JAMA Clinical Guidelines Synopsis

Management of Posttraumatic Stress Disorder

Michael J. Ostacher, MD, MPH, MMSc; Adam S. Cifu, MD

GUIDELINE TITLE VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder

RELEASE DATE June 2017

PRIOR VERSIONS 2010, 2004

DEVELOPER US Department of Veterans Affairs, US Department of Defense (VA/DoD)

FUNDING SOURCE VA/DoD

TARGET POPULATION Adults within the VA/DoD with exposure to traumatic events who have suspected posttraumatic stress disorder (PTSD) or acute stress disorder

MAJOR RECOMMENDATIONS

- IIndividual, manualized trauma-focused psychotherapy (TFP) that has a primary component of exposure and/or cognitive restructuring is recommended over pharmacologic and other nonpharmacologic interventions for primary treatment of PTSD (strong recommendation; quality of evidence not stated).
- When individual TFP is not readily available or not preferred by a patient, pharmacotherapy with sertraline, paroxetine, fluoxetine, or venlafaxine (weak recommendation; moderate-quality evidence) or individual non–trauma-based psychotherapy (weak recommendation; quality of evidence not stated) is recommended. There is insufficient evidence to recommend pharmacotherapy over non–trauma-based psychotherapy.
- The guideline recommends against prazosin as monotherapy or adjunctive pharmacotherapy for PTSD (weak recommendation; moderate-quality evidence) and makes no recommendation for or against prazosin for PTSD-related nightmares (moderate-quality evidence).
- The guideline recommends against or strongly against a long list of other medications including antidepressants, antipsychotics, and antiepileptics.
- The guideline states that there is insufficient evidence to recommend combination psychotherapy and pharmacotherapy.

Summary of the Clinical Problem

Individuals who have been personally or indirectly exposed to actual or threatened death, serious injury, or sexual violence have a wide range of psychological responses, from transient, nondebilitating reactions to symptoms that meet the *Diagnostic and Statistical Manual of Mental Disorders* (Fifth Edition) criteria for acute stress disorder or PTSD. Between 6% and 7% of adults in the US general population are estimated to experience PTSD during their lifetime. The prevalence is higher in women than in men. In 2016, 10.6% of veterans receiving care in the Veterans Health Administration had a diagnosis of PTSD. Among veterans who served in Iraq and/or Afghanistan, 26.7% of those seeking care in the Veterans Health Administration receive a PTSD diagnosis.[1]

Characteristics of the Guideline Source

The guideline was developed and funded by the VA/DoD, whose Evidence-Based Practice Work Group formed a PTSD Clinical Practice Guideline Work Group.[1] This group consisted of clinical leaders who lead guideline development and dissemination across the national VA/DoD health care systems and subject experts within the VA/DoD who recruited experts in a wide range of specialties and clinical areas of interest (**Table**). The task force was required to disclose any potential conflicts of interest; none were reported during the process.

A modified version of the GRADE methodology was used to assess the quality of the evidence base. A strong recommendation indicates that the group was highly confident about the balance between desirable and undesirable outcomes; if the group was less confident of this balance, they assigned a weak recommendation. A recommendation for a therapy indicates that benefits outweighed harms, while a recommendation against therapy indicates that harms outweigh benefits. If there was insufficient evidence, no recommendation was made.

Evidence Base

Twelve key questions were identified. The literature review, which updated the 2010 clinical practice guideline, included studies published between January 2009 and March 2016. There were 122 studies addressing 1 or more of the key questions. For the key questions addressed in this synopsis, the review included systematic reviews of randomized trials and individual randomized trials not evaluated in systematic reviews.

Table. Guideline Rating

Rating Standard	Rating
Establishing transparency	Good
Management of conflict of interest in the guideline development group	Good
Guideline development group composition	Good
Clinical practice guideline–systematic review intersection	Good
Establishing evidence foundations and rating strength for each of the guideline recommendations	Good
Articulation of recommendations	Good
External review	Fair
Updating	Good
Implementation issues	Fair

The recommendation for TFP was made on the basis of several meta-analyses, each of which suggested that the effect size is larger for TFP vs pharmacologic interventions or other forms of therapy and that the benefits of TFP are longer-lived.[2,3] The recommendation of TFP as preferable to medications was made even though medication use was common in patients in TFP studies.[2] The effect sizes for many forms of psychotherapy may be inflated by their comparison with wait-list controls rather than with active treatment.[4,5] For example, a recent study found that TFP was no more effective than non–trauma-based psychotherapy delivered with similar intensity.[6]

The recommendation for individual non–trauma-based psychotherapy as equivalent to antidepressant monotherapy is based on a comparison of effect sizes.[2] The quality of evidence for this recommendation was low.

The recommendation against use of prazosin for PTSD is based on data that adjunctive prazosin offered no benefit compared with placebo in reducing symptoms or improving functioning in veterans with PTSD.[7] The authors do not recommend for or against prazosin use for PTSD-related nightmares.

The recommendation against use of other medications is based on a lack of quality evidence for their use coupled with a probability of harm. This recommendation is particularly strong for risperidone (which has good-quality evidence showing no benefit but clear harm) and for benzodiazepines (for which evidence of harm exists) but also includes recommendations against cannabis and cannabis derivatives, all anticonvulsants, all antipsychotics, and many antidepressants.

Benefits and Harms

Many off-label therapies have been used to treat PTSD. The benefit of this guideline is that it identifies the therapies supported by the strongest evidence (TFP and a limited number of psychopharmacologic treatments) and therapies with weaker benefits but limited harms (non–trauma-based psychotherapy). Non–US Food and Drug Administration–approved use of most pharmacotherapies in current use for PTSD is not recommended because the risks outweigh the limited, uncertain, or absent benefits. A potential harm of this guideline is that it might reduce use of novel treatments for patients who do not respond to evidence-based therapies. However, current prescribing data suggest that pharmacotherapies not recommended by this guideline are already in widespread use.[8]

Discussion

The primary recommendation for use of individual, manualized TFP—which includes cognitive processing therapy and prolonged exposure therapy—is based on comparisons of effect sizes in meta-analyses and on studies in which the effect may be exaggerated because of methodology (the effect size of psychotherapy is often greater when compared with wait-list controls rather than with active treatment).

The guideline's recommendation against use of prazosin is in contrast to its widespread use in current management of PTSD.[8]

The issue of potential conflict of interest of a guideline written by the DoD and the VA is important to acknowledge. The DoD has an interest in keeping fighting forces at the ready and the VA must adhere to a global budget for delivering care. Accordingly, these interests, as well as substantial reliance on DoD and VA research in a guideline that was funded and developed by these agencies, should be considered in the interpretation of the guideline recommendations.

Areas in Need of Future Study or Ongoing Research

There is a need for easily implemented, safe, and effective treatments for PTSD. Intensive, individual TFP requires specialized training of psychotherapists and time and access on the part of patients. Both patients and physicians need to be highly committed to the process. Many first-line psychotherapies are not used because of the lack of trained mental health care practitioners, the burden to patients, and patient preference. Psychotherapies and medications are either ineffective or only partially effective for large proportions of patients—and few adjunctive therapies are well studied and safe. There remains a need for effective and widely available therapies.

ARTICLE INFORMATION

Author Affiliations: Veterans Administration, Palo Alto HCS, Stanford University School of Medicine, Palo Alto, California (Ostacher); University of Chicago, Chicago, Illinois (Cifu).

Corresponding Author: Adam S. Cifu, MD, University of Chicago, 5841 S Maryland Ave, MC 3051, Chicago, IL 60637 (adamcifu@uchicago.edu).

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