BRIEF REVIEW OF INTERNATIONAL CLINICAL PRACTICE GUIDELINES (CPGs) FOR TREATMENT OF PTSD (updated August, 2017)

NOTE: I consider this to be a “working document”, my own document meant to summarize some important elements of the CPGs for myself, that I am sharing with you. I have copied directly from some of the CPGs, and used materials from websites for this document. It is an informal collection and summary of important elements of the CPG process that leads to some questions at the end that I hope will spur discussion and thinking. I have noted elements of language from specific guidelines that seemed particularly important. There are many embedded hyperlinks (in blue and underlined), meant to take you directly to that guideline or resource. Finally, I have some links for assessment related resources on the final page.

A previous review:

A COUPLE OF USEFUL LINKS REGARDING ASSESSMENTS

1. APA’s PTSD assessments page (notably includes links to VA/DOD websites!)
2. This portion of the National PTSD website, has links to many assessments and assessment related materials. Additionally, it has links to specific recent presentations about PTSD, available both to VA clinicians and to community clinicians via the VHA TRAIN website.

COMMONALITIES AMONG THE MOST RECENT CPGs

- psychotherapies are first line treatments OR strongly recommended if the guideline hesitates to name something as “first-line”. The cornerstone of treatment involves confronting the traumatic memory and addressing thoughts and beliefs associated with the experience. If multiple layers of suffering need to be addressed in the treatment of PTSD, particularly after multiple traumatic events, traumatic bereavement, or when there is chronicity, significant comorbid disorders, or social problems are present then treatment must be extended.
- some medicines help, but the most recent guidelines (with gradations of explicitness) relegate them to a secondary treatment status. Given this, there is a great call for better pharmacotherapy (and psychotherapy augmented by medicine) research, so I’m hopeful for a resurgence in this area. Generally, there are some SSRIs but they are less effective in men, and have sexual side effects
that severely limit adherence. There is great concern that benzodiazepines might reduce the possibility of fear extinction from useful psychotherapies.

- treat comorbid disorders **concurrently whenever possible**—there is a great need for focus on concurrent treatment of addiction and PTSD in particular
- If at all possible, **don’t use benzodiazepines**, and **consider tapering off of them** given many problems, and concerns about these medications interfering with fear extinction.
- Consider CBTI for insomnia that lives on past PTSD recovery.

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HERE ARE LINKS TO A COUPLE OF ‘WHITEBOARD’ VIDEOS THAT CAN BE USEFUL TO SHOW TO VETERANS AND OTHER TRAUMA SURVIVORS:

- [What Is PTSD](#)
- [Know Your Options for Treating PTSD](#)
CLINICAL PRACTICE GUIDELINES PROVIDED IN ORDER OF MOST RECENT TO OLDEST GUIDELINES:

1) 2017 VA/DOD CLINICAL PRACTICE GUIDELINE FOR THE TREATMENT OF PTSD:
Here is the link to the whole CPG, and there you’ll also find a pocket guide and clinician summary.

2) APA uses the Institute of Medicine process for determining treatment recommendations: 2017 APA GUIDELINES FOR THE TREATMENT OF PTSD

PAGE 11:
"Recommendations
Following its detailed review and independent analysis of the findings of the systematic review, the APA Guideline Development Panel (GDP) strongly recommends the use of the following psychotherapies/interventions (all interventions that follow listed in alphabetical order) for adult patients with PTSD: cognitive behavioral therapy (CBT), cognitive processing therapy (CPT), cognitive therapy (CT), and prolonged exposure therapy (PE). The panel suggests the use of brief eclectic psychotherapy (BEP), eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (NET). There is insufficient evidence to recommend for or against offering Seeking Safety (SS) or relaxation (RLX). For medications, the panel suggests offering the following (in alphabetical order): fluoxetine, paroxetine, sertraline, and venlafaxine. There is insufficient evidence to recommend for or against offering risperidone and topiramate."
PAGE 67: “Although some other guidelines prioritize treatments into those that are “first-line” or “second-line,” the APA panel chose not to use these terms in its recommendations because sufficient evidence from comparative effectiveness studies was lacking to justify their use. The panel does, however, offer strong recommendations for some PTSD treatments and conditional recommendations for others.”

PAGE 91 “These recommendations are based primarily on the larger magnitude of benefits to harms for psychological treatments than for medications that is driven by larger magnitude reduction in PTSD symptoms and fewer known harms for psychological treatments than for medication treatments…”

3) 2015 (new guidelines in process since 2015). The United Kingdom’s National Institute for Health and Clinical Excellence developed guidelines:

**Psychological interventions**

1.9.2.1 All PTSD sufferers should be offered a course of trauma-focused psychological treatment (**trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing**). These treatments should normally be provided on an individual outpatient basis.

1.9.2.2 Trauma-focused psychological treatment should be offered to PTSD sufferers regardless of the time that has elapsed since the trauma.

1.9.2.3 The duration of trauma-focused psychological treatment should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person.

1.9.2.4 Healthcare professionals should **consider extending** the duration of treatment beyond 12 sessions if several problems need to be addressed in the treatment of PTSD sufferers, particularly after multiple traumatic events, traumatic bereavement, or where chronic disability resulting from the trauma, significant comorbid disorders or social problems are present. Trauma-focused treatment needs to be integrated into an overall plan of care.

1.9.2.5 For some PTSD sufferers, it may initially be very difficult and overwhelming to disclose details of their traumatic events. In these cases, healthcare professionals should consider **devoting several sessions to establishing a trusting therapeutic relationship and emotional stabilisation** before addressing the traumatic event.
1.9.2.6 Non-trauma-focused interventions such as relaxation or non-directive therapy, which do not address traumatic memories, should not routinely be offered to people who present with chronic PTSD.

1.9.2.7 For PTSD sufferers who have no or only limited improvement with a specific trauma-focused psychological treatment, healthcare professionals should consider the following options:

- an alternative form of trauma-focused psychological treatment
- the augmentation of trauma-focused psychological treatment with a course of pharmacological treatment.

1.9.2.8 When PTSD sufferers request other forms of psychological treatment (for example, supportive therapy/non-directive therapy, hypnotherapy, psychodynamic therapy or systemic psychotherapy), they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments on PTSD.

4) 2013 Australian Guidelines for PTSD treatment. They also have a specific guideline for the treatment of first responders with PTSD.

PAGE 14 OF THE MAIN PTSD TREATMENT GUIDELINES:
“Adults with PTSD should be offered trauma-focused psychological interventions – trauma-focused cognitive behavioural therapy (CBT) or eye movement desensitisation and reprocessing (EMDR).
• Where adults have developed PTSD and associated features following exposure to prolonged and/or severe traumatic events, more time to establish a trusting therapeutic alliance and more attention to teaching emotional regulation skills may be required.
• Medication should not be used as a routine first line treatment in preference to trauma-focused psychological therapy.
• Medication can be useful if the person receiving treatment is not getting sufficient benefit from the psychological intervention alone. It can also be used as an alternative when psychological treatment is refused or unavailable, or when the person has a comorbid condition where medication is indicated.
• Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor (SSRI) antidepressants should be the first choice.”


The 2013 WHO guideline does not give the highest recommendation in its grading system (i.e., “strong”) to any evidence-based psychotherapy for PTSD,
but gives CBT with a trauma focus, EMDR, and stress management a standard recommendation. The guideline recommends that the SSRIs and tricyclic antidepressants (TCAs) be considered under circumstances in which recommended psychotherapies (stress management, CBT with a trauma focus and EMDR therapy) have failed or are unavailable or when patients present with co-morbid depression of moderate or greater severity. They have specific guidance regarding acute stress reactions, insomnia, and enuresis after trauma. Additionally, they focus on dissociative and conversion disorders and hyperventilation treatment. Finally, there is guidance about traumatic bereavement.

6) 2012 Institute of Medicine has a 2012 report about treatment of PTSD in military and Veterans. You can download a free version of this PDF. It is really a compilation of evidence up to that point, and does not propose treatment recommendations, instead focusing on existing literature and guidelines and presenting ideas for how to determine efficacy of treatments. IOM 2008 indicated: “The committee further found there was sufficient evidence on the basis of RCTs of the efficacy of exposure therapy to treat PTSD, but that there was inadequate evidence for the efficacy of EMDR, cognitive restructuring, and coping skills training. The committee also concluded there was inadequate evidence on the efficacy of therapy delivered in a group format.” IOM (Institute of Medicine). 2008. Treatment of posttraumatic stress disorder: An assessment of the evidence. Washington, DC: The National Academies Press.

7) Adults Surviving Child Abuse (ASCA) (2012). The “Last Frontier”: Practice guidelines for treatment of complex trauma and trauma informed care and service delivery. In addition to the ISTSS 2012 complex trauma guidelines noted below, these are the only guidelines that I have found that explicitly focus on “complex trauma”.

8) 2009 ISTSS is updating guidelines now (and they are checking out ideas for commentary on internet based treatment for PTSD, and single session interventions to reduce or prevent PTSD soon after trauma exposure). The 2009 main treatment guidelines presented in Effective Treatments for PTSD, Second Edition are based on an extensive review of the clinical and research literature prepared by experts and intended to assist clinicians who provide treatment for adults, adolescents, and children with PTSD. There are also treatment guidelines for Complex PTSD (2012).


IN PROCESS GUIDELINES TO STAY TUNED FOR:

ISTSS General guidelines are also under revision, possibly out in 2017—see this link taking you to their scope/dissemination/questions page.

Lingering questions:

1. What are the system and service provision/access ramifications when guidelines state that medicine is not preferred and that first line treatment is psychotherapy?

2. There is relatively little guidance for how to choose from among the trauma focused treatments, and on what basis to make such choices. There are explicit indicators in the guidelines that in vivo exposure is useful, in addition to trauma-focused emotional processing. How are we determining which EBP to offer or recommend?

3. There is relatively little in the recent guidelines regarding the use of Complementary and Alternative Treatments in PTSD treatment, yet we all seem to have added them to our treatment offerings—what are the ramifications of this? Here is a recent review of material regarding meditative treatments for PTSD. Bessel Van der Kolk’s research and writings indicate that non-exposure based treatments are best—yoga, meditation/mindfulness, and EMDR.

4. There is relatively little in the guidelines about the prevention of dropout, yet this remains a significant problem for trauma focused therapies. Lisa Najavits, creator of Seeking Safety, has a very compelling article about this. Here is a 2013 meta-analysis about drop-out across treatment modalities. What are our thoughts about this? See this about ideas for keeping Veterans/clients in treatment against the dropout impulse.

- There is relatively little in the guidelines about motivational enhancement to engage in an EBP, and the PTSD mentoring program suggestion is to do away with extended orientation/education groups—how are we managing this issue?

5. There is explicit guidance that prolonged working alliance building and emotional distress tolerance training may be required for persons with severe symptoms—are we feeling free to do so? If so, what are we using for this? Skills Training in Affective and Interpersonal Regulation (This link may not open outside of the VA intranet)? Unified Protocol for the Transdiagnostic Treatment of Emotional Disorders? Mindfulness Based Stress Reduction? ACT for PTSD? DBT? Support Groups?
6. With the exception of the ISTSS complex trauma guidelines, there is relatively little indication about how to manage treatment for persons with moderate to severe functional impact from PTSD symptoms who want only supportive counseling, or who would clearly benefit from an EBP but are not feeling confident and hopeful that they can manage the treatment. The CPGs explicitly state that supportive is better than nothing. What are we doing in these situations?

7. What do we do for people who want sleep treatment before or instead of PTSD treatment? See this summary regarding what we know about sleep and PTSD.

8. How can we or should we incorporate technology into PTSD treatment? See this regarding applications meant for patients, or to augment treatments.