

Posttraumatic Stress Disorder, Part III

Professional Care

In terms of prevention and treatment of PTSD, it is important that evidence-based PTSD therapies be offered to all. Most research has focused on psychotherapies and pharmaceuticals. The following highlights are based on summary recommendations from the [VA/DOD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder](#), which was recently updated.

Overall Recommendations

General Clinical Management. Engage patients in shared decision-making and focus on collaborative care using evidence-based treatments.

Diagnosis and Assessment. Screen periodically with measures like the Primary Care PTSD Screen or the PTSD Checklist. In people with suspected PTSD, offer an appropriate diagnostic evaluation. In people diagnosed with PTSD, use self-report measures to monitor treatment progress.

Prevention. Evidence is limited for psychotherapy or medications in the time immediately after trauma. If someone is diagnosed with acute stress disorder, use Trauma-Focused Psychotherapy that includes exposure and/or cognitive restructuring. (These are described in the next section.) Evidence for medications is insufficient.

Treatment Priorities. Start with individual, manualized, trauma-focused psychotherapy (preferred over drug therapy). Drug therapy or non-trauma-focused psychotherapy can be used if trauma-focused psychotherapy is not available or not preferred by a patient. Certain medications (e.g., serotonin specific reuptake inhibitors, or SSRIs) are preferred, and other drug classes are suggested if those are ineffective.

There is not enough evidence to recommend for or against "...repetitive transcranial magnetic stimulation, electroconvulsive therapy, hyperbaric oxygen therapy, stellate ganglion block, or vagal nerve stimulation."

Acupuncture and other CIH practices are not recommended as *primary* treatments.

Psychotherapies

Psychotherapies, sometimes classed under "Mind and Emotions" as well, are being used with increasing frequency for PTSD, depending on the availability of clinicians trained to offer them. A 2016 review found large effect sizes for an array of therapies, noting that the number needed to treat was <4.¹ More research comparing the different therapies to one another is still needed.

The 2017 VA/DOD guidelines most strongly recommend the following trauma-focused therapies:

Prolonged Exposure Therapy (PET) is built around the idea that repeated exposure to thoughts, situations, and feelings can reduce their power to cause a person distress. It has four main parts, which include education, breathing retraining, practice in real-world situations, and talking through one's trauma.² A 2013 study of 1931 participants found that PET significantly decreased PTSD-related symptoms, as well as depression.³

Cognitive Processing Therapy (CPT). The primary goal of CPT is to improve mood and behavior by making efforts to change thoughts, beliefs, and expectations that are irrational or dysfunctional. Its four main parts include learning about symptoms, enhancing awareness about thoughts and feelings, learning skills to help challenge these thoughts and feelings, and understanding how trauma changes beliefs. Through these steps a person is able to deal with trauma in new ways.⁴

Eye Movement Desensitization and Reprocessing (EMDR). This involves an eight-phase approach for addressing experiences that contribute to PTSD. After taking an elaborate history and helping patients identify a target for the therapy, clinicians have them focus on a particular image, thought or sensation while their eyes follow the clinician's finger through a series of prescribed movements. Other stimuli might also be used.⁵ A 2018 review found trauma-focused EMDR and Cognitive-Behavioral Therapy to be equally efficacious (if not slightly better) at reducing PTSD symptoms.^{6,7} An August 2014 meta-analysis concluded that EMDR Therapy significantly reduces PTSD symptoms, anxiety, depression, and overall distress in people with PTSD.⁸

Other recommended therapies include Cognitive Behavioral Therapies (CBT) tailored specifically to PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and Written Narrative Exposure (WET).

Some non-trauma-focused therapies are also recommended:

Stress Inoculation Training (SIT) takes people through three stages.⁹ In the first, stressors and responses are identified, as are patterns of self-defeating dialog. The second stage, skill acquisition and rehearsal, allows a person to practice new, more rational thought patterns. In the third stage, they practice applying what they have learned in real-life situations. Present-Centered Therapy (PCT) and Interpersonal Psychotherapy (IPT) are also mentioned. Not mentioned in the guidelines but also used for aspects of PTSD care are Imagery Rehearsal Therapy (IRT) involves reducing nightmares by changing the end of remembered nightmares while awake.¹⁰

Psychodynamic Therapy (PT) is defined differently in various studies. Also known as insight-oriented therapy, it focuses on gaining insight into unconscious processes and how they manifest in the way a person behaves.¹¹ It has been used primarily in clinical practice for the treatment of depressive disorders.^{12,13,14} For more information, refer to [GoodTherapy](#) website.

Evidence is insufficient to recommend **other psychotherapies** for PTSD, including Dialectical Behavior Therapy (DBT), Skills Training in Affect and Interpersonal Regulation (STAIR), Acceptance and Commitment Therapy (ACT), Seeking Safety, and supportive counseling.

For more information about each individual therapy, refer to individual PTSD 101 courses on the [National Center for PTSD](#) website. Mental health services have supported the rollout training and dissemination of evidence-based PTSD treatments (CPT and PET) to large numbers of VA clinicians. Additional rollout trainings in the past year in cognitive-behavioral treatments for insomnia and pain, as well as problem-solving skills therapy, assist PTSD patients with recovery. These efforts are supported by didactic lectures in both psychotherapy and pharmacotherapy of PTSD, organized by the National Center for PTSD, as well as a broad array of educational courses and materials available on its website.

Pharmacotherapies

The 2017 VA/DOD guideline suggests that sertraline, paroxetine, fluoxetine, or venlafaxine be used as monotherapies for those who choose against or cannot access the preferred psychotherapies. Prazosin, an inexpensive alpha-1 antagonist, is recommended for PTSD-related nightmares.¹⁵ See the full [VA/DOD Clinical Practice Guideline the Management of PTSD and Acute Stress Disorder](#) for more specifics. Low-dose ketamine has also been used with increased frequency. More research is needed, but infusing it in a subanesthetic dose seems to be safe and potentially beneficial in Integrative Health approaches. In 2010, 39% of Americans with PTSD reported using complementary approaches (then referred to as complementary and alternative medicine, or CAM) in the past year, with mind-body therapies, relaxation/meditation, exercise, herbal remedies, massage, and chiropractic listed among the most popular.¹⁶ The majority of systematic reviews and meta-analyses conclude that “more research is needed” regarding treating PTSD with various complementary medicine modalities.¹⁷ Considerable research to investigate various CIH treatments for PTSD is now underway in the VA.

For a detailed summary of CIH research in PTSD, refer to the [National Center for PTSD](#) website. The information below summarizes many of the key research findings of this and other reviews of the literature.

Dietary Supplements

There is currently no research supporting the use of dietary supplements for PTSD, though there is interest in the use of omega-3 supplements. Many who recommend supplements will try supplements similar to those used for anxiety. For more information, go to the [“Anxiety”](#) overview.

Body-Based Therapies

Limited research is available to support the use of spinal manipulative therapies for PTSD. A small cross-sectional analysis conducted in 2009 with a group of 130 people with neck or low back pain found that the 21 people with PTSD were much *less* likely to benefit from chiropractic than those without PTSD.¹⁸ Few studies are available on massage and PTSD.

Energy Medicine (Biofield Therapies)

One small randomized controlled trial (RCT) of Healing Touch that included 123 returning active duty military personnel found statistically significant improvements ($p < 0.0005$) in PTSD and depression symptoms.¹⁹

Whole Systems

Acupuncture has shown increasing promise for PTSD in recent years. A 2018 systematic review and meta-analysis of seven trials with 709 participants found evidence was low-quality evidence but suggested significant benefit.²⁰ A 2012 systematic review of CIH therapies for PTSD found acupuncture superior to no treatment (being waitlisted) and comparable to group-based Cognitive-Behavioral Therapy (CBT). In that study, it was the only therapy found to have a moderate effect size;¹⁷ other approaches seemed to have less of an effect. A frequently cited 2007 study of acupuncture for PTSD found improvement in a cohort of men who received a series of 24 acupuncture sessions (one hour each) over 12 weeks.²¹ A separate article on acupuncture's mechanism of action offers detailed explanations of how acupuncture might affect PTSD at the biochemical level.²²

Emotional Freedom Technique (EFT) has been classed by some as a form of “energy psychology,” and involves a combination of making specific statements and tapping on various acupuncture points. A 2017 meta-analysis of seven trials, found EFT significantly beneficial for PTSD.²³ In addition, an uncontrolled 2014 trial that included 218 couples found significant benefit based on PTSD checklist scores.²⁴ A very small study suggested that EFT may also help prevent progression from subclinical to clinical PTSD.²⁵

Overall, research does *not* support using complementary approaches as replacements for first-line interventions for PTSD. However, there is room, especially regarding acupuncture and mindfulness-based meditation, to use these approaches adjunctively.

Neuromodulatory Therapies

Neuromodulatory therapies are techniques for altering nervous system circuitry using different types of electrical modulation. Examples include deep brain stimulation, transcranial magnetic stimulation (TMS), vagal nerve stimulation, and stellate ganglion block. A 2019 study concluded that, overall, research is insufficient to determine efficacy for these interventions, except perhaps for some benefits seen in small studies for repetitive TMS.

Back To the Patients

Each of the three patients with PTSD—Todd, Erica, and Melissa—completed a Personal Health Inventory (PHI). In every case, their care team members were careful to assess their suicide risk as a first priority and then to assess for current life stressors.

Todd reviewed his PHI with his health psychologist. Erica eventually went over hers with her psychologist, as well as her primary care practitioner, who specializes in women's health. An important member of her team was a social worker who could help her with her living situation. Melissa reviewed her PHI with a nurse practitioner she often sees, then followed up on her Personalized Health Plan (PHP) with both her psychologist and a Health Coach.

Todd decided that his MAP, his reason for wanting his health, was so that he could go back to school to study to be a counselor because “I want to help people like me, and it will help if they have someone who really knows what all this is like.” He also intends to get into a steady relationship. In the meantime, he plans to train as a Peer Support Specialist at his local VA.

Todd’s health plan outlined the following priorities:

1. Continue with his medications, as per his psychiatrist.
2. Work with a mental health expert who is skilled at offering trauma-based psychotherapies, which he has not yet tried.
3. Begin an MBSR course that is offered at his local VA Hospital.
4. Try acupuncture, not only for his PTSD, but also for his chronic low back pain.
5. Ramp up his exercise to 150 minutes weekly and develop a plan to ensure it happens. Of course, the physical activity will help him in many other ways, as well. Like many people with PTSD, he is at increased cardiac risk and is working on eating healthy, too.
6. Reduce alcohol consumption and explore other healthier ways to ease his stress levels. Todd was given some veteran handouts on relaxation approaches he can try even before his MBSR class starts.

Erica received help navigating the system from a clinical social worker recommended by her primary care clinician. Once her basic needs of safety and shelter were more reliably met, she and her health coach worked together on the following:

1. Erica was evaluated by a psychiatrist skilled in the management of PTSD (she had not been established in the health care system at all previously).
2. The social worker on her care team ensured she was able to get her medications, including prazosin for her nightmares.
3. She began to receive regular psychotherapy. PET was difficult for her but ultimately quite helpful. She also received CBT-I, and her sleep gradually improved.
4. Erica found a support group for women victims of sexual trauma and cultivated a support network. She ultimately chose to attend church services with some of her new-found friends/supporters. Spirit and Soul became a high priority for her.
5. Erica “isn’t quite ready” to focus on diet and exercise, but she says her primary goal is “to love my body again and really be in it.” She says she will just take it “day by day” and has plans for follow up with a Health Coach after counseling has been ongoing for a few weeks.

Melissa appreciated the psychotherapy she received for her PTSD, and with time, she was able to return to work with many fewer absences. EMDR was especially helpful to her. One thing that completing the PHI brought to her attention was that, as someone who works in health care, she wanted to do much more as far as “practicing what I preach.” For her health mission, she noted, “I want to enhance my ability to be a healer, understanding that it starts with me.”

Her PHP includes several steps:

1. She will begin by cutting down to, at most, a 50-hour work week (she was working 60 hours. She is considering becoming a Nurse Practitioner.

2. She realized that she has many ways she can become more resilient. She understands that starting a mindfulness-based practice (she prefers tai chi or something that allows her to stay active while she focuses her attention) can help with this and may (though more research is needed at this point) also help some of her PTSD symptoms.
3. Melissa is actively exercising and paying attention to daily calorie intake as part of her plan to model healthy living.
4. She created space during team meetings for herself and all interested care providers to honor the memory of children they took care of who died.

Author(s)

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