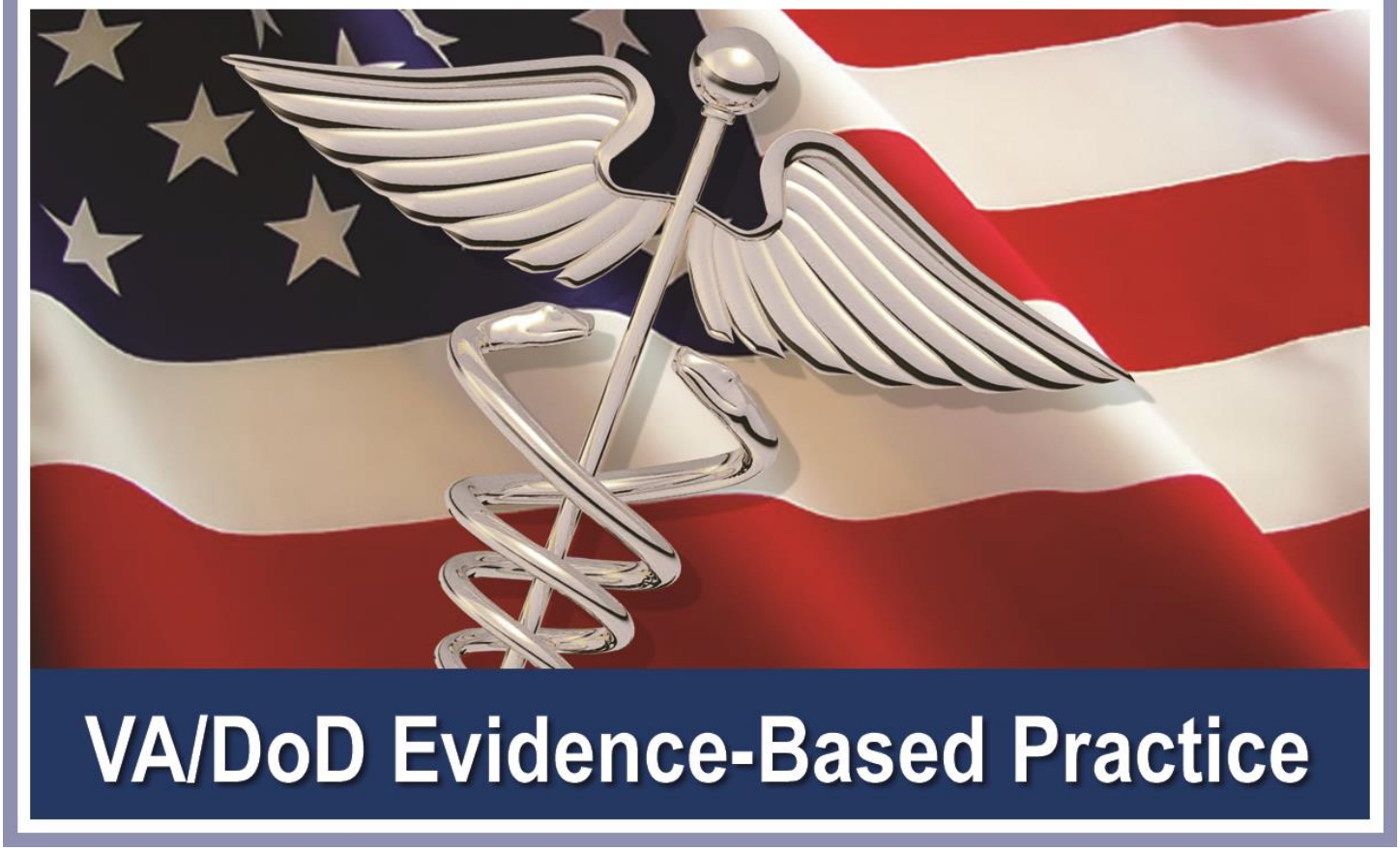
VA/DoD Clinical Practice Guidelines

Management of Posttraumatic Stress Disorder and Acute Stress Disorder



Quick Reference Guide

Version 4.0 | 2023

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

Department of Veterans Affairs
Department of Defense

Quick Reference Guide

Recommendations **Algorithm**

Recommendations

The following evidence-based clinical practice recommendations were made using a systematic approach considering four domains as per the GRADE approach (see *Summary of Guideline Development Methodology* on page 19 in full 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

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Prevention of PTSD	*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
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

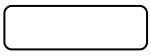
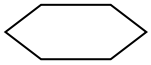
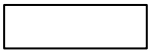
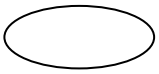
Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Treatment of PTSD (cont.)	Pharmacotherapy	15.	We recommend paroxetine, sertraline, or venlafaxine for the treatment of PTSD.	Strong for	Reviewed, New-replaced
		16.	There is insufficient evidence to recommend for or against amitriptyline, bupropion, 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
		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
		26.	We suggest Mindfulness-Based Stress Reduction® for the treatment of PTSD.	Weak for	Reviewed, New-replaced

Topic	Sub-topic	#	Recommendation	Strength[a]	Category[b]
Treatment of PTSD (cont.)	*Complementary, Integrative, and Alternative Approaches*	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 *Determining Recommendation Strength and Direction* on page 128 in the full CPG

[b] For additional information, see *Recommendation Categorization* on page 130 in the full CPG

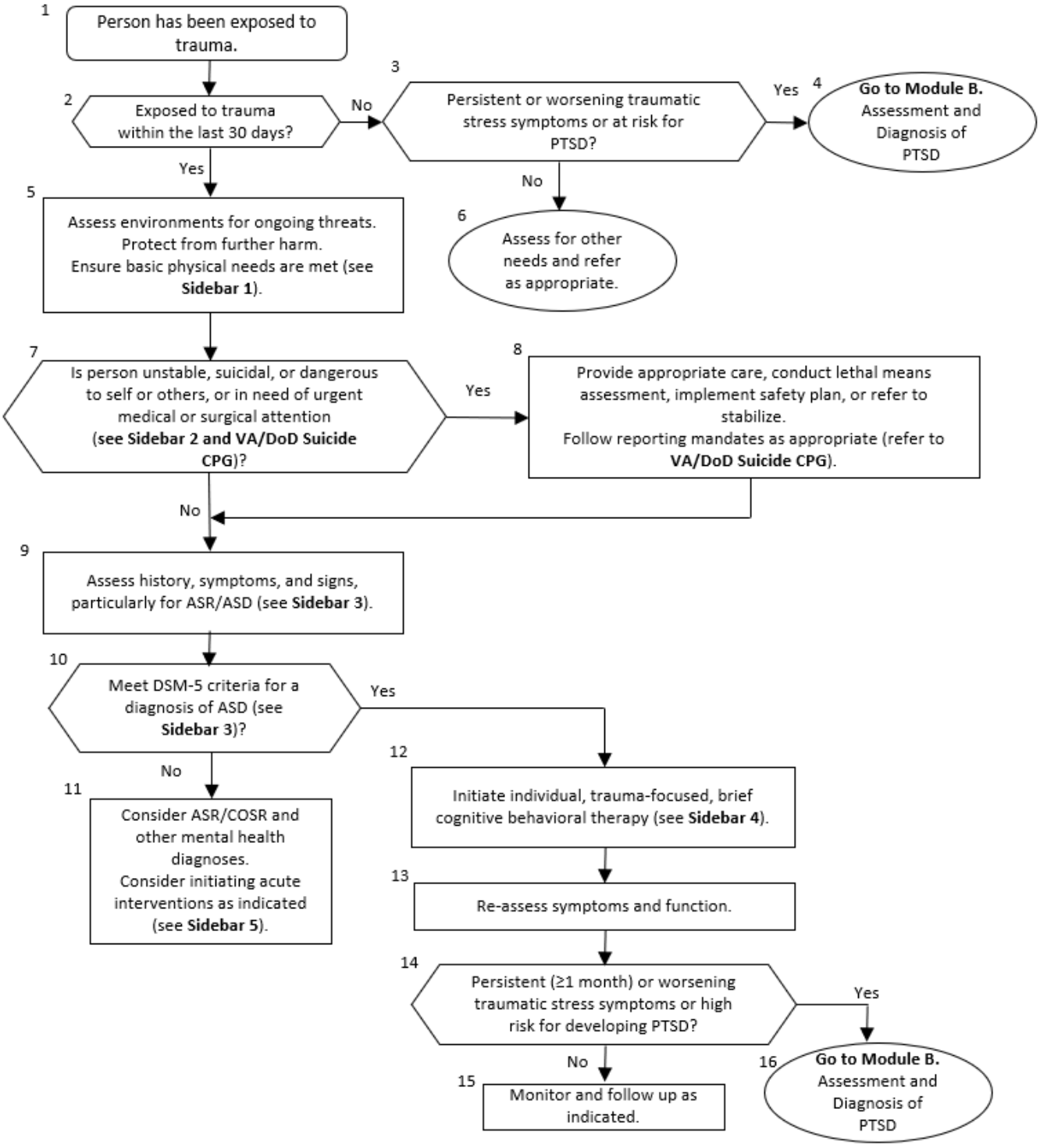
Algorithm

Shape	Description
	Rounded rectangles represent a clinical state or condition
	Hexagons represent a decision point in the process of care, formulated as a question that can be answered “Yes” or “No”
	Rectangles represent an action in the process of care
	Ovals represent a link to another section within the algorithm

The algorithm sidebars can be found on page 30 in the full CPG at https://www.healthquality.va.gov/

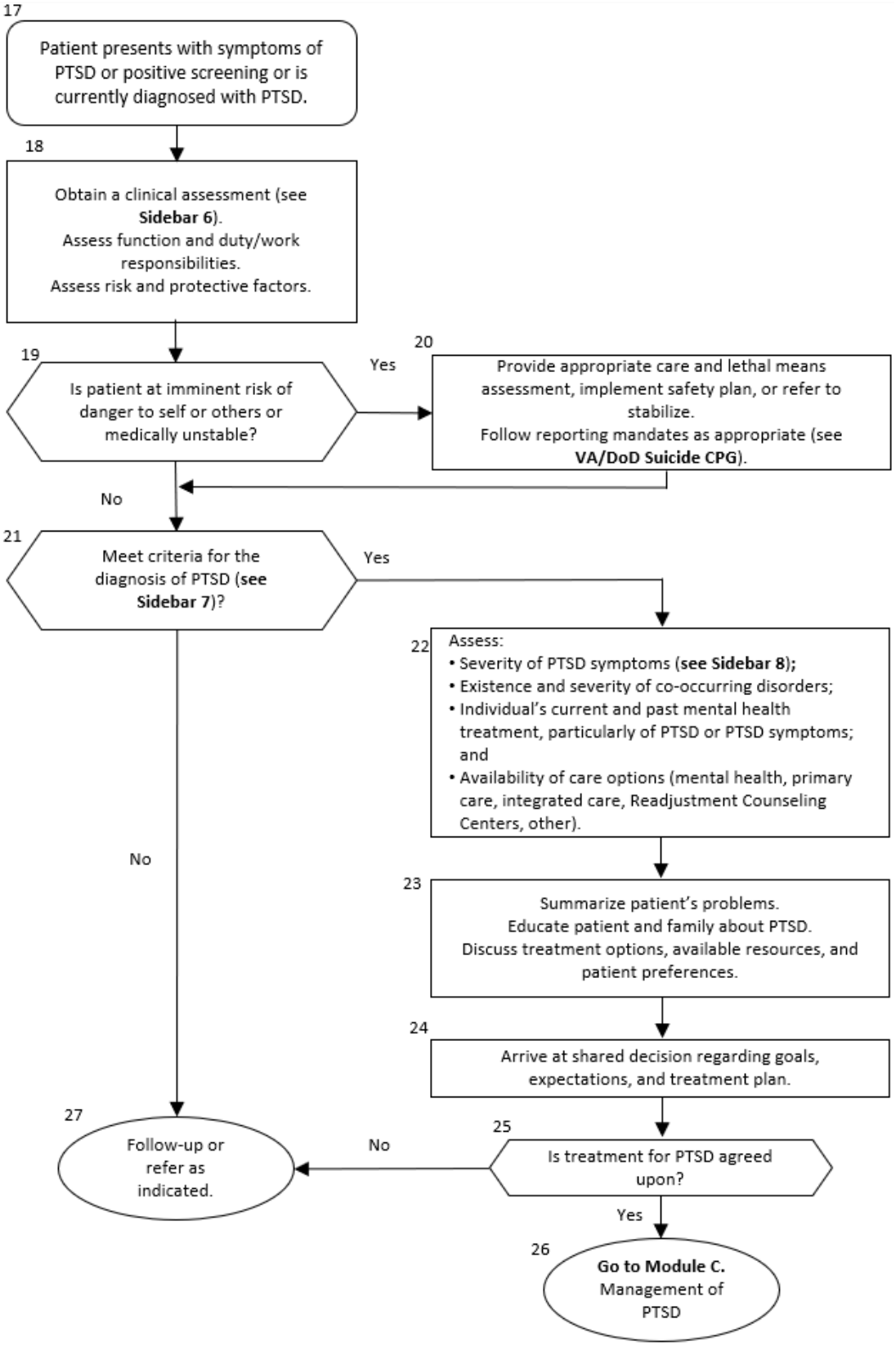
Appendix H (in the full CPG) contains the alternative text descriptions of the algorithm.

Module A: Acute Stress Reaction/Disorder



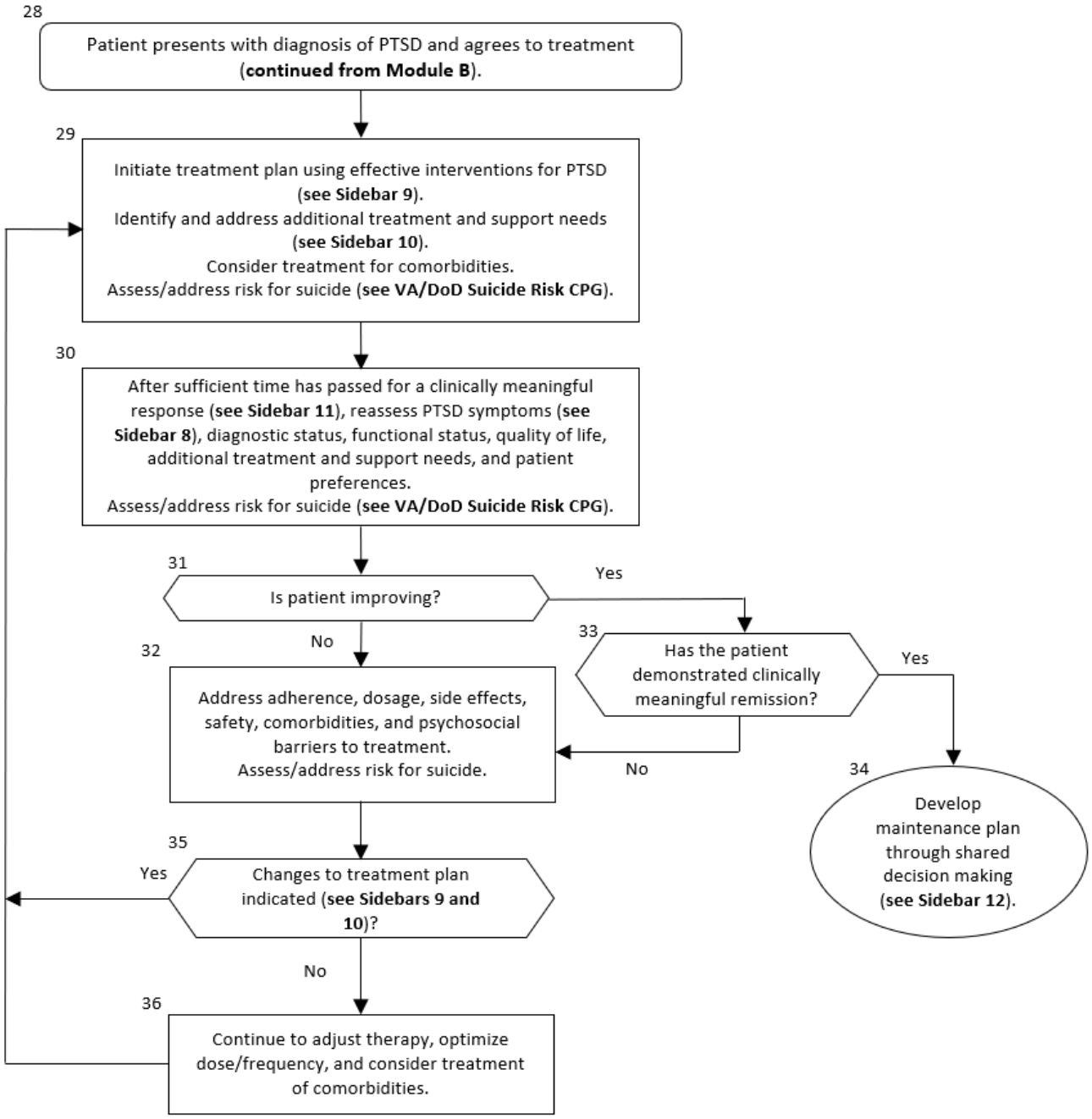
Abbreviations: ASR: Acute Stress Reaction; COSR: Combat and Operational Stress Reaction; CPG: clinical practice guideline; DSM: Diagnostic and Statistical Manual of Mental Disorders; PTSD: Posttraumatic stress disorder; VA: Veteran Affairs; DoD: Department of Defense.

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.

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