosis should specify whether the condition is with delayed expression (e.g., full diagnostic criteria not met until at least six months after the event).

Diagnosis and Assessment of PTSD

- Periodic screening for PTSD using validated measures such as the Primary Care PTSD Screen (PC-PTSD) is suggested.

- For patients with suspected PTSD, an appropriate diagnostic evaluation that includes the determination of DSM-5-TR criteria and an assessment of 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 PC-PTSD severity or a structured clinician-administered interview, such as the Clinician-Administered PTSD Scale, in the initial treatment planning and to monitor treatment progress is suggested.

General Clinical Management of PTSD

- 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 are 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 post-trauma period.

Indicated Prevention of PTSD and Treatment of ASD

- 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 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 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 are recommended that have a primary component of exposure and/or cognitive restructuring and that include prolonged exposure, cognitive processing therapy (CPT), or eye movement desensitization and reprocessing.
- For individual, manualized psychotherapies, Ehlers' Cognitive Therapy for PTSD, Present-Centered Therapy, or Written Exposure Therapy are suggested.
- There is insufficient evidence to recommend for or against the following individual psychotherapies for the treatment of PTSD: Accelerated Resolution Therapy; Adaptive Disclosure, Acceptance and Commitment Therapy; Brief Eclectic Psychotherapy; Dialectical Behavior Therapy; Emotional Freedom Techniques; Impact on Killing; Interpersonal Psychotherapy; Narrative Exposure Therapy; Prolonged Exposure in Primary Care; psychodynamic therapy; psychoeducation; Reconsolidation of Traumatic Memories; Seeking Safety; Stress Inoculation Training; Skills Training in Affective and Interpersonal

Regulation; Skills Training in Affective and Interpersonal Regulation in Primary Care; supportive counseling; Thought Field Therapy; Trauma-Informed Guilt Reduction; or Trauma Management Therapy.
- There is insufficient evidence to recommend using individual components of manualized psychotherapy protocols over or in addition to the full therapy protocol.
- There is insufficient evidence to recommend for or against any specific manualized group therapy.
- There is insufficient evidence to recommend using group therapy as an adjunct for the primary treatment of PTSD.
- There is insufficient evidence to recommend for or against the following couples therapies for the treatment of PTSD: Behavioral Family Therapy, Structured Approach Therapy, or Cognitive Behavioral Conjoint Therapy.

Pharmacotherapy
- Sertraline, PARoxetine, 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.
- There is insufficient evidence to recommend for or against amitriptyline, buPROPion, busPRIone, citalopram, desvenlafaxine, DULoxetine, escitalopram, eszopiclone, FLUoxetine, imipramine, mirtazapine, lamoTRIgine, nefazodone, OLANzapine, phenelzine, pregabalin, rivastigmine, topiramate, or QUEtiapine for the treatment of PTSD.
- 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.
- There is insufficient evidence to recommend for or against psilocybin, ayahuasca, dimethyltryptamine, ibogaine, or lysergic acid diethylamide for the treatment of PTSD.

Augmentation Therapy
- There is insufficient evidence to recommend for or against the combination or augmentation of psychotherapy or medications with any psychotherapy or medication for the treatment of PTSD, for antipsychotic medications and for 3-4-methylenedioxymethamphetamine (MDMA).
- Aripiprazole, asenapine, brexpiprazole, cariprazine, iloperidone, lumateperone, lurasidone, OLANzapine, paliperidone, QUEtiapine, risperiDONE, or ziprasidone for augmentation of medications for the treatment of PTSD is not recommended.

Prazosin
- Prazosin for the treatment of nightmares associated with PTSD is recommended.

Combination Therapy
- For partial- or nonresponders to psychotherapy, there is insufficient evidence to recommend for or against augmentation with pharmacotherapy.

- For partial- or nonresponders 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.
- There is insufficient evidence to recommend for or against MDMA-assisted psychotherapy for the treatment of PTSD.

Nonpharmacologic Biological Treatments

- There is insufficient evidence to recommend for or against the following somatic therapies for the treatment of PTSD: capnometry-assisted respiratory therapy, hyperbaric oxygen therapy, neurofeedback, NightWare, repetitive transcranial magnetic stimulation, stellate ganglion block, or transcranial direct current stimulation.

Complementary and Integrative Treatments

- Mindfulness-Based Stress Reduction for the treatment of PTSD is recommended. There is insufficient evidence to recommend for or against the following mind-body interventions for the treatment of PTSD: acupuncture; Cognitively Based Compassion Training Veteran version; creative arts therapies (e.g., music, art, dance); guided imagery; hypnosis or self-hypnosis; Loving Kindness Meditation; Mantram Repetition Program; Mindfulness-Based Cognitive Therapy; other mindfulness trainings (e.g., integrative exercise, Mindfulness-Based Exposure Therapy, brief mindfulness training); relaxation training; somatic experiencing; tai chi or qigong; Transcendental Meditation; and yoga.
- There is insufficient evidence to recommend for or against the following interventions for the treatment of PTSD: recreational therapy, aerobic exercise, animal-assisted therapy (e.g., canine, equine), and nature experiences (e.g., fishing, sailing).

Technology-Based Treatment Modalities

- There is insufficient evidence to recommend for or against facilitated internet-based Cognitive Behavioral Therapy for the treatment of PTSD. Secure video teleconferencing is recommended to deliver treatments when that therapy has been validated for use with video teleconferencing or when other options are unavailable.
- There is insufficient evidence to recommend for or against mobile apps or other self-help-based interventions for the treatment of PTSD.

Treatment of PTSD with Co-occurring Conditions

- Patient 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 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.

Reference

U.S. Department of Veterans Affairs & U.S. Department of Defense. (2023). *VA/DoD clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder, Version 4.0.* https://www.healthquality.va.gov/guidelines/MH/ptsd/VA-DoD-CPG-PTSD-Full-CPG.pdf