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## Treatment for PTSD: Clinical Practice Guidelines and steps toward further knowledge

The Department of Veterans Affairs (VA) has an overall commitment to providing evidence-based treatment in a context in which the clinician and patient together explore the symptoms and diagnosis, the goals of the patient, the array of possible interventions that may be helpful, and the patient's preference among interventions that can be recommended based on the available evidence. VA develops Clinical Practice Guidelines (CPGs) in conjunction with the Department of Defense (DOD) on a wide array of healthcare issues, including several mental health diagnoses and problems. This process is exemplary—it is fully interdisciplinary as well as interdepartmental across VA and DOD, input from stakeholders is invited in the process, and the process has a clearly defined methodology for identifying all evidence that should be reviewed in developing the CPG and for evaluating the level of evidence found in all relevant literature. The resulting CPGs are thoughtful, data-driven documents that guide assessment and disease management and, when possible, prevention of disorders. Thus, VA, in full collaboration with DOD, has been a leader in organizing important documents to guide clinical decision-making.

It is important to note that “guiding” clinical decision making is exactly what is meant. As noted on the Web site (<http://www.healthquality.va.gov/index.asp>) that describes the CPG process, “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 to provide information and assist decision making.” In addition, and increasingly in VA, it is not just the provider’s judgment but also the preferences of the patient that must be used in making final treatment planning decisions.

The revised *VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress* was published in 2010, as an update from the original 2004 CPG for Post-traumatic Stress disorder (PTSD); it can be accessed at [http://www.healthquality.va.gov/ptsd/ptsd\\_full.pdf](http://www.healthquality.va.gov/ptsd/ptsd_full.pdf) [1]. It is an excellent exemplar of the principles outlined here. It reviewed evidence on diagnosis, treatment, and early intervention to prevent PTSD that was published between January 2002 and August 2009. It also drew heavily on other literature reviews and guidelines related to PTSD, including the guidelines developed by the International Society for Traumatic Stress Studies (ISTSS) [2] and a thorough review of PTSD treatment conducted by the Institute of Medicine [3].

In particular, the VA/DOD Working Group adopted several recommendations that mirror those of the ISTSS guideline.

In addition to providing guidance on assessment and treatment of PTSD, the 2010 CPG also provides extensive review and guidelines related to acute stress reaction. The full specific components of the CPG begin with a review of acute stress reaction/disorder (Algorithm A), covering assessment, treatment (early intervention, specifically), re-assessment, and follow-up, to detect possible development of an acute stress reaction into PTSD. The next module covers management of PTSD, progressing from assessment to triage management of the patient, to planning and implementing treatment, to re-assessment. The final module provides additional information on the specific treatments with the strongest evidence base for acute stress reaction and PTSD. This section again presents possible early interventions, this time with specific documentation of which interventions have the strongest evidence base and which are not recommended because of possible negative effects. Similar information for PTSD treatment is provided, broken down into the specific evidence regarding psychotherapy, pharmacotherapy, adjunctive services, somatic treatment, and complementary and alternative medicine approaches. Finally, this module also covers treatment for some prominent symptoms of PTSD that may be a focus of treatment, either independently or as part of an overall treatment plan. These specific common symptoms are (1) sleep disturbances, (2) pain, and (3) the grouping of irritability, severe agitation, or anger.

Taken as a whole, the 2010 CPG covers a full range of responses to acute stress, starting with possible early interventions following an acute episode of stress, through comprehensive treatment of PTSD, and with guidance regarding specific symptoms that may need special attention in addition to, or as an alternative to, primary treatment of PTSD. We feel that the new CPG truly advances the guidance to the field, with its increased focus on issues beyond simply the most effective, traditional treatments for PTSD alone. Certainly, VA shares the commitment to

(and is likely leading the United States in) dissemination of knowledge and awareness of evidence-based treatments with the most empirical support, such as prolonged exposure and cognitive processing therapy. However, we also recognize that the clinical presentations of individuals who have experienced traumatic events are complex. It is the uncommon client who presents simply with PTSD that is not comorbid with at least one other behavioral or physical health problem.

If such guidelines are to remain relevant to practicing clinicians, they must increasingly provide recommendations for adjustments that should or should not be made when clients present with common comorbidities, such as pain, insomnia, anger, substance use disorders, or traumatic brain injury (TBI). Thus, we laud the new guidelines for beginning to lay out the existing evidence for treatment of these co-occurring problems in the presence of PTSD. Although the evidence base in many of these areas is not yet mature, it is important to provide what information is there, as well as to signal to the field that these issues are recognized and important to address. Even those clinicians who are fully trained and competent in the provision of evidence-based treatment for PTSD frequently indicate that they are not sure what they should do when clients have significant co-occurring problems with substance use or the sequelae of mild TBI. It will be important to support ongoing research that can provide guidance about whether traditional treatments for PTSD should be used with these more complex cases, either with or without modifications. It is our hope that as these new research findings come in, the CPG process will be able to adapt and provide more detailed suggestions to the field over time. The current CPG underscores the importance of fully integrated and coordinated care in the presence of these complex comorbidities, which are more often the rule than the exception.

This important, thorough package was developed by an outstanding interdisciplinary team, cochaired on the VA side by Matthew Friedman, MD, PhD, the Director of the executive Division of VA's National Center for PTSD (NCPTSD), and Josef Ruzek, PhD,

Director of the NCPTSD Division on Dissemination and Training. On the DOD side, the guideline development group was cochaired by COL Patrick Lowry, MD. The group that contributed to development and review of the CPG included psychiatrists, psychologists, pharmacists, nurses, and social workers. Having a document like this that is not focused on the interests of any single profession, but rather supports the inherently interprofessional nature of VA health care is vitally important. This is captured at various points in the guideline. For example, in planning care for a Veteran or servicemember diagnosed with PTSD, a key element of the CPG guides practitioners to, “Develop collaborative interdisciplinary treatment plan; determine optimal setting for care.”

The PTSD CPG also provides explicit recognition that this is a “guideline,” not a prescriptive document. Specifically, this statement appears in the guideline, and its spirit also is captured at various other places in the CPG: “**Disclaimer:** This Clinical Practice Guideline is intended for use only as a tool to assist a clinician/healthcare professional and should not be used to replace clinical judgment.” Good clinicians and clinical teams need information that can support clinical decision-making—but such decision-making is still essential to planning individualized care that fits the specific patient.

Also supporting such individualized care, the PTSD CPG builds in the importance of a patient-centered approach to care throughout the document. For example, the guideline indicates that the following steps are key in care planning: “Educate patient and family about PTSD; discuss treatment options and resources; arrive at shared decision regarding goals, expectations and treatment.” It also guides providers to ask the Veteran (in the case of patients seen in VA) whether he or she prefers to be treated for PTSD in primary care or specialty care. This is a major step forward from earlier CPGs, which were more focused on laying out for the provider the evidence base on which to base a decision about appropriate treatments. Laying out the evidence for possible treatment approaches is certainly the core function of the CPG. However, as treatment options

that have the potential to be effective increase, it is both more possible and more essential to lay out all of the options for Veterans and allow them to take a very active role in deciding how various options fit with their goals, strengths, challenges, etc.

It is important that these guidelines continue to evolve and include information about settings and modes of care that are considered relevant or potentially desired by the client and that move beyond traditional, individual mental health treatment settings. For example, many Veterans indicate that they are interested in having their family members more involved in PTSD treatment [4], and VA has expanded authority to provide such care; however, there is very little empirical evidence to guide exactly how clinicians and treatment settings may effectively adapt to these preferences. Monson and Brown-Bowers (this issue) lay out additional information beyond what was captured in the CPG that is important to consider in this emerging area. Furthermore, many Veterans and servicemembers indicate informally that they are interested in complementary and alternative medicine approaches to treatment of PTSD, such as acupuncture or meditation. Although the literature is not yet ripe for broad implementation of these approaches, the inclusion of the current state of the science in this CPG is an important advancement.

It is still the responsibility of the provider to educate the patient on PTSD, possible treatments, and the evidence that they can be effective. It also is the responsibility of the provider to be able to effectively deliver the treatments that are rated most highly in the guideline or to be able to make good referrals to those who can provide them. When the provider and the Veteran determine collaboratively what the individual treatment plan will be, the provider also is responsible for ensuring that the appropriate resources needed to implement the overall treatment plan are made available to the Veteran. These responsibilities are well described in the 2010 PTSD CPG.

Given the support of the VA Office of Mental Health Services (OMHS) for the 2010 PTSD CPG, we also have put effort into turning that support into action. The responsibilities of the OMHS, or any other

office, are not described in any way in the CPG, but we recognize the importance of ensuring a proactive role to help clinicians in the field know and use the guidance in this document. We have particularly taken a lead role in identifying the training needs of VA's mental health work force and developing training programs to target those needs, using extensive resources. The second editorial in this special issue, by Dr. Brad Karlin, lays out those actions in more detail. In addition, the NCPTSD, which reports to OMHS, has developed invaluable approaches to mentoring and training VA's mental health providers. They have developed a national mentoring program to share best practices in delivering the kind of care outlined in the CPG. This program involves every Veterans Integrated Service Network (VISN) in VA, with identified mentors in every VISN who work closely with the other facilities in that VISN to provide tailored support and guidance to improve quality of and access to PTSD treatment at each facility. Nationally, the NCPTSD provides extensive support and guidance for the mentoring sites. The NCPTSD also has a national Consultation Service that can be accessed by any site or individual provider, to help with specific situations in which their expertise can be vital. Finally, the NCPTSD has a monthly telephone conference for interested VA clinicians that is focused specifically on training related to specific provisions of the CPG. OMHS disseminates information about this series, helps identify relevant speakers, and participates on the Steering Committee that plans and implements this series.

In many ways, this special issue is a culmination of these efforts, and we are delighted to introduce the articles included. They lay out important advances in care for PTSD that exemplify the approach presented in the 2010 PTSD CPG. We hope that you will learn from this series, that your learning will influence how you think about your clinical work, and that your practice will be influenced by the guidance available in the 2010 PTSD CPG and this important special issue, whether you practice in VA or any other setting. Providing the best possible care for acute stress reactions and PTSD is crucial to the care of those who have served our country, when that service

has resulted in problematic responses to stress. This is true in VA and has been a major focus of our efforts to transform VA mental health care over the last several years, and it is also true for Veterans who are served by community providers. We are all partners in striving to provide the best possible, evidence-based, patient-centered care.

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