

# VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POST TRAUMATIC STRESS

## Interventions Module Summary

### PHARMACOTHERAPY INTERVENTIONS

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

**Table A1: Summary Table**

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

R = level of recommendation (see page 15)

Although the effectiveness of selective serotonin reuptake inhibitor (SSRI) has been demonstrated for PTSD – it has not been tested in ASD and therefore can not 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 role function) and diminish the likelihood of chronicity.

#### BACKGROUND

Stress reactions produce biologic, psychological and behavioral changes. Biologic alterations include disruptions in neurochemicals, sleep patterns, hyper-arousal, and somatic symptoms (e.g., pain, gastrointestinal symptoms, etc). Psychological changes include: mood disturbances (e.g., lability, irritability, blunting, numbing), anxiety (e.g., increased worry, ruminations) and cognitive disturbances (e.g., memory impairment, confusion and

impaired task completion). Different types of trauma can lead to ASD, from interpersonal assaultive violence to accidents to combat related trauma.

Empiric studies in ASD pharmacotherapy are lacking. To facilitate providing physical needs, normalization and psycho-education, it may be prudent to wait 24 to 48 hours before beginning medications. Pharmacotherapy may be aided by determining whether the patient suffers from excessive adrenergic arousal or symptoms of psychomotor withdrawal. If non-pharmacological treatments fail to improve symptomatology and potential medical causes of neuropsychiatric impairment are ruled out, then medications may be considered.

The use of medications for short-term treatment of targeted symptoms may be beneficial (e.g., insomnia).

## RECOMMENDATIONS

1. Provide for physical needs, sleep, normalization, and other non-pharmacological modalities.
2. Consider the use of medication for individuals who do not respond to non-pharmacological treatment.
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)
    - Chloral hydrate (up to 5 days)
- Hyperarousal/excessive arousal/panic attacks
  - Propranolol and other anti-adrenergic agents (up to 10 days)
  - Imipramine (up to 7 days)
  - Benzodiazepines (up to 5 days) avoid short acting agent [e.g., alprazolam]
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.

## B. Post Traumatic Stress Disorder (PTSD) Pharmacotherapy

**Table B1: Summary Table**

R	Significant Benefit	Some Benefit	Unknown	No Benefit/Harm
A	SSRIs			
B		TCA MAOIs		
C		Sympatholytics Novel Antidepressants		
I			Anticonvulsants Atypical Antipsychotics Buspirone Non-benzodiazepine hypnotics	
D				Benzodiazepines Typical Antipsychotics

R = level of recommendation (see page 15)

There is growing evidence that PTSD is characterized by specific psychobiological dysfunctions, which has contributed to a growing interest in the use of medications to treat trauma-related biological effects.

### RECOMMENDATIONS

#### MONOTHERAPY:

1. Strongly recommend selective serotonin reuptake inhibitors (SSRIs) for the treatment of PTSD.
2. Recommend tricyclic antidepressants (TCAs) and monoamine oxidase inhibitors (MAOIs) as second-line treatments for PTSD.
3. Consider an antidepressant therapeutic trial of at least 12 weeks before changing therapeutic regimen.
4. Consider a second-generation (e.g., nefazodone, trazodone, venlafaxine, mirtazapine, bupropion, etc) in the management of PTSD.

#### AUGMENTED THERAPY FOR TARGETED SYMPTOMS:

5. Consider prazosin to augment the management of nightmares and other symptoms of PTSD.
6. Recommend medication compliance assessment at each visit.

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.
8. There is insufficient evidence to recommend a mood stabilizer (e.g. lamotrigine) for the treatment of PTSD.
9. There is insufficient evidence to recommend atypical antipsychotics for the treatment of PTSD.
10. There is insufficient evidence to support the recommendation for a pharmacological agent to prevent the development of PTSD.
11. Recommend against the long-term use of benzodiazepines to manage core symptoms in PTSD.
12. Recommend against typical antipsychotics in the management of PTSD.

**Table B2: Symptom Response by Drug Class and Individual Drug  
(based on controlled and uncontrolled trials)**

		Global Improvement	Re-experiencing (B)	Avoidance/ Numbing (C)	Hyper-arousal (D)
SSRIs					
	Fluoxetine	X	X	X	X
	Sertraline	X		X	X
	Paroxetine	X	X	X	X
TCAs		X	X		
MAOIs		X	X	X	
Sympatholytics					
	Prazosin		X		X
	Propranolol	X			
Novel Antidepressants					
	Trazodone		X	X	X
	Nefazodone		X	X	X
Anticonvulsants					
	Carbamazepine		X		X
	Valproate			X	X
Benzodiazepines					X
Atypical antipsychotics			X		X

**Table B3: Drug Details Table**

Agent	Oral Dose	Absolute/Relative Contraindications	Adverse Events	Remarks
<b>Selective Reuptake Serotonin Inhibitors (SSRIs)</b>				
Fluoxetine Paroxetine Sertraline Fluvoxamine Citalopram	20 – 60 mg/d 20 – 60 mg/d 50 – 200 mg/d 50 – 150 mg bid 20 – 60 mg/d	<b>Contraindications</b> • MAOI inhibitor within 14 days <b>Relative contraindication</b> • Hypersensitivity	• Nausea • Headache • Sexual dysfunction • Hyponatremia/syndrome of inappropriate antidiuretic hormone (SIADH) • Serotonin syndrome	• Avoid abrupt discontinuation of all except fluoxetine • Citalopram and sertraline are less likely to be involved in hepatic enzyme drug interactions • Fluoxetine and fluvoxamine are generically available • Therapeutic blood levels not established for PTSD
<b>Tricyclic Antidepressants</b>				
Imipramine Amitriptyline Desipramine Nortriptyline Protriptyline Clomipramine	150 – 300 mg/d 150 – 300 mg/d 100 – 300 mg/d 50 – 150 mg/d 30 – 60 mg/d 150 – 250 mg/d	<b>Contraindications</b> • Clomipramine – seizure disorder • MAOI use within 14 days • Acute MI within 3 months <b>Relative Contraindications</b> • Coronary artery disease • Prostatic enlargement	• Anticholinergic effects • Orthostatic hypotension • Increased heart rate • Ventricular arrhythmias	• Therapeutic blood levels not established for PTSD • Desipramine and nortriptyline have lower rate of anticholinergic and hypotensive effects
<b>Monoamine Oxidase Inhibitors</b>				
Phenelzine Tranylcypromine	Target 1 mg/kg/d Target 0.7 mg/kg/d	<b>Contraindications</b> • All antidepressants within 7 days of start of a MAOI, except fluoxetine is 5 weeks • CNS stimulants and decongestants	• Hypertensive crisis with drug/tyramine interactions • Bradycardia • Orthostatic hypotension • Insomnia	• Patient must maintain tyramine-free diet • Doses should be taken in the morning to reduce insomnia
<b>Sympatholytics</b>				
Propranolol Prazosin	40 mg/d Target 6 – 10 mg/d Start with 1 mg at bedtime and increase as blood pressure allows.	Propranolol – sinus bradycardia, congestive heart failure	• Propranolol – hypotension, bronchospasm, bradycardia • Prazosin – first dose syncope	• Propranolol has only been used in a single dose for prevention of PTSD • Prazosin primarily used for management of recurrent distressing dreams
<b>Novel Antidepressants</b>				
Bupropion Nefazodone Trazodone Venlafaxine	150 – 450 mg/d 300 – 600 mg/d 300 – 600 mg/d 150 – 375 mg/d	<b>Contraindications</b> • MAOI use within 14 days • Bupropion – single doses of regular-release >150 mg/d and total daily dose >450 mg/d. Reduce dose in low-weight patients – seizure disorder – anorexia/bulimia	• Trazodone and nefazodone – sedation, rare priapism • Venlafaxine – hypertension in patients with pre-existing hypertension • Nefazodone – hepatotoxicity	• Need to taper venlafaxine to prevent rebound signs/symptoms • The group has a lower rate of sexual dysfunction compared to SSRIs • Obtain baseline & periodic LFTs when treating with nefazodone

**Table B3: Drug Details Table (Cont.)**

Agent	Oral Dose	Absolute/Relative Contraindications	Adverse Events	Remarks
<b>Anticonvulsants</b>				
Carbamazepine	Target 400 - 1600 mg/d	• Bone marrow suppression, particularly leukopenia	• Leukopenia, SIADH, drowsiness, ataxia	Therapeutic blood levels are not established for PTSD, but blood level monitoring may be useful in cases of suspected toxicity
Gabapentin	Target 300 - 3600 mg/d	• Renal impairment	• Sedation, ataxia	
Lamotrigine	Target 25 - 500 mg/d Start 25 mg qod x 2 weeks, then 25 mg qd x 2 weeks, then 25 - 50 mg qd q1-2 weeks to 400 mg/d or as tolerated.	• Increased rash with valproate; max dose of 200 mg	• Stevens - Johnson syndrome, fatigue	
Topiramate	Target 200 - 400 mg/d. Start with 25 - 50 mg/d and increase by 15 - 50 mg/week to maximum dose or as tolerated	• Hepatic impairment	• Angle closure glaucoma, secondary, sedation, dizziness, ataxia	
Valproate	Target 10 - 15 mg/kg/d	• Impaired liver function, thrombocytopenia	• Nausea/vomiting, sedation, ataxia, thrombocytopenia	
<b>Benzodiazepines</b>				
Clonazepam  Lorazepam Alprazolam Diazepam	Start - 0.25 mg bid, increase by 0.25 mg q 1-2 days; maximum 20 mg/d  2 - 4 mg/d 1.5 - 6 mg/d 10 - 40 mg/d	• Caution in elderly patients and patients with impaired liver function. • Risk of abuse in patients with history of substance abuse	• Sedation • Memory impairment • Ataxia • Dependence	• If doses sustained > 2 months at therapeutic doses, then drug should be tapered over 4-week period • Alprazolam – concern with rebound anxiety
<b>Typical antipsychotics</b>				
Chlorpromazine Haloperidol Thioridazine	100 – 800 mg/d 2 – 20 mg/d 100 – 800 mg/d	<b>Contraindication</b> • Parkinson's disease • QT corrected (QTc) prolongation	• Sedation • Orthostatic hypotension with chlorpromazine, thioridazine • Akathisia • Dystonia • Drug-induced parkinsonism • Tardive dyskinesia may occur with all antipsychotics with long-term use. • Neuroleptic malignant syndrome • QTc changes	• Therapeutic doses not established in the treatment of PTSD • Use should be well justified in medical record because of the risk of tardive dyskinesia. • Maximum daily dose of thioridazine is 800 mg/d because of pigmentary retinopathy

**Table B3: Drug Details Table (Cont.)**

Agent	Oral Dose	Absolute/Relative Contraindications	Adverse Events	Remarks
<b>Atypical antipsychotics</b>				
Olanzapine Quetiapine Risperidone	5 – 20 mg/d 300 – 800 mg/d 1 – 6 mg/d	<u>Relative contraindication</u> • Parkinson's disease	<ul style="list-style-type: none"> <li>• Sedation</li> <li>• Weight gain</li> <li>• Neuroleptic malignant syndrome</li> <li>• Higher doses may cause akathisia, drug-induced parkinsonism, especially with risperidone doses &gt;6 mg/d</li> </ul>	<ul style="list-style-type: none"> <li>• Therapeutic doses not established for PTSD</li> <li>• Weight gain occurs with all agents; however, olanzapine produces significantly greater gain</li> <li>• The relative risk of tardive dyskinesia compared to typical antipsychotics has not been established for these agents</li> <li>• Monitor for development of diabetes/hyperglycemia</li> </ul>
<b>Non-benzodiazepine</b>				
<i>Hypnotics</i> - Zaleplon - Zolpidem	5 – 10 mg/d 5 – 10 mg/d	<ul style="list-style-type: none"> <li>• Caution with alcohol/drug abuse history</li> <li>• Caution in elderly and patients with liver dysfunction</li> </ul>	<ul style="list-style-type: none"> <li>• Sedation</li> <li>• Ataxia</li> <li>• Rebound insomnia may occur</li> </ul>	<ul style="list-style-type: none"> <li>• Abuse has occurred resulting in withdrawal reactions</li> </ul>
<i>Anti-anxiety</i> - Buspirone	20 – 60 mg/d	<u>Contraindication</u> • MAOI use within 14 days	<ul style="list-style-type: none"> <li>• Nausea</li> <li>• headache</li> </ul>	<ul style="list-style-type: none"> <li>• Abuse has occurred resulting in withdrawal reactions</li> </ul>

**C. PSYCHOTHERAPY INTERVENTIONS**

**Table C1: Summary Table**

R	Significant Benefit	Some Benefit	Unknown	No Benefit/Harm
<b>A</b>	Cognitive Therapy [CT] Exposure Therapy [ET] Stress Inoculation Training [SIT] Eye Movement Desensitization and Reprocessing [EMDR]			
<b>B</b>		Imagery Rehearsal Therapy [IRT] Psychodynamic Therapy		
<b>C</b>				
<b>I</b>		PTSD - Patient Education		
<b>D</b>				

R = level of recommendation (see page 15)

**Table C2. Adjunctive Treatments**

<b>B</b>	Dialectical Behavioral Therapy [DBT]		
<b>B</b>	Hypnosis		

**Table C3. Adjunctive Problem-Focused Methods/Services**

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

**Hospitalization:**

There have been no satisfactory studies on **inpatient** treatment for patients with PTSD in trauma related conditions. Clinical consensus supports that it is appropriate for crisis intervention, management of complex diagnostic cases, delivery of emotionally intense therapeutic procedures, and relapse prevention.

## 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]

*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.*

**Supportive psychotherapy** is not considered to be effective for the treatment of PTSD. However, if the patient has reasonable control over his/her symptoms and is not in severe and acute distress, the goal may be to prevent relapse and supportive therapy may be helpful in that endeavor. Or, for the patient with certain co-morbid disorders, supportive therapy may be all they can tolerate without causing additional harm. Psychodynamic, interpersonal, experiential (e.g., Gestalt therapy), and many other approaches may also be beneficial parts of an effectively integrated approach. Most experienced therapists integrate diverse therapies, which are not mutually exclusive in a fashion that is designed to be especially beneficial to a given patient.

## THE PSYCHOTHERAPY INTERVENTIONS

### 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 SSRI to the regimen of ongoing psychotherapy.

### **B. Cognitive Therapy (CT)**

Aaron Beck, at the University of Pennsylvania, developed Cognitive Therapy as a structured, short term, present-oriented psychotherapy for depression. It is an approach that focuses on improving mood by modifying dysfunctional thinking and behavior. Beck and others have successfully adapted CT to the treatment of a diverse set of psychiatric disorders, including PTSD.

CT for PTSD typically begins with an introduction of how thoughts affect emotions and behavior. The cognitive model of change and expectations for participation in therapy is reviewed. Early in treatment, new skills to identify and clarify patterns of thinking are taught using techniques such as recording thoughts about significant events, identifying distressing trauma-related thoughts

and converting such dysfunctional thought patterns into more accurate thoughts. CT also emphasizes the identification and modification of distorted core beliefs about self, others and the larger world. CT teaches that improved accuracy of thoughts and beliefs about self, others and the world leads to improved mood and functioning.

### **C. Exposure Therapy (ET)**

Randomized control trials have shown that Exposure Therapy helps men and women with PTSD reduce the fear associated with their experience through repetitive, therapist-guided confrontation of feared places, situations, memories, thoughts, and feelings. ET usually lasts from 8 to 12 sessions depending on the trauma and treatment protocol. Patients are repeatedly exposed to their own individualized fear stimuli, until their arousal and fear responses are consistently diminished. In session, exposure is often supplemented by therapist-assigned and monitored self-exposure to the memories or situations associated with traumatization. ET providers can vary the pacing and intensity of exposing patients to the most frightening details of their trauma based on the patient’s emotional response to the trauma and to the therapy itself.

Exposure can be accomplished via “imaginal” exposure or “in vivo” exposure. Imaginal exposure involves encouraging the patient to revisit the experience in imagination, recalling the experience through verbally describing the emotional details of the trauma. In vivo exposure involves asking the patient to physically confront realistically safe but still feared stimuli (e.g. driving a car after having been in a serious motor vehicle accident). This exposure can also be arranged in a hierarchical fashion. In the preceding example the patient might first sit in a car in the passenger seat, and then in the driver’s seat, and then start the car, etc. The patient repeats each situation until a reduction in the intensity of emotional and physiological response is achieved, at which point, they move on to the next item in their hierarchy.

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

Stress Inoculation Training is a type of CBT that can be thought of as a tool box or set of skills for managing anxiety and stress. This treatment was developed for the management of anxiety symptoms and adapted for treating women rape trauma survivors. SIT typically consists of education and training of coping skills, including deep muscle relaxation training, breathing control, assertiveness, role playing, covert modeling, thought stopping, positive thinking, and self-talk. The rationale for this treatment is that trauma related anxiety can generalize to many situations. The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder notes that anxiety management is among the most useful psychotherapeutic treatments for patients.

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

EMDR is a psychotherapy treatment that was originally designed to alleviate the distress associated with traumatic memories. The developer of EMDR, psychologist Dr. Francine Shapiro, proposes the idea that EMDR facilitates the accessing and processing of traumatic memories to bring these to an adaptive resolution. The possibility of obtaining significant clinical improvements in PTSD in a few sessions presents this treatment method as an attractive modality worthy of consideration.

During EMDR, the patient is asked to identify: (1) a disturbing image that encapsulates the worst part of the traumatic event; (2) associated body sensations; (3) a negative self-referring cognition (in concise words) that expresses what the patient “learned” from the trauma; (4) a positive self-referring cognition that the patient wishes could replace the negative cognition. The patient is then asked to hold the disturbing image, sensations, and the negative cognition in mind while tracking the clinician’s moving finger back and forth in front of his or her visual field for about 20 seconds. In successive tracking episodes, the patient concentrates on whatever changes or new associations have occurred. Tracking episodes are repeated according to the protocol until the patient has no further changes. More tracking episodes reinforce the positive cognition.

Between sessions, the patient is directed to keep a journal of any situations that provoke PTSD symptoms and of any insights or dreams about the trauma. The sessions required may be as few as two for uncomplicated PTSD. More sessions are required for multiple or more complicated trauma.

Standard CBT rating scales are used throughout the sessions to document changes in the intensity of the symptoms and the negative cognition and the patient’s belief in the positive cognition. The patient only needs to tell the therapist the concise negative and positive cognitions and whether (and what) cognition, image, emotion, or body sensation has changed. The therapist is close to the patient and maintains direct eye contact as part of the protocol. This fosters a non-directive interaction that usually detects adverse reactions, which the therapist helps the patient manage with cognitive techniques. EMDR processing is internal to the patient, who does not have to reveal the traumatic event.

The protocol allows for substitution of left-right alternating tone or touch as alternatives in place of the eye movements. Studies attempting to ascertain the relative contribution of the eye-movement component have suggested comparable treatment results with or without eye movements, indicating that this aspect of the treatment protocol may not be critical to effectiveness.

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

Occurrence of nightmare as a problem is frequent; 4 to 8 percent in the general population and 60 percent in PTSD. Evidence shows that nightmares are associated with psychological distress and sleep impairment. A conditioning pattern similar to classic psychophysiological insomnia is produced in the nightmare disturbed loop, along with the negative cognition of “fear of going to sleep.” Studies using brief CBT (desensitization and imagery rehearsal) have demonstrated large reduction in nightmares. Many studies, including Forbes et al. (2001), suggest that PTSD is associated with a propensity toward image, particularly where the posttraumatic symptom picture is characterized by nightmares and flashbacks. IRT incorporates a system to increase the imagery control.

IRT is aimed at changing the content of the patient's nightmare to promote mastery over the content-threat, thereby altering the meaning, importance, and orientation to the nightmare. The key to successful treatment is the use of imagery. IRT focuses on the following main approaches:

- Deemphasizes exposure by avoiding discussion of trauma or traumatic content of nightmares
- Focuses on habitual components of disturbing dreams and sleeplessness
- Provides no group psychotherapy
- Offers minimal instruction for dealing with unpleasant imagery
- Emphasizes relaxation
- Conveys no specific non-sleep-related instructions for managing posttraumatic stress, anxiety or depressive symptoms

### **G. Psychodynamic Therapy**

In 1895, Joseph Breuer and Sigmund Freud based their studies on hysteria on the proposition that traumatic life events can cause mental disorder. This principle, radical for its time, grew in scope and application over the next century and strongly influenced military psychiatry in World War I and World War II. Psychodynamic principles were later applied to the psychological problems of Holocaust survivors, Vietnam veterans, rape survivors, adult survivors of childhood sexual trauma, and survivors of other traumatic events. Psychodynamic ideas have also helped providers manage the sometimes complex issues that may surface in the relationship between survivor and psychotherapist. The following statements summarize the basic elements of psychodynamic psychotherapy:

- Based on the assumption that addressing unconscious mental contents and conflicts (including those that may have been blocked from consciousness as part of a maladaptive response) can help survivors better cope with the effects of psychological trauma
- Explores psychological meanings of posttraumatic responses by sifting and sorting through fears, fantasies, and defenses stirred up by the traumatic event

- Spans a continuum ranging from supportive to expressive but usually includes a mixture of both
- Transference and countertransference are recognized and managed by the therapist but may or may not be brought to the patient's attention
- Approached within the context of a therapeutic relationship that emphasizes safety and honesty and which is, in itself, a crucial factor in the patient's response

Course of treatment for psychodynamic therapy:

- Most commonly involves one to two meetings per week and can be relatively short term (10 to 20 sessions), focal or long term (lasting years) and open ended
- Sessions usually last 45 to 50 minutes and, although they average once a week, may be held more or less frequently depending on the patient's needs and tolerance
- Can be conducted individually, in groups or in family settings on an inpatient or outpatient basis

### **H. Patient Education**

Psychoeducation is a broad term that is often included as a component of other treatment interventions. The expert consensus guidelines on PTSD describe psychoeducation as educating patients and their families about the symptoms of PTSD and the various treatments that are available. They note that it is a useful adjunct therapy for patients with PTSD. In addition to education, reassurance is given that trauma related symptoms are normal and expectable shortly after a trauma and can often be overcome with time and treatment. Education about the symptoms and treatment of comorbid disorders may also be included. Psychoeducational group treatment models for PTSD treatment have been described for women with multiple traumas as well as combat veterans.

### **I. Group Therapy**

The material in this annotation is taken primarily from David Foy and colleagues' discussion of Group Therapy in the recent practice guideline, *Effective Treatment for PTSD* (Foy et al., 2000). This guideline represents the most recent and most comprehensive review of current treatments for PTSD available in the literature.

The authors briefly review the use of group therapy for PTSD. They note that it first began to be used as a “front-line treatment” for PTSD in the 1970’s, and that it has continued to be used and researched up to the present. They note the intuitive appeal of providing this form of therapy to patients who, by the nature of their disorder, have to deal with “isolation, alienation and diminished feelings”. They further acknowledge the possibility that group therapy may foster “survivor helping survivor” feelings in participants.

Foy characterize group approaches as “supportive,” “psychodynamic” or “cognitive-behavioral.” While all three approaches share certain features such as homogeneous groups, acknowledgement of the trauma and normalization of traumatic response, they also differ in significant ways:

#### Supportive approach

- “Covering” approach in which the emphasis is placed on addressing current life issues
- Interventions explore middle-range affects such as frustration, with the goal of diffusing more extreme affects
- Less reliance on formal content or structured materials than psychodynamic or cognitive-behavioral groups
- Low demand on clients for homework or mastery of materials
- Designed to maintain a sense of interpersonal comfort and to keep transference at a low to moderate level
- Orients members toward current coping
- Can be conducted in a range of clinical and paraclinical settings

#### Psychodynamic (“trauma focus”) approach

- “Uncovering” approach designed to address members’ specific traumatic experiences and memories
- Helps patients find meaning in the traumatic experience
- Encourages patients to confront the continuing issues presented by the experience
- Allows patients to trace painful affects back to their self-views and views of others, which may be irrational

- Seeks to provide appropriate affective involvement, monitored to control any overwhelming feelings and to offset the risk for precipitating dissociative reactions

#### Cognitive-behavioral (“trauma focus”) approach

- “Uncovering” approach designed to address members’ specific traumatic experiences and memories
- Primary goals are to reduce symptoms, enhance members’ self-control and improve quality of life
- Emphasizes application of systematic, prolonged exposure and cognitive restructuring to each individual’s traumatic experience
- Provides relapse prevention training through emphasis on mobilizing coping resources
- May feature an autobiographical emphasis
- Incorporates trauma processing

#### RECOMMENDATIONS

1. Consider group treatment for patients with PTSD
2. Current findings do not favor any particular type of group therapy over other types.

#### **J. Dialectical Behavior Therapy (DBT)**

Dialectical Behavior Therapy is a comprehensive cognitive-behavioral treatment for complex, difficult-to-treat mental disorders, specifically designed to treat chronically suicidal individuals, and patients with multi-disordered individuals with borderline personality disorder (BPD).

DBT has since been adapted for other seemingly intractable behavioral disorders involving emotion dysregulation, including substance dependence in individuals with BPD and binge eating, to other clinical populations (e.g., depressed, suicidal adolescents) and to a variety of settings (e.g., inpatient, partial hospitalization, forensic).

While considerable evidence supports the use of exposure-based treatment for PTSD, its utilization may pose some problems for patients where the symptoms of PTSD are complicated. High rates of attrition, suicidality, dissociation, destructive impulsivity, and chaotic life problems are reasons cited by clinicians for abandoning empirically supported exposure treatment. Some

practitioners have suggest that the approach of DBT, designed to address many of these issues, offers useful strategies for addressing the needs of patients considered poor candidates for exposure therapy.

The DBT approach incorporates what is valuable from other forms of therapy and is based on a clear acknowledgement of the value of a strong relationship between therapist and patient. Therapy is structured in stages and at each stage, a clear hierarchy of targets is defined. The techniques used in DBT are extensive and varied, addressing essentially every aspect of therapy. These techniques are underpinned by a dialectical philosophy that recommends a balanced, flexible and systemic approach to the work of therapy. Patients are helped to understand their problem behaviors and then deal with situations more effectively. They are taught the necessary skills to enable them to do so and helped to deal with any problems that they may have in applying those skills. Advice and support is available between sessions. Patients are encouraged and helped to take responsibility for dealing with life's challenges.

### **K. Hypnosis**

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

#### **BACKGROUND**

Hypnosis is not a therapy per se, but an adjunct to psychodynamic, cognitive-behavioral or other therapies, and has been shown to enhance significantly their efficacy for a variety of clinical conditions. In the specific context of posttraumatic symptomatology, hypnotic techniques have been used for the psychological treatment of shell shock, battle fatigue, traumatic neuroses, and more recently, PTSD, and dissociative symptomatology.

Hypnosis is defined by the APA as “a procedure during which a health professional or researcher suggests that a client, patient or subject experience changes in sensations, perceptions, thought, or behavior. The hypnotic context is generally established by an induction procedure. An induction procedure typically entails instructions to disregard extraneous concerns and focus on the experiences and behaviors that the therapist suggests or that may arise spontaneously.

Hypnosis should only be used by credentialed health care professionals, who are properly trained in the clinical use of hypnosis and who are working within the areas of their professional expertise.

### **L. Psychosocial Adjunctive Methods/Services**

Patients with chronic PTSD may develop a persistent incapacitating mental illness marked by severe and intolerable symptoms; marital, social, and vocational disability; and extensive use of psychiatric and community services. These patients may sometimes benefit more from case management and psychosocial rehabilitation than from psycho-or pharmacotherapy.

#### **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 the identified 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. Since psychosocial rehabilitation is not trauma-focused, it should occur concurrently or shortly after a course of treatment for PTSD.

### **M. Spiritual Support**

Spiritual and existential issues: “Given the complex range of PTSD symptomatology, a successful treatment program will address not only the emotional issues that characterize the disorder but also its psychophysiological, cognitive and interpersonal processes and existential meanings” (Hunter, 1996).

#### **RECOMMENDATIONS**

Provide access to religious/spiritual resources, if sought.

### **Level of 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