Complete Summary

GUIDELINE TITLE

VA/DoD clinical practice guideline for the management of post-traumatic stress.

BIBLIOGRAPHIC SOURCE(S)

Veterans Health Administration, Department of Defense. VA/DoD clinical practice guideline for the management of post-traumatic stress. Version 1.0. Washington (DC): Veterans Health Administration, Department of Defense; 2004 Jan. Various p. [479 references]

GUIDELINE STATUS

This is the current release of the guideline.

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- December 12, 2007, Carbamazepine: The U.S. Food and Drug Administration (FDA) has provided recommendations for screening that should be performed on specific patient populations before starting treatment with carbamazepine.
- May 2, 2007, Antidepressant drugs: Update to the existing black box warning on the prescribing information on all antidepressant medications to include warnings about the increased risks of suicidal thinking and behavior in young adults ages 18 to 24 years old during the first one to two months of treatment.
- March 14, 2007, Sedative-hypnotic drug products: Revisions to product labeling to include stronger language concerning potential risks including severe allergic reactions and complex sleep-related behaviors, such as sleep-driving.

COMPLETE SUMMARY CONTENT

** REGULATORY ALERT **
SCOPE
METHODOLOGY - including Rating Scheme and Cost Analysis
RECOMMENDATIONS
EVIDENCE SUPPORTING THE RECOMMENDATIONS
BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS
CONTRAINDICATIONS

QUALIFYING STATEMENTS
IMPLEMENTATION OF THE GUIDELINE
INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES
IDENTIFYING INFORMATION AND AVAILABILITY
DISCLAIMER

SCOPE

DISEASE/CONDITION(S)

Post traumatic stress disorder

GUIDELINE CATEGORY

Diagnosis
Evaluation
Management
Prevention
Treatment

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Psychiatry
Psychology

INTENDED USERS

Health Care Providers
Health Plans
Hospitals
Managed Care Organizations
Nurses
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians

GUIDELINE OBJECTIVE(S)

To survey best practices in post-traumatic stress disorder prevention, diagnosis, and treatment and to determine whether the evidence supports current practices, or whether the evidence suggests they should be modified or discontinued

TARGET POPULATION

Any person who is eligible for care in the Veterans Affairs or Department of Defense health care delivery system, specifically, military men or women and veterans who have survived traumatic events

INTERVENTIONS AND PRACTICES CONSIDERED

Initial Evaluation and Triage (includes Primary Prevention)

1. Education and training to promote hardiness and resiliency
    - Provide realistic training
    - Strengthen perceived ability to cope
    - Create supportive interpersonal work environments
    - Develop and maintain adaptive beliefs
    - Develop workplace-specific comprehensive traumatic stress management programs
2. Screen for Post-Traumatic Stress Disorder (PTSD) symptoms
    - Primary care PTSD Screen
    - PTSD Brief Screen
    - Short Screening Scale for Diagnostic and Statistical Manual, 4th edition (DSM IV) PTSD

Management of Acute Stress Reaction (ASR)

1. Screen for ASR
2. Assess medical and functional status based on general appearance and screening instruments
3. Medical status including:
    - History, physical examination, and a neurological examination
    - Use of prescribed medications, mood or mind-altering substances, and possible biological or chemical agent exposure
    - A minimal mental status examination to assess cognitive function
    - Screen for toxicology
    - Radiological assessment of patients with focal neurological findings or possible head injury
    - Appropriate laboratory studies to rule out medical disorders that may cause symptoms of acute stress reactions (e.g., complete blood count [CBC], chemistry profile, thyroid studies, human chorionic gonadotropin [HCG], electrocardiogram, electroencephalogram)
    - A focused psychosocial assessment
    - Brief assessment of function
4. Ensure basic physical needs are met by protecting, directing, connecting with, and triaging patients.
5. Acute symptom management
    - Assurance/reassurance
    - Defusing (3-phased discussion provided within hours of the crisis for purpose of assessment triage and acute symptom mitigation)
    - Mitigate fear and anxiety
    - Sleep hygiene
    - Re-establish routine
    - Exercise and nutrition
    - Bereavement
    - Survivor success
    - Advise about alcohol/substance use
    - Modulate mood/irritability
6. Psychological debriefing
7. Facilitate social and psychological support

8. Pharmacotherapy
    - Propranolol
    - Benzodiazepines
    - Other sympatholytics
    - Antidepressants
    - Anticonvulsants
    - Atypical antipsychotics
    - Antihistamines
    - Typical antipsychotics
9. Reassessment after acute intervention by evaluation of risk factors
10. Referral and consultation with mental health professionals

Management of Combat and Ongoing Operation Stress Reaction (COSR)

1. Screening for symptoms of COSR
2. Assess risk of harm to self or others
3. Identification of service members who can return to functioning in unit
4. Acute symptom management according to "PIES" principle (proximity, immediacy, expectancy, simplicity)
5. Transfer for treatment, as needed.

Management of Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD) in Primary Care

1. Assessment of trauma exposure, trauma-related symptoms, and dangerousness to self or others
2. Obtain medical history, physical examination, mental status examination, laboratory tests, psychosocial assessment, functional assessment, and other evaluations
3. Patient education
4. Referral to Vet Centers

Management of Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD) in Specialty Care

1. Mental health assessment
2. Medical history, physical examination, mental status examination, psychosocial assessment, and appropriate lab tests
3. Documentation of DSM-IV criteria in medical record
4. Patient and family education
5. Initiation of therapy for PTSD
6. Reassessment of status after therapeutic interventions
7. Follow-up in mental health and referral

Evidence-Based Intervention for Treatment of PTSD

1. Cognitive Therapy
2. Exposure Therapy
3. Stress Inoculation Testing
4. Eye Movement Desensitization and Reprocessing
5. Imagery Rehearsal Therapy
6. Psychodynamic Therapy

7. Group Therapy
8. Dialectical Behavior Therapy
9. Hypnosis
10. Spiritual Support
11. Acute Stress Disorder Pharmacotherapy
    - Imipramine
    - Propranolol
    - Benzodiazepines
    - Anticonvulsants
    - Other antidepressants
    - Other sympatholytics
    - Atypical antipsychotics
    - Choral hydrate
    - Typical antipsychotics (not recommended)
12. Post-traumatic stress disorder pharmacotherapy using monotherapy and/or augmented therapy for targeted symptoms
    - Selective serotonin reuptake inhibitors (SSRIs)
    - Tricyclic antidepressants (TCAs)
    - Monoamine oxidase inhibitors (MAOIs)
    - Sympatholytics
    - Novel antidepressants
    - Anticonvulsants
    - Atypical antipsychotics
    - Buspirone
    - Non-benzodiazepines hypnotics
    - Benzodiazepines (not recommended)
    - Typical antipsychotics (not recommended)

MAJOR OUTCOMES CONSIDERED

- Effect of treatment on Clinician Administered Post-traumatic Stress Disorder Scale (CAPS) or other measures of post-traumatic stress disorder (PTSD)
- Effect of treatment on symptoms of PTSD
- Relapse rate in persons with PTSD
- Prevention of PTSD
- Risk factors for PTSD
- Sensitivity and specificity of screening tools for PTSD

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The following three guidelines were identified by the Working Group as appropriate seed guidelines. They served as the starting point for the development of questions and key terms.

- Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies. Foa EB, Keane TM, Friedman MJ (Eds) 2000. New York: Guilford Publications
- Expert Consensus Guideline Series: Treatment of Post-traumatic Stress Disorder. Foa EB, Davidson JRT, Francis A. J Clin Psychiatry 1999; 60 (Suppl 16)
- Mental Health and Mass Violence: Evidenced-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices. National Institute of Mental Health 2002. NIH Publication No. 02-5138. Washington, D.C.: U.S. Government Printing Office. http://www.nimh.nih.gov/publicat/massviolence.pdf

The Working Group developed eighteen researchable questions and associated key terms after orientation to the seed guidelines and to goals that had been identified by the Working Group. The questions specified (adapted from the Evidence-Based Medicine (EBM) toolbox, Centre for Evidence-Based Medicine, (http://www.cebm.net):

- Population – characteristics of the target patient population
- Intervention – exposure, diagnostic, or prognosis
- Comparison – intervention, exposure, or control used for comparison
- Outcome –outcomes of interest

These specifications served as the preliminary criteria for selecting studies.

Selection of Evidence

Published, peer-reviewed, randomized controlled trials (RCTs) were considered to constitute the strongest level of evidence in support of guideline recommendations. This decision was based on the judgment that RCTs provide the clearest scientifically sound basis for judging comparative efficacy. The Working Group made this decision recognizing the limitations of RCTs, particularly considerations of generalizability with respect to patient selection and treatment quality. Meta-analyses that included random controlled studies were also considered to be the strongest level of evidence, as well as reports of evidence-based systematic reviews.

A systematic search of the literature was conducted. It focused on the best available evidence to address each key question and ensured maximum coverage of studies at the top of the hierarchy of study types: evidence-based guidelines, meta-analyses, and systematic reviews. When available, the search sought out critical appraisals already performed by others that described explicit criteria for deciding what evidence was selected and how it was determined to be valid. The sources that have already undergone rigorous critical appraisal include Cochrane Reviews, Best Evidence, Technology Assessment, and Evidence-based Practice Center (EPC) reports.

The search continued using well-known and widely available databases that were appropriate for the clinical subject. In addition to Medline/PubMed, the following databases were searched: Database of Abstracts of Reviews of Effectiveness (DARE) and Cochrane Central Register of Controlled Trials (CCTR). For Medline/PubMed, limits were set for language (English), date of publication (1998

through July 2002), and type of research (RCT and meta-analysis). For most of the pharmacotherapy topics the only limit was date, 1990 through March 2003).

Once definitive reviews or clinical studies that provided valid relevant answers to the question were identified, the search ended. The search was extended to studies/reports of lower quality (observational studies) only if there were no high quality studies.

Exclusion criteria included reviews that omitted clinical course or treatment. Some retrieved studies were rejected on the basis of published abstracts, and a few were rejected after the researchers scanned the retrieved citation for inclusion criteria. Typical exclusions included studies involving children and adolescents.

The results of the search were organized and reported using reference manager software. At this point, additional exclusion criteria were applied. The bibliographies of the retrieved articles were hand-searched for articles that may have been missed by the computer search. Additional experts were consulted for articles that may also have been missed.

Literature Review and Inclusion Criteria

The articles identified during the literature reviews formed the basis for formulating the guideline recommendations. The literature search for the guideline development was validated by: (1) comparing the results to a search conducted by the independent research and appraisal team; (2) a review of the database by the expert panel; and (3) requesting articles pertaining to special topics from the experts in the working group.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus
Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

The following rating schemes are from the U.S. Preventive Services Task Force (USPSTF) (2001).

Quality of Evidence (QE)

I At least one properly done randomized controlled trial (RCT)
II-1 Well designed controlled trial without randomization
II-2 Well designed cohort or case-control analytic study
II-3 Multiple time series, dramatic results of uncontrolled experiment
III Opinion of respected authorities, case reports, and expert committees

Overall Quality

Good: High grade evidence (I or II-1) directly linked to health outcome
Fair: High grade evidence (I or II-1) linked to intermediate outcome or moderate grade evidence (II-2 or II-3) directly linked to health outcome
Poor: Level III evidence or no linkage of evidence to health outcome

Net Effect of the Intervention

Substantial: More than a small relative impact on a frequent condition with a substantial burden of suffering; *or* a large impact on an infrequent condition with a significant impact on the individual patient level

Moderate: A small relative impact on a frequent condition with a substantial burden of suffering; *or* a moderate impact on an infrequent condition with a significant impact on the individual patient level

Small: A negligible relative impact on a frequent condition with a substantial burden of suffering; *or* a small impact on an infrequent condition with a significant impact on the individual patient level

Zero or Negative: Negative impact on patients; *or* no relative impact on either a frequent condition with a substantial burden of suffering; or An infrequent condition with a significant impact on the individual patient level

METHODS USED TO ANALYZE THE EVIDENCE

Review of Published Meta-Analyses
Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Preparation of Evidence Tables (reports)

A group of clinician reviewers and other researchers in health care with experience in evidence-based appraisal independently read and coded each article that met inclusion criteria. Each article was turned into a one-page summary of the critical appraisal by the research team and added to a central electronic database. Clinicians from the Center for Evidence-Based Practice at the State University of New York [SUNY], Upstate Medical University, Department of Family Medicine contributed several of the appraisal reports. Each of the evidence reports covered:

- Summary of findings
- Methodology
- Search terms
- Resources searched
- Summary table of findings
- Critical appraisal of each study

Evidence-based practice involves integrating clinical expertise with the best available clinical evidence derived from systematic research. The Working Group

reviewed the evidence and graded it using the rating scheme developed by the United States Preventive Service Task Force (USPSTF) (2001). The experts themselves, after an orientation and tutorial on the evidence grading process, formulated Quality of Evidence ratings, a rating of Overall Quality, a rating of the Net Effect of the Intervention (see "Rating Scheme for the Strength of the Evidence"), and an overall Recommendation (see "Rating Scheme for the Strength of the Recommendations").

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

The development of the Veterans Affairs/Department of Defense (VA/DoD) Clinical Practice Guideline for the Management of Traumatic Stress Symptoms was initiated in May 2002 and continued through May 2003. The development process followed the steps described in "Guideline for Guidelines" an internal working document of Veterans Health Administration´s National Clinical Practice Guideline Council, which requires an ongoing review of the work in progress.

The Offices of Quality and Performance and Patient Care Service, in collaboration with the network Clinical Managers, the Deputy Assistant Under Secretary for Health, and the Medical Center Command of the DoD identified clinical leaders to champion the guideline development process. During a preplanning conference call, the clinical leaders defined the scope of the guideline and identified a group of clinical experts from the VA and DoD that formed the Guideline Development Working Group.

The Working Group participated in several face-to-face sessions to reach a consensus about the guideline recommendations and to prepare a draft document. The draft was revised by the experts through numerous conference calls and individual contributions to the document.

The majority of the literature supporting the science for these guidelines is referenced throughout the document and is based upon key randomized controlled trials and longitudinal studies published from 1998 through July 2002. Following the independent review of the evidence, a consensus meeting was held to discuss discrepancies in ratings and formulate recommendations. Where existing literature was ambiguous or conflicting, or where scientific data was lacking on an issue, recommendations were based on the clinical experience of the Working Group. These recommendations are indicated in the evidence tables as based on "Working Group Consensus".

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

The following rating scheme is from the U.S. Preventive Services Task Force (USPSTF) (2001). The Task Force uses its assessment of the evidence and magnitude of net benefit to make a recommendation.

A A strong recommendation that the intervention is always indicated and acceptable
B A recommendation that the intervention may be useful/effective
C A recommendation that the intervention may be considered
D A recommendation that a procedure may be considered not useful/effective, or may be harmful
I Insufficient evidence to recommend for or against – the clinician will use clinical judgment

COST ANALYSIS

In a presentation to the United States Food and Drug Administration (FDA), one study quantified some of the costs of post-traumatic stress disorder (PTSD) to patients and to the health care system:

- Early outcome studies show that early diagnosis and appropriate treatment of trauma-related disorders are cost effective, especially when compared with the cost of incorrect or inadequate treatment occurring prior to a correct diagnosis.
- In one study of women with trauma related dissociative disorders, if a correct diagnosis had been made after 12 months of treatment, rather than after an average of 99 months of treatment, the estimated savings would have been $250,000 per patient.
- In a study of rape victims, severely victimized female members in a Health Maintenance Organization (HMO) had outpatient medical expenses double those of control HMO members.
- Findings suggest that from 3.1 to 4.7 million crime victims received mental health treatment in 1991, for an estimated total cost of $8.3 to $9.7 billion. These recipients represent only a small portion of trauma victims in need of treatment, since those with PTSD are typically reluctant to seek professional help.

METHOD OF GUIDELINE VALIDATION

Clinical Validation-Trial Implementation Period
External Peer Review
Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The final draft was reviewed by mental health and primary care experts in the Department of Veterans Affairs (VA) and Department of Defense (DoD). Their feedback was integrated into the final draft. Nonetheless, this document is a work in progress. It will be updated every two years, or when significant new evidence is published.

Parts of the Clinical Practice Guideline have already served in Afghanistan and Iraq.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The recommendations for the management of post-traumatic stress are organized into 5 major algorithms. The algorithms, the objectives, and recommendations that accompany them, and the evidence supporting the recommendations are presented below. The quality of evidence (I, II-1, II-2, II-3, III), overall quality (Good, Fair, Poor), net effect of intervention (Substantial, Moderate, Small, Zero Or Negative), strength of recommendation grading (A-D, I) are defined at the end of the "Major Recommendations" field.

Note: A list of abbreviations is provided at the end of the "Major Recommendations" field.

CORE MODULE - INITIAL EVALUATION AND TRIAGE

Primary Prevention

A. **Education And Training to Promote Hardiness and Resiliency**

Objective

Prepare individuals and groups for exposure to traumatic experiences in ways that minimize the likelihood of development of post traumatic stress disorder (PTSD) and other trauma-related problems.

Recommendations

1. In high-risk occupations for which probability of trauma exposure is moderate or high, efforts should be undertaken to increase psychological resilience of workers to the negative effects of trauma exposure. (Working Group Consensus) (**Quality of Evidence [QE] – III, Overall Quality – Poor, Recommendation [R]– I**)

Populations At-Risk For Developing PTSD

B. **People At-Risk For Developing Stress Symptoms After Trauma**

Objective

Identify persons at risk for developing a traumatic stress disorder (PTSD) after trauma exposure.

Recommendations

1. Persons exposed to trauma should be assessed for known risk factors for developing PTSD – both pre-trauma risks and post-trauma risks. (Brewin, Andrews, & Valentine, 2000) (**QE – II, Overall Quality – Good, R – B**)

2. The trauma type, nature, and severity should be assessed. (Brewin et al., 1999; Bryant et al., 2000; Harvey & Bryant, 2000; Mellman et al., 2001) (**QE – II, Overall Quality – Good, R - B**)
3. Assessment of existing social supports and ongoing stressors is important. (Litz et al., 2002) (**QE – II, Overall Quality – Good, R – B**)
4. Patients with Acute Stress Disorder (ASD) warrant careful clinical attention, as they are at high-risk for developing PTSD. (Birmes et al., 2001; Brewin et al., 1999; Bryant et al., 2000, Harvey & Bryant, 2000; Mellman et al., 2001; Murray, Ehlers, & Mayou, 2002) (**QE – II, Overall Quality – Good, R – B**)
5. Patients with dissociative symptoms may also warrant careful clinical attention. (Brewin et al., 1999; Murray, Ehlers, & Mayou, 2002)(**QE– II, Overall Quality – Fair, R – C**)

Secondary Prevention – Surveillance Screening

C. **Screen For PTSD Symptoms**

Objective

Identify possible cases of PTSD.

Recommendations

1. All new patients should be screened for symptoms of PTSD (Breslau et al., "Previous exposure," 1999; Leskin & Westrup, 1999; Prins et al. 1999; Taubman-Ben-Ari et al., 2001) (**QE – II-2, Overall Quality – Fair, R – B**) initially and then on an annual basis or more frequently if clinically indicated due to clinical suspicion, recent trauma exposure (e.g., major disaster), or history of PTSD.(Working Group Consensus) (**QE – III, Overall Quality – Poor, R – I**)
2. Patients should be screened for symptoms of PTSD using paper and pencil or computer-based screening tools.
3. No studies are available that compare the benefits of one PTSD screening tool versus another. However, the following screening tools have been validated and should be considered for use:
    - Primary Care PTSD Screen (PC-PTSD)
    - PTSD Brief Screen
    - Short Screening Scale for DSM IV PTSD

    (Breslau et al. "Previous exposure," 1999; Leskin & Westrup, 1999; Prins et al., 1999) (**QE – II-2, Overall Quality – Fair, R – B**)

4. There is, as yet, insufficient evidence to recommend special screening or differing PTSD treatment for members of any cultural or racial groups. (Frueh, Brady & de Arellano , 1998; Frueh et al., 1997; Frueh, Smith, & Libet, 1996; Ortega & Rosenheck, 2000; Penk et al., 1989; Rosenheck & Fontana, 1996; Trent et al., 2000) (**QE – III, Overall Quality – Poor, R – I**)

D. **Are Trauma Related Symptoms Present?**

Objective

Identify people exposed to trauma who are at risk for developing an acute stress reaction (ASR), acute stress disorder (ASD), or post-traumatic stress disorder (PTSD).

Recommendations

1. Individuals who are presumed to have symptoms of PTSD or who are positive for PTSD on the initial 4-item screening should receive specific assessment of their symptoms.
2. Useful information may include details such as time of onset, frequency, course, severity, level of distress, functional impairment, and other relevant information.
3. The elapsed time since the exposure to trauma is very important in assessing the risk of developing PTSD and determining the appropriate intervention. See the original guideline document for definitions of stress-related disorders and syndromes that will help providers select the appropriate treatment algorithm.

E. **Normalization For Asymptomatic Survivors And Responders**

Objective

Help trauma survivors and responders who are NOT themselves experiencing signs or symptoms recognize that these reactions in others are common in the aftermath of trauma and do not signify personal inadequacy, health problems, mental illness, or other enduring negative consequences.

Recommendations

1. Pre- and post-trauma education should include helping asymptomatic trauma survivor or responder understand that the acute stress reactions of other people are common and do not indicate personal failure or weakness, mental illness, or health problems. The responders should be taught the simple words and measures that will support quick recovery, rather than push survivors towards a persisting disorder. (Working Group Consensus); (**QE – III, Overall Quality Poor, R - I**)
2. Education should include sufficient review of the many ways that post-traumatic problems can present, including symptoms in the ASD/PTSD spectrum, behavioral problems with family and friends, occupational problems, and alcohol or other substance misuse/abuse.
3. Provide education and access information to include the following:
    - Begin with clear statement about ASR being normal, common, and expectable responses to trauma; the reliance on self and buddy management, and other available resources if stress symptoms persist or worsen.
    - Maximize positive expectation of mastery.

- Demystify PTSD (before listing symptoms) and emphasize the human brain and mind´s natural resiliency (e.g., our forefathers/mothers, generations ago survived very bad situations or we wouldn´t be here, and we can survive also).
- Painful memories sometimes get stuck, through no fault of the sufferer. Such memories cause real biological changes that can cause physical change and illness elsewhere in the body. Many of these changes can be reversed. All can be compensated for by developing new brain skills, aided by medication when appropriate.
- Professionals with special skills and capabilities (including some religious pastors and mental health professionals, other medical people, and others with special training and supervision) can intervene to reverse this process.
- Resolving developing symptoms and problems

MODULE A1 - ACUTE STRESS REACTION (ASR)

Assessment

A. **Trauma Exposure**

Definition

Traumatic events are events that cause a person to fear that he or she may die or be seriously injured or harmed. These events also can be traumatic when the person witnesses them happening to others. Such events often create feelings of intense fear, helplessness, or horror for those who experience them. Among the common kinds of traumatic events are:

- Combat in a war zone
- Rape or other sexual assault
- Natural disaster (e.g., hurricanes, floods, or fires)
- Child physical and/or sexual abuse
- Domestic violence (battering)
- Motor vehicle accidents
- Exposure to the sudden or unexpected death of others
- Sudden life-threatening physical illness (e.g., heart attack or cancer)

B. **Screen For ASR**

Objective

Identify individuals who may be at risk for endangering themselves or others due to emotional distress or functional incapacity.

Recommendations

1. Identification of a patient with ASR symptoms is based on observation of behavior and function.
2. There is no evidence to support any specific screening tool.

3. Individuals exhibiting the following responses to trauma should be screened for ASR:
    - Physical: exhaustion, hyperarousal, somatic complaints (gastrointestinal [GI], genitourinary [GU], musculoskeletal [MS], cardiovascular [CV], respiratory, nervous system [NS]), conversion disorder symptoms
    - Emotional: anxiety, depression, guilt/hopelessness
    - Behavioral: avoidance, problematic substance use
    - Cognitive/mental: amnestic or dissociative symptoms, hypervigilance, paranoia, intrusive re-experiencing.

C. **Dangerousness To Self Or Others**

Objective

Protect individuals who may be at risk for endangering themselves or others due to emotional distress or functional incapacity.

Recommendations

1. Acute medical issues should be addressed to preserve life and avoid further harm:
    - ABC´s (Maintain: Airways, Breathing, Circulation)
    - Substance intoxication or withdrawal
    - Danger to self or others: suicidal, homicidal behavior
    - Self-injury or mutilation
    - Inability to care for oneself
2. A safe private, and comfortable environment should be arranged for continuation of the evaluation.
    - Establish a working treatment alliance with the patient
    - Maintain a supportive, nonblaming nonjudgmental stance throughout the evaluation
    - Help with the removal of any ongoing traumatic event
    - Minimizing further traumas that may arise from the initial traumatic event
    - Assess and optimize social supports
3. Legal mandates should be followed:
    - Reporting of violence, assault
    - Confidentiality for the patient
    - Mandatory testing
    - Attend to chain of evidence in criminal cases (e.g., rape, evaluation)
    - Involuntary Commitment procedures if needed
4. Carefully consider the following potential interventions to secure safety:
    - Find safe accommodation and protecting against further trauma
    - Voluntary Admission
    - Restraint/seclusion only if less restrictive measures are ineffective
    - Forced medications

D. **Assess Medical and Functional Status Based on General Appearance and Screening Instruments**

Recommendations

1. Medical status should be obtained for all persons presenting with symptoms to include:
    - History, physical examination, and a neurological examination
    - Use of prescribed medications, mood or mind-altering substances, and possible biological or chemical agent exposure
    - A minimal mental status examination to assess cognitive function
2. The history and physical examination findings should lead the provider to other assessments as clinically indicated. There is no test for acute stress reaction, so testing is directed towards detection of associated medical conditions. Assessment may include:
    - Screen for toxicology if the symptom presentation indicates
    - Radiological assessment of patients with focal neurological findings or possible head injury
    - Appropriate laboratory studies to rule out medical disorders that may cause symptoms of acute stress reactions (e.g., complete blood count [CBC], chemistry profile, thyroid studies, human choriogonadotropin [HCG}, electrocardiogram [EKG], electroencephalography [EEG])
3. A focused psychosocial assessment should be performed including active stressors, losses, current social supports, basic needs (e.g. housing, food, financial resources).
4. A brief assessment of function based on general appearance and behavior should be completed to evaluate: 1) objectively impaired function; 2) subjectively impaired function; 3) baseline level of function (LOF) vs. current LOF; and 4) family and relationship functioning.

The approach to triage in the immediate response to traumatic exposure for service members with symptoms during Ongoing Military Operations may vary markedly from the management of civilians exposed to traumatic events. Combat and Operational Stress Reactions (COSR) management is targeted to preserve the fighting force and return the service member (SM) to functional status.

See module A2 - Management of Combat and Operational Stress Reaction (COSR)

E. **Assess Preexisting Psychiatric And Medical Conditions**

Recommendations

1. Assessment of patients with preexisting psychiatric conditions to identify the vulnerable, high-risk individuals and groups
2. Referral to mental health specialty when indicated or emergency hospitalization if needed

F. **Risk Factors For Developing ASD/PTSD**

Recommendations

1. Individuals exposed to trauma should be screened for one or more of the following risk factors for developing ASD/PTSD.

   Pre-traumatic factors:

   - Ongoing life stress
   - Lack of social support
   - Preexisting psychiatric disorder
   - Other pre-traumatic factors including: female gender, low socioeconomic status, lower level of education, lower level of intelligence, race (Hispanic, Japanese, other ethnic minority), reported abuse in childhood, report of other previous traumatization, report of other adverse childhood factors, family history of psychiatric disorders, poor training or preparation for the traumatic event

   Peri-traumatic or trauma related factors:

   - Severe trauma
   - Type of trauma (interpersonal traumas such as torture, rape, or assault convey high risk of PTSD)
   - High perceived threat to life
   - Age at trauma (school age youth, 40–60 years of age)
   - Community (mass) trauma
   - Other peri-traumatic factors including: history of peri-traumatic dissociation and interpersonal trauma

   Post-traumatic factors:

   - Ongoing life stress
   - Lack of social support
   - Bereavement
   - Major loss of resources
   - Other post-traumatic factors including children at home and female with distressed spouse

Triage And Treatment

G. **Ensure Basic Physical Needs Are Met**

Objective

Ensure trauma-exposed persons with acute stress symptoms have their basic needs met.

Recommendations

1. Acute intervention should ensure that the following needs are met:

   Basic Needs:

   - Safety/security/survival
   - Food, hydration, clothing, and shelter
   - Sleep
   - Medication (i.e., replace medications destroyed/lost)
   - Orientation
   - Communication with family, friends, and community
   - Protection from ongoing threats/toxins/harm

   Psychological First Aid:

   - Protect survivors from further harm
   - Reduce physiological arousal
   - Mobilize support for those who are most distressed
   - Keep families together and facilitate reunion with loved ones
   - Provide information, foster communication and education
   - Use effective risk communication techniques

H. **Acute Symptom Management**

Recommendations

1. Symptoms treatment should be provided after basic needs are met (e.g., sleep, normalization, and other nonpharmacological modalities).
2. Apply a series of specific psychological interventions (individually or in a group) to reduce acute stress symptoms and to address both general recovery and specific symptoms (e.g., breathing/relaxation treatment). Individual psychological interventions may include:
   - Assurance/reassurance
   - Defusing (3-phased discussion provided within hours of the crisis for purpose of assessment triage and acute symptom mitigation)
   - Mitigate fear and anxiety
   - Sleep hygiene
   - Reestablish routine
   - Exercise and nutrition
   - Bereavement
   - Survivor success
   - Advise about alcohol/substance use
   - Modulate mood/irritability

   Group psychological interventions:

   - Groups may be effective vehicles for providing trauma-related education, training in coping skills, and increasing social support especially in the context of multiple group sessions.
   - Group participation should be voluntary.

3. Peoples´ reaction to ASR varies. Some want and feel a need to discuss the event, and some have no such need. Respect individual and cultural preferences in the attempt to meet their needs as much as possible. Allow normal recovery, and monitor.
4. Consider a short course of medication for some individuals targeted for specific symptoms (e.g., sleep disturbance). [See Annotation M]

I. Psychological Debriefing

Objective

Reduce risk for development of PTSD following traumatic event.

Recommendation

Individual:

1. Recommend against psychological debriefing as a viable means of reducing acute post-traumatic distress (ASR or ASD) or progression to PTSD. (Hobbs et al., 1996; Mayou, Ehlers, & Hobbs, 2000; Bisson et al., 1997)(**QE – I, Overall Quality – Fair, Strength of R – D**)

Group:

1. There is insufficient evidence to recommend for or against conducting structured group debriefing.
2. Compulsory repetition of traumatic experiences in a group may be counterproductive.
3. Group debriefing with preexisting groups (teams, units, Emergency Medical Teams [EMTs], co-workers, family members) may assist with group cohesion, morale, and other important variables that have not been demonstrated empirically. (Foa, Keane, & Friedman, 2000; Rose, Bisson, & Wessely, 2002) (**QE – III, Overall Quality – Poor, Strength of R – I**)
4. Group participation should be voluntary.

J. Education and Normalization / Expectancy Of Recovery

Recommendation

1. All survivors should be given educational information to help normalize common reactions to trauma, improve coping, enhance self-care, facilitate recognition of significant problems, and increase knowledge of and access to services. Such information can be delivered in many ways, including public media, community education activities, and written materials.

K. Facilitate Social and Spiritual Support

Recommendation

1. Preserve an interpersonal safety zone protecting basic personal space (e.g., privacy, quiet, personal effects).
2. Provide nonintrusive ordinary social contact (e.g., a "sounding board," judicious use of humor, small talk about current events, silent companionship).
3. Provide opportunities for grieving for losses. Provide access to religious/spiritual resources when sought. (Providing space and opportunities for prayers, mantras, rites and rituals, and end-of-life care as determined important by the patient)
4. Consider providing direct spiritual care or ensuring patient access to spiritual care when sought.

Evidence

1. Consider referral for religious/spiritual counseling as indicated for patient symptoms, consistent with available resources, and resonant with patient belief systems (Baldacchino & Draper, 2001; Bell Meisenhelder, 2002; Calhoun et al., 2000; Humphreys et al., 2001; Nixon et al., 1999; Strawbridge et al., 1998) (**QE – III, Overall Quality – Poor, R – I**)
2. When providing psychological first aid or primary care services, consider providing direct spiritual care or ensuring patient access to spiritual care (Bogia & Preston, 1985; Everly, "The role of pastoral crisis," 2000) (**QE – II**, **Overall Quality – Fair, R – C**)
3. For patients who have developed PTSD, consider referral for religious/spiritual counseling as indicated for patient symptoms, consistent with available resources, and resonant with patient belief systems (Baldacchino & Draper, 2001; Bell Meisenhelder, 2002; Calhoun et al., 2000; Humphreys et al., 2001; Nixon et al., 1999; Strawbridge et al., 1998) (**QE – III, Overall Quality – Poor, R – I**)

L. **Pharmacotherapy**

Objective

To lessen the physical, psychological, and behavioral morbidity associated with acute stress reaction, hasten the return to full function (duty), and diminish the likelihood of chronicity

Recommendations

Summary Table – Pharmacotherapy for ASR

R*	Significant Benefit	Some Benefit	Unknown	No Benefit/Harm
A				
B		Propranolol		

R*	Significant Benefit	Some Benefit	Unknown	No Benefit/Harm
C				
I		Benzodiazepines	Other aympatholytics Antidepressants Anticonvulsants Atypical antipsychotics Antihistamines	
D				Typical antipsychotics

*R = Level of recommendation

1. Strongly recommend providing for physical needs, sleep, normalization, and other non-pharmacological modalities.
2. Recommend the use of medication only for individuals that do not respond to non-pharmacological treatment as a normal recovery is expected from ASR.
3. Consider a short course of medication targeted for specific symptoms.
    - Sleep disturbance/insomnia (e.g., benzodiazepines, antihistamines)
    - Hyperarousal/excessive arousal/panic attacks. (e.g., benzodiazepines, propranolol [up to 10 days])
4. There is insufficient evidence to support a recommendation for preventative use of a pharmacological agent to prevent the development of ASD or PTSD.

Evidence

1. Benzodiazepines (Mellman, Byers, & Augenstein, 1998)(**QE -- III , Overall Quality – Poor, Net Effect – Moderate, R – I**)
2. Antihistamines (**QE – III, Overall Quality -- Poor, Net Effect – Small, R – I**)
3. Propranolol (Pitman et al., 2002) (**QE – I, Overall Quality – Good, Net Effect -- Moderate, R – B**)
4. Pharmacotherapy prophylaxis for ASD or PTSD (Stein et al., 2000) (**QE – I, Overall Quality – Poor, Net Effect -- Small, R – I**)

M. **Reassessment**

Objective

Identify patients with persistent traumatic stress symptoms, related dysfunction, or additional treatment needs.

Recommendations

1. Treatment response to the acute intervention should be reassessed. This should include an evaluation for the following risk factors:
    - Persistent or worsening traumatic stress symptoms (e.g., dissociation, panic, autonomic arousal, cognitive impairment)
    - Significant functional impairments (e.g. role/work, relationships)
    - Dangerousness (suicidal or violent ideation, plan, and/or intent)
    - Severe psychiatric comorbidity (e.g., psychotic spectrum disorder, substance use disorder or abuse)
    - Maladaptive coping strategies (e.g., pattern of impulsivity, social withdrawal under stress)
    - New or evolving psychosocial stressors
    - Poor social supports
2. Follow-up after acute intervention to determine patient status.
    - Patient does not improve or status worsens – refer to mental health provider and/or PTSD specialty team. Recommend continued involvement of the primary care provider in the treatment. Patients with multiple problems may benefit from a multi-disciplinary approach to include occupational therapy, spiritual counseling, recreation therapy, social work, psychology, and/or psychiatry.
    - Patient demonstrates partial improvement (e.g., less arousal, but no improvement in sleep) – consider augmentation or adjustment of the acute intervention within 2 weeks.
    - Patient recovers from acute symptoms – provide education about acute stress reaction and contact information with instructions for available follow-up if needed.

Follow-up

N. **Referral And Consultation With Mental Health**

Objective

Provide guidance for primary care providers on optimal referral for potential PTSD patients.

Recommendations

1. Individuals who exhibit any of the following conditions should be referred to mental health:
    - Failure to respond to acute supportive interventions
    - Worsening of stress related symptoms
    - High potential for dangerousness
    - Development of ASD/PTSD
    - New onset of dangerousness or maladaptive coping to stress
    - Exacerbation of pre existing psychiatric conditions
    - Deterioration in function
    - New onset stressors, poor social supports, or inadequate coping skills.

O. **Monitor And Follow-Up**

Recommendations

1. Follow-up should be offered to those individuals who request it.
2. Follow-up should be offered to individuals and groups at high risk of developing adjustment difficulties following exposure to major incidents and disasters, including individuals who:
    - Have ASD or other clinically significant symptoms stemming from the trauma
    - Are bereaved
    - Have a preexisting psychiatric disorder
    - Have required medical or surgical attention
    - Were exposed to a major incident or disaster that was particularly intense and of long duration

MODULE A2 - COMBAT AND ONGOING OPERATION STRESS REACTION (COSR)

The approach to triage in the immediate response to traumatic exposure for service members with symptoms during Ongoing Military Operations is directed by dual sets of objectives:

Military Considerations

Management of combat and operational stress reactions (COSR) during ongoing military operations is targeted to preserve the fighting force and return the service member (SM) to functional status. Context and setting of care delivery may vary markedly.

Military Clinical Objectives

1. Prevent exacerbation of symptoms/mitigate symptoms of acute stress
2. Prevent development of traumatic stress sequelae (e.g., ASD, PTSD, depressive disorders, anxiety disorders, and substance use disorders)
3. Keep SM with his/her unit and prevent unnecessary medical evacuation
4. Return SM to duty as soon as possible
5. Maintain and enhance unit capabilities and readiness

Prior to deployment and regularly thereafter, ensure appropriate primary prevention in the form of COSR briefs are offered to combatants, providers, and the chain of command.

NOTE: For further discussion of the key element, please see Module A1: Acute Stress Reaction.

A. **Service Member With Symptoms Of Combat And Operational Stress Reaction (COSR) During Ongoing Military Operations**

Recommendations

1. Identify service member with symptoms compatible with COSR. Symptoms are not attributed to identified medical/surgical condition requiring other urgent treatment (a service member can have COSR concurrent with minor return-to-duty [RTD] wounds/illness)
2. Evacuate to next level of care, if unmanageable
3. Screen service member for symptoms of COSR, which include:
    - Exhaustion/burnout
    - Hyperarousal and anxiety
    - Somatic complaints (gastrointestinal, genitourinary, musculoskeletal, cardiovascular, respiratory, nervous system)
    - Depression or guilt/hopelessness
    - Conversion Disorder symptoms
    - Amnestic or dissociative symptoms
    - Behavioral changes
    - Emotional dysregulation
    - Anger/irritability
    - Brief, manageable "psychotic symptoms" (e.g., hallucination due to sleep deprivation and mild "paranoia")
4. Address the underlying cause of symptoms (e.g., sleep deprivation) in brief restoration program. Advise service member´s Commander, chaplain, etc. on follow-up actions. Document symptoms and observations.

B. **Assess Risk Of Harm To Self Or Others; Seek Collateral Information About Stressors, And Service Member´s Function, Medical History, And Absence Or Impairment On Operation Or Mission**

Objective

Obtain information to assess service member´s condition and triage for appropriate care.

Recommendations

1. Arrange for a safe and comfortable environment to continue the evaluation. Secure any weapons and explosives.
2. Medical triage to rule out:
    - Neurotoxicant exposure
    - Head injury
    - Undetected wounds
    - Acute physical illness (e.g., infectious)
3. Document symptoms of COSR, obtain collateral information from unit leaders, and assess service member´s function, to include:
    - Any changes in productivity?
    - Coworker or supervisor reports of recent changes in appearance, quality of work, or relationships?
    - Any tardiness/unreliability, loss of motivation, or loss of interest?
    - Forgetful or easily distracted?
    - Screening for substance use

C. **Can Service Member Return To Duty Within Hours?**

Objective

Identify service members who can rapidly resume effective functioning in the unit.

Recommendations

1. Consider the service member's role and functional capabilities and the complexity and importance of his/her job when determining when to return the service member to duty.
2. The continuing presence of symptoms of COSR alone should not constitute a basis for preventing a return to duty.
3. Educate and "normalize" observed psychological reactions to the chain of command.

D. **Initiate Acute Intervention For COSR; Coordinate With Service Member´s Unit/Command; Treat Within Closest Proximity To Service Member´s Unit, As Is Logistically Feasible**

Objective

Initiate acute symptom management.

Recommendations

1. Maintain sense of unit integrity:
    - Normalization
    - Validation
    - Keep positive approach
    - Set up expectation for recovery and RTD (role)
2. Keep treatment consistent with the "PIES" principle:
    - *Proximity*: Prevention and treatment are conducted in proximity to the battlefield or the origin of the stressor. Treatment proximate to the member´s unit where he/she can be visited by fellow military members is ideal. Consider all options for proximate treatment; strive to maintain connection to unit to maintain unit integrity
    - *Immediacy*: Treatment should begin as soon as tactically and logistically possible
    - *Expectancy*: From the outset, the expectation is that the SM is experiencing a normal reaction to an abhorrently abnormal situation and will return to duty following resolution, restitution and adaptation
    - *Simplicity*: All modalities of prevention and treatment are simple and clearly understood. No dynamic therapy. No medical model. The only "model" is the military model—military members caring for military members.
3. Initiate treatment:
    - Treat according to SM´s prior role and not as a "patient;" avoid a hospital setting
    - Assure or provide the following, as needed:
        - Reunion or contact with primary group

- Respite from intense stress
- Thermal comfort
- Oral hydration
- Oral food
- Hygiene (toileting, shower, shave, and feminine)
- Sleep (to facilitate rest and restoration, use anxiolytic medication judiciously and sparingly in the acute setting)
- Encourage talk about the event with supportive others

4. Reserve group debriefing for members of preexisting and continuing groups at appropriate time and setting. Attendance should be voluntary and only be conducted by personnel trained in debriefing methods
5. Assign job tasks and recreational activities that will restore focus and confidence and reinforce teamwork (limited duty)
6. Avoid further traumatic events until recovered for full duty
7. Evaluate periodically
8. Consider using a short course of medication targeted for specific symptoms (see "Pharmacotherapy for COSR" in the original guideline document)

E. **Transfer To More Definitive Level of Care For Combat And Operational Stress Control**

Objective

Transfer service member for treatment augmentation or mental health treatment or referral.

Recommendations

1. Service members who do not respond to first line supportive interventions may warrant a transfer for treatment augmentation or mental health treatment or referral.
2. Transfer to a more definitive level of treatment may include more intense or prolonged treatment at a Combat Refresher Training facility. Service members should be prepared for the transfer with continued positive expectation of recovery from their symptoms and return to normal level of functioning.
3. Ensure that casualties being transferred due to other medical conditions (wounded in action) receive psycho-education relating to anticipated psychological changes, provide positive expectations, and offer support prior to departure from the area of responsibility.

MODULE B: ACUTE STRESS DISORDER (ASD) AND POST-TRAUMATIC STRESS DISORDER (PTSD) IN PRIMARY CARE

A. **Assessment of Trauma Exposure Related Symptoms**

Recommendations

Assessment in Primary Care

1. Patients who are presumed to have symptoms of PTSD or who are positive for PTSD on the initial screening should receive specific assessment of their symptoms. (For a list of "Common Symptoms After Exposure to Trauma or Loss," see Table B-1 in the original guideline document.)
2. A thorough assessment of the symptoms is necessary for accurate diagnosis, rating the severity of the disorder, and making correct clinical decisions. (Lagomasino, Daly, & Stoudemire , 1999; Williams & Shepherd, 2000); (**QE – III, Overall Quality – Poor, R – I**)
3. Consider self-administered checklists to ensure systematic, standardized, and efficient review of the patient´s symptoms.
4. Useful information may include details such as time of onset, frequency, course, severity, level of distress, functional impairment, and other relevant information.

B. **Assessment of Trauma Exposure**

Recommendations

1. Assessment of the trauma exposure 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 the time of the trauma
    - Patient´s reaction at time of trauma (e.g., helplessness, horror, and fear)
    - Existence of multiple traumas
2. When assessing trauma exposure, the clinician must consider the patient´s ability to tolerate the recounting of traumatic material, since it may exacerbate PTSD symptoms.
3. The assessment should be performed cautiously, especially in situations where the trauma source is still present and the patient perceives himself or herself to be in danger.

C. **Assessment Of Dangerousness To Self Or Others**

Recommendation

1. All patients with ASD/PTSD should be assessed for safety and dangerousness including current risk to self or others, as well as historical patterns of risk:
    - Suicidal or homicidal ideation, intent (plan), means (e.g., weapon, excess medications), history (e.g., violence or suicide attempts), behaviors (e.g., aggression, impulsivity), comorbidities (substance abuse, medical conditions) (Breslau at al., 2000; Bullman & Kang, 1994; Ferrada-Noli et al., 1998; Kaslow et al., 2000; Marshall et al., 2001; Prigerson & Slimack, 1999; Swanson et al., 2002)(**QE – II, II-2, III; Overall Quality – Good; R – B**)

- Family and social environment – including risks to the family (Seng, 2002; Swanson et al., 2002)(**QE—III , II; Overall Quality – Good; R – B**)
- Ongoing health risks or risk-taking behavior (Acierno et al., 1996; Hutton et al., 2001) (**QE—II-2, II; Overall Quality – Good; R – B**)
- Medical/psychiatric comorbidities or unstable medical conditions (Davidson et al., 1991; Farrell & Ganzini, 1995; Weisberg et al., 2002)(**QE – II, III; Overall Quality – Good; R – B**)
- Consider potential to jeopardize mission in operational environment (Working Group Consensus)(**QE – III, Overall Quality – Poor, R – I**)

D. **Obtain Medical History, Physical Examination, Mental Status Examination (MSE), and Laboratory Tests**

Objective

Obtain comprehensive patient data in order to reach a working diagnosis.

Recommendations

1. All patients should have a thorough medical and psychiatric history (Lagomasino, Daly, & Stoudemire, 1999; Williams & Shepherd, 2000)(**QE – III, Overall Quality – Poor, R – I**), with particular attention paid to the following:
   - Baseline functional/mental status
   - Past medical history
   - Medications, to include herbal and over-the-counter (OTC) drugs
   - Past psychiatric history, to include prior treatment, past hospitalization for depression or suicidality, and substance use disorders
   - Current life stressors

   If trauma exposure is recent (<1 month) particular attention should be given to the following:

   - Exposure to/environment of trauma
   - Ongoing traumatic event
   - Exposure, perhaps ongoing, to environmental toxin
   - Ongoing perceived threat

2. All patients should have a thorough physical examination. On physical examination, particular attention should be paid to the neurological exam and stigmata of physical/sexual abuse, self-mutilation, or medical illness. Note distress caused by or avoidance of diagnostic tests/examination procedures.
3. All patients, particularly the elderly, should have a Mental Status Examination (MSE) to include assessment of the following:
   - Appearance and behavior
   - Language/speech

- Thought process (loose associations, ruminations, obsessions) and content (delusions, illusions, and hallucinations)
- Mood (subjective)
- Affect (to include intensity, range, and appropriateness to situation and ideation)
- Level of Consciousness (LOC)
- Cognitive function

4. All patients should have routine laboratory screening tests including thyroid stimulating hormone (TSH), Complete Metabolic Panel, Hepatitis, human immunodeficiency virus (HIV), and human choriogonadotropin (HCG) (for females). Also consider CBC, urinalysis (UA), toxicology ethanol (Tox EtoH) panel and other tests, as clinically indicated. (Lagomasino, Daly & Stoudemire, 1999; Williams & Shepherd, 2000)(**QE – III, Overall Quality – Poor, R – I**)
5. Other assessments may be considered (radiology studies, EKG, and EEG), as clinically indicated. (Lagomasino, Daly & Stoudemire, 1999)(**QE – III, Overall Quality – Poor, R – I**)
6. All patients should have a narrative summary of psychological assessments to include work/school, family, relationships, housing, legal, financial, unit/community involvement, and recreation, as clinically appropriate.

E. **Assessment Of Functioning**

Recommendation

1. Assessment of global function should be obtained, such as the Global Assessment of Function (GAF) scale or the SF-36. (Working Group Consensus) (**QE – III, Overall Quality – Poor, R – I**)

F. **Assessment of Risk Factors**

Recommendations

1. All patients should be assessed for risk factors for developing ASD or PSTD. Special attention should be given to post-traumatic factors (i.e., social support and functional incapacity) that may be modified by intervention.
2. Because of the high prevalence of psychiatric comorbidities in the PTSD population, assessment for depression and other psychiatric comorbidities is warranted (see also VA/DoD Clinical Practice Guideline for the Management of MDD and Psychotic Disorders).
3. Substance use patterns of persons with trauma histories or PTSD should be routinely assessed to identify substance misuse or dependency (alcohol, nicotine, prescribed drugs, and illicit drugs) (see also VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders)

Evidence

<u>Pre-trauma</u>

1. Prior exposure to traumatic events (Breslau et al., "Previous exposure" 1999; Brewin, Andrews, & Valentine, 2000; Dougall et al., 2000; Green et al., 2000; Maes et al., 2001; Neria, Bromet, & Marshall, 2002; Ozer et al., 2003; Seedat & Stein, 2000; Zatzick et al., 2002)(**QE – II, I; Overall Quality – Good; R – B**)
2. Female gender (Breslau, "Gender differences," 2002; Breslau et al., "Vulnerability," 1999; Brewin, Andrews, & Valentine, 2000, I; Finnsdottir & Elklit, 2002; Neria, Bromet, & Marshall, 2002; Seedat & Stein, 2000; Stretch, Knudson, & Durand, 1998; Zatzick et al., 2002)(**QE – II, I; Overall Quality – Good; R – B**)
3. Psychiatric disorders or personality dimensions (Breslau, "Epidemiologic studies," 2002; Brewin, Andrews, & Valentine, 2000; Maes et al., 2001; Norris et al., 2002; Ozer et al., 2003) (**QE – III, I, II; Overall Quality – Good; R – B**)
4. Cognitive factors: Lower intelligence, Neurological soft signs (Brewin, Andrews, & Valentine, 2000; Gurvits et al., 2000) (**QE – I, II; Overall Quality – Good; R – B**)
5. Parental or family history of PTSD (Yehuda et al., 1998) (**Quality of evidence – II**; Overall Quality – Poor; R – I)
6. Childhood abuse/assault (Breslau et al., "Previous exposure," 1999; Breslau, "Epidemiologic studies," 2002; Brewin, Andrews, & Valentine, 2000; Neria, Bromet, & Marshall, 2002)(**QE – II, III, I; Overall Quality – Good; R – B**)
7. Low educational level or socioeconomic status (Armenian et al., 2000; Brewin, Andrews, & Valentine, 2000; Bromet et al., 2002; Finnsdottir & Elklit, 2002) (**QE – II, I; Overall Quality – Good; R – B**)

<u>Peri-trauma</u>

8. Severity of trauma; Perceived life threat (Armenian et al., 2000, II; Brewin, Andrews, & Valentine, 2000; Feehan et al., 2001; Ozer et al., 2003; Woods, 2000)(**QE – II, I; Overall Quality – Good; R – B**)
9. Peri-traumatic dissociation (Ozer et al., 2003) (**QE – I; Overall Quality – Good; R – B**)
10. Youth at time of exposure (Brewin, Andrews, & Valentine, 2000; Finnsdottir & Elklit, 2002; Neria, Bromet, & Marshall, 2002; Norris et al., 2002) (**QE – I, II, III; Overall Quality – Good; R – B**)
11. Biological factors such as heart rate (HR) increase (Shalev et al., "A prospective study," 1998; Yehuda, McFarlane, & Shalev, 1998) (**QE – II; Overall Quality – Fair; R – C**)

<u>Post-trauma</u>

12. Resource loss/unemployment (Feehan et al., 2001; Norris et al., 2002) (**QE – II, III; R – B**)
13. Impaired social support system (Armenian et al., 2000; Brewin, Andrews, & Valentine, 2000; Gregurek et al., 2001; Ozer et al., 2003)(**QE – II, I; Overall Quality – Good; R – B**)
14. Health problems (Norris et al., 2002) (**QE – III, Overall Quality – Poor, R – I**)
15. On-going life stress (Brewin, Andrews, & Valentine, 2000; Norris et al., 2002) (**QE – I, III; Overall Quality – Good,**)

G. **Are There Clinical Significant Symptoms Suggestive of PTSD or ASD?**

Recommendations

1. Primary care providers should formulate a presumptive diagnosis of stress related disorder consistent with *Diagnostic and Statistical Manual of Mental Disorders (4th edition)* criteria for ASD and PTSD.
2. Primary care providers should consider initiating treatment or referral based on a working diagnosis of stress related disorder.
3. Patients with difficult or complicated presentation of the psychiatric component should be referred to mental health specialty for diagnosis and treatment.

Evidence for all Recommendations: (Working Group Consensus)(**QE – III; Overall Quality – Poor; R – C**)

H. **Patient Education**

Objective

Help trauma survivors cope with ASD/PTSD by providing information that may help them manage their symptoms and benefit from treatment.

Recommendation

1. Trauma survivors should be educated about PTSD symptoms, other potential consequences of exposure to traumatic stress, practical ways of coping with traumatic stress symptoms, processes of recovery from ASD/PTSD, and the nature of treatment. (Working Group Consensus) (**QE – III; Overall Quality – Poor; R – I**)

I. **Coexisting Severe Medical Conditions**

Objective

Improve management of PTSD symptoms when they are complicated by the presence of a medical or psychiatric comorbidity.

Recommendations

1. Primary care providers should recognize that medical disorders/symptoms, mental disorders, and psychosocial problems commonly coexist with PTSD and should screen for them during the evaluation and treatment of PTSD. (Working Group Consensus) **(QE – III; Overall Quality – Poor; R – I**)
2. Consider the existence of comorbid conditions when deciding whether to treat patients in the primary care setting or refer them for specialty mental health care. (Working Group Consensus) (**QE – III; Overall Quality – Poor; R – I**)

J. **Concurrent PTSD and Substance Abuse**

Objective

Improve the management of PTSD symptoms when they are complicated by a concurrent substance abuse problem.

Recommendations

1. Substance use patterns of clients with trauma histories or PTSD should be routinely assessed (see the VA/DoD Clinical Practice Guideline for the Management of Substance Use Disorders) (Working Group Consensus) (**QE – III; Overall Quality – Poor; R – I**)
2. Substance abusers should be routinely screened for trauma exposure and PTSD. (Dansky et al., 1997) (**QE – III; Overall Quality – Poor; R – I**)
3. Integrated PTSD-Substance Abuse Treatment should be considered. (Working Group Consensus) (**QE – III; Overall Quality – Poor; R – I**)
4. Substance-abusing patients with PTSD should be educated about the relationships between PTSD and substance abuse, referred for concurrent PTSD treatment, or provided with integrated PTSD/Substance Abuse treatment. (Working Group Consensus; Najavits, 2002; Ouimette et al., 1998) (**QE – III; Overall Quality – Poor; R – I**)
5. Substance Abuse-PTSD patients should receive follow-up care that includes a continued focus on PTSD issues. (Ouimette et al., 2000) (**QE – II-3, Overall Quality – Fair, R – I**)

K. **Referral to Mental Health Specialty**

Objective

Provide guidance for primary care providers on optimal referral for PTSD patients.

Recommendations

1. Primary care providers should consult with a mental health provider and/or a PTSD Specialty Team for all patients with acute or chronic stress disorders.
2. Primary care providers should continue to be involved in the treatment of patients with acute or chronic stress disorders.
3. Treatment for patients with ASD or acute or chronic PTSD should involve a multidisciplinary team approach to include occupational therapy (OT), spiritual counseling, recreation therapy, social work, psychology, and/or psychiatry.
4. Patients with clinically significant symptoms or comorbidities to PTSD, including chronic pain, insomnia, anxiety, and depression, should receive treatment for those complicating problems.
5. Case management should be provided, as indicated, to address high utilization of medical resources.

6. Consider referral for alternative care modalities as indicated for patient symptoms, consistent with available resources, and resonant with patient belief systems.

Evidence for all recommendations: (Working Group Consensus)(**QE – III; Overall Quality – Poor; R – I**).

L. **Treatment in Primary Care**

Recommendations

ALL PATIENTS with Stress Related Disorders

1. A supportive and collaborative treatment relationship or therapeutic alliance should be developed and maintained with patients with ASD/PTSD inclusive of their input in treatment planning.
2. Primary care providers should routinely provide the following services for all patients with stress related disorders, especially those who are reluctant to seek specialty mental health care:
    - Supportive counseling
    - PTSD-related education
    - Regular follow-up and monitoring of symptoms
    - Early recognition of PTSD
3. Primary care providers should consider consultation with mental health providers for patients with ASD/PTSD who warrant a mental health referral but may be reluctant or refuse it.
4. Primary care providers should take leadership in convening a collaborative team for patients with PTSD. Team members may include the primary care providers, mental health specialists, chaplains, pastors, social worker, occupational or recreational therapists, Vet Centers, family support centers, exceptional family member programs, VA benefit counselors, peer-support groups, and others.

ASD

5. Because ASD does not occur in all people who later develop PTSD, consider treatment for acutely traumatized people with ASD, with severe PTSD symptoms as well as for those who are incapacitated by acute psychological or physical symptoms.
6. Patients with ASD should be monitored for development of PTSD (Brewin et al., 1999; Bryant et al., 1998) (**QE – I, Overall Quality – Good, R – A**). The use of validated PTSD symptom measure such as the PTSD Checklist should be considered (see Appendix D in the original guideline document).
7. Primary care providers should consider the pharmacological management of disruptive symptoms (e.g., sleep) (see "Pharmacotherapy for ASD" in the original guideline document).
8. Brief intervention (4 to 5 sessions) of cognitive behavioral therapy (CBT) is an effective early intervention for patients with ASD (Bryant et al., 1998; Foa et al., 1995)(**QE – I, Overall Quality –Good, R – A**). In addition to targeted brief interventions, some trauma survivors

may benefit from follow-up provision of ongoing counseling or treatment.

PTSD

9. All patients with PTSD should have a specific primary care provider assigned to coordinate their overall health care.
10. Pharmacological management of PTSD or related symptoms may be initiated based on a presumptive diagnosis of PTSD. Long-term pharmacotherapy will be coordinated with other intervention once the patient has been referred to a mental health clinic (see "Pharmacotherapy for PTSD" in the original guideline document).
11. Primary care providers should perform a brief PTSD symptom assessment at each visit. The use of a validated PTSD symptom measure, such as PTSD Checklist, should be considered (see Appendix D in the original guideline document).
12. Primary care providers should assess patients with PTSD for associated high-risk behaviors (e.g., smoking, alcohol/drug abuse, HIV, and hepatitis risks) and comorbid medical and psychiatric illnesses.

M. **Referral to Vet Centers**

Objective

Provide timely mental health services to veterans in need of support.

Recommendations

1. Veterans with symptoms of PTSD should have an initial assessment of needs.
2. Veterans who are dangerous to self or others should be referred to the local Veterans Affairs Medical Center (VAMC) or nearest emergency room.
3. Veterans who are seeking to have basic needs met should be referred to the VA Homeless Coordinator or community resources for food, shelter, or emergency financial assistance.
4. Veterans who are eligible for Vet Center services should have an in-depth psychological history taken, including a comprehensive military history and treatment plan.
5. Treatment plans in the Vet Center may include individual, family, or group therapy. Veterans can receive medical treatment or medication management at the Vet Center by a psychiatrist, registered nurse (RN), or advanced registered nurse practitioner (ARNP) or be referred to the local VAMC, Community Based Outpatient Clinic (CBOC), or community resources.
6. Veterans who are eligible for Vet Center services should be made aware of the Center resources and referred if the patient desires.

N. **Assess Duty/Work Responsibilities and Patient´s Fitness (In Relation to Military Operation)**

Recommendations

1. The determination of when to return a service member to duty should take into consideration the individual´s service member´s role, the complexity and importance of his or her job, and the service member´s functional capabilities.
2. The continuing presence of symptoms of PTSD should not be considered as the sole basis for preventing a return to duty.

MODULE C

MANAGEMENT OF PTSD IN MENTAL HEALTH SPECIALITY CARE

A. **Patient Presenting To Mental Health With Suspected PTSD Symptoms**

Recommendations

Assessment in Mental Health Specialty

1. Mental health clinicians should obtain a comprehensive diagnostic assessment that includes, but is not limited to, the symptoms that characterize PTSD.
2. Routine use of self-administered checklists may ensure systematic, standardized, and efficient review of the patient´s symptoms and history of trauma exposure (see Appendix C [PCL-C] in the original guideline document).
3. The assessment should also include review of other salient symptoms (guilt, dissociation, derealization, depersonalization, reduction, and awareness of surrounding) that impact on treatment decisions. Structured psychiatric interviews, such as the clinician administered PTSD scale (CAPS), may be considered.

For discussion see CORE Module Annotation D, and Module B – Management of ASD and PTSD in Primary Care Annotations A and B

B. **Obtain Medical History, Physical Examination, MSE, Psychosocial Assessment, and Appropriate Lab Tests**

See Module B: Management of ASD & PTSD in Primary Care, Annotation D, E and F.

C. **Does Patient Meet DSM-IV Criteria For ASD/PTSD?**

Objective

Diagnose ASD/PTSD by DSM-IV criteria.

Recommendation

1. Diagnostic criteria should be documented in the medical record.

D. **Educate Patients and Family About Treatment Options; Develop Collaborative and Interdisciplinary Treatment Plan**

See Module B: Management of ASD & PTSD in Primary Care, Annotation H.

E. **Initiate Therapy for PTSD**

See Intervention Module

F. **PTSD with other Comorbid Symptoms (Addiction, Substance Use Disorder [SUD], Psychosis, Bipolar)**

See Module B: Management of ASD & PTSD in Primary Care, Annotation I & J

G. **Reassess PTSD Symptoms; Diagnostic Status, Functional Status; Quality of Life; Additional Treatment Needs; Patient Preferences**

Objective

Assess patient status following therapeutic intervention to determine future direction.

Recommendations

1. Follow-up status of patients with PTSD should be monitored at least every three months. Use interview and questionnaire methods to assess PTSD symptoms and function.
    - Diagnostic status and symptom severity
    - Functional status/health-related quality of life
    - Psychosocial treatment needs
    - Patient preferences
    - Therapy adherence
    - Adverse treatment effects

H. **Follow-up in Mental Health**

Recommendations

1. If patient does not improve or status worsens, consider one of the following treatment modification options:
    - Continued applications of the same modality at intensified dose and/or frequency
    - Change to a different treatment modality
    - Apply adjunctive therapies
    - Increase level of care (e.g., referral facility, partial hospitalization, inpatient hospitalization, residential care)
    - Consider a referral to adjunctive services for treatment for comorbid disorders or behavioral abnormalities (e.g., homelessness, domestic violence, or aggressive behavior)
2. If patient demonstrates partial (insufficient) remission, consider one of the following treatment modification options:

    - Continue the present treatment modality to allow sufficient time for a full response
    - Continue applications of the same modality at intensified dose and/or frequency
    - Change to a different treatment modality
    - Apply adjunctive therapies
    - Increase level of care (e.g., referral facility, partial hospitalization, inpatient hospitalization, residential care)
    - Consider a referral to adjunctive services for treatment of comorbid disorders or behavioral abnormalities (e.g., homelessness or domestic violence)
3. If patient demonstrates improved symptoms and functioning but requires maintenance treatment:
    - Continue current course of treatment
    - Consider stepping down the type, frequency, or dose of therapy
        - Transition from intensive psychotherapy to case management contacts
        - Transition from individual to group treatment modalities
    - Discuss patient status and need for monitoring with the primary care provider
    - Consider a referral to adjunctive services for treatment of disorders or behavioral abnormalities (e.g., homelessness or domestic violence)

4. If patient demonstrates remission from symptoms and there are no indications for further therapy:
    - Discontinue treatment
    - Educate the patient about indication and route of future care access
    - Monitor by primary care for relapse/exacerbation.

I. **Referral**

Objective

Treat symptoms, support function, and alleviate suffering in those patients with PSTD who are unwilling, unable, or unsuitable for treatment in a mental health setting.

Recommendations

1. Evaluate psychosocial function and refer for psychosocial services, as indicated. Available resources include, but are not limited to chaplains, pastors, Family Support Centers, Exceptional Family Member Programs, VA benefit counselors, occupational or recreational therapists, Vet Centers, and peer-support groups.
2. Provide case management, as indicated, to address high utilization of medical resources.
3. Consider psychotherapeutic interventions as appropriate for level of training and available resources.
4. For patients with severe symptoms or coexisting psychiatric problems consider referrals to:

- Specialized PTSD programs
- Specialized programs for coexisting problems and conditions
- Partial psychiatric hospitalization or "day treatment" programs
- Inpatient psychiatric hospitalization

Evidence for all Recommendations: (Working Group Consensus)(**QE – III; Overall Quality – Poor; R – I**)

EVIDENCE-BASED INTERVENTION FOR TREATMENT OF PTSD

A. **Acute Stress Disorder (ASD) Pharmacotherapy**

Summary Table – Pharmacotherapy for ASD

R*	Significant Benefit	Some Benefit	Unknown	No Benefit/Harm
A				
B		Imipramine		
C		Propranolol		
I			Benzodiazepines Other Sympatholytics Other Antidepressants Anticonvulsants Atypical Antipsychotics Chloral Hydrate	
D				Typical Antipsychotics

*R = level of recommendation

Although the effectiveness of selective serotonin reuptake inhibitors (SSRIs) has been demonstrated for PTSD, it has not been tested in ASD and therefore cannot be recommended.

Objective

To lessen the physical, psychological, and behavioral morbidity associated with acute stress reaction, hasten the return to full function (duty, work, social function), and diminish the likelihood of chronicity.

Recommendations

1. Recommend providing for physical needs, sleep, normalization, and other non-pharmacological modalities (Working Group Consensus)(**QE – III; Overall Quality – Poor; R -- not graded**)
2. Consider the use of medication for individuals that do not respond to non-pharmacological treatment (Working Group Consensus) (**QE – III; Overall Quality – Poor; R – I**)
3. Consider the use of imipramine to ameliorate the symptoms of ASD
4. Consider a short course of medication targeted for specific symptoms
    - Sleep disturbance/insomnia
        - Benzodiazepines (up to 5 days) (Gelpin et al., 1996; Mellman, Byers, & Augenstein, 1998) (**QE – II-2; Overall Quality – Fair; Net Effect – M; R – C**)
        - Chloral hydrate (up to 5 days) (Robert et al., 1999) (**QE – I**; **Overall Quality – Fair; Net Effect – S; R – C**)
    - Hyperarousal/excessive arousal/panic attacks
        - Propranolol and other anti-adrenergic agents (up to 10 days) (Pittman et al., 2002) (**QE – I; Overall Quality – Good; Net Effect – M; R – C**)
        - Imipramine (up to 7 days) (Robert et al., 1999) (**QE – I; Overall Quality – Fair; Net Effect – M; R – B**)
        - Benzodiazepines (up to 5 days) avoid short acting agent (e.g., alprazolam) (Gelpin et al., 1996; Mellman, Byers, & Augenstein, 1998) (**QE – II-2; Overall Quality – Fair; Net Effect – M; R – C**)

5. There is insufficient evidence to support a recommendation for preventative use of a pharmacological agent to prevent the development of PTSD.
6. There is insufficient evidence to support a recommendation for PTSD pharmacotherapies for patient presenting symptoms for less than 4 weeks. (**QE – I; Overall Quality – Poor; R -- I**)

B. **Post-Traumatic Stress Disorder (PSTD) Pharmacotherapy**

Summary Table for PTSD Pharmacotherapy*

R*	Significant Benefit	Some Benefit	Unknown	No Benefit/Harm
A	SSRIs			
B		TCAs MAOIs		
C		Sympatholytics Novel Antidepressants		

R*	Significant Benefit	Some Benefit	Unknown	No Benefit/Harm
I			Anticonvulsants Atypical Antipsychotics Buspirone Nonbenzodiazepine hypnotics	
D				Benzodiazepines Typical Antipsychotics

*R = level of recommendation; SSRIs = selective serotonin reuptake inhibitors; TCAs = tricyclic antidepressants; MAOIs = monoamine oxidase inhibitors.

Objective

To minimize signs and symptoms of PTSD and maintain function.

Recommendations

Monotherapy

1. Strongly recommend selective serotonin reuptake inhibitors (SSRIs) for the treatment of PTSD. (Stein et al., 2000) (**QE – I; Overall Quality – Good; Net Effect – M; R – A**)
2. Recommend tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) as second-line treatments for PTSD. (Stein et al., 2000; Cochrane Review) (**QE – I; Overall Quality – Good; Net Effect – M; R – B**)
3. Consider an antidepressant therapeutic trial of at least 12 weeks before changing therapeutic regimen. (Martenyi et al., 2002) (**QE – I; Overall Quality – Fair; Net Effect – M; R – B**)
4. Consider a second-generation (e.g., nefazodone, trazodone, venlafaxine, mirtazapine, bupropion) in the management of PTSD. (Hidalgo et al., 1999) (**QE – II-2; Overall Quality – Fair; Net Effect – S; R – C**)

Augmented Therapy for Targeted Conditions

5. Consider prazosin to augment the management of nightmares and other symptoms of PTSD. (Raskind et al., 2003) (**QE – I; Overall Quality – Fair; Net Effect – M; R – C**)
6. Recommend medication compliance assessment at each visit. (Group Consensus) (**QE – III; Overall Quality – Poor; R – I**)
7. Since PTSD is a chronic disorder, responders to pharmacotherapy may need to continue medication indefinitely; however, it is recommended

that maintenance treatment should be periodically reassessed. (Rapaport, Endicott, & Clary, 2002) (**QE – II; Overall Quality – Fair; Net Effect – S; R – C**)

8. There is insufficient evidence to recommend a mood stabilizer (e.g., lamotrigine) for the treatment of PTSD. (Hertzberg et al., 1999) (**QE – I; Overall Quality – Fair; Net Effect – M; R – C**)
9. There is insufficient evidence to recommend atypical antipsychotics for the treatment of PTSD. (Hamner et al., 2003) (**QE – I; Overall Quality – Good; Net Effect – S; R – I**)
10. There is insufficient evidence to support the recommendation for a pharmacological agent to prevent the development of PTSD. (**QE – III; Overall Quality – Poor; Net Effect – S; R – I**)
11. Recommend against the long-term use of benzodiazepines to manage core symptoms in PTSD. (Kosten et al., 2000) (**QE – II-2; Overall Quality – Fair; Net Effect – M; R – I**)
12. Recommend against typical antipsychotics in the management of PTSD. (Stein et al., 2000) (**QE – I; Overall Quality – Poor; Net Effect – S; R – D**)

C. **Psychotherapy Interventions**

Objective

Reduce symptoms severity and improve of global functioning.

Summary Table for Psychotherapy Interventions

R*	Significant Benefit	Some Benefit	Unknown	Harm
A	Cognitive Therapy (CT) Exposure Therapy (ET) Stress Inoculation Training (SIT) Eye Movement Desensitization and Reprocessing (EMDR)			
B		Imagery Rehearsal Therapy (IRT) Psychodynamic Therapy		
C				

R*	Significant Benefit	Some Benefit	Unknown	Harm
D				
I		PTSD- Patient Education		

*R = level of recommendation

Recommendations

1. Providers should explain to all patients with PTSD the range of available and effective therapeutic options for PTSD. (Expert Consensus)
2. Cognitive Therapy (CT), Exposure Therapy (ET), Stress Inoculation Training (SIT), and Eye Movement Desensitization and Reprocessing (EMDR) are strongly recommended for treatment of PTSD in military and non-military populations. EMDR has been found to be as effective as other treatments in some studies and less effective than other treatments in some other studies. (**A***)
3. Imagery Rehearsal Therapy [IRT] and Psychodynamic Therapy may be considered for treatment of PTSD. (**B***)
4. Patient education is recommended as an element of treatment of PTSD for all patients. (**C***)
5. Consider Dialectical Behavioral Therapy (DBT) for patients with a borderline personality disorder typified by parasuicidal behaviors. (**B**)
6. Consider hypnotic techniques especially for symptoms associated with PTSD, such as pain, anxiety, dissociation and nightmares, for which hypnosis has been successfully used. (**B***)
7. Specialized PTSD psychotherapies may be augmented by additional problem specific methods/services and pharmacotherapy. (Expert Consensus)
8. Combination of cognitive therapy approaches (e.g., ET plus CT), while effective, has not proven to be superior to either component alone. (**B**)
9. Specific psychotherapy techniques may not be uniformly effective across all patients. When selecting a specific treatment modality, consideration of patient characteristics such as gender, type of trauma (e.g., combat vs. other trauma), and past history may be warranted. (Expert Consensus)
10. Patient and provider preferences should drive the selection of evidence-based psychotherapy and/or evidence-based pharmacotherapy as the first line treatment. (Expert Consensus)
11. Selection of individual interventions should be based upon patient preference, provider level of skill and comfort with a given modality, efforts to maximize benefit and minimize risks to the patient, and consideration of feasibility and available resources. (Expert Consensus)
12. Psychotherapies should be provided by practitioners who have been trained in the particular method of treatment, whenever possible. (Expert Consensus)

13. A stepped care approach to therapy administration may be considered, though supportive evidence is lacking. (Expert Consensus)

*Detailed evidence tables for each therapy are included in the applicable following Discussion sections.

Note: Psychotherapy interventions are aimed at reduction of symptoms severity and improvement of global functioning. However, the clinical relevance and importance of other outcome indicators (e.g., improvement of quality of life, physical and mental health) are not currently well known.

A. Selection of Therapy for PTSD

In clinical practice, providers and patients alike are often faced with important decisions relating to type, number, frequency, and dose of various psychotherapies and pharmacologic therapies. Therapies may be broadly divided into (1) evidence-based psychotherapies, (2) evidence-based pharmacotherapies, and (3) key adjunctive or supplemental treatment modalities. Providers should explain to all patients with PTSD the range of therapeutic options that are available and effective for PTSD. This discussion should include general advantages and disadvantages (including side-effects) associated with each therapeutic option. In general, PTSD therapy research has provided insufficient evidence to favor medication or evidence-based psychotherapy as a first-line treatment. There is also insufficient evidence to suggest for or against combined medication and psychotherapy over only one of the two approaches.

It may be helpful to add therapies using a stepped care approach, even though supporting evidence does not exist. The use of stepped care has been advocated for many chronic conditions including hypertension, low back pain, and depression. In stepped care, the intensity of care is augmented for patients who do not achieve an acceptable outcome with lower levels of care. Stepped care is based on three assumptions: different people require different levels of care; finding the right level of care often depends on monitoring outcomes; and moving from lower to higher levels of care based on patient outcomes often offers efficient increases in overall effectiveness.

The level or intensity of care is guided by illness trajectory (degree of chronicity and current illness severity), observed outcomes, and previously attempted therapies. Active follow-up is used to determine the level of care each patient requires over time. In PTSD for example, the patient and provider may determine that the first-line therapy will be psychotherapy. If, after a period of treatment, the patient is not responding adequately, the patient may be "stepped up" in therapeutic intensity by adding a medication, such as a selective serotonin reuptake inhibitor (SSRI) to the regimen of ongoing psychotherapy. Contrary to clinical intuition, there is no evidence indicating the superiority of programs that combine different cognitive behavioral therapies.

B. Cognitive Therapy (CT)

Recommendations

1. CT is effective with civilian men and women exposed to combat and noncombat trauma. (Lovell, et al., 2001; Marks et al., 1998) (**QE – I; Overall Quality – Good; R – A**)
2. CT is effective with military and veterans with combat- and noncombat-related PTSD. (Working Group Consensus) (**QE – III; Overall Quality – Poor; R – I**)
3. CT is effective for women with PTSD associated with sexual assault. (Resick et al., 2002)(**QE – I, Overall Quality – Good, R – A**)

C. **Exposure Therapy**

Recommendations

1. ET is effective in the treatment of PTSD (compared to placebo or waiting list) (Cooper & Clum, 1989; Foa et al., 1991; Foa et al., "A comparison," 1999; Ironson et al., 2002; Keane et al., 1989; Marks et al., 1998; Tarrier et al., 1999) (**QE – I; Overall Quality – Good; R – A**)
2. ET compared to other forms of therapy show equivalent results (Foa et al., 1991; Foa et al., "A comparison,"1999; Marks et al., 1998; Paunovic & Ost, 2001; Resnick & Nishisth, 2001; Schnurr, 2001; Tarrier et al., 1999) (**QE – I; Overall Quality – Good; R – A**)

D. **Stress Inoculation Training (SIT)**

Recommendations

1. SIT is effective as a treatment for PTSD related to sexual assault (Foa et al., 1991; Foa et al., "A comparison," 1999; Kilpatrick, Veronen, & Resick, 1982; Rothbaum et al., 2000) (**QE – I; Overall Quality – Good; R – A**)

E. **Eye Movement Desensitization and Reprocessing (EMDR)**

Recommendations

1. EMDR is more efficacious for PTSD than wait-list, routine care, and active treatment controls. (Chemtob, Tolin, & van der Kolk, 2000; Davidson & Parker, 2001; Foa & Meadows, 1997; Maxfield & Hyer, 2002; Shepherd, Stein, & Milne, 2000) (**QE – I; Overall Quality – Good; R – A**)
2. Eye movements are not critical to the effects of EMDR (Foa & Meadows, 1997) (**QE – I; Overall Quality – Poor; R – C**)
3. EMDR compared with ET and CT shows mixed results (Cahill, 2000; Davidson & Parker, 2001; Foa & Meadows, 1997; Ironson et al., 2002; Lee et al., 2002; Power et al., 2002; Servan-Schrieber, 2000; Shepherd, Stein, & Milne, 2000; Taylor, Thordarson, & Maxfield, 2002; Van Etten & Taylor, 1998) (**QE – I, Overall Quality – Fair, R – B**)

F. **Imagery Rehearsal Therapy (IRT)**

Recommendations

1. IRT can be considered for treatment of PTSD (nightmare and sleep disruption in particular). (Krakow et al., 1995; Krakow et al., "Imagery rehearsal," 2001; Krakow et al., "Treatment of chronic nightmares," 2001; Forbes, Phelps, & McHugh, 2001) (**QE – I; Overall Quality – Fair; R – B**)

G. **Psychodynamic Therapy**

Recommendations

1. Psychodynamic psychotherapy for the treatment of PTSD (Brom, Kleber, & Defares, 1989**) (QE – I; Overall Quality – Good; R – B**)
2. Psychodynamic psychotherapy for patients with complex PTSD (Courtois, 1999; Roth & Batson, 1997; Shengold, 1989) (**QE – II-2; Overall Quality – Fair; R – B**)

H. **Patient Education**

Objective

Provide a therapeutic intervention that reduces the symptoms and functional impairments of PTSD.

Recommendation

1. Psychoeducation is recommended (Foa, Davidson, & Frances, 1999) (**QE – III; Overall Quality – Poor; R – C**) (Lubin et al., 1998) (**QE – II-2; Overall Quality – Fair; R – B**)

I. **Group Therapy**

Objective

Provide a supportive environment in which a patient with PTSD may participate in therapy with other PTSD patients.

Recommendations

1. Consider group treatment for patients with PTSD (Donovan, Padin-Rivera, & Kowaliw, 2001; Foy et al., 2000; Rogers et al., 1999) (**QE – III, II, I; Overall Quality – Fair; R – B**)
2. Current findings do not favor any particular type of group therapy over other types. (Foy et al., 2000) (**QE – II, Overall Quality – Poor, R – I**)

J. **Dialectical Behavior Therapy**

1. Consider DBT for patients with a borderline personality disorder typified by parasuicidal behaviors. (Evans et al., 1999; Hawton et al., 2000; Linehan, Heard, & Armstrong, 1993; Safer, Telch, & Agras,

2001; Telch, Agras, & Linehan, 2001; van den Bosch et al., 2002; Verheul et al., 2003) (**QE – I; Overall Quality – Fair; R – B**)

K. **Hypnosis**

Objective

A therapeutic intervention that may be an effective adjunctive procedure in the treatment of PTSD

Recommendation

1. Hypnosis may be used to alleviate PTSD symptoms. (Brom, Kleber, & Defares, 1989; Sherman, 1998) (**QE – I; Overall Quality –Fair; R – B**)

L. **Psychosocial Adjunctive Methods/Services**

Objective

Provide a therapeutic intervention that facilitates generalizing skills for coping with PTSD from clinic to home/work/community.

Recommendations

1. Consider psychosocial rehabilitation techniques once the client and clinician identify the following kind of problems associated with the diagnosis of PTSD: persistent high-risk behaviors, lack of self care/independent living skills, homelessness, interactions with a family that does not understand PTSD, socially inactive, unemployed, and encounters with barriers to various forms of treatment/rehabilitation services.
2. Client and clinician should determine whether such problems are associated with core symptoms of PTSD and, if so, then ensure that rehabilitation techniques are used as a contextual vehicle for alleviating PTSD symptoms.
3. Psychosocial rehabilitation should occur concurrently or shortly after a course of treatment for PTSD, since psychosocial rehabilitation is not trauma-focus.

M. **Spiritual Support**

Objective

Reduce symptoms of PTSD and improve patient´s functioning through social and spiritual support.

Recommendation

1. Provide access to religious/spiritual resources, if sought.

Evidence

Provide opportunities to vent & defuse, to share feelings and talk (Bogia & Preston, 1985; Everly, "The role of pastoral crisis," 2000; Hunter, 1996) (**QE – II, Overall Quality – Fair, R – C**)

Abbreviation/Acronym List

ABCs Airway, breathing, circulation
AHCPR Agency for Healthcare Policy and Research
APA American Psychiatric Association
ASD Acute stress disorder
ASR Acute stress reaction
AUDIT Alcohol Use Disorders Identification Test
CAGE Alcohol abuse/dependence screening test mnemonic
CAPS Clinician Administered PTSD Scale
CBC Complete blood count
CBT Cognitive Behavioral Therapy
CCTR Cochrane Central Register of Controlled Trials
CDR Commander
CNS Central nervous system
COSR Combat and operational stress reactions
CISD Critical Incident Stress Debriefing
CT (Interventions) Cognitive Therapy
CT Computed tomography
CV Cardiovascular
DARE Database of Abstracts of Reviews of Effectiveness
DAST Drug Abuse/Dependence Screener
DBT Dialectical Behavioral Therapy
DoD Department of Defense
DSM-IV Diagnostic and Statistical Manual of Mental Disorders (4th edition)
DTE Direct Therapeutic Exposure
EBM Evidence-based medicine
EBPTU Evaluation and Brief PTSD Treatment Unit
EEG Electroencephalography
EKG Electrocardiogram
EMDR Eye Movement Desensitization and Reprocessing
EMTs Emergency Medical Teams
ESRT Emotional Self-Regulation Therapy
EtoH Ethanol
ET Exposure Therapy
FDA U. S. Food and Drug Administration
GAF Global Assessment of Function
GI Gastrointestinal
GU Genitourinary
HCG Human Choriogonadotropin
HIV Human immunodeficiency virus
IRT Image Rehearsal Therapy
LOC Level of consciousness
LOF Level of function
MAOIs Monoamine oxidase inhibitors
MAST Michigan Alcohol Screening Test

MDD Major Depressive Disorder
MHP Mental health providers
MI Myocardial infarction
MMSE Mini-Mental State Examination
MRI Magnetic resonance imaging
MSE Mental status examination
NIMH National Institute of Mental Health
NS Nervous system
OMO Ongoing military operations
OTC Over-the-counter
PCL-C PTSD Checklist – Civilian Version
PCL-M PTSD Checklist – Military Version
PCL-S PTSD Checklist – Stressor Specific Version
PCP Primary care provider
PE Physical examination
PE (Interventions) Prolonged Exposure
PIES Proximity, Immediacy, Expectancy, Simplicity
PTSD Post-traumatic Stress Disorder
QE Quality of evidence
RCS Readjustment Counseling Services
RCT Randomized controlled trial
RTD Return-to-duty
SC Supportive Counseling
SIADH Syndrome of inappropriate antidiuretic hormone
SIPU Specialized Inpatient PTSD Unit
SIT Stress Inoculation Therapy
SM Service member
SR Strength of recommendation
SSRI Selective Serotonin Reuptake Inhibitors
SUD Substance Use Disorder
SUNY State University of New York
TCAs Tricyclic Antidepressants
TSH Thyroid Stimulating Hormone
USPSTF U.S. Preventive Service Task Force
VA Veterans Affairs
VAMC Veterans Affairs Medical Center
VHA Veterans Health Administration

Rating Scheme for the Strength of the Evidence:

I At least one properly done randomized controlled trial (RCT)
II-1 Well designed controlled trial without randomization
II-2 Well designed cohort or case-control analytic study
II-3 Multiple time series, dramatic results of uncontrolled experiment
III Opinion of respected authorities, case reports, and expert committees

Overall Quality

Good -- High grade evidence (I or II-1) directly linked to health outcome
Fair -- High grade evidence (I or II-1) linked to intermediate outcome; *or* moderate grade evidence (II-2 or II-3) directly linked to health outcome
Poor -- Level III evidence or no linkage of evidence to health outcome

Net Effect of the Intervention

Substantial -- More than a small relative impact on a frequent condition with a substantial burden of suffering; *or* a large impact on an infrequent condition with a significant impact on the individual patient level

Moderate -- A small relative impact on a frequent condition with a substantial burden of suffering; *or* a moderate impact on an infrequent condition with a significant impact on the individual patient level

Small -- A negligible relative impact on a frequent condition with a substantial burden of suffering; *or* a small impact on an infrequent condition with a significant impact on the individual patient level

Zero or Negative -- Negative impact on patients; *or* no relative impact on either a frequent condition with a substantial burden of suffering; *or* an infrequent condition with a significant impact on the individual patient level.

Final Grade of Recommendation is determined according to the following chart:

	The net benefit of the intervention			
Quality of Evidence	**Substantial**	**Moderate**	**Small**	**Zero or Negative**
Good	**A**	**B**	**C**	**D**
Fair	**B**	**B**	**C**	**D**
Poor	**I**	**I**	**I**	**I**

Rating Scheme for the Strength of the Recommendations

A A strong recommendation that the intervention is always indicated and acceptable
B A recommendation that the intervention may be useful/effective
C A recommendation that the intervention may be considered
D A recommendation that a procedure may be considered not useful/effective, or may be harmful
I Insufficient evidence to recommend for or against – the clinician will use clinical judgment

CLINICAL ALGORITHM(S)

Clinical algorithms are provided in the original guideline document for:

- Initial Evaluation and Triage

- Acute Stress Reaction (ASR)
- Combat and Ongoing Operation Stress Reaction (COSR)
- Acute Stress Disorder (ASD) and Post-Traumatic Stress Disorder (PTSD) in Primary Care
- Management of PTSD in Mental Health Specialty Care

EVIDENCE SUPPORTING THE RECOMMENDATIONS

REFERENCES SUPPORTING THE RECOMMENDATIONS

References open in a new window

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

By providing effective assistance to persons who have suffered a trauma, some of those persons might not go on to develop post-traumatic stress disorder (PTSD).

POTENTIAL HARMS

A detailed recounting of a traumatic experience may cause further distress to the patient and is not advisable unless a provider has been trained and is able to support the patient through this experience.

Pharmacological Adverse Effects

Note: See Table 4 of Module 1 – *Treatment Interventions for PTSD – for detailed list of drug adverse effects and cautions*.

- Selective serotonin reuptake inhibitors (SSRIs) (fluoxetine, paroxetine, sertraline, fluvoxamine, citalopram): nausea, headache, sexual dysfunction, hyponatremia/syndrome of inappropriate antidiuretic hormone (SIADH), serotonin syndrome
- Tricyclic antidepressants (imipramine, amitriptyline, desipramine, nortriptyline, protriptyline, clomipramine): anticholinergic effects, orthostatic hypotension, increased heart rate, ventricular arrhythmias
- Monoamine oxidase inhibitors (phenelzine, tranylcypromine): hypertensive crisis with drug/tyramine interactions, bradycardia, orthostatic hypotension, insomnia
- Sympatholytics: propranolol – hypotension, bronchospasm, bradycardia; prazosin – first dose syncope
- Novel antidepressants: trazodone and nefazodone – sedation, rare priapism; venlafaxine – hypertension in patients with preexisting hypertension; nefazodone – hepatoxicity

- Anticonvulsants: carbamazepine – leukopenia, SIADH, drowsiness, ataxia; gabapentin – sedation, ataxia; lamotrigine - Stevens-Johnson syndrome, fatigue; topiramate – secondary angle closure glaucoma, sedation, dizziness, ataxia; valproate – nausea/vomiting, sedation, ataxia, thrombocytopenia
- Benzodiazepines (clonazepam, lorazepam, alprazolam, diazepam): sedation, memory impairment, ataxia, dependence
- Typical antipsychotics (chlorpromazine, haloperidol, thioridazine): sedation, orthostatic hypotension (with chlorpromazine and thorazine), akathisia, dystonia, drug-induced parkinsonism, tardive dyskinesia , neuroleptic malignant syndrome, QTc changes
- Atypical antipsychotics (olanzapine, quetiapine, risperidone): sedation, weight gain, neuroleptic malignant syndrome, akathisia (at high doses), drug-induced parkinsonism, especially with doses >6 mg/d
- Non-benzodiazepine hypnotics (zaleplon, zolpidem): sedation, ataxia, rebound insomnia
- Non-benzodiazepine anti-anxiety (buspirone): nausea, headache

CONTRAINDICATIONS

CONTRAINDICATIONS

- Selective serotonin reuptake inhibitors (SSRIs) (fluoxetine, paroxetine, sertraline, fluvoxamine, citalopram) are contraindicated with MAO inhibitor use within 14 days and relatively contraindicated in patients with hypersensitivity.
- Tricyclic Antidepressants (imipramine, amitriptyline, desipramine, nortriptyline, protriptyline, clomipramine) are contraindicated with monoamine oxidase inhibitor (MAOI) use within 14 days, and acute myocardial infarction within 3 months, and relatively contraindicated in patients with coronary artery disease and prostatic enlargement. Clomipramine is contraindicated in patients with seizure disorder.
- Monoamine Oxidase Inhibitors (MAOI)(phenelzine, tranylcypromine) are contraindicated with use of all antidepressants within 7 days of start of MAOI, except fluoxetine is 5 weeks, and use of central nervous system stimulants and decongestants.
- Propranolol: Sinus bradycardia, congestive heart failure are contraindications.
- Novel antidepressants (bupropion, nefazodone, trazodone, venlafaxine) are contraindicated with MAOI use within 14 days, and bupropion.
- Anticonvulsants: Carbamazepine is contraindicated in patients with bone marrow suppression, particularly leukopenia. Gabapentin is contraindicated in those with renal impairment. Lamotrigine is contraindicated in patients who experience increased rash with valproate (max. dose of 200 mg). Topiramate is contraindicated in patients with hepatic impairment, and valproate with impaired liver function and thrombocytopenia.
- Benzodiazepines (clonazepam, lorazepam, alprazolam, diazepam) should be used with caution in elderly patients and patients with impaired liver function, and there is a risk of abuse in patients with history of substance abuse.
- Typical antipsychotics (chlorpromazine, haloperidol, thioridazine) are contraindicated in patients with Parkinson´s disease and QTc prolongation.
- Atypical antipsychotics (olanzapine, quetiapine, risperidone) are relatively contraindicated in Parkinson´s disease.

- Non-benzodiazepine hypnotics (zaleplon, zolpidem) should be used with caution with alcohol/drug abuse history and with caution in elderly patients with liver dysfunction.
- Non-benzodiazepine anti-anxiety (buspirone) is contraindicated with MAOI use within 14 days.
- Contraindications for Cognitive Therapy have not been empirically established, but may include psychosis, severe brain damage, or severe intellectual impairment.
- Patients living in dangerous circumstances (e.g., domestic violence or a threatening environment) are not candidates for Exposure Therapy until their security can be assured. Other contraindications for Exposure Therapy have not been confirmed in empirical research, but may include health problems that preclude exposure to intense physiological arousal, current suicidal ideation, substance abuse not in stable remission, comorbid psychosis, or lack of motivation to undergo the treatment.
- Contraindications for Group Therapy include active psychosis, severe organicity or limited cognitive capacity, pending litigation, or compensation seeking.
- There are a number of contraindications for using traditional hypnotic techniques in the treatment of PTSD:
    - In the rare cases of individuals who are refractory or minimally responsive to suggestions, hypnotic techniques may not be the best choice, because there is some evidence that hypnotizability is related to treatment outcome efficacy.
    - Some PTSD patients may be reluctant to undergo hypnosis, either because of religious belief or other reasons. If the resistance is not cleared after dispelling mistaken assumptions, other suggestive techniques can be tried, including emotional self-regulation therapy (ESRT), which is done with open eyes and uses sensory recall exercises rather than a hypnotic induction.
    - For patients who have low blood pressure or are prone to fall asleep, hypnotic procedures such as "alert hand," which emphasize alertness and activity rather than relaxation, may be substituted.
- Psychosocial rehabilitation techniques are contraindicated when client and clinician conclude that the problems are resolved.
- Marriage counseling is typically contraindicated in cases of domestic violence, until the batterer has been successfully (individually) rehabilitated.

QUALIFYING STATEMENTS

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Clinical practice guidelines, which are increasingly being used in health care, are seen by many as a potential solution to inefficiency and inappropriate variations in care. Guidelines should be evidenced-based as well as based upon explicit criteria to ensure consensus regarding their internal validity. However, it must be remembered that the use of guidelines must always be in the context of a health care provider's clinical judgment in the care of a particular patient. For that reason, the guidelines may be viewed as an educational tool analogous to textbooks and journals, but in a more user-friendly tone.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

This guideline builds on Department of Defense (DoD) and Veterans Affairs (VA) expertise to promote state-of-the-art assessment and intervention. It is a tool designed for this time of trauma and challenge. Parts of this Clinical Practice Guideline have already served in Afghanistan and Iraq.

IMPLEMENTATION TOOLS

Clinical Algorithm
Resources

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Veterans Health Administration, Department of Defense. VA/DoD clinical practice guideline for the management of post-traumatic stress. Version 1.0. Washington (DC): Veterans Health Administration, Department of Defense; 2004 Jan. Various p. [479 references]

ADAPTATION

The guideline draws from other evidence based guidelines that were available to the Working Group:

- Effective Treatments for PTSD: Practice Guidelines from the International Society for Traumatic Stress Studies. Foa EB, Keane TM, Friedman MJ (Eds) 2000
- The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. Foa EB, et al., 1999

- Mental Health and Mass Violence: Evidenced-Based Early Psychological Intervention for Victims/Survivors of Mass Violence. A Workshop to Reach Consensus on Best Practices. National Institute of Mental Health 2002. NIH Publication No. 02-5138. Washington, D.C.: U.S. Government Printing Office. (http://www.nimh.nih.gov/publicat/massviolence.pdf)

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The Management of Post-traumatic Stress Working Group

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the Department of Veterans Affairs Web site.

Print copies: Available from the Department of Veterans Affairs, Veterans Health Administration, Office of Quality and Performance (10Q) 810 Vermont Ave. NW, Washington, DC 20420.

AVAILABILITY OF COMPANION DOCUMENTS

- Various companion documents are available from the: Veterans Health Administration (VHA) Web site.
- In addition, the VHA Web site provides references to related guidelines, performance measures, and other resources.
- Guideline for guidelines. Draft. Washington (DC): Veterans Health Administration, Department of Veterans Affairs. Available at: VHA Web site.

Print copies: Department of Veterans Affairs, Veterans Health Administration, Office of Quality and Performance (10Q) 810 Vermont Ave. NW, Washington, DC 20420.

The following is also available:

- Putting clinical practice guidelines to work [online tutorial]. Available from the Department of Veterans Affairs Web site.

See also the following related QualityTool summaries on the Health Care Innovations Exchange Web site:

- Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guideline for the management of post traumatic stress acute stress reaction (ASR) module: pocket guide
- Management of post-traumatic stress in primary care: core module: initial evaluation and triage algorithm
- Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guideline for the management of post traumatic stress: core module summary
- Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guideline for the management of post-traumatic stress: module A1 summary
- Management of post-traumatic stress: module A1: acute stress reaction (2-4 days after trauma) algorithm
- Management of post-traumatic stress: module A-2: combat/ongoing military operation stress reaction (COSR) algorithm
- Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guideline for the management of post-traumatic stress: module A2 summary
- Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guideline for the management of post-traumatic stress: module B summary
- Management of post-traumatic stress: module B: management of acute stress disorder/post-traumatic stress disorder (ASD/PTSD) in primary care algorithm
- Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guideline for the management of post traumatic stress: module C summary
- Management of post-traumatic stress: module C: management of acute stress disorder/post-traumatic stress disorder (ASD/PTSD) in mental health specialty algorithm
- Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guideline for the management of post traumatic stress: key points card
- Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guideline for the management of post traumatic stress (PTSD) or acute stress disorder (ASD) in primary care module: pocket guide
- Department of Veterans Affairs/Department of Defense (VA/DoD) clinical practice guideline for the management of post traumatic stress: interventions module summary

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on August 31, 2004. The information was verified by the guideline developer on November 15, 2004. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on October 3, 2005, following the U.S. Food and Drug Administration advisory on Paxil (paroxetine). This summary was updated by ECRI on December 12, 2005, following the U.S. Food and Drug Administration advisory on Paroxetine HCL - Paxil and generic paroxetine. This summary was updated by ECRI on May 31, 2006 following the U.S. Food and Drug Administration advisory on Paxil (paroxetine hydrochloride). This summary was updated by ECRI on November 22, 2006, following the FDA advisory on Effexor (venlafaxine HCl). This summary was updated by ECRI Institute on April 30, 2007, following the FDA advisory on Sedative-hypnotic drug products. This summary was updated by ECRI Institute on November 6, 2007, following the U.S. Food and Drug Administration advisory on Antidepressant drugs. This summary was updated by ECRI Institute on January 10, 2008, following the U.S. Food and Drug Administration advisory on Carbamazepine.

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