National Center for PTSD
Posttraumatic Stress Disorder
U.S. Department of Veterans Affairs
National Center for PTSD
ADVANCING SCIENCE AND PROMOTING UNDERSTANDING OF TRAUMATIC STRESS
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PTSD 101 Course

Transcript for: Complementary Alternative Medicine (CAM) and PTSD

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Hello. Welcome to this presentation of Complementary and Alternative Medicine and PTSD.

My name is Stephen Ezeji-Okoye, and I am the Chair of the VHACO Field Advisory Committee on Complementary and Alternative Medicine. I have been the chair since its inception in 2004, and my day job is the Deputy Chief of Staff at the VA Palo Alto Health Care System, where I am a practicing internist.

How did we get here? How is it that we are considering complementary and alternative medicines in the treatment of medical conditions? Well, in March of 2000, formed by executive order, a White House Commission on complementary and alternative medicine was started. Its aim was to ensure the potential benefits of complementary and alternative medicine became available to all citizens. It issued 29 recommendations which covered four areas:Research, helping promote the rigorous scientific study of CAM. Education, to ensure the appropriate education and training of CAM and conventional practitioners. To ensure the availability of quality information on complementary and alternative medicine and the training of practitioners. CAM products and standards, to make sure that there is consistency in the quality, and the consistency of the modalities themselves. That advertising would be truthful, and that they would be able to collect data on any adverse effects from the use of these products. And the fourth area was on access and delivery, to make sure that we were to improve access to safe and effective CAM practices and there would be some national oversight of how CAM practices were used. They were also hoping that they would be able to develop and disseminate information on optimum models, complementary and integrative care. And, they had also hoped that there will be some form on coverage and reimbursement of these modalities by various health plans. All federal agencies are required to respond.

In October of 2002, VA formulated a CAM advisory group to respond to the White House Commission on complementary and alternative care. The advisory group essentially concurred with the bulk of the recommendations – certainly those that were applicable to VA. And, in hopes of beginning able to promote the further study and use of complementary and alternative medicine within VA, it recommended the formation of a field advisory committee to help identify and integrate those CAM modalities which would benefit Veterans. So, in approximately July of 2004, a field advisory committee was chartered under Patient Care Services and it was given a charter to identify practices which should be considered for integration into VA care, to promote and integrate appropriate CAM therapies and practices into clinical practices guidelines, to identify areas where additional research was needed in

terms of the safety and efficacy of CAM practices and to establish standards for the training convention of VA CAM providers.

There are three objectives today. One is to describe complementary and alternative medicine otherwise known as CAM and provide an overview of the 2010 VA/DoD Clinical Practice Guideline for the use of CAM for PTSD. Two, to review the research evidence that supports the use of CAM in PTSD and three to describe the recommendations for usage and special issues to consider.

Objective 1, describe CAM and provide an overview of the 2010 VA/DoD Clinical Practice Guideline for the use of CAM for PTSD.

First, I'd like to go through the definitions. Complementary and alternative medicine refers to a group of medical and health care systems, practices, and products which are not presently considered to be part of conventional medicine. Complementary medicine refers to complementary and alternative medicine modalities which were used in conjunction with conventional medicine whereas alternative medicine refers to those modalities which were used in place of conventional medicine. Integrative medicine refers to a combination of mainstream and CAM therapies when the CAM therapies actually have some scientific evidence to support their use.

So, what is the state of CAM in the United States? In the 2007 National Health Interview Survey they estimated that 38% of adults in the United States use some form of CAM. This represents over 83 million people, and they were spending approximately over 34 billion dollars in out-of-pocket costs. Of these expenditures, two thirds of it was going on essentially self-help measures; things such as non-vitamin, non-mineral, natural products and other CAM modalities such as yoga, tai chi, qi gong. About 12 billion, or one-third, of it was going on the use of CAM practitioners. This total expenditure represents about 11% of the total out-of-pocket expenditures that people spend on healthcare. Compared with a survey 10 years earlier, what we are seeing is a great increase in the use of CAM for self-care, and a decline in visits to practitioners. In fact, there was approximately a 50% decline in the use of practitioners, and the biggest declines being seen in visits to energy healers and practitioners of relaxation techniques. Interestingly, visits to acupuncturists saw a 3-fold increase over the same 10-year time period.

So, how is CAM used by Veterans? Well, in a survey by Baldwin, which is a telephone interview of Veterans using the Southern Arizona VA Health Care System, which was conducted in 2002, they estimated that almost 50% of Veterans are using some form of complementary and alternative medicine. And the use of CAM was generally associated with non-Hispanic, white Veterans, making more than $50,000, and having greater than 12 years of education. They view themselves as having current high degrees of stress and perceived that there was a negative impact of their military life on both their physical, mental health and their chronic illnesses.

Now, there is a lot of CAM offered by VA. The use is really very widespread. The Healthcare Analysis and Information Group has conducted two studies on CAM provided by VA. The first study was done in 2002, and another study was completed in 2011, and that report is currently in draft form. What they found was that the use of CAM has gone up from 84% of facilities offering some form of CAM to now 89% of facilities. What we find is that of those facilities who were providing CAM, more of them are providing it directly, that is, they are providing it instead of referring it out. And, if the facilities offers a complementary and alternative medicine modality, they are likely to offer more of them in 2011 than they did in 2002. Of those modalities offered, the most common ones are: meditation, stress management and relaxation therapy, progressive muscle relaxation, biofeedback, and guided imagery. Most CAM provided within VA is provided by convention-trained practitioners with psychologists being the most common plan providers. In general, CAM is integrated into treatment plans as opposed to being used in lieu of conventional medicine. However, we did find that there is limited oversight in the training, experience and certification and practice of CAM providers. And, there is also wide variation in the

process used for credentialling providers. It ranges from essentially no oversight in the credentialing. or process. to formal credentialing going through professional standards board or clinical executive board. While a lot of the sites believe that they are using evidence to support the use of CAM, it does suggest that the belief in the evidence that's available to support CAM may actually outweigh what the literature can support.

So, what do the VA/DoD Practice Guideline on PTSD say? Well, they use a recommendation system, which is based on the US Preventive Services Task Force strength of recommendation grading system, where modalities are, or interventions, are granted a strength of rating from "A" to "I": "A" being a strong recommendation that this be provided to eligible patients; "B" being a recommendation that clinicians provide this service to eligible Veterans or eligible patients; "C" being no recommendation either for or against it being made but intervention can be considered; "D" being a recommendation against routinely providing the intervention, and "I" being a recommendation there's insufficient evidence to recommend either for or against routinely providing the intervention.

So, in looking at how the US Preventive Services assesses the evidence to support a recommendation, an "A" recommendation really means there is high certainty that the net benefit is substantial. Whereas a "B" recommendation means that the net benefit is either moderate or there is moderate certainty that the net benefit is moderate to substantial. A "C" recommendation means that there is at least moderate certainty that the net benefit is small. A "D" recommendation means there is moderate or high certainty that the service has no benefit or the harms outweigh the benefits. Whereas an "I" recommendation means that the current evidence is insufficient to assess the balance of benefits and harms of the service.

Now, in terms of the recommendations that were given to the various allopathic treatments for PTSD, there was an "A' recommendation, that is, a strong recommendation, that for patients diagnosed with PTSD, they should be offered one of the evidence-based trauma-focused psychotherapeutic interventions that include components of exposure and/or cognitive restructuring; or stress inoculation training.Other therapies such as relaxation techniques, Imagery Rehearsal Therapy, Brief Psychodynamic Therapy, Hypnotic Techniques and group therapy were given a "C" recommendation, which means they can be considered, but that the evidence is not sufficient to say that there is a positive or a negative effect. Dialectical Behavioral Therapy was given an insufficient rating, meaning that there is insufficient to recommend for or against it as a first line treatment for PTSD.

So, in terms of the practice guideline recommendations on CAM therapies, acupuncture was given a "B" recommendation in its consideration as a treatment for patients with PTSD. However, for other CAM approaches, it was really felt that, as first line treatments for PTSD, there was insufficient evidence to recommend for or against them. This includes other CAM approaches that facilitate a relaxation response such as mindfulness, yoga, massage, and others, were all given an "I" recommendation. The use of CAM modalities as an adjunctive approach to address co-morbid conditions that are seen with people with PTSD, such as pain, was given a "C" recommendation, and the example that was cited was the use of acupuncture in this setting.

So, let's go onto objective two. Let's review some of the research and some of the evidence that may support these recommendations

The VA Technical Advisory Panel did a review of the literature on CAM and PTSD in 2009 and updated it again in 2011. They reviewed randomized clinical trials, meta-analyses, clinical studies, systematic reviews, and guidelines. In 2009, this search revealed 247 citations of which 4 studies met inclusion criteria. This included 2 empirical studies, 1 systematic review, and 1 Cochrane review.In 2011, there were 863 new citations which shows there have been a tremendous increase in the amount of research and literature published on CAM therapies. However, only 6 studies met inclusion criteria. This included

2 empirical studies, one of which was a dissertation, 3 systematic reviews and 1 Cochrane review. VATAP evaluated each of these studies and gave a strength of recommendations based, again, on the US Preventative Services Task Force rating.

Let's go take a look at their analysis of the systematic reviews.

So, here they looked at meditation, yoga, use of reiki, some pharmacological therapies, psychological treatments, as well as medicines and homeopathic remedies, physical treatments, lifestyle and dietary changes. In all the cases, the recommendation they gave was an "I" recommendation, meaning there was insufficient evidence either for or against the modality. A lot of this was based either on those studies meeting inclusion criteria, or the studies being poorly defined or the results being inconclusive.

So, let's go on to review the clinical trials that were identified by VATAP

The first is taking a look at Mantram Repetition and the treatment of PTSD, and this was actually a study conducted by Jill Bormann, who is a VA practitioner.

So, Mantram meditation is a form of meditation where sacred words are repeated, and it is felt that it is associated with reduced arousal, reduced respiration and decreased stress, and it's felt that it's possibly a mechanism to interrupt flight or fight symptoms.

So, this was, actually, not done as an efficacy trial but was largely done as a feasibility study, and they wanted to see whether or not it was possible to recruit and retain Veterans into a program. They also did look at the effect side for PTSD symptom severity and the psychological and quality of life outcomes as well as the level of patient satisfaction. It was a randomized trial looking at usual care, which consisted of a delayed treatment control or intervention for 6 weeks.

The intervention consisted of 90 minutes per week of a meditation to include education on PTSD symptoms and how to choose and silently repeat a mantram. Whereas the usual care delayed treatment control, it continued with usual medical care, which included weekly or monthly visits with a provider and medication management, but there were no group meetings

In order to be included in the study, you had to be a combat Veteran, 18 years or older, enrolled in VA healthcare and have combat-related PTSD. And, you had to have self-rated yourself with score of 50 or greater on the PTSD Checklist. If you were psychotic or showing evidence of suicidality, or inable to participate in a group, you were excluded from this study.

The study enrolled 33 Veterans, of which 29 participated; 14 in the intervention arm and 15 in the control. The racial demographic of the study included 66% white, 14% Black, 10% Hispanic, and 10% other, with the age ranging between 40-76.

What they found was that there was a large effect seen in terms of the self-reported PTSD severity, and psychological distress findings. There was a moderate to large effect on spiritual wellbeing, however, only a small effect seen in the clinician's assessment of the PTSD severity. Because this was a feasibility study, there were no tests of significance. It would seem the patients were moderately to highly satisfied with the intervention.

And, their conclusion was, that mantram repetition was a well accepted treatment. They had no difficulties with recruitment and retention, however, the study did not include any Veterans from the most recent conflicts in Iraq and Afghanistan. Veterans did show high levels of satisfaction with the intervention. Again, the intervention showed medium to large treatment effects, the one exception being that the clinicians' assessment of PTSD symptoms was only a small effect. One of the possible problems

of the study is that it had a very small sample size. Based on these findings, VATAP gave it a recommendation of “B” / ”I”, meaning that there is some evidence that would support its provision, however, in total, there was insufficient evidence to say that the net benefits outweighed any potential harms.

The conclusion, from the author, was the results were promising and warranted further research in a larger randomized trial, and the results of this study couldn’t be generalized to those Veterans who have experienced more recent war related trauma, such as those returning from Operation Enduring Freedom and Operation Iraqi Freedom.

So, let’s go on to the study of acupuncture for PTSD. This is a study done by Michael Hollifield and really forms the basis for most recommendations about the efficacy of acupuncture in the management of PTSD. It is said that the Army has done multiple, or actually the military, has done multiple studies on the use of acupuncture in PTSD, but these so far have not been published.

So, in this study, it was a randomized clinical trial with three arms. There was an acupuncture treatment arm, a cognitive behavioral therapy arm and a wait list control.

In the acupuncture arm, people received individual sessions of manual acupuncture. There were 25 standard points and 15 flexible points, of which 3 of these 15 points may be used at any given session. Individuals received acupuncture 2 times a week for 12 weeks, and in addition, they were asked to do 15 minutes a day of home-based therapy. In the home based therapy, ear seeds were placed, and the patients were to massage this as essentially a form of acupressure. For group cognitive behavioral therapy, it was once a week for two hours and the patients had 15 minutes of homework a day. In the wait list control they’re only contacted at assessment periods.

So, this study included 84 participants, only 17% of whom were over age of 17 at the time the traumatic experience occurred. 29 were randomized acupuncture, 28 to cognitive behavioral therapy and 27 were wait list control. The inclusion criteria consisted of a DSM-IV diagnosis of PTSD prior to randomization, willingness to accept randomization, no active substance abuse or psychosis and no active treatment specifically for PTSD.

The outcomes were measured at baseline, mid-treatment, end of treatment and at one-, and three-month, follow-up. The primary outcome was to look at if there were changes in PTSD symptoms and in secondary outcomes looking at changes in feelings of depression, anxiety and impairment in daily functioning and general satisfaction with care.

What they found was there were a significant reduction in the PTSD symptoms for both of the active treatment groups, that is, for both cognitive behavioral therapy and acupuncture, and these effects were maintained through the three-month follow-up. We also saw significant improvement in the feelings of depression, anxiety, and general impairment, and there was no significant difference between acupuncture and cognitive behavioral therapy, and there were same levels of satisfaction seen with both cognitive behavioral therapy and acupuncture.

The conclusions really were that there is evidence to suggest that acupuncture could be an effective and acceptable modality for treatment of PTSD. However, there are potential problems. It is a small sample size, and the participants were largely highly educated treatment group who were seeking or actually responding to ads for non-medication study. Given the majority of these patients were under the age of 17, they also would not really fit in with our usual demographic of combat related PTSD, when by definition, patients are going to be older than age 18 at the time of the traumatic exposure. VATAP gave this study, again, a “B” / ”I” recommendation.The author concluded that this study needed to be

interpreted with cautious optimism, and acupuncture should not be recommended for the treatment of PTSD unless further corroborative, and more definitive, data becomes available.

So, let's look at another study. This study looked at yoga breathing and exposure therapy for PTSD.

In this study they wanted to look at the effects of yoga breathing and trauma exposure techniques on PTSD and depression in survivors of the 2004 Asian tsunami. This was a non-randomized trial, and the reason for this is that the people running the refugee camps would not allow the camps to randomize and to receive completely different treatments from each another. So, what they did was take 183 tsunami survivors, in 3 different refugee camps, scoring 50 or above on the Post-traumatic checklist-17 and assigned to one of 3 interventions. Measurements of the PCL-17 and Beck Depression Inventory -21 were taken at baseline 6 weeks, 12 weeks, and 24 weeks.

So, in terms of the interventions, there were yoga breathing, yoga breathing followed by exposure therapy intervention and the last was a 6-week wait list. So, in terms of yoga breathing, what they did was teach 4 different yoga breathing techniques. These were taught in four 2-hour sessions over 4 consecutive days.The exposure therapy intervention consisted of traumatic incident reduction. It was given 3 to 5 days following yoga breathing training. Individuals received 3 to 5 sessions, each being 1 to 3 hours in length. In traumatic incident reduction the goal is to flood individual with cues that are associated with traumatic memories, the hope being to induce a state similar to traumatic state, and the hope is that with repeated exposure these cues become less traumatic over time.

So, what they found was that there were statistically significant reductions in PTSD and depression scores at 6 weeks, and this was maintained through 24 weeks, in both treatment arms compared with the control. There was no difference between the treatment arms. Now, there were several limitation in this study. First of all, there were no practice logs or weekly attendance, so it's not clear how much of these interventions any individual did. Although this study was non-randomized, they did try to have similarities in age, degree of loss and initial test scores in the participants. However, 87% of the participants were women, but women didn't outnumber men in the camps.Their conclusion was that yoga breath-based interventions may help relieve psychological distress following mass disasters. VATAP gave this a strength of recommendation of "C" / "I". Now, again, this technique does not necessarily represent something that would be of benefit amongst combat related PTSD, as this is not, necessarily, the same mechanism of action for the creation of PTSD state in Veterans as was seen in this Asian tsunami.

So, I want to go ahead and take a look at the use of CAM in the treatment of co-morbid conditions

In particular, I want to take a look at the use of acupuncture and pain, in particular low back pain. The use of CAM modalities such as acupuncture in the treatment of co-morbid conditions, such as pain, is one of the things that was mentioned in the VA/DoD Practice Guideline.

Back pain is the leading reason for patients to seek out an acupuncturist. In this study, they looked at four arms. Patients were either randomized to individual acupuncture, standard acupuncture, simulated acupuncture, or usual care. In individual acupuncture, they underwent an evaluation by an acupuncturist. And, at that time, the decision was made upon what points would be stimulated with acupuncture needles. In standard acupuncture, standard acupuncture points correlating with back pain were utilized. In simulated acupuncture, non-therapeutic acupuncture points were used. In this study, 638 patients with chronic low back pain, of greater than 3-months duration, were randomized. Their age range was between 18 and 70. They were given disability questionnaires at 8, 26, and 52 weeks. They received 10 treatments over 7 weeks, 2 times a week times 3 weeks, and then weekly for 4 weeks.

What they found was there was a statistically significant improvement in dysfunction scores in all the acupuncture groups compared to usual care. This was seen at 8 weeks and persisted right through

52 weeks. There was no difference between the acupuncture groups. There was a statistical improvement in symptoms in acupuncture groups at week 8 but not at week 26 and 52. And, the use of medications decreased significantly in all the acupuncture groups, and this persisted through the full 52 weeks.

The conclusion was that acupuncture was effective in the treatment of chronic low back pain. However, the site of needling seemed to be unimportant. This study is actually quite important, because this finding, where sham acupuncture or simulated acupuncture, is as effective as real acupuncture is seen in multiple studies. And, this calls into question, what is the effect that is occurring? Does this mean that this is a practitioner effect, or that the stimulation of the skin with an acupuncture needle creates a therapeutic benefit, but the belief in the meridians or the therapeutic points perhaps is not important?

So, in Objective 3, we are going to describe recommendations for usage of CAM and some special issues to consider.

In looking at the utility of CAM in the treatment of PTSD, there is a relatively consistent theme. The VA/DoD Practice Guideline talks about how “CAM may facilitate engagement in medical care and may be considered in some patients who refuse evidence-based treatments. However, providers should discuss the evidence for effectiveness and risk-benefits of different options, and ensure that the patient is appropriately informed.” The VA Technical Advisory Panel reviewing the evidence on CAM and the management of PTSD concluded that, basically, the evidence for CAM therapies is insufficient to assess a net benefit for these interventions as a primary therapy for PTSD. And, at best, the evidence suggests an adjunctive role for acupuncture or mantram repetition, but they are still considerable uncertainty about the balance and harms of these interventions. And, the VA Complementary and Alternative Medicine Field Advisory Committee, based on the findings of the VATAP, felt that, at this time, no CAM practices should be recommended for the treatment of PTSD. If it is to be used, it shouldn’t form the primary basis of therapy, and patients should be informed of the lack of evidence on the benefits and harms of the modalities. So, again, looking at, potentially, an adjunctive, but not a primary, role for the use of CAM in the management of PTSD.

So, what issues are there to consider when providing CAM? First, are complementary and alternative medicines even part of the uniformed benefits package? The VA employee handbook, which was revised in June of 1998, talks about the VA Public Law which established the uniformed benefits package. And, it calls for VA to furnish hospital and medical services that are defined as needed. And, VA defines needed as a need for care or services that will promote, preserve, and restore health. Well, with the focus of many CAM modalities being on disease prevention, chronic disease management, and general wellness, it certainly could be considered that CAM modalities would be included underneath the uniformed benefits package, although, this was not specifically stated. And, certainly, the uniform benefits package seemed to be focusing more about allopathic treatment rather than CAM therapies. If one looks at the VHA vision statement, it states that VHA will continue to be the benchmark of excellence and value in health care and benefits by providing exemplary services that are both patient-centered and evidence-based. While many CAM therapies can certainly be considered to be patient centered, what hopefully you’ve seen from the preceding slides, and the preceding time we’ve spent, is that the evidence supports CAM’s use is, at best, in a state of flux. Hopefully, with new evidence coming forward, it will help clarify many of the questions that are raised that resulted in insufficient ratings being given to the use of CAM modalities, not just in PTSD, but also in its use for treatment of co-morbid conditions or other conditions.

So, at the present time, there is not sufficient evidence to suggest that CAM modality is the best treatment for any condition. In general, evidence to support CAM is very limited. And, there is not that much study of the use of CAM in combination with conventional treatments, which is the way that CAM therapies are generally given in VA. That is, either a complementary fashion or integrated fashion. Now, if one looks at the national picture, it suggests that CAM based on practitioner-delivered care on the

whole is decreasing and there is a greater reliance on self-care. And one of the questions is: does the use of CAM by Veterans mirror this national picture? Meaning, although we know that potentially up to 50% of veterans may be using some CAM modality, are they basically using it in the same way as the general populace? That is, they're using it for issues of wellness or issues where they're able to control the delivery of CAM both in the quantity, and the frequency, of its use. Or, are they using CAM in primarily a practitioner basis? When one looks at what's offered in VA, although technically one might say that a lot of this of what we offer is practitioner delivered, a lot of the modalities, such as yoga and tai chi, and the like, which are offered in the VA, are actually things which would really fall more into the picture of self-care. And so, I think further study in terms of how Veterans use CAM, needs to be done to look to see how that compares to how care is offered by VA.

Then there's the issue of wellness versus treatment. In general, VA promotes wellness activities but does not provide it. By that I mean, VA will offer such programs, the move programs, to help support to help Veterans exercising, eating healthier, reducing weight and in those fashions, inducing positive effects on their health. However, we don't provide things such as gym memberships to allow them to do this. When we look at CAM modalities, there are certainly some which are clearly treatment. So, the use of acupuncture to reduce pain, will be an example of a CAM modality that is used as treatment because it's addressing a specific diseased condition and there's a specific outcome that's expected. However, if someone is doing an activity such as tai chi to improve their general strength and conditioning, that's really more of a wellness activity. And how one views the level of evidence that is needed to support the use of a CAM modality might vary depending upon whether or not you view it as a wellness activity or a treatment activity. And similarly, the level of training, education, and certification that will be needed by the practitioner who is assisting the Veteran in getting that care might differ if you are looking at it as a wellness activity versus a treatment activity, with the higher level or the higher bar being set for the use of CAM modalities as treatment. And then there's a question of: what exactly are the CAM modalities offering? As we saw in the acupuncture and the treatment of low back pain example, it's not actually clear: what is the intervention that's being brought forth? And is it possible that sometimes CAM activities are replacing things that have been taken out of our general lives? So, are activities like tai chi really bringing out the therapeutic effects of exercise? Do things like mindfulness meditation really bring us periods of rest and tranquility which may have been eliminated by our continuously plugged-in world? Or, do they offer the opportunity for people to come together to participate in activities that support community and support integration and that deal with issues of isolation that may be increasingly common.

So, if you are going to use CAM, particularly if you are going to use it for treatment, I think it's important that the modalities that are permitted within VA be safe and effective. Ideally, you want to see a US preventative services task force rating of "B" or better when you are going to use something as a treatment. That being that there is high certainty that the net benefit is moderate or there is moderate certainty the net benefit is moderate to substantial. If you are going to use something without clear evidence of effectiveness, there should at least be some evidence of effectiveness. And so, that's really going to mean modalities are going to fall into a "C" or potentially an "I" level recommendation. They should be known to be safe. They should be used when treatment options are limited, and there is some reason to believe on the behalf of the provider that it may offer some benefit to the Veteran. But it really should not be offered to the general population. It really should be an individualized decision.

So, any CAM procedure that is offered as treatment really should have informed consent. And, this is really no different that the provision of allopathic treatments. This does not mean that it has to be written consent, but there should be verbal consent. And, by providing this form of informed consent, the patient should be informed of the evidence to support the use of this treatment, any risks and any potential benefits that could be expected to be seen in this treatment. In order to provide the treatment, the CAM providers should be appropriately credentialed, they should be licensed in that modality and they should have proof of appropriate education and training. The care they deliver should also be documented in the

medical record. VHA employees who are going to deliver CAM treatments really should only do so if the provision of that CAM modality is allowed within their occupational class. This does pose a potential problem. There are no occupational classes for CAM providers within VA. And, so in order to be able to provide a CAM modality, this would mean that the modality would need to fall within the general scope of that person's occupation. By this, I mean physicians may provide acupuncture, as acupuncture is considered within the scope of a physician. However, acupuncture is not considered within the scope of a nurse. So, if a nurse is a licensed acupuncturist and they may be very well trained, and certainly would be someone who is capable providing acupuncture but unfortunately, there is not a class for licensed acupuncturist. And, acupuncture is not considered within the scope of practice of a nurse.

So, if after hearing this talk, you're thinking that acupuncture might be something that you want to recommend or at least consider for your patient, I think it's useful to have some understanding of what might be expected to occur in a visit when a patient sees an acupuncturist. An acupuncturist is going to do a thorough evaluation of the patient which is going to consist of a history of the presenting illness and they're also going to do a physical examination. A physical examination from an acupuncturist however, differs from that which may be seen with an internist or surgeon, for example. In acupuncture, two areas that form the bulk of the physical exam and are perhaps most important in the physical exam, are (1) examination of the pulse, where the acupuncturist is looking at both the strength and the character of the pulse and (2) examination of the tongue, where the color, shape and any coatings on the tongue are all observed. Through the basis of the history and the basis of the physical exam, the acupuncturist selects what acupuncture points will need to be stimulated to create a therapeutic effect. In stimulating the points, there are a number of different ways that this can be done. In general, a sort of standard acupuncture would refer to dry needling, in which a hollow point needle is put into the skin over the therapeutic point versus enhanced modality acupuncture, such as electroacupuncture, where a weak electrical current will be applied through the needle over the acupuncture point. Other modalities may include things such as laser acupuncture, the thought being that some of these enhanced modality acupunctures may provide a greater strength of response in the stimulation of the acupuncture point. What we're going to do now is show you a brief video of acupuncture.

So in summary, complementary and alternative medicine is widespread. It's found in 89% of all VA facilities. And in general, multiple modalities are offered in each facility. The evidence to support the efficacy of CAM modalities is limited. However, the evidence base is growing and hopefully, in many of these conditions where we have insufficient ratings, there shall be further clarity in coming years. In terms of using CAM in the treatment of PTSD, the best evidence is really for acupuncture and meditation. And, as I hope that you will have picked up, the evidence support its use in acupuncture is somewhat mixed. The rating from the VA DoD Practice guideline is a "B". The VATAP Rating is really more in the range of a "B/I". There is also some evidence that suggest meditation may be effective. However, some care must be taken as this was primarily a feasibility, rather than efficacy trial, that this statement is based upon. And, if we were to use CAM, really we should not be using it as a primary treatment for PTSD, although, you could consider it as an adjunctive treatment.