VA/DoD Clinical Practice Guidelines

Management of Posttraumatic Stress Disorder and Acute Stress Disorder

VA/DoD Evidence-Based Practice

Provider Summary

Version 4.0 | 2023

VA/DoD CLINICAL PRACTICE GUIDELINE FOR MANAGEMENT OF POSTTRAUMATIC STRESS DISORDER AND ACUTE STRESS DISORDER

Department of Veterans Affairs

Department of Defense

Provider Summary

QUALIFYING STATEMENTS

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) guidelines are based on the best information available at the time of publication. The guidelines are designed to provide information and assist decision making. They are not intended to define a standard of care and should not be construed as one. Neither should they be interpreted as prescribing an exclusive course of management.

This clinical practice guideline (CPG) is based on a systematic review (SR) of both clinical and epidemiological evidence. Developed by a panel of multidisciplinary experts, it provides a clear explanation of the logical relationships between various care options and health outcomes while rating both the quality of the evidence and the strength of the recommendation.

Variations in practice will inevitably and appropriately occur when providers consider the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Therefore, every health care professional using these guidelines is responsible for evaluating the appropriateness of applying them in the setting of any particular clinical situation with a patient-centered approach.

These guidelines are not intended to represent VA or DoD policies. Further, inclusion of recommendations for specific testing, therapeutic interventions, or both within these guidelines does not guarantee coverage of civilian sector care.

Version 4.0 - 2023

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Introduction

The VA and DoD Evidence-Based Practice Work Group (EBPWG) was established and first chartered in 2004, with a mission to advise the VA/DoD Health Executive Committee "on the use of clinical and epidemiological evidence to improve the health of the population . . ." across the Veterans Health Administration (VHA) and Military Health System (MHS), by facilitating the development of CPGs for the VA and DoD populations.(1) Development and update of VA/DoD CPGs is funded by VA Evidence Based Practice, Office of Quality and Patient Safety. The system-wide goal of evidence-based CPGs is to improve patient health and wellbeing.

In 2017, VA and DoD published a CPG for Management of Posttraumatic Stress Disorder and Acute Stress Disorder (2017 VA/DoD PTSD CPG), which was based on evidence reviewed through March 2016. Since the release of that CPG, the evidence base on PTSD has expanded. Consequently, the EBPWG initiated the update of the 2017 VA/DoD PTSD CPG in 2022. This updated CPG's use of Grading of Recommendations Assessment, Development, and Evaluation (GRADE) approach reflects a more rigorous application of the methodology than previous iterations.(2) Therefore, the strength of some recommendations might have been modified because of the confidence in the quality of the supporting evidence (see Evidence Quality and Recommendation Strength in the full VA/DoD PTSD CPG).

This CPG provides an evidence-based framework for evaluating and managing care for individuals with posttraumatic stress disorder (PTSD) or acute stress disorder (ASD) toward improving clinical outcomes. Successful implementation of this CPG will:

- Assess the patient's condition and collaborate with the patient, family, and caregivers to determine optimal management of patient care;
- Emphasize the use of patient-centered care and shared decision making;
- Minimize preventable complications and morbidity; and
- Optimize individual health outcomes and quality of life (QoL).

Highlights in this Guideline

The 2023 VA/DoD PTSD CPG reflects a more rigorous application of the GRADE methodology than the 2017 VA/DoD PTSD CPG. This approach has resulted in the exclusion or downgrading of studies included in previous versions of this CPG and has impacted the strength of some recommendations (e.g., *Strong for* downgraded to *Weak for*), despite a similar evidence base. For additional information on GRADE or CPG methodology, see Appendix A in the full CPG.

In the 2017 VA/DoD PTSD CPG, trauma-focused psychotherapies were evaluated as a class that included Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), and Prolonged Exposure (PE). In the 2023 CPG, the evidence on trauma-focused psychotherapies was reviewed for each treatment individually, rather than as a class, for comparison with medications. This review, combined with the more rigorous application of GRADE and accumulated new evidence, resulted in the downgrading of some specific treatments.

Significant changes to the strength of the recommendations include the following.

- Downgrading of some trauma-focused psychotherapies that previously received a *Strong for* recommendation (Brief Eclectic Psychotherapy and Narrative Exposure Therapy [NET] were downgraded to *Neither for nor against* [Recommendation 10], and Ehlers' Cognitive Therapy [CT] for PTSD and written narrative exposure, now called Written Exposure Therapy [WET], was downgraded to *Weak for* [Recommendation 9]).
- Downgrading of some non-trauma-focused psychotherapies that previously received a *Weak for* recommendation (Stress Inoculation Training [SIT] and Interpersonal Psychotherapy [IPT] were downgraded to *Neither for nor against* [Recommendation 10]).
- Downgrading of one medication that previously received a *Strong for* recommendation (Fluoxetine was downgraded to *Neither for nor against* [Recommendation 16]).
- Downgrading of some medications that previously received a *Weak for* recommendation (Nefazodone, phenelzine, and imipramine were downgraded to *Neither for nor against* [Recommendation 16]).
- Adding Weak for recommendations for prazosin for nightmares (Recommendation 32) and Mindfulness-Based Stress Reduction® (MBSR) for overall PTSD symptoms (Recommendation 26).

Other changes in the CPG include the following.

- Updated algorithm for screening and treatment of ASD and PTSD
- Greater attention to discussing the generalizability of evidence to subgroups based on gender identity, sexuality, race, ethnicity, age, and other patient characteristics

and clearer delineation of complementary, integrative, and alternative health treatment

- Updated recommendations on research needed to strengthen future guidelines

Recommendations

The evidence-based clinical practice recommendations listed (see Table 1) were made using a systematic approach considering four domains as per the GRADE approach (see Summary of Guideline Development Methodology in the full VA/DoD CPG). These domains include confidence in the quality of the evidence, balance of desirable and undesirable outcomes (i.e., benefits and harms), patient values and preferences, and other implications (e.g., resource use, equity, acceptability).

Table 1. Evidence-based Clinical Practice Recommendations with Strength and Category

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Assessment and Diagnosis of PTSD		1.	When screening for PTSD, we suggest using the Primary Care PTSD Screen for DSM-5.	Weak for	Reviewed, New-replaced
		2.	For confirmation of the diagnosis of PTSD, we suggest using a validated structured clinician-administered interview, such as the Clinician-Administered PTSD Scale or PTSD Symptom Scale - Interview Version.	Weak for	Reviewed, New-replaced
		3.	To detect changes in PTSD symptom severity over time, we suggest the use of a validated instrument, such as the PTSD Checklist for DSM-5, or a structured clinician-administered interview, such as the Clinician-Administered PTSD Scale.	Weak for	Reviewed, New-replaced
Prevention of PTSD	*Selective Prevention of PTSD*	4.	For the prevention of PTSD among individuals who have been exposed to trauma, there is insufficient evidence to recommend for or against psychotherapy or pharmacotherapy in the immediate post-trauma period.	Neither for nor against	Not Reviewed, Amended
	Indicated Prevention of PTSD	5.	For the prevention of PTSD among patients diagnosed with acute stress disorder, we suggest trauma-focused cognitive behavioral psychotherapy.	Weak for	Reviewed, New-replaced
		6.	For the prevention of PTSD among patients diagnosed with acute stress reaction/acute stress disorder, there is insufficient evidence to recommend for or against any pharmacotherapy.	Neither for nor against	Reviewed, New-replaced

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Treatment of PTSD	Treatment Selection	7.	We recommend individual psychotherapies, listed in Recommendation 8, over pharmacologic interventions for the treatment of PTSD.	Strong for	Reviewed, New-replaced
	Psychotherapy	8.	We recommend the individual, manualized trauma-focused psychotherapies for the treatment of PTSD: Cognitive Processing Therapy, Eye Movement Desensitization and Reprocessing, or Prolonged Exposure.	Strong for	Reviewed, New-replaced
		9.	We suggest the following individual, manualized psychotherapies for the treatment of PTSD: Ehlers' Cognitive Therapy for PTSD, Present-Centered Therapy, or Written Exposure Therapy.	Weak for	Reviewed, New-replaced
		10.	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.	Neither for nor against	Reviewed, New-replaced
		11.	There is insufficient evidence to recommend using individual components of manualized psychotherapy protocols over, or in addition to, the full therapy protocol for the treatment of PTSD.	Neither for nor against	Reviewed, Not Changed
		12.	There is insufficient evidence to recommend for or against any specific manualized group therapy for the treatment of PTSD.	Neither for nor against	Reviewed, New-replaced
		13.	There is insufficient evidence to recommend using group therapy as an adjunct for the primary treatment of PTSD.	Neither for nor against	Reviewed, New-replaced
		14.	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.	Neither for nor against	Reviewed, Not Changed

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Treatment of PTSD (cont.)	Pharmacotherapy	15.	We recommend paroxetine, sertraline, or venlafaxine for the treatment of PTSD.	Strong for	Reviewed, New-replaced
		16.	There is insufficient evidence to recommend for or against amitriptyline, bupropion, buspirone, citalopram, desvenlafaxine, duloxetine, escitalopram, eszopiclone, fluoxetine, imipramine, mirtazapine, lamotrigine, nefazodone, olanzapine, phenelzine, pregabalin, rivastigmine, topiramate, or quetiapine for the treatment of PTSD.	Neither for nor against	Reviewed, New-replaced
	Pharmacotherapy (cont.)	17.	There is insufficient evidence to recommend for or against psilocybin, ayahuasca, dimethyltryptamine, ibogaine, or lysergic acid diethylamide for the treatment of PTSD.	Neither for nor against	Reviewed, New-added
		18.	We suggest against divalproex, guanfacine, ketamine, prazosin, risperidone, tiagabine, or vortioxetine for the treatment of PTSD.	Weak against	Reviewed, New-replaced
		19.	We recommend against benzodiazepines for the treatment of PTSD.	Strong against	Reviewed, New-replaced
		20.	We recommend against cannabis or cannabis derivatives for the treatment of PTSD.	Strong against	Reviewed, Amended
	Augmentation Therapy	21.	There is insufficient evidence to recommend for or against the combination or augmentation of psychotherapy (see Recommendation 8 and Recommendation 9) or medications (see Recommendation 15) with any psychotherapy or medication for the treatment of PTSD (see Recommendation 22 for antipsychotic medications and Recommendation 23 for 3,4-methylenedioxymethamphetamine).	Neither for nor against	Reviewed, New-replaced
		22.	We suggest against aripiprazole, asenapine, brexpiprazole, cariprazine, iloperidone, lumateperone, lurasidone, olanzapine, paliperidone, quetiapine, risperidone, or ziprasidone for augmentation of medications for the treatment of PTSD.	Weak against	Reviewed, New-replaced
		23.	There is insufficient evidence to recommend for or against 3,4-methylenedioxymethamphetamine assisted psychotherapy for the treatment of PTSD.	Neither for nor against	Reviewed, New-added
	Non-pharmacologic Biological Treatments	24.	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.	Neither for nor against	Reviewed, New-replaced
		25.	We suggest against electroconvulsive therapy or vagus nerve stimulation for treatment of PTSD.	Weak against	Reviewed, New-replaced

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Treatment of PTSD (cont.)	Complementary, Integrative, and Alternative Approaches	26.	We suggest Mindfulness-Based Stress Reduction® for the treatment of PTSD.	Weak for	Reviewed, New-replaced
		27.	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.	Neither for nor against	Reviewed, New-replaced
		28.	There is insufficient evidence to recommend for or against the following interventions for the treatment of PTSD: recreational therapy, aerobic or non-aerobic exercise, animal-assisted therapy (e.g., canine, equine), and nature experiences (e.g., fishing, sailing).	Neither for nor against	Reviewed, New-replaced
	Technology-based Treatment	29.	We recommend secure video teleconferencing to deliver treatments in Recommendation 8 and Recommendation 9 when that therapy has been validated for use with video teleconferencing or when other options are unavailable.	Strong for	Reviewed, New-replaced
		30.	There is insufficient evidence to recommend for or against mobile apps or other self-help-based interventions for the treatment of PTSD.	Neither for nor against	Reviewed, New-added
		31.	There is insufficient evidence to recommend for or against facilitated internet-based cognitive behavioral therapy for the treatment of PTSD.	Neither for nor against	Reviewed, New-replaced
Treatment of Nightmares		32.	We suggest prazosin for the treatment of nightmares associated with PTSD.	Weak for	Reviewed, Amended
		33.	There is insufficient evidence to recommend for or against the following treatments for nightmares associated with PTSD: Imagery Rehearsal Therapy, Exposure Relaxation and Rescripting Therapy, Imaging Rescripting and Reprocessing Therapy, or NightWare.	Neither for nor against	Reviewed, New-added
Treatment of PTSD with Co-Occurring Conditions		34.	We suggest that the presence of co-occurring substance use disorder and/or other disorder(s) not preclude treatments in Recommendation 8 and Recommendation 9 for PTSD.	Weak for	Reviewed, New-replaced

[a] For additional information, see Grading Recommendations in the full VA/DoD PTSD CPG.

[b] For additional information, see Recommendation Categorization and Appendix E in the full VA/DoD PTSD CPG.

Scope of the CPG

This CPG is based on published clinical evidence and related information available through May 4, 2022. It is intended to provide general guidance on best evidence-based practices (see Appendix A in the full VA/DoD PTSD CPG for additional information on the evidence review methodology). Although the CPG is intended to improve the quality of care and clinical outcomes (see Introduction in the full VA/DoD PTSD CPG), it is not intended to define a standard of care (i.e., mandated or strictly required care).

This CPG is intended for use by providers and others involved in the care of active duty Service members and Veterans with PTSD.

The patient population of interest for this CPG is adults with PTSD or ASD caused by any type of trauma who are eligible for care in VA or DoD health care delivery systems.

Guideline Development Team

Table 2. Guideline Work Group and Guideline Development Team

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*Additional contributor contact information is available in Appendix F in the full VA/DoD PTSD CPG.

Patient-centered Care

Intended to consider patient needs and preferences, guideline recommendations represent a whole/holistic health approach to care that is patient centered, culturally appropriate, and available to people with limited literacy skills and physical, sensory, or learning disabilities. VA/DoD CPGs encourage providers to use a patient-centered, whole/holistic health approach (i.e., individualized treatment based on patient needs, characteristics, and preferences). This approach aims to treat the particular condition while also optimizing the individual's overall health and wellbeing.

Regardless of the care setting, all patients should have access to individualized evidence-based care. Patient-centered care can decrease patient anxiety, increase trust in providers, and improve treatment adherence.(3, 4) A whole/holistic health approach (https://www.va.gov/wholehealth/) empowers and equips individuals to meet their personal health and wellbeing goals. Good communication is essential and should be supported by evidence-based information tailored to each patient's needs. An empathetic and non-judgmental approach facilitates discussions sensitive to gender, culture, ethnicity, and other differences.

Shared Decision Making

This CPG encourages providers to practice shared decision making, a process in which providers, patients, and patient care partners (e.g., family, friends, caregivers) consider clinical evidence of benefits and risks as well as patient values and preferences to make

decisions regarding the patient's treatment.(5) Shared decision making is emphasized in *Crossing the Quality Chasm,* an Institute of Medicine, now NAM, report in 2001 (6) and is inherent within the whole/holistic health approach. Providers must be adept at presenting information to their patients regarding individual treatments, expected risks, expected outcomes, and levels or settings of care or both, especially where patient heterogeneity in weighing risks and benefits might exist. VHA and MHS have embraced shared decision making. Providers are encouraged to use shared decision making to individualize treatment goals and plans based on patient capabilities, needs, and preferences.

Algorithm

This CPG's algorithm is designed to facilitate understanding of the clinical pathway and decision-making process used in managing patients with PTSD. This algorithm format represents a simplified flow of the management of patients with PTSD and helps foster efficient decision making by providers. It includes

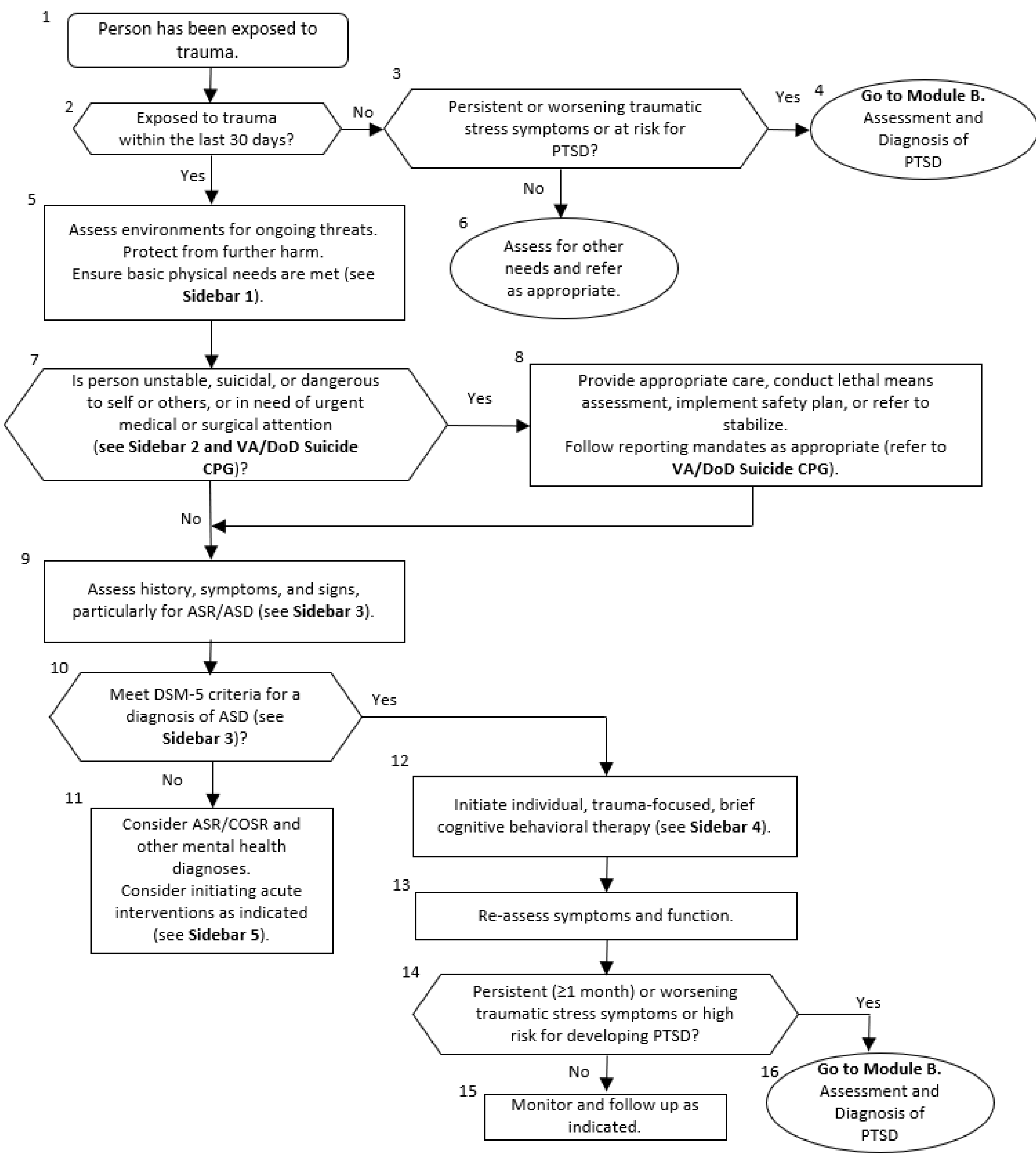
- Steps of care in an ordered sequence,
- Decisions to be considered,
- Decision criteria recommended, and
- Actions to be taken.

The algorithm is a step-by-step decision tree. Standardized symbols display each step, and arrows connect the numbered boxes indicating the order in which the steps should be followed.(7) Sidebars 1–11 provide more detailed information to assist in defining and interpreting elements in the boxes.

Shape	Description
(rounded rectangle)	Rounded rectangles represent a clinical state or condition.
(hexagon)	Hexagons represent a decision point in the process of care, formulated as a question that can be answered "Yes" or "No."
(rectangle)	Rectangles represent an action in the process of care.
(oval)	Ovals represent a link to another section within the algorithm.

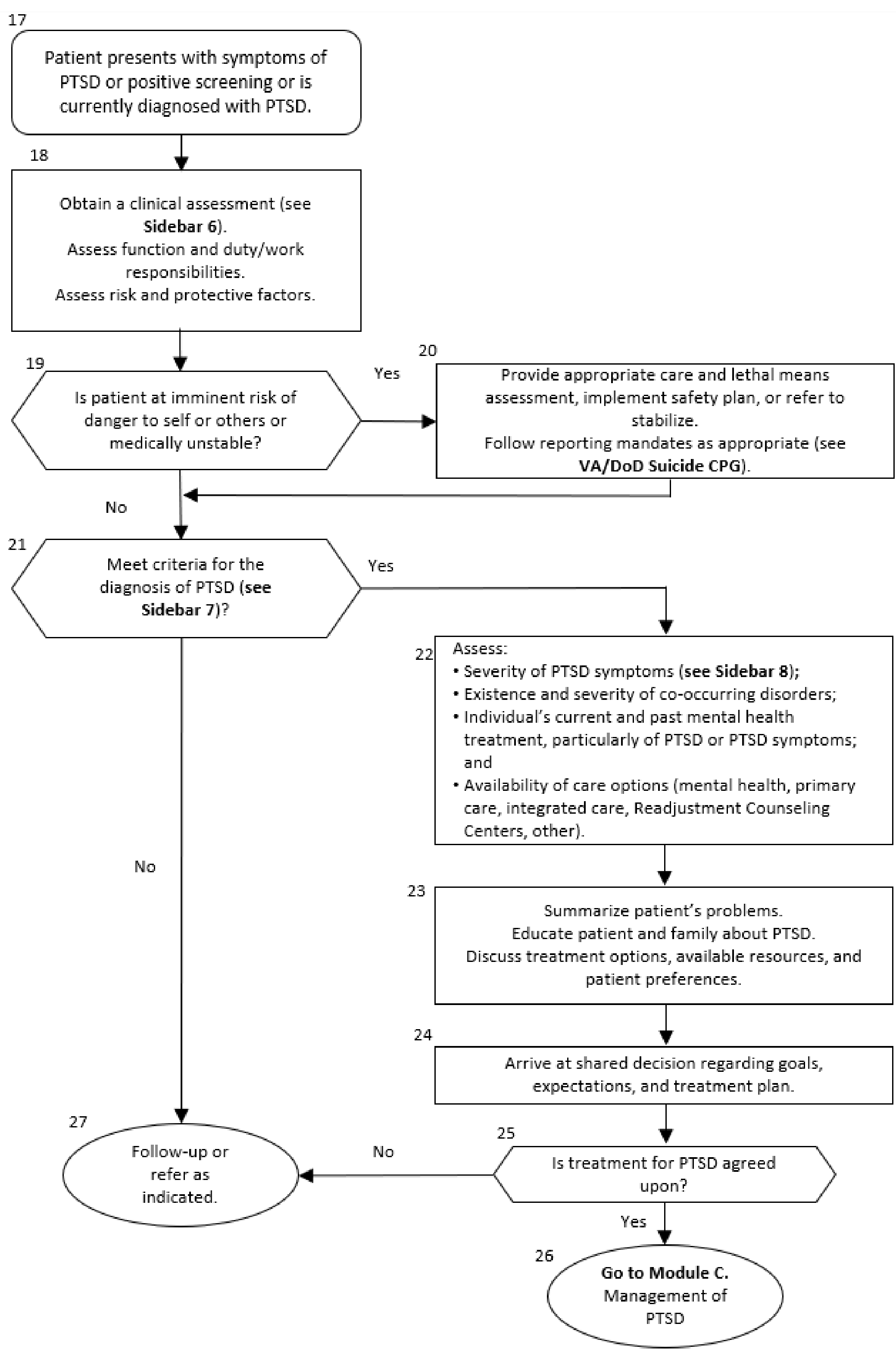
For alternative text descriptions of the algorithm, please refer to Appendix H in the full VA/DoD CPG PTSD.

Module A: Acute Stress Reaction/Disorder



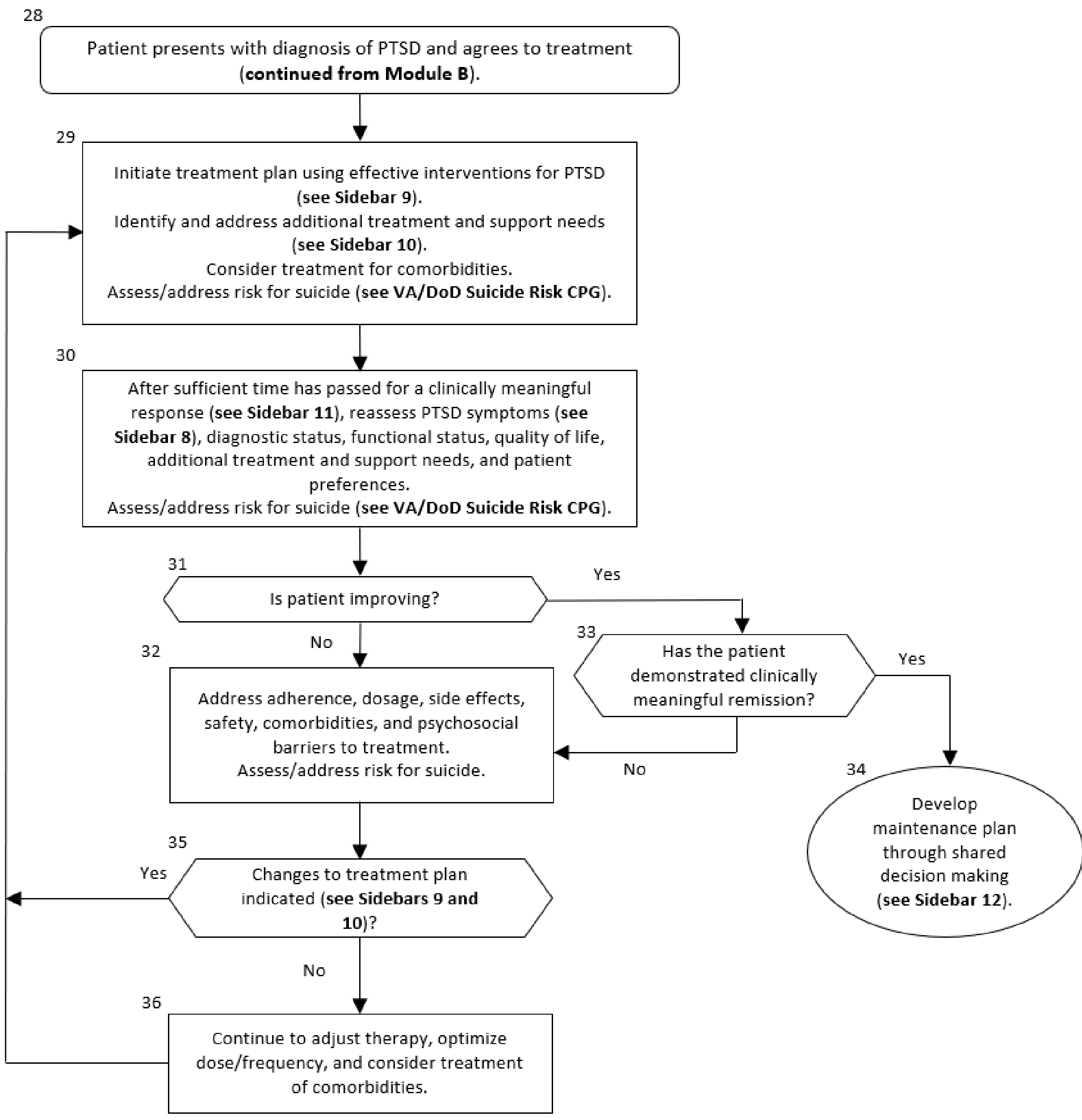
Abbreviations: ASR: Acute Stress Reaction; COSR: Combat and Operational Stress Reaction; CPG: clinical practice guideline; DSM: Diagnostic and Statistical Manual of Mental Disorders; PTSD: Posttraumatic stress disorder; VA: Veteran Affairs; DoD: Department of Defense.

Module B: Assessment and Diagnosis of Posttraumatic Stress Disorder



Abbreviations: CPG: clinical practice guideline; PTSD: Posttraumatic stress disorder; VA: Veteran Affairs; DoD: Department of Defense.

Module C: Management of Posttraumatic Stress Disorder



Abbreviations: CPG: clinical practice guideline; PTSD: Posttraumatic stress disorder; VA: Veteran Affairs; DoD: Department of Defense.

Sidebar 1: Immediate Needs

- Survival (including first aid and stabilizing physical condition), safety, and security
- Food, hydration, shelter, and clothing
- Sleep
- Orientation
- Communication with unit, family, friends, and community
- Education and normalization of reactions to trauma

Sidebar 2: Assessment

- History of trauma and mental health concerns
- Symptoms
- Consider screening for PTSD symptoms using the PC-PTSD-5 (Recommendation 1)
- Medical status
- Mental status, including suicidality (consult VA/DoD CPG for Assessment and Management of Patients at Risk for Suicide,[a] as needed)
- Functional status
- Psychosocial status, including intimate and family relationships; financial problems; legal issues
- Occupational performance
- Substance use
- Strengths, coping skills, and protective factors

[a] See the VA/DoD CPG for the Assessment and Management of Patients at Risk for Suicide, available at https://www.healthquality.va.gov/.

Abbreviations: PC-PTSD-5: Primary Care PTSD Screen for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; PTSD: posttraumatic stress disorder; VA: Veteran Affairs; DoD: Department of Defense.

Sidebar 3: DSM-5-TR Diagnostic Criteria for Acute Stress Disorder(8)

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.

Sidebar 3: DSM-5-TR Diagnostic Criteria for Acute Stress Disorder(8)

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).

Negative Mood

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

Dissociative Symptoms

6. An altered sense of the 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 (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 3 days to 1 month after trauma exposure.

Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to 1 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 a brief psychotic disorder.

Sidebar 4: Acute Interventions for Acute Stress Disorder

- Individual, manualized trauma-focused cognitive behavioral psychotherapy
- Consider: Collaborative care or wellness-oriented activities

Sidebar 5: Acute Interventions for Acute Stress Response/Combat and Operational Stress Reaction

- Education and normalization, acute symptom management, social support
- Suggest: Brief cognitive behavioral psychotherapy

Sidebar 6: General Assessment

- Complete comprehensive clinical assessment of presenting complaints and comorbid conditions
- Perform safety, lethal means, and environmental assessment
- Consider history and presenting complaints: mental health, medical, military, marital, family, substance use, social and spiritual life, functional status
- Identify lifetime trauma history and duration of exposure
- Record current and past medications (including over-the-counter drugs and herbals) and psychosocial treatment
- Consider, with patient consent, obtaining an additional history from family, significant other, or both
- Perform mental status exam
- Consider, in cases of diagnostic uncertainty, use of validated structured clinical interviews for PTSD (i.e., CAPS-5, PSSI) (see Recommendation 2)

Abbreviations: CAPS-5: Clinician-Administered Posttraumatic Stress Disorder Scale for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision; PSSI: PTSD Symptom Scale - Interview Version

Sidebar 7: DSM-5-TR Diagnostic Criteria for PTSD(8)

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 traumatic event(s) occurred to a close family member or close friend. 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: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures unless this exposure is work related.

Sidebar 7: DSM-5-TR Diagnostic Criteria for PTSD(8)
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).
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 themself 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, or loving feelings).
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 toward 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 or restless sleep).
Criterion F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

Sidebar 7: DSM-5-TR Diagnostic Criteria for PTSD(8)
Criterion G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
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 meet the criteria for posttraumatic stress disorder, 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 or of 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 6 months after the event (although the onset and expression of some symptoms may be immediate).

Sidebar 8: Assessment of PTSD Symptoms
• Assess PTSD symptoms using validated instruments, such as the PTSD Checklist for DSM-5 (PCL-5), or a structured clinician-administered interview (e.g., CAPS-5) (see Recommendation 3).

Abbreviations: CAPS-5: Clinician-Administered PTSD Scale for DSM-5; DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; PCL-5: PTSD Checklist for DSM-5; PTSD: posttraumatic stress disorder

Sidebar 9: Treatment Selection
1. Initiate recommended individual, manualized psychotherapy (see Recommendation 8) according to patient preference. 2. If individual psychotherapy is unavailable or not preferred, initiate recommended pharmacotherapy (see Recommendation 15). 3. If options 1 and 2 are infeasible or are not preferred, offer suggested psychotherapy (see Recommendation 9) or suggested CIH (see Recommendation 26). 4. If options 1, 2, and 3 are infeasible or are not preferred, consider other psychotherapies (see Recommendation 10, Recommendation 12, and Recommendation 14), other pharmacotherapy (see Recommendation 16), complementary, integrative, or alternative approaches (see Recommendation 27 and Recommendation 28) based on availability, patient preference, and review of current evidence. 5. If none of the options above are acceptable to the patient, consider treating other disorders, issues, or both and reevaluating for PTSD treatment later.

Abbreviations: CIH: complementary and integrative health; PTSD: posttraumatic stress disorder

Sidebar 10: Additional Treatment and Support Needs

- Consider treatment for comorbidities and other identified problems (see Recommendation 34 as well as other relevant VA/DoD CPGs*).
- Consider symptom-specific management (e.g., sleep, pain).
- Facilitate social support.
- Address Whole Health by offering CIH, alternative approaches, health and wellbeing coaching, recreation therapy, etc.

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

Abbreviations: CIH: complementary and integrative health

Sidebar 11: Clinically Meaningful Response Time

- Psychotherapies require an adequate dosage to be fully effective in reducing PTSD symptoms; some effects might also not become apparent until some period has elapsed after treatment is initiated. For the indicated psychotherapies for PTSD (see Recommendation 8), it is generally accepted that initial treatment effects will be noticeable after 4–8 sessions typically delivered over 8–12 weeks. Psychotherapies might have an attenuated effect if delivered less than weekly.
- The pharmacological management of PTSD requires the SSRI (e.g., sertraline) or SNRI (e.g., venlafaxine) be given at an appropriate dosage for an adequate time to allow for the full therapeutic effects before moving to alternative or augmentative treatment options. These medications should be initiated at the recommended starting dose and titrated based on clinical response and tolerability (see Appendix B in the full VA/DoD PTSD CPG). The duration of the trial should be 8-12 weeks.

Abbreviations: PTSD: posttraumatic stress disorder; SNRI: serotonin-norepinephrine reuptake inhibitor; SSRI: selective serotonin reuptake inhibitor

Sidebar 12: Maintenance Plan

- Terminate PTSD treatment or taper based on clinician judgment and patient preference, normalize fluctuations in symptoms, discuss self-monitoring for symptoms that warrant future attention, and provide resources for seeking care in the future.
- Before termination of psychopharmacology, discuss the risks and benefits of discontinuing medication, including possible side effects and return of symptoms. Make a schedule to taper based on patient preference with a discussion of the length of time required and consideration of anticipated life events and stressors. Discuss the plan for monitoring during and post taper, including steps needed to reinitiate pharmacology.
- Should the patient wish to continue pharmacotherapy, investigate, and discuss continuing medications with behavioral health or primary care.
- Refer the patient for treatment of other disorders or functional issues (e.g., relationship distress).
- If desired, facilitate referral to health and wellbeing programs as a part of a Whole Health approach to care.

Abbreviations: PTSD: posttraumatic stress disorder

Pharmacotherapy Dosing Table

Table 3: Pharmacotherapy Dosing Table

Therapeutic Category	Initial Dose	Dose Range	Clinical Considerations: Comorbidities and Safety
Antidepressants ***Monotherapy***			• All antidepressants have a Black Box warning for increased risk of suicidality in children and young adults (≤24 years) in short-term studies of MDD and other psychiatric disorders. • Avoid abrupt discontinuation; withdrawal symptoms can occur with sudden discontinuation of SSRIs and SNRIs, paroxetine and venlafaxine in particular. • Paroxetine and sertraline have FDA indications for treating PTSD. • Common adverse effects of the SSRIs and SNRIs include nausea, headache, diarrhea, nervousness, sexual dysfunction, dizziness. • Hyponatremia or SIADH can occur; risk is elevated in patients >65 years. • Venlafaxine can elevate blood pressure; caution is advised with patients with hypertension. • Serotonin syndrome can occur, especially with concomitant medications that affect serotonin.
• Paroxetine	IR: 10–20 mg daily CR: 12.5 mg daily	20–50 mg daily 12.5–50 mg	
• Sertraline	25–50 mg daily	50–200 mg daily	
• Venlafaxine	IR: 25 mg 2 or 3 times a day XR: 37.5 mg daily	75–375 mg in 2–3 divided doses 75–300 mg once daily	
Other Agents			• Prazosin might cause syncope with a sudden loss of consciousness. Syncopal episodes usually occur within 30 to 90 minutes of the initial dose. • Addition of a diuretic, other antihypertensive agents, or a PDE5 inhibitor might cause an additive hypotensive effect.
• Prazosin#	1 mg at bedtime; titrate to clinical response.	3–20 mg at bedtime	

Abbreviations: CR: controlled release; FDA: Food and Drug Administration; IR: immediate release; MDD: major depressive disorder; mg: milligram; PDE5: phosphodiesterase-5; PTSD: posttraumatic stress disorder; SIADH: syndrome of inappropriate antidiuretic hormone; SNRI: serotonin/norepinephrine reuptake inhibitor; SSRI: selective serotonin reuptake inhibitor; XR: extended release

for the treatment of nightmares associated with PTSD

Methods

The methodology used in developing this CPG follows the *Guideline for Guidelines*, an internal document of the VA/DoD EBPWG updated in January 2019 that outlines procedures for developing and submitting VA/DoD CPGs.(1) The *Guideline for Guidelines* is available at http://www.healthquality.va.gov/policy/index.asp. This CPG also aligns with the National Academy of Medicine's (NAM) principles of trustworthy CPGs (e.g., explanation of evidence quality and strength, management of potential conflicts of interest [COI], interdisciplinary stakeholder involvement, use of SR and external review).(9) Appendix A in the full VA/DoD PTSD CPG provides a detailed description of the CPG development methodology.

The Work Group used the Grading of Recommendations Assessment, Development and Evaluation (GRADE) approach to craft each recommendation and determine its strength. Per GRADE approach, recommendations must be evidence-based and cannot be made based on expert opinion alone. The GRADE approach uses the following four domains to inform the strength of each recommendation: confidence in the quality of the evidence, balance of desirable and undesirable outcomes, patient values and preferences, other considerations as appropriate (e.g., resource use, equity) (see Grading Recommendations in the full VA/DoD PTSD CPG).(10)

Using these four domains, the Work Group determined the relative strength of each recommendation (*Strong* or *Weak*). The strength of a recommendation is defined as the extent to which one can be confident that the desirable effects of an intervention outweigh its undesirable effects and is based on the framework above, which incorporates the four domains.(11) A *Strong* recommendation generally indicates *High* or *Moderate* confidence in the quality of the available evidence, a clear difference in magnitude between the benefits and harms of an intervention, similar patient values and preferences, and understood influence of other implications (e.g., resource use, feasibility).

In some instances, insufficient evidence exists on which to base a recommendation for or against a particular therapy, preventive measure, or other intervention. For example, the systematic evidence review might have found little or no relevant evidence, inconclusive evidence, or conflicting evidence for the intervention. The manner in which this finding is expressed in the CPG might vary. In such instances, the Work Group might include among its set of recommendations a statement of insufficient evidence for an intervention that might be in common practice although it is unsupported by clinical evidence and particularly if other risks of continuing its use might exist (e.g., high opportunity cost, misallocation of resources). In other cases, the Work Group might decide to exclude this type of statement about an intervention. For example, the Work Group might remain silent where an absence of evidence occurs for a rarely used intervention. In other cases, an intervention might have a favorable balance of benefits and harms but might be a standard of care for which no recent evidence has been generated.

Using these elements, the Work Group determines the strength and direction of each recommendation and formulates the recommendation with the general corresponding text as shown in Table 4.

Table 4. Strength and Direction of Recommendations and General Corresponding Text

Recommendation Strength and Direction	General Corresponding Text
Strong for	We recommend . . .
Weak for	We suggest . . .
Neither for nor against	There is insufficient evidence to recommend for or against . . .
Weak against	We suggest against . . .
Strong against	We recommend against . . .

The GRADE of each recommendation made in the 2023 CPG can be found in the section on Recommendations. Additional information regarding the use of the GRADE system can be found in Appendix A in the full VA/DoD PTSD CPG.

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11. Andrews J, Guyatt G, Oxman AD, Alderson P, Dahm P, Falck-Ytter Y, et al. GRADE guidelines: 14. Going from evidence to recommendations: the significance and presentation of recommendations. Journal of clinical epidemiology. 2013;66(7):719-25. Epub 2013/01/15. doi: 10.1016/j.jclinepi.2012.03.013. PubMed PMID: 23312392.

Access to the full guideline and additional resources is available at:
https://www.healthquality.va.gov/.