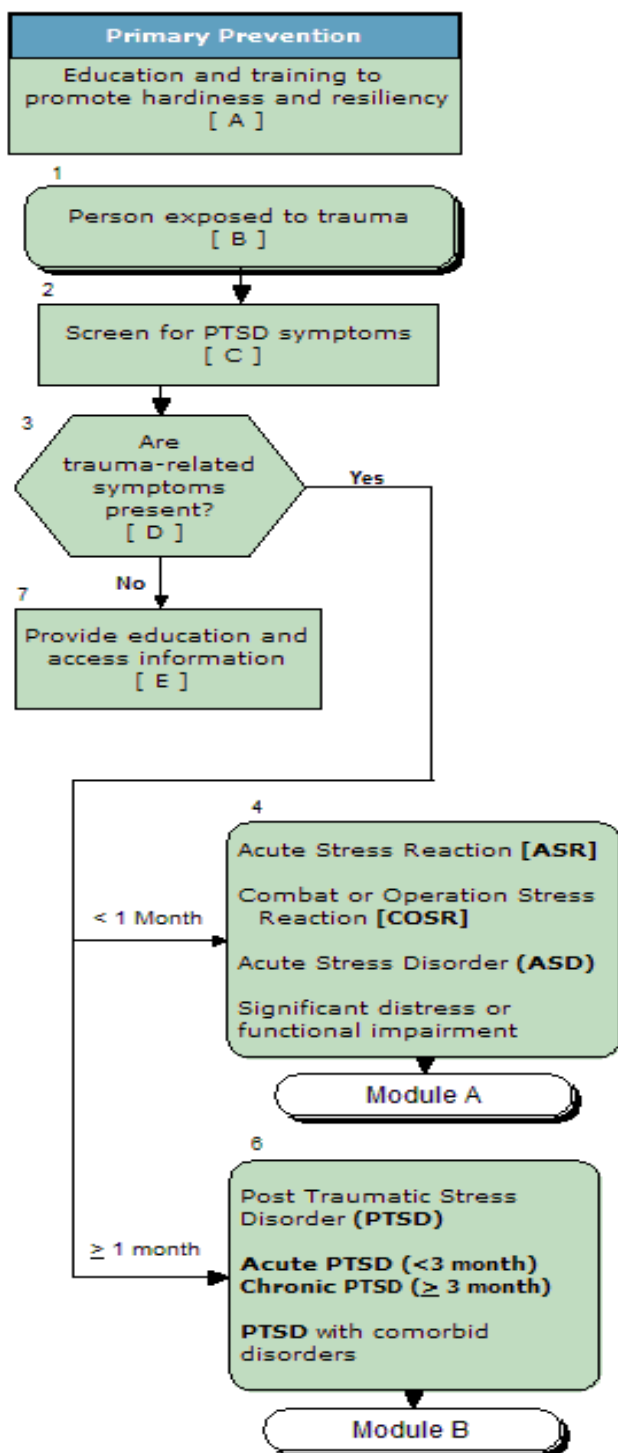
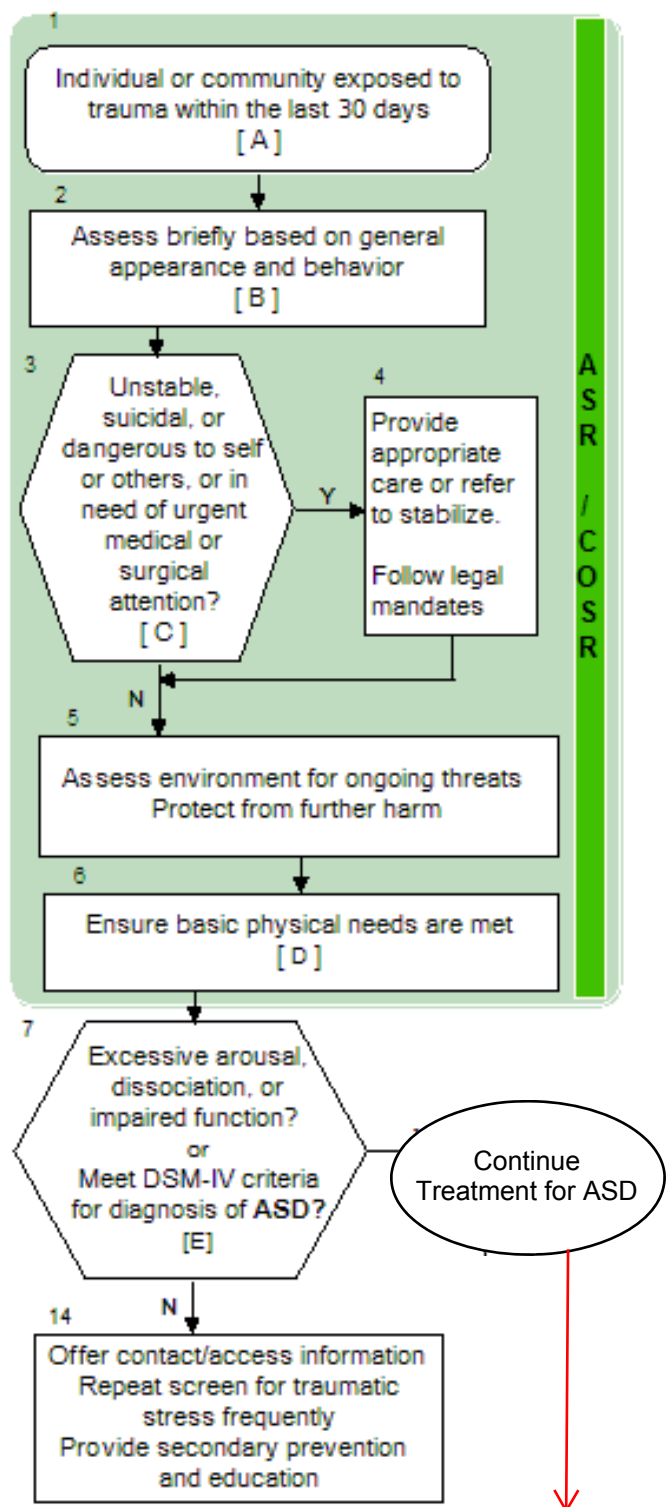


# VA/DoD Clinical Practice Guideline for Management of Post Traumatic Stress

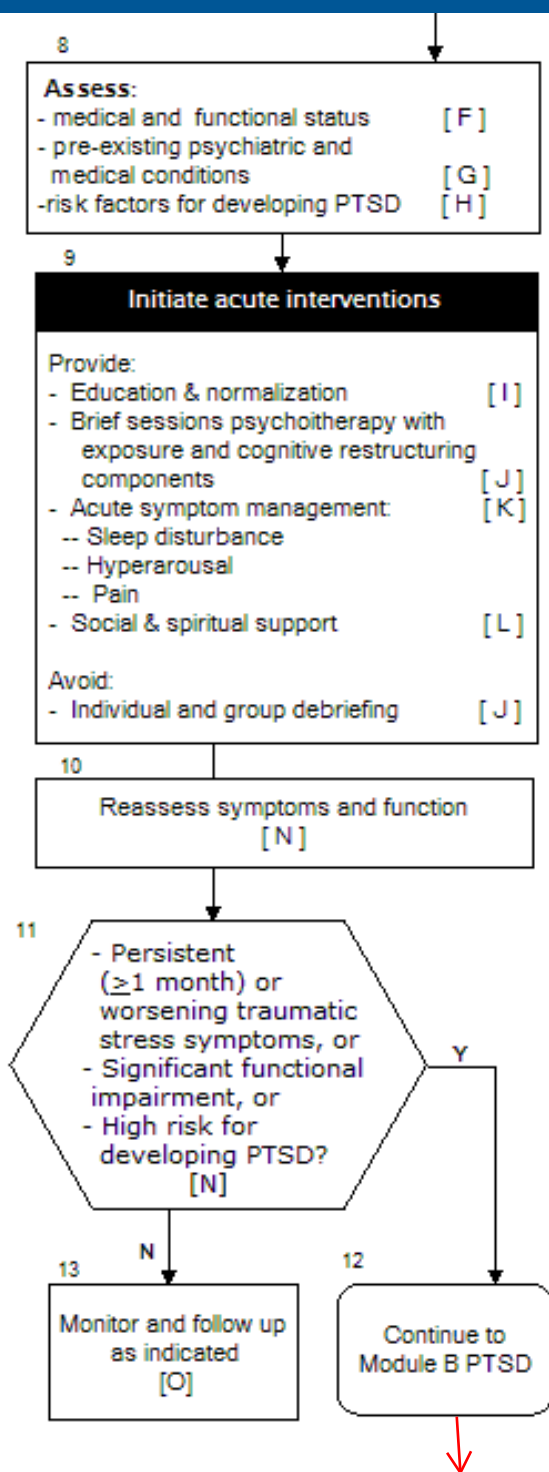
## Core Module



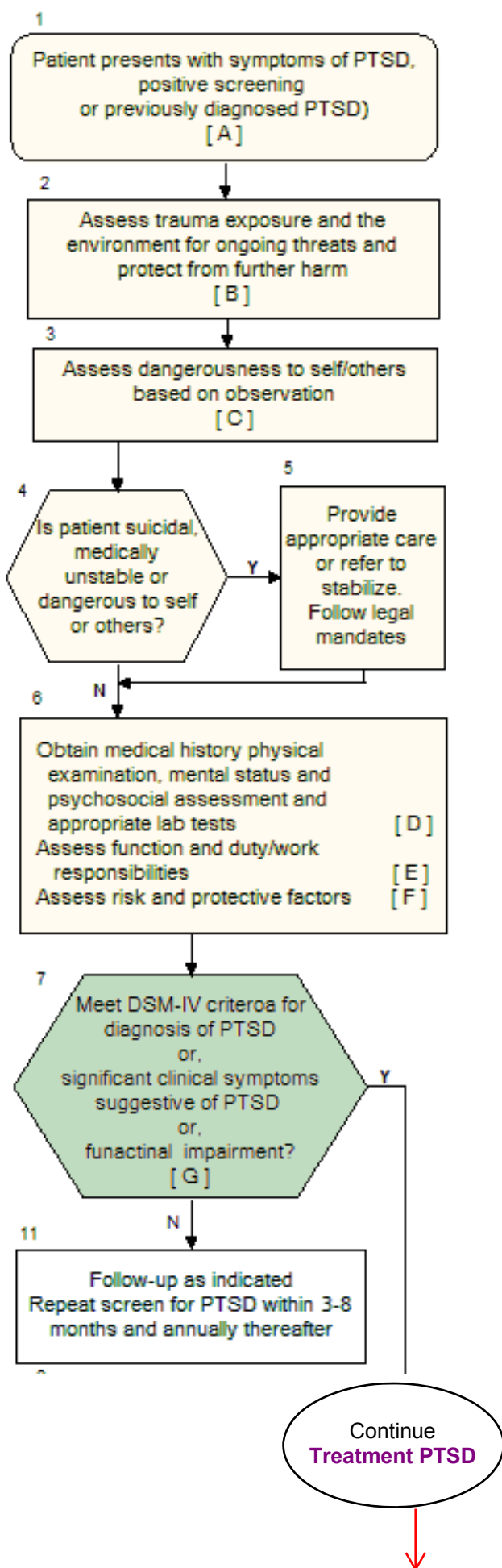
## Module A- Acute Stress



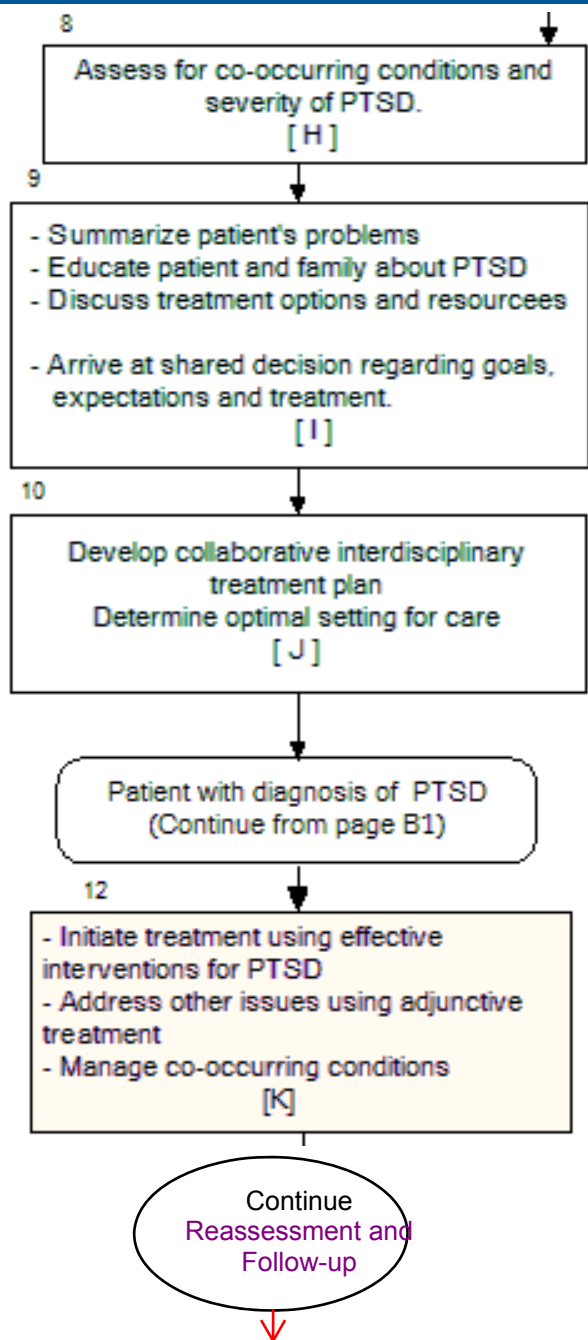
## Treatment for ACUTE Stress Disorder



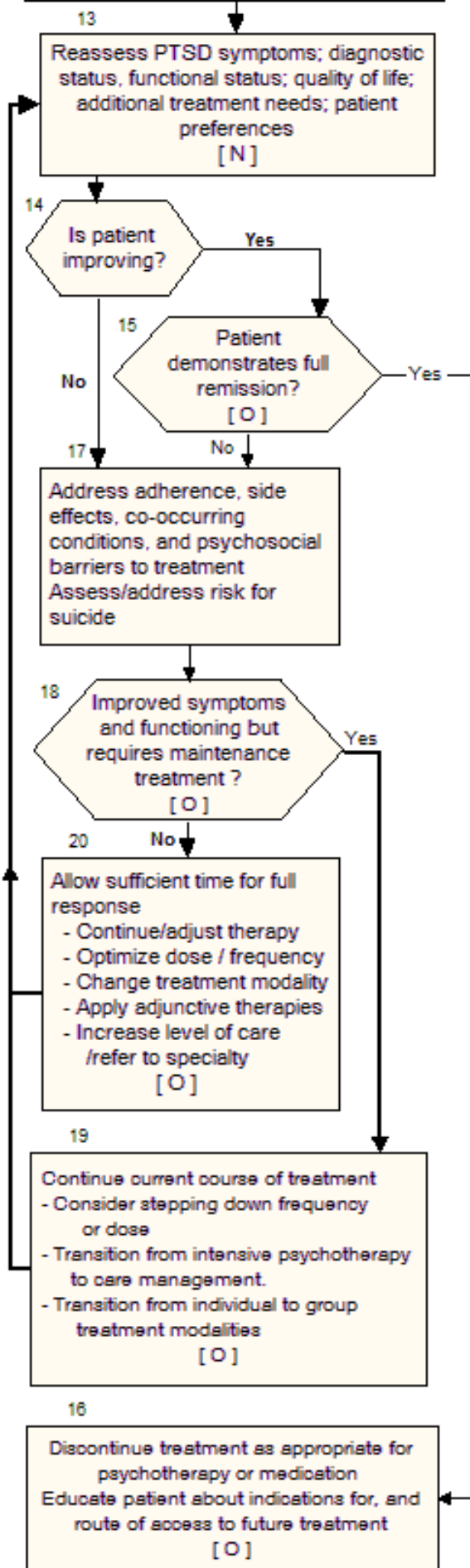
## Module B—PTSD



## Treatment for PTSD



## Reassessment/Follow-up PTSD



**Table 1: Common Symptoms After Exposure to Trauma or Loss**

## Physical

\* Chest pain \* Chills \* Difficulty breathing \* Dizziness \* Elevated blood pressure \* Fainting \* Nausea \* Fatigue \* Grinding teeth \* Headaches \* Muscle tremors \* Profuse sweating \* Rapid heart rate \* Shock symptoms \* Thirst \* Twitches \* Visual difficulties \* Vomiting \* Weakness

## Cognitive/Mental

\* Blaming someone \* Change in alertness \* Confusion \* Difficulty identifying familiar objects or people \* Hyper-vigilance \* Increased or decreased awareness of surroundings \* Intrusive images \* Loss of orientation to time, place, person \* Memory problems \* Nightmares \* Poor abstract thinking \* Poor attention \* Poor concentration \* Poor decisions \* Poor problem solving

## Emotional

\* Agitation \* Anxiety \* Apprehension \* Denial \* Depression \* Emotional shock \* Fear \* Feeling overwhelmed \* Grief \* Guilt \* Inappropriate emotional response \* Irritability \* Loss of emotional control \* Severe pain \* Uncertainty

## Behavioral

\* Alcohol consumption \* Antisocial acts \* Change in activity \* Change in communication \* Change in sexual functioning \* Change in speech pattern \* Emotional outbursts \* Erratic movements \* Hyper-alert to environment \* Inability to rest \* Loss or increased appetite \* Pacing \* Somatic complaints \* Startle reflex intensified \* Suspiciousness \* Withdrawal

## Symptoms Presentation

**Physical** - chronic pain, migraines, or vague somatic complaints

**Mental** - substance abuse, MDD, anxiety, or depression

**Behavior** - irritability, avoidance, anger or non-compliance, self risk behavior (HIV), **evokes** aversion or fear in provider

**Change** in function

## Key Elements of Psychological First Aid (PFA)

- Contact and Engagement - Respond to contacts initiated by affected persons, or initiate contacts in a non-intrusive, compassionate, and helpful manner
- Safety and Comfort - Enhance immediate and ongoing safety, and provide physical and emotional comfort
- Stabilization (if needed) - Calm and orient emotionally overwhelmed or distraught survivors
- Information Gathering - Current Needs and Concerns - Identify immediate needs and concerns, gather additional information, and tailor PFA interventions
- Practical Assistance - Offer practical help to the survivor in addressing immediate needs and concerns
- Connection with Social Supports - Help establish opportunities for brief or ongoing contacts with primary support persons or other sources of support, including family members, friends, and community helping resources
- Information on Coping - Provide information (about stress reactions and coping) to reduce distress and promote adaptive functioning
- Linkage to Collaborative Services - Link survivors with needed services and inform them about available services that may be needed in the future.

## Risk Factors for Developing ASD/PTSD

### Pre-traumatic factors

1. Ongoing life stress
2. Lack of social support
3. Young age at time of trauma
4. Pre-existing psychiatric disorders, or substance misuse
5. History of traumatic events (e.g., MVA)
6. History of post-traumatic stress disorder (PTSD)
7. Other pre-traumatic factors, including: female gender, low socioeconomic status, lower level of education, lower level of intelligence, race (e.g., Hispanic, African-American, American Indian, and Pacific Islander), reported abuse in childhood, report of other previous traumatization, report of other adverse childhood factors, family history of psychiatric disorders, and poor training or preparation for the traumatic event.

### Peri-traumatic or trauma related factors

1. Severe trauma
2. Physical injury to self or other
3. Type of trauma (combat, interpersonal traumas, such as killing another person, torture, rape, or assault, convey high risk of PTSD)
4. High perceived threat to life of self or others
5. Community (mass) trauma
6. Other peri-traumatic factors, including: history of peri-traumatic dissociation and interpersonal trauma.

### Post-traumatic factors

1. Ongoing life stress
2. Lack of positive social support
3. Bereavement or traumatic grief
4. Major loss of resources
5. Negative social support (shaming or blaming environment)
6. Poor coping skills
7. Other post-traumatic factors, including: children at home and/or a distressed spouse.

## Early Interventions after Exposure to Trauma (<4 days after exposure)

Balance of Benefit and Harm				
SR	Significant Benefit	Some Benefit	Unknown Benefit	No Benefit Potential Harm
I	--	<ul style="list-style-type: none"> <li>- Psychological First Aid</li> <li>- Psychoeducation and normalization</li> <li>- Social support</li> </ul>	Spiritual support	--
D	--	--	--	Psychological debriefing

## Early Interventions after Exposure to Trauma (4 to 30 days after exposure)

Balance of Benefit and Harm				
SR	Significant Benefit	Some Benefit	Unknown Benefit	No Benefit
A	- Brief Cognitive Behavioral Therapy (4-5 sessions)			
C		- Social support		
D				<ul style="list-style-type: none"> <li>- Individual psychological debriefing</li> <li>- Formal psychotherapy for asymptomatic survivors</li> <li>- Benzodiazepines</li> <li>- Typical Antipsychotics</li> </ul>
I		- Psychoeducation and normalization	<ul style="list-style-type: none"> <li>- Imipramine</li> <li>- Propranolol</li> <li>- Prazosin</li> <li>- Other Antidepressants</li> <li>Anticonvulsants</li> <li>- Atypical Antipsychotics</li> <li>- Spiritual support</li> <li>- Psychological First Aid</li> </ul>	- Group psychological debriefing

## Psychotherapy Intervention for Treatment of PTSD

Balance Benefit and Harm			
S R	Significant Benefit	Some Benefit	Unknown Benefit
A	<ul style="list-style-type: none"> <li>- <b>Trauma-focused</b> psychotherapy that includes components of exposure and/or cognitive restructuring; or,</li> <li>- <b>Stress inoculation</b> training</li> </ul>		
C		Patient Education - Imagery Rehearsal Therapy - Psychodynamic Therapy - Hypnosis - Relaxation Techniques - Group Therapy	
I		- Family Therapy	<ul style="list-style-type: none"> <li>- WEB-Based CBT</li> <li>- Acceptance and Commitment Therapy</li> <li>- Dialectical Behavioral Therapy</li> </ul>

Strongly recommend that patients who are 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]

The choice of a specific approach should be based on the severity of the symptoms, clinician expertise in one or more of these treatment methods and patient preference, and may include :

- **Exposure-based therapy** (e.g., Prolonged Exposure),
- **Cognitive-based therapy** (e.g., Cognitive Processing Therapy),
- **Stress management therapy** (e.g., SIT) or
- **Eye Movement Desensitization and Reprocessing** (EMDR).

## Pharmacotherapy Interventions for Treatment of PTSD

Balance of Benefit and Harm				
S R	Signifi- cant	Some Benefit	Unknown	No Benefit
A	SSRIs SNRIs			
B		- Mirtazapine - Atypical antipsy- chotics (as adjunct) - Prazosin (for sleep/ nightmares) - TCAs - Nefazodone [Caution] MAOIs (phenelzine)		
C			- Prazosin (for global PTSD)	
D				- Benzodi- azepines [Harm] - Tiagabine - Guanfacine - Valproate - Topiramate
I			- Atypical antipsy- chotic (monotherapy) - Conventional antip- sychotics - Buspirone - Non-benzodiazepine hypnotics - Bupropion - Trazodone (adjunctive) - Gabapentin - Lamotrigine - Propranolol - Clonidine	

### **General Recommendations:**

Risks and benefits of long-term pharmacotherapy should be discussed prior to starting medication and should be a continued discussion item during treatment.

Monotherapy therapeutic trial should be optimized before proceeding to subsequent strategies by monitoring outcomes, maximizing dosage (medication or psychotherapy), and allowing sufficient response time (for at least 8 weeks). [C]

If there is some response and patient is tolerating the drug, continue for at least another 4 weeks.

If the drug is not tolerated, discontinue the current agent and switch to another effective medication.

If no improvement is observed at 8 weeks consider:

- Increasing the dose of the initial drug to maximum tolerated
- Discontinuing the current agent and switching to another effective medication
- Augmenting with additional agents.

Recommend assessment of adherence, side effects and management to minimize or alleviate adverse effects.

Assess for treatment burden (e.g., medication adverse effects, attending appointments) after initiating or changing treatment when the patient is non-adherent to treatment or when the patient is not responding to treatment.

## PHARAMCOTHERAPY FOR PTSD

### Monotherapy:

Strongly recommend that patients diagnosed with PTSD should be offered selective serotonin reuptake inhibitors (SSRIs), for which fluoxetine, paroxetine, or sertraline have the strongest support, or serotonin norepinephrine reuptake inhibitors (SNRIs), for which venlafaxine has the strongest support, for the treatment of PTSD. [A]

Recommend mirtazapine, nefazodone, tricyclic antidepressants (TCAs), amitriptyline and imipramine, or monoamine oxidase inhibitors (phenelzine) for the treatments for PTSD. [B]

Recommend against the use of guanfacine, anticonvulsants (tiagabine, topiramate, or valproate) as monotherapy in the management of PTSD. [D]

The existing evidence does not support the use of bupropion, buspirone, and trazodone, anticonvulsants (lamotrigine or gabapentin) or atypical antipsychotics as monotherapy in the management of PTSD. [I]

There is evidence against the use of benzodiazepines in the management of PTSD. [D]

There is insufficient evidence to support the use of prazosin as monotherapy in the management of PTSD. [I]

### Augmented Therapy for PTSD:

Recommend atypical antipsychotics as adjunctive therapy: risperidone or olanzapine [B] or, quetiapine [C].

Recommend adjunctive treatment with prazosin for sleep/nightmares. [B]

There is insufficient evidence to recommend a sympatholytic or an anticonvulsant as an adjunctive therapy for the treatment of PTSD. [I]

## Adjunctive Problem-Focused Method/Services for PTSD

If the client and clinician together conclude that the patient with PTSD:		Service/Training
1	Is not fully informed about aspects of health needs and does not avoid high-risk behaviors (e.g., PTSD, substance use)	Provide patient education
2	Does not have sufficient self-care and independent living skills	Refer to self-care/independent living skills training services
3	Does not have safe, decent, affordable, stable housing that is consistent with treatment goals	Use and/or refer to supported housing services
4	Does not have a family that is actively supportive and/or knowledgeable about treatment for PTSD	Implement family skills training
5	Is not socially active	Implement social skills training
6	Does not have a job that provides adequate income and/or fully uses his or her training and skills	Implement vocational rehabilitation training
7	Is unable to locate and coordinate access to services such as those listed above	Use case management services
8	Does request spiritual support	Provide access to religious/spiritual advisors and/or other resources
<b>OTHER CONDITIONS</b>		
9	Does have a borderline personality disorder typified by parasuicidal behaviors	Consider Dialectical Behavioral Therapy
10	Does have concurrent substance abuse problem	Integrated PTSD substance abuse treatment (e.g., Seeking Safety)