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REVIEW ARTICLE

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A clinician's guide to the 2023 VA/DoD Clinical Practice Guideline for Management of Posttraumatic Stress Disorder and Acute Stress Disorder

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Abstract

A clinical practice guideline (CPG) is a rigorously established set of recommendations based on currently available evidence about the efficacy, safety, acceptability, and feasibility of interventions to assist with clinical decision-making. The 2023 Department of Veterans Affairs /Department of Defense Clinical Practice Guideline for Management of Posttraumatic Stress Disorder and Acute Stress Disorder is described herein. The CPG recommendations are accompanied by a clinical algorithm, which incorporates principles of evidence-based practice, shared decision-making, and functional and contextual assessments of goals and outcomes. An overview of the CPG recommendations is combined with a discussion of questions that clinicians and patients may face in implementing the CPG and suggestions for how to effectively work with the CPG.

The U.S. Department of Veterans Affairs (VA) and the U.S. Department of Defense (DoD) jointly launched the Evidence-Based Practice Work Group (EBPWG) in 2004 to establish a process for using clinical and epidemiological evidence to guide clinical care (VA/DoD Health Executive Committee, 2017). In 2023, per best practices in guideline development (Institute of Medicine [IoM] Committee on Standards for Developing Trustworthy Clinical Practice Guidelines [CPGs], 2011), the VA and DoD updated the Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder, which was last revised in 2017 (VA/DoD, 2017). The 2023 CPG is

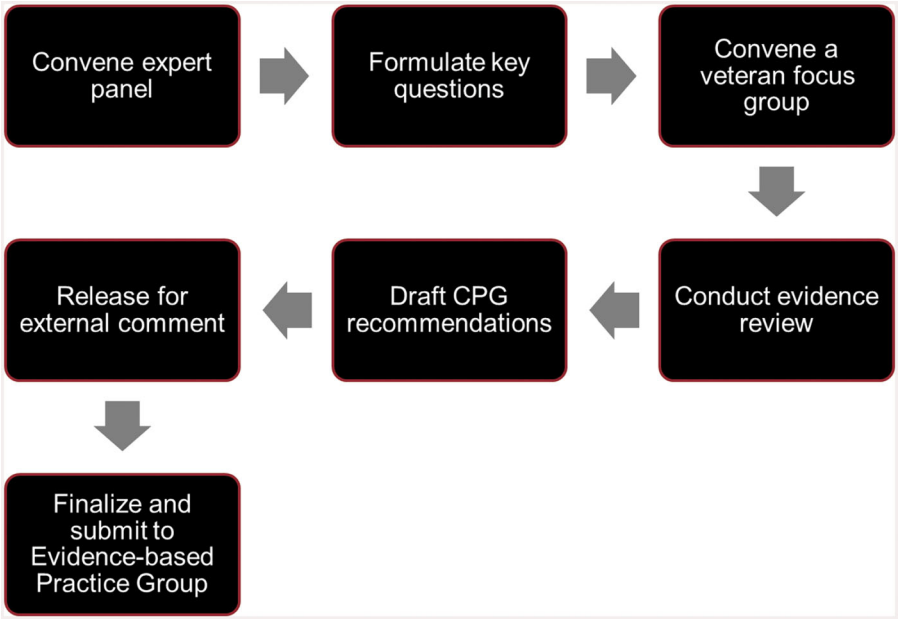

FIGURE 1 Clinical practice guideline (CPG) development process.

described in Schnurr et al. (2023) and can be found on the VA website (VA/DoD, 2023) along with a provider summary, quick reference guide, and patient summary. The purpose of this article is to assist clinicians in effectively applying the CPG in practice. First, we briefly describe how the CPG was developed and summarize and explain the CPG recommendations We then provide guidance on how to apply the CPG in practice and address frequently asked questions.

DEVELOPMENT OF THE CPG

The process of developing the CPG is depicted in Figure 1. First, a multidisciplinary work group was assembled from both VA and DoD, including individuals with expertise in psychology, psychiatry, pharmacy, nursing, and social work. The VA/DoD PTSD CPG Work Group (Work Group) then developed a set of 12 key questions to guide the evidence review and determined critical and important outcomes. Simultaneously, a veteran focus group was held to gather veterans' opinions about the management of posttraumatic stress disorder (PTSD) and acute stress disorder (ASD). Attempts were made to recruit active-duty military personnel to participate, but none attended the focus group. The evidence review was conducted employing GRADE methodology (i.e., Grading of Recommendations, Assessment, Development, and Evaluation; Guyatt et al., 2008) to generate an estimate of the quality of the evidence based on a set of criteria related to the nature of the study design and/or its execution. The evidence prioritized results from systematic reviews and meta-analyses, which were augmented by results from individual studies when necessary. The Work Group then drafted an initial set of recommendations that took into account an evidence review and veteran feedback. Recommendations took five forms based on the quality of the evidence, weight of benefits and harms, patient input, and other considerations (e.g., feasibility, subgroup considerations; see Figure 2). The draft guideline was then distributed for external peer review and revised accordingly, resulting in the final CPG.

The Work Group determined that PTSD symptom change as determined by clinician interview would be the critical outcome (i.e., the outcome that was given the most weight in summarizing the evidence) for most of the questions and subsequent CPG recommendations. Clinician interview retains blind assessment, something not possible with self-report. This was a change from the previous guideline and is a more rigorous application of GRADE. Additional important outcomes (i.e., those taken into consideration in the final CPG recommendation) included serious adverse events, a loss of diagnosis or a remission, treatment retention and dropout, self-reported PTSD symptoms, comorbid symptoms, and quality of life and functioning. Another notable change from the 2017 CPG was that psychotherapies were evaluated individually rather than as a class for consistency with the pharmacotherapy recommendations. For example, the evidence for prolonged exposure (PE; Foa et al., 2007) and brief eclectic therapy (Gersons et al., 2015) were reviewed separately rather than as the class of trauma-focused psychotherapies. These two methodological modifications resulted in significant changes in recommendations relative to the previous CPG.

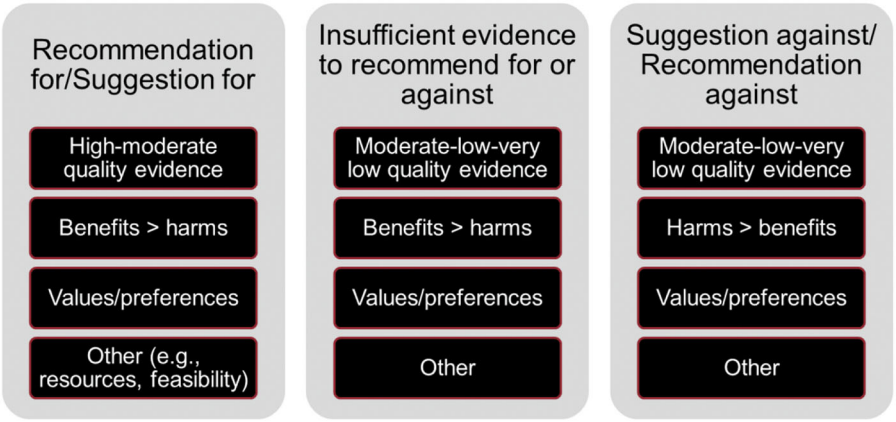

FIGURE 2 Basis for Work Group recommendations.

The Work Group made one of five determinations about a particular treatment. A *recommendation for* any treatment indicates strong evidence in support of its efficacy and limited concerns (e.g., side effects); a *suggestion for* a treatment designates some evidence that the treatment works but with limitations to the available research (e.g., a small number of studies, lower quality ratings). Similarly, a *recommendation against* a treatment indicates a treatment for which there is good research evidence that the treatment does not work and that there are significant concerns with the treatment, whereas a *suggestion against* is used to denote a treatment that has no, or very limited, research to support its efficacy and some concerns associated with its use. The designation of *insufficient evidence to recommend for or against* a particular treatment indicates that (a) there was too little research on the treatment to determine if it worked to treat PTSD, (b) the research reviewed was of such quality that the Work Group could not determine efficacy, (c) the available research was ambiguous as to whether the treatment worked, or (d) some combination of the three. As a result, most newer treatment approaches were included in the insufficient evidence category.

CLINICIAN'S SUMMARY OF THE CPG

Evidence-based practice (EBP) is an approach to care that brings together the best-available, well-researched treatments; clinician acumen, and patient interests and preferences (American Psychological Association Presidential Task Force on Evidence-Based Practice, 2006) to guide clinical decisions. In this context, the CPG is a critical resource for clinicians to familiarize themselves with current research evidence to inform clinical decision-making. Selected treatment recommendations from the 2023 PTSD CPG are presented in Figure 3; refer to the guideline for a complete list (VA/DoD, 2023). The narrative provided in the CPG gives information about the state of the literature for each recommended treatment and offers references for clinicians who want additional understanding.

The clinical algorithm, which is included in the CPG (VA/DoD, 2023, pp. 25–34) provides a decision tree designed to guide clinicians as they incorporate CPG recommendations into good clinical practice; CPG recommendations are noted by the recommendation number (e.g., Recommendation 1) and/or original CPG page number so the reader can quickly locate relevant information, including details about the evidence review. Integrated into the clinical algorithm are the concepts of (a) patient-centered care, which emphasizes the importance of the patient's needs and preferences, including accessibility and cultural appropriateness (Agency for Healthcare Research and Quality [AHRQ], 2014); (b) shared decision-making, whereby patients, providers, and other involved persons work together to make treatment choices (IoM, 2001); and (c) measurement-based care, or incorporating the regular and systematic assessment of patients' perceptions of progress (American Psychological Association, 2023b).

Assessment of trauma-exposed patients

The first three CPG recommendations address different questions of the assessment of PTSD symptoms. Recommendation 1 suggests that the Primary Care PTSD Screen for *DSM-5* (PC-PTSD; Prins et al., 2016), which assesses symptoms based on symptom criteria outlined in the *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*; American Psychiatric Association, 2013), be used when screening for PTSD. Notably, veterans who

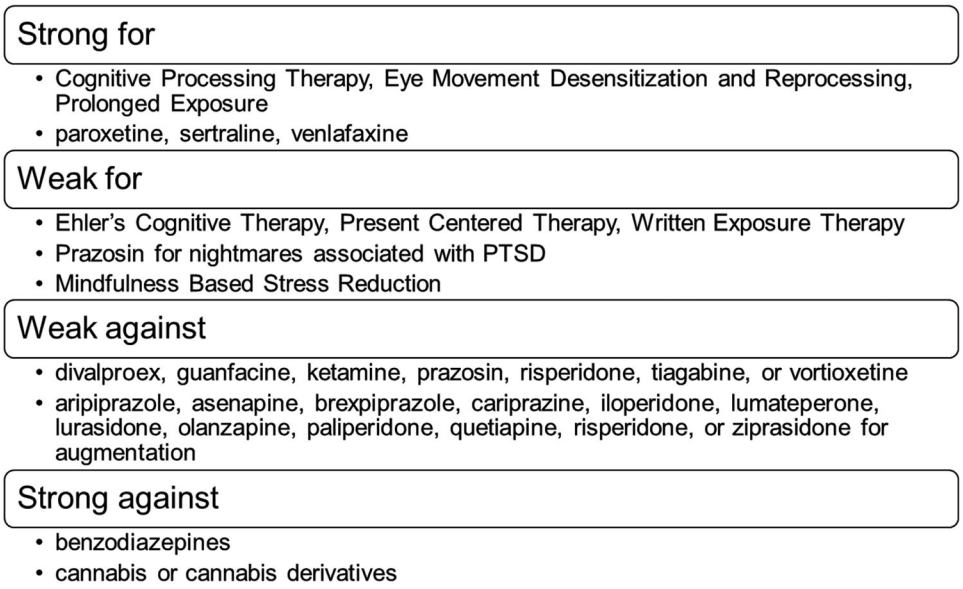

FIGURE 3 Posttraumatic stress disorder (PTSD) clinical practice guideline highlights: Intervention recommendations.

participated in the focus group emphasized the need for increased screening and outreach to engage more veterans with PTSD in treatment. It is important, though, to recognize that the effectiveness of a screening tool depends on features of the population (e.g., gender, trauma type, time since exposure) and setting (e.g., base rate of the disorder, relative importance of errors; Streiner, 2003); thus, clinician judgment should be used along with screening information to determine when additional clinical evaluation is indicated. Importantly, screening tools should not be used to establish a diagnosis. Recommendation 2 focuses on making a diagnosis. This CPG recommendation suggests using a validated clinician-administered interview, such as the Clinician-Administered PTSD Scale for *DSM-5* (CAPS; Weathers, Blake, et al., 2013) or PTSD Symptom Scale–Interview Version (PSS-I; Foa et al., 2016), to make or confirm a diagnosis of PTSD. Finally, reflecting the ideal of measurement-based care, Recommendation 3 suggests the repeated use of either a clinician-administered interview or a validated self-report instrument, such as the PTSD Checklist for *DSM-5* (PCL-5; Weathers, Litz, et al., 2013), to assess treatment progress and aid ongoing treatment decision-making. For reference, Modules A and B (pp. 26–27) of the clinical algorithm focus on the assessment of ASD and PTSD. Although the CPG is focused on ASD and PTSD, clinicians are reminded that PTSD is only one of a myriad of responses people may have to trauma. Therefore, the algorithm acknowledges the importance of the holistic assessment of an individual, with validated measures used when available.

Acute stress reaction (ASR) and ASD

The Work Group found insufficient evidence to recommend any interventions to prevent the development of ASD/PTSD among trauma-exposed populations (Recommendation 4). Of note, two randomized controlled trials found no advantage to using critical incident stress debriefing compared to no debriefing (Forneris et al., 2013). One study did suggest that modified group PE was more effective than a waitlist control condition at reducing the severity of PTSD symptoms assessed 4 and 12 weeks posttrauma (Rothbaum et al., 2012), but the feasibility of using this approach for large groups of traumatized individuals (e.g., survivors of natural disasters) is challenging because of the limited numbers of trained personnel, displacement, and other factors. It will be important to identify scalable, population-level interventions for PTSD prevention in the future. Existing interventions, such as psychological first aid (Brymer et al., 2006), could not be evaluated for inclusion because no randomized controlled trials of these approaches were identified in the review for the CPG; however, other researchers have concluded that the evidence that this approach is effective in preventing PTSD is weak (Hermosilla et al., 2023). In the interim, clinicians should strive to address basic needs (e.g., shelter, food), identify individuals at high risk of adverse outcomes, and support wellness (e.g., community support, exercise; Magruder et al., 2017; Tan et al., 2023). Module A (p. 26) of the clinical algorithm outlines strategies for identifying and managing ASR and ASD.

For trauma-exposed individuals who experience acute distress sufficient to be diagnosed with ASD in the month following trauma exposure, the CPG suggests trauma-focused cognitive behavioral therapy (CBT) for the management of ASD and prevention of PTSD (Recommendation 5). The Work Group reviewed but was unable to identify any pharmacological intervention for which there was sufficient evidence to recommend for or against its use to treat ASD and prevent PTSD (Recommendation 6).

PTSD

The CPG offers a number of treatment approaches for clinicians treating patients with PTSD. Among psychotherapies, the CPG recommends (Recommendation 8) cognitive processing therapy (CPT; Resick, Monson, & Chard, 2017), eye movement desensitization and reprocessing (EMDR; Shapiro, 2017), and PE (Foa et al., 2007). Among pharmacotherapies, the CPG recommends (Recommendation 15) paroxetine, sertraline, and venlafaxine. Treatment selection for any particular patient will necessarily take into consideration issues such as treatment feasibility and patient preferences. However, the CPG prioritizes the recommended psychotherapies over recommended pharmacotherapies (Recommendation 7) because of systematic reviews and meta-analyses that indicate larger and more persistent improvement with psychotherapy (Lee et al., 2016; Merz et al., 2019; Watts et al., 2013, 2015).

In addition to the previously described recommended treatments, clinicians may consider using other treatments that show promise in treating PTSD. The Work Group suggests the following psychotherapies for PTSD (Recommendation 9): Ehler's cognitive therapy (Ehlers et al., 2014), present-centered therapy (PCT; Schnurr et al., 2007), and written exposure therapy (WET; Sloan & Marx, 2019). In addition, the Work Group suggests (Recommendation 26) mindfulness-based stress reduction (MBSR; Santorelli et al., 2017), a mind–body approach. There are no suggested medications. Module C (p. 28) of the clinical algorithm guides clinicians through the various treatment options for situations in which the interventions with stronger evidence are not available or do not fit with patient preferences, which can vary widely across gender, cultural background, and trauma type (Monteith et al., 2021).

The CPG includes two recommendations against specific treatments for PTSD, meaning that they are strongly contraindicated: benzodiazepines (Recommendation 19) and cannabis derivatives (Recommendation 20). A systematic review of the literature showed no clinical benefit of benzodiazepines (Williams et al., 2022). The "strong against" position reflects this as well as the potential for misuse and cognitive impairment associated with benzodiazepines (Guina et al., 2015). The cannabis recommendation is similarly based on a lack of good-quality trials showing benefit combined with well-documented serious side effects (Belendiuk et al., 2015; Kansagara et al., 2017; Steenkamp et al., 2017; Wilkinson et al., 2016). Several medications have suggestions against use as monotherapy for PTSD (Recommendation 18) or as augmentation of medications for PTSD (Recommendation 22). Notably, this includes a suggestion against the use of prazosin to treat PTSD; however, prazosin is suggested to treat nightmares, a specific symptom of PTSD (Recommendation 32). The CPG suggests against electroconvulsive therapy and vagus nerve stimulation for the treatment of PTSD (Recommendation 25) given the lack of evidence to support their efficacy combined with their invasiveness and potential for adverse effects. Treatments that lack evidence for the treatment of PTSD might be used for conditions that can coexist with PTSD, such as major depressive disorder (e.g., ketamine infusions). CPGs for a range of other conditions are available on the VA website (VA/DoD, n.d.).

Numerous other treatments used in clinical practice were deemed to lack sufficient evidence to recommend for or against their use for PTSD. These include additional psychotherapies, medications, and mind–body approaches (Recommendations 10, 16, 17, and 27); couples therapy (Recommendation 14); somatic therapies, including neurofeedback, repetitive transcranial magnetic stimulation, and stellate ganglion block (Recommendation 24); recreational therapies (Recommendation 28); mobile apps, self-help, and internet-based therapies (Recommendations 30 and 31); and nightmare treatments (Recommendation 33).

HELPING PATIENTS MAKE TREATMENT DECISIONS

Given the number and variety of recommended and suggested treatments, clinicians may feel unsure of which treatment to offer a particular patient. The guideline and algorithm direct clinicians to begin by considering one of the three recommended trauma-focused psychotherapies but shift to medication or one of the suggested treatments based on patient preference or treatment availability. Several approaches can be useful for determining which treatment to deliver.

Patient-centered care

Patient-centered care encourages collaboration between patients and providers to develop a treatment plan that works to ensure the correct care is provided in a manner

that maximizes its effectiveness. Within this framework, patient preferences and values are respected when making treatment decisions. Patient preference appears to be an important consideration when selecting a treatment approach. A recent meta-analysis of 53 studies demonstrated associations between patient preference and both lower attrition and improved clinical outcomes (Swift et al., 2018). Zoellner and colleagues (2019) found that PTSD patients who received their preferred treatment were more adherent, more likely to respond to treatment, and more likely to lose their PTSD diagnosis. To this end, clinicians must strive to share information about treatments with patients so that patients can make informed decisions about their care. The CPG can provide guidance and information to clinicians as they discuss treatment options with patients.

Patient preferences may be based on a variety of considerations that can guide the alternatives offered. For example, individuals who decline trauma-focused care may be offered recommended medications or one of the suggested approaches (e.g., PCT or MBSR) as an initial strategy. In these cases, it is important for clinicians to have a discussion with the prospective patient about the relative strength of the evidence for different treatment approaches.

Shared decision-making

Shared decision-making, which is highlighted as a good clinical practice in the CPG (p. 24), is a process by which patients and clinicians work collaboratively to arrive at a treatment choice that considers evidence about treatment effectiveness, patient goals, and patient values. Shared decision-making also is important in helping patients set goals that feel personally meaningful and reflect individual capabilities, needs, and preferences. The veteran focus group highlighted that feeling "understood, heard, and validated" is central to success, and the value of shared decision-making is borne out in research. For example, a randomized clinical trial found that veterans with PTSD who used a decision aid were more likely to want, and get, evidence-based trauma-focused treatment and to have improved PTSD outcomes relative to those who did not use the decision aid (Watts et al., 2015).

A critical piece of shared decision-making is helping patients understand the evidence supporting various treatments and what treatment entails. Providers who regularly familiarize themselves with evidence about treatment options will be best able to present accurate information to patients, discuss potential risks, and facilitate well-considered choices. To support this process, the Work Group developed a patient summary to help patients become informed consumers of the CPG. It can be difficult for a patient who is not accustomed to thinking in scientific terms to understand the high standard of evidence required by the CPG, particularly when the internet and social media provide a wide variety of compelling, but not necessarily scientific, "evidence." The National Center for PTSD also provides patient-focused materials to explain treatment options (National Center for PTSD, n.d.b) and a decision aid (National Center for PTSD, n.d.a) to facilitate an informed discussion of treatment options. A discussion about the CPG with a patient may begin like this:

> We have several effective treatment options for PTSD, so we will spend some time talking about options for you, and I can share some resources with you so you can learn more on your own if you like. I'll describe some treatments and tell you what we know about how well they work. You can take your time and think about your options or discuss these choices with a friend or loved one, and then we can select the treatment that best fits with your preferences, values, and goals. Once we decide upon a treatment, we'll set goals and check in regularly to make sure that we are making progress toward them. It will be important for us to maintain good communication throughout this process, so as we discuss your treatment options, please ask any questions that you might have. As we move forward with treatment, I hope that you will feel comfortable sharing with me what is going well and what isn't. If things aren't going well, we'll talk about how to adjust things to help you achieve your goals.

Measurement-based care

Another strategy implied in the discussion about shared decision-making is the need to repeatedly measure the effectiveness of the selected treatment for this patient. This can guide decisions about when to terminate treatment because the goals have been reached, when and how to troubleshoot with a patient who may not be making progress, and when an alternate treatment approach should be considered. Utilizing validated measures can be tremendously helpful in this effort, as relying solely on the subjective judgments of patients and providers may introduce bias and inaccuracy. Enlisting a patient in an empirical approach to their treatment may foster engagement with the use of standardized measures to assess

treatment outcomes (Recommendation 3). One approach to introducing this is illustrated here:

> Think about the way that you judge whether you have gained or lost weight. You look in the mirror to see how your clothes fit, and you also use a scale to measure how much weight you have lost. We will check in with one another to see how we think things are progressing, but we will also use questionnaires to track progress—this will be our scale. When you reach your goals, we can talk about ending treatment. But if we don't see the expected improvement, that will be our signal to talk about how to make the treatment we are using more effective or whether we should try a different treatment.

FREQUENTLY ASKED QUESTIONS ABOUT THE CPG

The CPG recommendations were intended to guide assessment and treatment planning. However, clinicians will still be faced with judgments about how best to meet the needs of individuals in their care. In this section, we will focus on common questions clinicians face as they implement the CPG.

What is the difference between the recommended psychotherapies?

There is growing evidence that the recommended psychotherapies—CPT, EMDR, and PE—are all relatively equally effective, so selecting a treatment often depends on aspects of the treatment, provider training, and patient preferences. For example, both PE and EMDR ask patients to engage with specific traumatic memories, whereas CPT does not. Similarly, CPT requires more writing than PE or EMDR, and PE and CPT rely more heavily on "homework" to be completed between sessions than EMDR. Any or all of these factors could contribute to a patient preferring one of these treatments over the others. Pragmatic factors may also enter the decision-making process. For example, individuals who have experienced sexual trauma may prefer a therapist of a specific gender, thus preferring the approach that is available with a provider of their choice. Emerging evidence suggests that treatment names influence choices and may elicit irrelevant associations, so it is best to describe key aspects of the approach in accessible language rather than emphasizing professional terminology (Grubbs et al., 2023). An example of patient-friendly ways of describing these treatments follows:

> We have a few options among the most effective treatments for PTSD. I would like to tell you a little about each and answer any questions you may have. I'm also happy to share web-based resources where you can learn more about the treatments and hear from people who have been through them talk about their experiences. Trauma changes the way that people look at themselves, other people, and the world. Some of those changes may be helpful, but some may not. Even though they are meant to protect you, they may actually not be realistic and keep your symptoms going. The first treatment [CPT] teaches you how to evaluate and change upsetting thoughts about the trauma in order to change how you feel. You'll learn a strategy to decide whether there are other, less upsetting ways to think about your trauma and how it affected you. The second [EMDR] helps you process trauma by focusing on memories, thoughts, and feelings related to your trauma while focusing on a back-and-forth movement or sensation. The last treatment [PE] teaches you to face your fears and stop avoidance behavior. You'll repeatedly talk about your trauma in session and gradually approach safe situations you've been avoiding. Each of these treatments reduces PTSD symptoms. What questions could I answer that would help you to select a treatment approach?

This discussion shouldn't be rushed. Elaborating on the basic descriptions above with metaphors, analogies, and clear examples to explain key features of the treatments may help patients envision the treatment process (Larsen et al., 2023).

Another major consideration is the clinician's ability to deliver the recommended treatments as they were designed. The psychotherapies and complementary approaches recommended or suggested in the CPG generally follow manuals that provide a framework that is flexible enough to allow therapists to shape the intervention to meet the needs of a specific client. However, the evidence used to guide the CPG is based on therapies being delivered with fidelity, and if a clinician makes significant deviations from the protocol, the reviewed studies no longer apply because there is insufficient evidence for the use of modified manuals or components of

established protocols for treatment of PTSD (Recommendation 11). Several of the recommended and suggested treatments in the CPG (i.e., CPT, EMDR, MBSR, PE, WET) have well-established training programs that include didactic instruction and case consultation. It is important to complete recommended trainings and adhere to manuals. If a clinician is not able to offer these recommended or suggested treatments with fidelity, they should be prepared to discuss the issue with patients and provide referrals for empirically supported care. Providers should seek consultation if they are struggling to find a balance between attention to the protocol and meeting individual patient needs or if the intervention is not proceeding as hoped.

What if a recommended treatment is not having the desired effect?

Most of the therapies recommended or suggested in the CPG require 10–12 sessions to reach an adequate dosage, and some patients do not reach their full treatment gains until 15 or more sessions. That said, many patients will begin to experience relief from their PTSD symptoms over the first four to six sessions (Brown et al., 2019). If a treatment is not having the desired effect, providers are encouraged to evaluate the patient's engagement with treatment. Several of the treatments recommended or suggested in the CPG (e.g., PE, CPT, PCT, MBSR) include homework. Both the quantity and quality of homework adherence are important predictors of response to PTSD treatment (e.g., Cooper et al, 2017; Stirman et al., 2018) and to CBTs more generally (Kazantzis et al., 2016). Clinicians who use these treatments should set the expectation for homework completion from the inception, reinforce compliance (e.g., review homework, praise homework completion), and work with patients to address barriers to homework completion. Similarly, clinicians should attend to missed sessions, as they may be a precursor to dropping out of treatment (Fleming et al., 2020), and treatment effects may be attenuated by longer gaps between sessions (Gutner et al., 2016). It is important to keep in mind that there may be many reasons patients are not fully engaging with the treatments, and providers should invite open communication so that they can be addressed. For example, not showing up to therapy sessions or not completing homework may be a sign of avoidance or ambivalence about recovery. Using motivational enhancement approaches, including asking open-ended questions, can be a way to bring such ambivalence to light and help patients and clinicians address such struggles.

Like psychotherapy, medications need to be taken at an adequate dose and for an adequate length of time to be effective. For each of the recommended medications (i.e., paroxetine, sertraline, and venlafaxine), there is a range for dose—if a patient is not responding to a lower dose, then dose escalation may help. These medications typically take up to 12 weeks or more to reach maximal effect, though some patients may notice some benefit after only a few weeks of treatment. Therefore, it is generally reasonable to wait 3–4 weeks before considering a dose increase and at least 12 weeks before considering discontinuation or switching medications.

If a patient is unable to comply with a selected treatment or has fully complied with an adequate number of sessions and has not improved sufficiently, consider switching to another recommended or suggested treatment. Clinicians may also consider augmenting the current treatment, particularly if a specific need can be identified (e.g., CBT for insomnia may be a useful addition for lingering sleep problems; Morin & Espie, 2003). Regardless of the reason, a change in treatment approach or the addition of another targeted treatment should be discussed with the patient to ensure that they are agreeable to the change.

It is also important to ensure that patients are educated about the expected course and expected outcome of treatment. Trauma-focused therapy can cause initial distress, and patients should understand that an emotional response may be a sign of effective engagement rather than a reason to stop treatment. Approximately 15%–30% of patients experience increased distress in trauma-focused treatments, and this may be more common for individuals who have not previously disclosed their trauma. Importantly, increased distress is not associated with worse treatment outcomes (Larsen et al., 2016; Tripp et al., 2021). If distress does occur, it can be useful to normalize the experience and encourage continued treatment. Additionally, individuals sometimes enter PTSD treatment with the expectation that the treatment will solve all of their problems or, at least, they will never again be upset by memories of their trauma. Patients may experience frustration when treatment does not lead to such complete amelioration. Clinicians should have up-front discussions with patients about what they can realistically expect from treatment. For example:

> Many patients who go through this treatment attain their goals or make significant progress toward them. Many also experience a great deal of improvement in their PTSD symptoms and quality of life. Remember though that even with successful treatment, it does not mean that you will never again have a bad night of sleep or that you won't be

TABLE 1 Telehealth guidelines for providers and patients

Provider guidelines	Patient guidelines
Use private space	Use private space, make provider aware of anyone off-camera
Speak in a normal tone but slightly slower	Minimize distractions/interruptions
Substitute verbal for nonverbal cues	Do not be under the influence of alcohol or drugs
Educate about the modality, assess patient experience	Sit upright and be alert
Have emergency plans in place (know patient location and emergency resources)	Treat the session like any other medical appointment (e.g., dress appropriately, arrive on time)
Make eye contact	Place device on a solid surface at eye level
Minimize noise/distractions, fidgeting	Have your device fully charged

Note: Adapted from Morland, L. A., & Myers, U. (2021, May 5). *PTSD telehealth: The nuts and bolts* [Invited talk]. Center of Excellence VISN 16 Mental Illness Research Education Clinical Center of Excellence (MIRECC).

> upset by memories. Some people continue to experience improvement after treatment, and others may want additional intervention for their PTSD or other issues in their lives. We will carefully monitor your progress so we can adjust course if needed and make sure we are doing our best to meet your needs.

What if someone asks for virtual care?

The COVID-19 pandemic changed the care landscape as telehealth became an overnight necessity, and many patients and clinicians now prefer this modality. Based on the extant literature, videoconferencing is not inferior to in-person care (Liu et al., 2020; McClellan et al., 2022; Morland et al., 2020), so the CPG notes that videoconferencing is recommended when treatments have been validated for that modality or when it is the best option because of accessibility or patient preference (Recommendation 29). Some veterans in the focus group expressed a preference for in-person care, with one noting that they felt more "accountable" when meeting in person. Clinicians who wish to deliver care for PTSD using videoconferencing should keep in mind that the characteristics of the patient (e.g., negative beliefs about telehealth), treatment protocol, technology (e.g., a lack of access to a secure platform), and environment (e.g., a lack of private space) may interfere with telehealth care delivery (Borghouts et al., 2021). Where possible, videoconferencing should be utilized rather than telephone-based care, as the Work Group was unable to identify studies offering PTSD treatment exclusively via telephone, and the face-to-face format better facilitates a therapeutic alliance (Chen et al., 2021). Refer to Table 1 for pragmatic guidelines for the use of telehealth. Telehealth guidelines also are available through the American Psychological Association (2023a).

What if a patient wants a treatment that is not recommended?

Patients may be highly motivated to try things that are featured in the popular press or social media, particularly if they are touted for dramatic and rapid change (e.g., psychedelic-assisted psychotherapy) or have been helpful to a friend. It is good practice to educate patients about the value of evidence-based approaches during the treatment planning process. This may also be useful when encouraging a patient to consider a treatment recommended in the CPG rather than one that is merely suggested. A decision aid, such as that developed by the National Center for PTSD (n.d.a.), can increase the preference for evidence-based treatment (Watts et al., 2015). Also, a clinician might say:

> I think it's great that you are seeking care and that you already have some ideas about what might be helpful for you. I'd like us to spend some time discussing what treatments are available. In particular, I would like to share some treatments that we are pretty confident will help you and discuss why we think so. Mostly, I would like to make sure that you have all the information you need so that we can make an informed choice about how to proceed.

A clinician can ask a patient what appeals to them about the treatment with less empirical support to help guide a conversation about how best to meet the patient's treatment goals. A clinician may also help patients contextualize choosing a nonrecommended treatment in this way:

> I know it may have taken a lot for you to come into treatment and so, on my end, I want

> to make sure to offer you what we know is most likely to help your PTSD. Often it is the newer treatments that get much more attention and may get promoted as potential cures, but, in fact, we have very little information about their effectiveness or safety. It may be worth it to try a treatment we know is likely to help your PTSD first and move on to a more experimental treatment if the frontline one does not work for you. Would you be willing to try one of the approaches we know are effective first, knowing the experimental approach is always an option?

If a patient chooses to engage in a treatment that is not recommended or suggested by the CPG, it remains important to assess progress regularly. If the clinician elects not to engage with the patient in that treatment, the patient should be encouraged to monitor their symptoms and progress themselves and be reminded that they can return to the clinician, or their treatment program, for treatment later. Maintaining good rapport and therapeutic alliance can help a patient make the choice to return and try other treatments if needed.

Animal-assisted approaches. A common example of this conundrum is animal-assisted therapy. The idea of service dogs is nearly universally popular, but evidence for positive effects of service dogs is lacking, and existing studies are generally of low quality (Van Houtert et al., 2018; Vitte et al., 2021). A recent large study in a veteran population showed that having a service dog did not differ from having a generally well-behaved dog (Richerson et al., 2023). Service dogs may negatively impact the family (Nieforth et al., 2022) or interfere with the "antiavoidance" principle of trauma-focused psychotherapy. For example, a dog sweeping a room for safety prevents the patient from learning that the room is actually a safe place. Thus, clinicians who are asked to support the use of a service dog should explain that it is unclear whether service dogs are helpful for PTSD, carefully discuss the dog's role in conjunction with therapeutic goals, and be prepared to manage contextual factors that arise.

Patients may be open to implementing approaches such as getting a dog or meditating as an adjunct to recommended therapy. The CPG was unable to recommend specific adjunctive approaches as treatments for PTSD because of a lack of evidence, but certain activities (e.g., exercise, art) can be good health and stress-management tools for anyone. Therapists could discuss with the patient implementing such approaches as part of a healthy lifestyle while also completing or following a recommended PTSD treatment.

Saying no to treatments that have been shown to cause harm. The CPG recommends against benzodiazepines (Recommendation 19) as well as cannabis and its derivatives (Recommendation 20). Despite this, most seasoned therapists have probably treated patients who relied heavily on one or both of these agents, particularly since the legalization of marijuana in many states. This puts the clinician in the difficult position of working to reduce usage, an agenda that the patient may not share. Clinicians may be well-served by using motivational enhancement strategies (Miller et al., 1992; Murphy & Rosen, 2014) to raise awareness and increase a patient's confidence in coping in other ways. One possible way of opening such a discussion follows:

> I know that you feel that smoking really takes the edge off your day, but as we understand more about cannabis and PTSD, data show that it really doesn't seem to help in the long run, and there are long-term effects on your physical health and thinking ability. I am wondering if you'd consider working with me to see if we could find other ways to help you manage symptoms and reduce your cannabis use.

What if recommended treatments aren't feasible in my setting?

Delivery of care in austere and resource-challenged environments is a reality for many clinicians, and referral to recommended care may not always be available. Fortunately, the list of recommended and suggested treatments includes multiple options for both psychotherapy and medication approaches that could be selected, and care can be delivered via telehealth. Therapists should also be aware that recommended treatments have been used successfully in austere environments, including during military deployments (e.g., Kaysen et al., 2020; Peterson et al., 2020). However, such trials are limited in number and sometimes require the treatments to be modified (e.g., Peterson, et al., 2020), so clinicians are encouraged to monitor outcomes closely over the course of treatment as one would when using other treatments with limited empirical support. The CPG can be a useful tool to advocate for more staff or needed resources to enable the provision of more evidence-based care (e.g., Kirchner et al., 2020). The art in such circumstances is to work at all levels—provider, clinic, and system—to provide the best treatment possible to as many patients as possible.

Therapy groups have been suggested as a strategy for delivering therapy when resources are limited. Unfortunately, the Work Group concluded there is insufficient evidence to recommend for or against any group treatment for the treatment of PTSD (Recommendation 12). This is

based on a systematic review in which the authors found that group therapies were more effective than no treatment but were unable to identify any particular group treatment as effective (Schwartze et al., 2019). Direct comparisons suggest that one-on-one therapy may be more effective; for example, individual CPT outperformed group CPT in a sample of predominantly male active-duty service members (Resick, Wachen, et al., 2017). Groups, however, are a reality in many settings. Although group treatment cannot be recommended at this juncture, groups may combat social isolation, foster hope, destigmatize symptoms, and improve functioning (Levi et al., 2017), and some veterans from the focus group felt very positive about their group experience. In sum, groups should be avoided if possible as a primary treatment for PTSD. If desired, they may be considered as an add-on to a recommended treatment. If a group modality is the only option, trauma-focused groups may be more effective (Sloan et al., 2018), and outcomes should be monitored as discussed for other insufficient evidence interventions.

Should multiple treatments be combined?

The Work Group was unable to recommend any therapies (Recommendation 13) or medications (Recommendation 21) as an adjunct to a primary treatment that might not be achieving the desired results. One unique situation arises with prazosin, which is suggested specifically for the management of PTSD-related nightmares (Recommendation 32), though not for PTSD treatment more generally (Recommendation 18).

Despite the lack of evidence for adjunctive therapies, many patients with PTSD are engaged in combinations of treatments, and clinicians must navigate this complex treatment regimen. Though there will always be exceptions, a few basic principles may be helpful in guiding adjunctive uses. First, *treat serially*. If an individual starts two treatments at the same time, it will be very difficult to know which is responsible for what changes. If interventions are introduced one at a time and outcomes are measured, it will be easier for both patient and provider to know which treatment helped which symptoms. This information can impact maintenance planning and coping with future symptomatic episodes. Second, *be aware of burden.* Many effective PTSD treatments require an investment of time and emotional energy. Thus, adding an additional treatment may be detrimental if it sacrifices the patient's level of engagement with either approach. Clinicians should emphasize a "quality over quantity" principle in treatment planning. Third, *be methodical.* Clinicians should know why they are adding an additional treatment. Having a strong conceptual understanding of the patient's presentation is critical to combining approaches. For example, if nightmares are driving excessive distress or reducing compliance with trauma-focused treatment, a clinician might consider prazosin to address that symptom.

Does the CPG apply to everyone with PTSD?

Many of the large treatment studies that informed this guideline were conducted in veteran or military populations, and these approaches have been evaluated in Western civilian samples as well. Non-White individuals are underrepresented in the extant literature (Benuto et al., 2020), and the literature is inconclusive as to whether there are differences in treatment response based on race/ethnicity (e.g., Rutt et al., 2018; Sripada et al., 2020). Culture may certainly affect a patient's understanding of PTSD and experience of empirically supported treatments. Race- or gender-based discrimination may be the context in which traumatic events occur, so it is important to attend to contextual factors when working with marginalized groups (Carter et al., 2020).

PTSD associated with military trauma may be less responsive to treatment than civilian PTSD, although the CPG took military status into account, and the recommended treatments are still effective with veterans (Hamblen et al., 2022; Straud et al., 2019). This may relate to clinically meaningful differences between typical civilian and military trauma exposure or to factors unique to the military population, such as combat and military culture. These issues should be addressed by following best practices to acknowledge individuals' identities and contexts in treatment (American Psychological Association, 2017).

How should clinicians manage comorbidities?

Comorbidities are often a barrier to patients receiving recommended treatments for PTSD. Frequently this is because of clinician concerns that such patients are more fragile and asking them to engage with trauma memories may lead to clinical worsening (e.g., symptom exacerbation, increased substance use, increased suicidal ideation). The literature reviewed in the CPG demonstrates that across many comorbidities (e.g., psychosis, substance use, depression), patients can benefit from PTSD treatment. As a result, the CPG suggests that the presence of comorbidities, including substance use disorders, should not preclude people from receiving a recommended or suggested treatment for PTSD (Recommendation 34). Clinicians should consider integrated or concurrent treatment

for comorbidities. Clinicians who do not have expertise in a patient's comorbidity may want to collaborate with colleagues to ensure their patient has access to the recommended treatments for both disorders in a concurrent or integrated fashion.

The VA/DoD *Clinical Practice Guideline on Assessment and Management of Patients at Risk for Suicide* (VA/DoD, 2019) is available to guide clinicians through the appropriate identification of risk and the management of these patients. Individuals at high acute risk typically need to be monitored (e.g., in an inpatient psychiatric setting) until the risk is reduced. The treatment of co-occurring conditions, such as PTSD, following established best practices is recommended for individuals with an intermediate-to-low risk. The findings from a recent systematic review demonstrated that PTSD treatments, most frequently CPT and PE, and treatment plans that combined PTSD treatment with suicide-focused treatments reduced both PTSD symptoms and suicidality, whereas suicide-focused treatments alone had beneficial effects on suicidality but led to less change in PTSD symptoms (Rozek et al., 2021).

SUMMARY

The number of recommended and suggested treatment options show that there are effective treatments for PTSD. However, more work is needed to make these treatments widely available to patients with PTSD and to clear barriers that hinder clinicians from putting CPG recommendations into practice. There are also many treatments reviewed in the CPG that were deemed as having insufficient evidence that may prove to be effective, so continued research on the efficacy of these treatments is important. Clinicians may have questions about how to use the CPG. The goal of this paper was to consider some of the common questions clinicians have about implementing the CPG and offer suggestions for navigating challenging situations. It is our belief that the CPG can be a valuable tool for clinicians who spend their days working to improve the lives of patients with PTSD. CPGs provide a framework for clinical decision-making that aims to deliver the most effective treatments to patients while being flexible enough to allow situationally specific decisions, modifications, and adjustments to be made. The CPG aligns with patient-centered care that incorporates the measurement of outcomes to ensure that good intentions have not derailed the expected improvement. For researchers and funding agencies, we hope that the CPG is a call to action; crucial clinical questions remain unanswered, and only systematic and collaborative science will lead to meaningful changes in the next revision of the CPG.

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REFERENCES

Agency for Healthcare Research and Quality. (2014). *Chapter 5. Patient centeredness: National Healthcare Disparities Report, 2010*. http://archive.ahrq.gov/research/findings/nhqrdr/nhdr10/Chap5.html

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychological Association. (2017). *Multicultural guidelines: An ecological approach to context, identity, and intersectionality*. http://www.apa.org/about/policy/multicultural-guidelines.pdf

American Psychological Association. (2023a). Guidelines for the practice of telepsychology. https://www.apa.org/practice/guidelines/telepsychology

American Psychological Association. (2023b). *Measurement-based care*. https://www.apaservices.org/practice/measurement-based-care

American Psychological Association, Presidential Task Force on Evidence-Based Practice. (2006). Evidence-based practice in psychology. *American Psychologist*, *61*(4), 271–285. https://doi.org/10.1037/0003-066X.61.4.271

Belendiuk, K. A., Baldini, L. L., & Bonn-Miller, M. O. (2015). Narrative review of the safety and efficacy of marijuana for the treatment of commonly state-approved medical and psychiatric disorders. *Addiction Science & Clinical Practice*, *10*(1), 1–10. https://doi.org/10.1186/s13722-015-0032-7

Benuto, L. T., Bennett, N. M., & Casas, J. B. (2020). Minority participation in randomized controlled trials for prolonged exposure therapy: A systematic review of the literature. *Journal of Traumatic Stress*, *33*(4), 420–431. https://doi.org/10.1002/jts.22539

Borghouts, J., Eikey, E., Mark, G., De Leon, C., Schueller, S. M., Schneider, M., Stadnick, N., Mukamel, D., & Sorkin, D. H. (2021). Barriers to and facilitators of user engagement with digital mental health interventions: Systematic review. *Journal of Medical*

Internet Research, *23*(3), Article e24387. https://doi.org/10.2196/24387

Brown, L. A., Clapp, J. D., Kemp, J. J., Yarvis, J. S., Dondanville, K. A., Litz, B. T., Mintz, J., Roache, J. D., Young-McCaughan, S., Pederson, A., Foa, E. B., & the STRONG STAR Consortium. (2019). The pattern of symptom change during prolonged exposure therapy and present-centered therapy for PTSD in active duty military personnel. *Psychological Medicine*, *49*(12), 1980–1989. https://doi.org/10.1017/S0033291718002714

Brymer, M., Layne, C., Jacobs, A., Pynoos, R., Ruzek, J., Steinberg, A., Vernberg, E., & Watson, P. (2006). *Psychological first aid field operations guide* (2nd ed.). National Child Traumatic Stress Network & National Center for PTSD. https://www.ptsd.va.gov/professional/treat/type/PFA/PFA_2ndEditionwithappendices.pdf

Carter, R. T., Kirkinis, K., & Johnson, V. E. (2020). Relationships between trauma symptoms and race-based traumatic stress. *Traumatology*, *26*(1), 11–18. https://doi.org/10.1037/trm0000217

Chen, P. V., Helm, A., Fletcher, T., Wassef, M., Hogan, J., Amspoker, A., Cloitre, M., & Lindsay, J. (2021). Seeing the value of video: A qualitative study on patient preference for using video in a Veteran Affairs telemental health program evaluation. *Telemedicine Reports*, *2*(1), 156–162. https://doi.org/10.1089/tmr.2021.0005

Cooper, A. A., Kline, A. C., Graham, B., Bedard-Gilligan, M., Mello, P. G., Feeny, N. C., & Zoellner, L. A. (2017). Homework "dose," type, and helpfulness as predictors of clinical outcomes in prolonged exposure for PTSD. *Behavior Therapy*, *48*(2), 182–194. https://doi.org/10.1016/j.beth.2016.02.013

Ehlers, A., Hackmann, A., Grey, N., Wild, J., Liness, S., Albert, I., Deale, A., Stott, R., & Clark, D. M. (2014). A randomized controlled trial of 7-day intensive and standard weekly cognitive therapy for PTSD and emotion-focused supportive therapy. *American Journal of Psychiatry*, *171*(3), 294–304. https://doi.org/10.1176/appi.ajp.2013.13040552

Fleming, C. E., Hawrilenko, M., Wachen, J. S., Peterson, A. L., Yarvis, J. S., Borah, A., Litz, B. T., Young-McCaughan, S., Hale, W. J., Mintz, J., Resick, P. A., & the STRONG STAR Consortium. (2020). It's about time: Examining the role of session timing in Cognitive Processing Therapy in active duty military personnel. *Journal of Behavioral and Cognitive Therapy*, *30*(3), 231–239. https://doi.org/10.1016/j.jbct.2020.04.001

Foa, E. B., Hembree, E., & Rothbaum, B. O. (2007). *Prolonged exposure: Emotional processing of traumatic experiences*. Oxford University Press.

Foa, E. B., McLean, C. P., Zang, Y., Zong, J., Rauch, S., Porter, K., Knowles, K., Powers, M. B., & Kauffman, B. (2016). Psychometric properties of the Posttraumatic Stress Disorder Symptoms Scale Interview for *DSM-5* (PSSI-5). *Psychological Assessment*, *28*(10), 1159–1165. https://doi.org/10.1037/pas0000259

Forneris, C. A., Gartlehner, G., Brownley, K. A., Gaynes, B. N., Sonis, J., Coker-Schwimmer, E., Jonas, D. E., Greenblatt, A., Wilkins, T. M., Woodell, C. L., & Lohr, K. N. (2013). Interventions to prevent post-traumatic stress disorder: A systematic review. *American Journal of Preventive Medicine*, *44*(6), 635–650. https://doi.org/10.1016/j.amepre.2013.02.013

Gersons, P. R. B., Meewisse, M., & Nijdam, M. J. (2015). Brief eclectic psychotherapy for PTSD. In Schnyder, U. & Cloitre, M. (Eds.) *Evidence-based Treatments for Trauma-related psychological disorders* (pp. 255–276). Springer International Publishing.

Grubbs, K., Larsen, S. E., & Hamblen, J. (2023, November). Patient opinions of names, elements, and varying descriptions of PTSD treatments. In S. Larsen (Chair), What do patients want in a PTSD treatment – and why? [Symposium presentation]. International Society for Traumatic Stress Studies 39th Annual Meeting, Los Angeles, CA, United States.

Guina, J., Rossetter, S. R., DeRhodes, B. J., Nahhas, R. W., & Welton, R. S. (2015). Benzodiazepines for PTSD: A systematic review and meta-analysis. *Journal of Psychiatric Practice*, *21*(4), 281–303. https://doi.org/10.1097/PRA.0000000000000091

Gutner, C. A., Suvak, M. K., Sloan, D. M., & Resick, P. A. (2016). Does timing matter? Examining the impact of session timing on outcome. *Journal of Consulting and Clinical Psychology*, *84*(12), 1108–1115. https://doi.org/10.1037/ccp0000120

Guyatt, G. H., Oxman, A. D., Vist, G. E., Kunz, R., Falck-Ytter, Y., Alonso-Coello, P., & Schünemann, H. J. (2008). GRADE: An emerging consensus on rating quality of evidence and strength of recommendations. *BMJ*, *336*(7650), 924–926. https://doi.org/10.1136/bmj.39489.470347.AD

Hamblen, J. L., Grubbs, K. M., Cole, B., Schnurr, P. P., & Harik, J. M. (2022). "Will it work for me?" Developing patient-friendly graphical displays of posttraumatic stress disorder treatment effectiveness. *Journal of Traumatic Stress*, *35*(3), 999–1010. https://doi.org/10.1002/jts.22808

Hermosilla, S., Forthal, S., Sadowska, K., Magill, E. B., Watson, P., & Pike, K. M. (2023). We need to build the evidence: A systematic review of psychological first aid on mental health and well-being. *Journal of Traumatic Stress*, *36*(1), 5–16. https://doi.org/10.1002/jts.22888

Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st century*. National Academies Press.

Institute of Medicine Committee on Standards for Developing Trustworthy Clinical Practice Guidelines. (2011). *Clinical practice guidelines we can trust*. National Academies Press.

Kansagara, D., O'Neil, M., Nugent, S., Freeman, M., Low, A., Kondo, K., Elven, C., Zakher, B., Motu'apuaka, M., Paynter, R., & Morasco, B. J. (2017). *VA evidence-based synthesis program reports. Benefits and harms of cannabis in chronic pain or post-traumatic stress disorder: A systematic review*. Department of Veterans Affairs.

Kaysen, D., Stappenbeck, C. A., Carroll, H., Fukunaga, R., Robinette, K., Dworkin, E. R., Murray, S. M., Tol, W. A., Annan, J., Bolton, P., & Bass, J. (2020). Impact of setting insecurity on cognitive processing therapy implementation and outcomes in eastern Democratic Republic of the Congo. *European Journal of Psychotraumatology*, *11*(1), Article 1735162. https://doi.org/10.1080/20008198.2020.1735162

Kazantzis, N., Whittington, C., Zelencich, L., Kyrios, M., Norton, P. J., & Hofmann, S. G. (2016). Quantity and quality of homework compliance: A meta-analysis of relations with outcome in cognitive behavior therapy. *Behavior Therapy*, *47*(5), 755–772. https://doi.org/10.1016/j.beth.2016.05.002

Kirchner, J. A. E., Smith, J. L., Powell, B. J., Waltz, T. J., & Proctor, E. K. (2020). Getting a clinical innovation into practice: An introduction to implementation strategies. *Psychiatry Research*, *283*, Article 112467. https://doi.org/10.1016/j.psychres.2019.06.042

Larsen, S. E., Hooyer, K., Hamblen, J., & Kehle-Forbes, S. (2023, November). Patients' choice of a PTSD treatment: Why patients chose and how providers influenced them. In S. Larsen (Chair), *What do patients want in a PTSD treatment – and why?* [Sym-

posium presentation]. International Society for Traumatic Stress Studies 39th Annual Meeting, Los Angeles, CA, United States.

Larsen, S. E., Wiltsey Stirman, S., Smith, B. N., & Resick, P. A. (2016). Symptom exacerbations in trauma-focused treatments: Associations with treatment outcome and non-completion. *Behaviour Research and Therapy*, *77*, 68–77. https://doi.org/10.1016/j.brat.2015.12.009

Lee, D. J., Schnitzlein, C. W., Wolf, J. P., Vythilingam, M., Rasmusson, A. M., & Hoge, C. W. (2016). Psychotherapy versus pharmacotherapy for posttraumatic stress disorder: Systemic review and meta-analyses to determine first-line treatments. *Depression and Anxiety*, *33*(9), 792–806. https://doi.org/10.1002/da.22511

Levi, O., Shoval-Zuckerman, Y., Fruchter, E., Bibi, A., Bar-Haim, Y., & Wald, I. (2017). Benefits of a psychodynamic group therapy (PGT) model for treating veterans with PTSD. *Journal of Clinical Psychology*, *73*(10), 1247–1258. https://doi.org/10.1002/jclp.22443

Liu, L., Thorp, S. R., Moreno, L., Wells, S. Y., Glassman, L. H., Busch, A. C., Zamora, T., Rogers, C. S., Allard, C. A., Morland, L., & Agha, Z. (2020). Videoconferencing psychotherapy for veterans with PTSD: Results from a randomized controlled non-inferiority trial. *Journal of Telemedicine and Telecare*, *26*(9), 507–519. https://doi.org/10.1177/1357633X19853947

Magruder, K. M., McLaughlin, K. A., & Elmore Borbon, D. L. (2017). Trauma is a public health issue. *European Journal of Psychotraumatology*, *8*(1), Article 1375338. https://doi.org/10.1080/20008198.2017.1375338

McClellan, M. J., Osbaldiston, R., Wu, R., Yeager, R., Monroe, A. D., McQueen, T., & Dunlap, M. H. (2022). The effectiveness of telepsychology with veterans: A meta-analysis of services delivered by videoconference and phone. *Psychological Services*, *19*(2), 294–304. https://doi.org/10.1037/ser0000522

Merz, J., Schwarzer, G., & Gerger, H. (2019). Comparative efficacy and acceptability of pharmacological, psychotherapeutic, and combination treatments in adults with posttraumatic stress disorder: A network meta-analysis. *JAMA Psychiatry*, *76*(9), 904–913. https://doi.org/10.1001/jamapsychiatry.2019.0951

Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1992). *Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence*. National Institute on Alcohol Abuse and Alcoholism.

Monteith, L. L., Holliday, R., Schneider, A. L., Miller, C. N., Bahraini, N. H., & Forster, J. E. (2021). Institutional betrayal and help-seeking among women survivors of military sexual trauma. *Psychological Trauma: Theory, Research, Practice, and Policy*, *13*(7), 814–823. https://doi.org/10.1037/tra0001027

Morin, C. M., & Espie, C. A. (2003). *Insomnia: A clinical guide to assessment and treatment*. Kluwer Academics/Plenum Publishers.

Morland, L. A., Mackintosh, M. A., Glassman, L. H., Wells, S. Y., Thorp, S. R., Rauch, S. A., Cunningham, P. B., Tuerk, P. W., Grubbs, K. M., Golshan, S., Sohn, M. J., & Acierno, R. (2020). Home-based delivery of variable length prolonged exposure therapy: A comparison of clinical efficacy between service modalities. *Depression and Anxiety*, *37*(4), 346–355. https://doi.org/10.1002/da.22979

Murphy, R. T., & Rosen, C. S. (2014). Addressing readiness to change PTSD with a brief intervention: A description of the PTSD motivation enhancement group. In J. Garrick & M. B. Williams, *Trauma treatment techniques* (pp. 7–28). Routledge.

National Center for PTSD. (n.d.a). *Decision aid*. https://www.ptsd.va.gov/apps/decisionaid/

National Center for PTSD. (n.d.b). *Treatment basics*. https://www.ptsd.va.gov/understand_tx/tx_basics.asp

Nieforth, L. O., Miller, E. A., MacDermid Wadsworth, S., & O'Haire, M. E. (2022). Posttraumatic stress disorder service dogs and the wellbeing of veteran families. *European Journal of Psychotraumatology*, *13*(1), Article 2062997. https://doi.org/10.1080/20008198.2022.2062997

Peterson, A. L., Foa, E. B., Resick, P. A., Hoyt, T. V., Straud, C. L., Moore, B. A., Favret, J. V., Hale, W. J., Litz, B. T., Rogers, T. E., Stone, J. M., Villareal, R., Woodson, C. S., Young-McCaughan, S., Mintz, J., & the STRONG STAR Consortium. (2020). A non-randomized trial of prolonged exposure and cognitive processing therapy for combat-related posttraumatic stress disorder in a deployed setting. *Behavior Therapy*, *51*(6), 882–894. https://doi.org/10.1016/j.beth.2020.01.003

Prins, A., Bovin, M. J., Smolenski, D. J., Marx, B. P., Kimerling, R., Jenkins-Guarnieri, M. A., Kaloupek, D. G., Schnurr, P. P., Kaiser, A. P., Leyva, Y. E., & Tiet, Q. Q. (2016). The primary care PTSD Screen for *DSM-5* (PC-PTSD-5): Development and evaluation within a veteran primary care sample. *Journal of General Internal Medicine*, *31*(10), 1206–1211. https://doi.org/10.1007/s11606-016-3703-5

Resick, P. A., Monson, C. M., & Chard, K. M. (2017). *Cognitive processing therapy for PTSD: A comprehensive manual*. Guilford Press.

Resick, P. A., Wachen, J. S., Dondanville, K. A., Pruiksma, K. E., Yarvis, J. S., Peterson, A. L., Mintz, J., & the STRONG STAR Consortium. (2017). Effect of group vs individual cognitive processing therapy in active-duty military seeking treatment for posttraumatic stress disorder: A randomized clinical trial. *JAMA Psychiatry*, *74*(1), 28–36. https://do.org/10.1001/jamapsychiatry.2016.2729

Richerson, J. T., Wagner, T. H., Abrams, T., Skelton, K., Biswas, K., Illarmo, S., McSherry, F., Fallon, M. T., Frakt, A., Pizer, S., Magruder, K. M., Groer, S., Dorn, P. A., Huang, G. D., & Stock, E. M. (2023). Therapeutic and economic benefits of service dogs versus emotional support dogs for veterans with PTSD. *Psychiatric Services*, *74*(8), 790–800. https://doi.org/10.1176/appi.ps.20220138

Rothbaum, B. O., Kearns, M. C., Price, M., Malcoun, E., Davis, M., Ressler, K. J., Lang, D., & Houry, D. (2012). Early intervention may prevent the development of posttraumatic stress disorder: A randomized pilot civilian study with modified prolonged exposure. *Biological Psychiatry*, *72*(11), 957–963. https://doi.org/10.1016/j.biopsych.2012.06.002

Rozek, D. C., Baker, S. N., Rugo, K. F., Steigerwald, V. L., Sippel, L. M., Holliday, R., Roberge, E. M., Held, P., Mota, N., & Smith, N. B. (2021). Addressing co-occurring suicidal thoughts and behaviors and posttraumatic stress disorder in evidence-based psychotherapies for adults: A systematic review. *Journal of Traumatic Stress*, *35*(2), 729–745. https://doi.org/10.1002/jts.22774

Rutt, B. T., Oehlert, M. E., Krieshok, T. S., & Lichtenberg, J. W. (2018). Effectiveness of cognitive processing therapy and prolonged exposure in the Department of Veterans Affairs. *Psychological Reports*, *121*(2), 282–302. https://doi.org/10.1177/0033294117727746

Santorelli, S. F., Kabat-Zinn, J., Blacker, M., Meleo-Meyer, F., & Koerbel, L. (2017). *Mindfulness-based stress reduction (MBSR)*

authorized curriculum guide. Center for Mindfulness in Medicine, Health Care, and Society (CFM), University of Massachusetts Medical School.

Schnurr, P. P., Friedman, M. J., Engel, C. C., Foa, E. B., Shea, M. T., Chow, B. K., Resick, P. A., Thurston, V., Orsillo, S. M., Huag, R., Turcer, C., & Bernardy, N. (2007). Cognitive behavioral therapy for posttraumatic stress disorder in women: A randomized controlled trial. *JAMA*, *297*(8), 820–830. https://doi.org/10.1001/jama.297.8.820

Schnurr, P. P., Hamblen, J. L., Wolf, J., Coller, R., Collie, C., Fuller, M. A., Holtzheimer, P. E., Kelly, U., Lang, A. J., McGraw, K., Morganstein, J. C., Norman, S. B., Papke, K., Petrakis, I., Riggs, D., Sall, J. A., Shiner, B., Wiechers, I., & Kelber, M. (2023). The management of posttraumatic stress disorder and acute stress disorder: Synopsis of the 2023 U.S. Department of Veterans Affairs and U.S. Department of Defense clinical practice guideline [Manuscript submitted for publication].

Schwartze, D., Barkowski, S., Strauss, B., Knaevelsrud, C., & Rosendahl, J. (2019). Efficacy of group psychotherapy for posttraumatic stress disorder: Systematic review and meta-analysis of randomized controlled trials. *Psychotherapy Research*, *29*(4), 415–431. https://doi.org/10.1080/10503307.2017.1405168

Shapiro, F. (2017). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures* (3rd ed.). Guilford Press.

Sloan, D. M., & Marx, B. P. (2019). *Written exposure therapy for PTSD: A brief treatment approach for mental health professionals*. American Psychological Association.

Sloan, D. M., Unger, W., Lee, D. J., & Beck, J. G. (2018). A randomized controlled trial of group cognitive behavioral treatment for veterans diagnosed with chronic posttraumatic stress disorder. *Journal of Traumatic Stress*, *31*(6), 886–898. https://doi.org/10.1002/jts.22338

Sripada, R. K., Ready, D. J., Ganoczy, D., Astin, M. C., & Rauch, S. A. (2020). When to change the treatment plan: An analysis of diminishing returns in VA patients undergoing prolonged exposure and cognitive processing therapy. *Behavior Therapy*, *51*(1), 85–98. https://doi.org/10.1016/j.beth.2019.05.003

Steenkamp, M. M., Blessing, E. M., Galatzer-Levy, I. R., Hollahan, L. C., & Anderson, W. T. (2017). Marijuana and other cannabinoids as a treatment for posttraumatic stress disorder: A literature review. *Depression and Anxiety*, *34*(3), 207–216. https://doi.org/10.1002/da.22596

Stirman, S. W., Gutner, C. A., Suvak, M. K., Adler, A., Calloway, A., & Resick, P. (2018). Homework completion, patient characteristics, and symptom change in cognitive processing therapy for PTSD. *Behavior Therapy*, *49*(5), 741–755. https://doi.org/10.1016/j.beth.2017.12.001

Straud, C. L., Siev, J., Messer, S., & Zalta, A. K. (2019). Examining military population and trauma type as moderators of treatment outcome for first-line psychotherapies for PTSD: A meta-analysis. *Journal of Anxiety Disorders*, *67*, Article 102133. https://doi.org/10.1016/j.janxdis.2019.102133

Streiner, D. L. (2003). Diagnosing tests: Using and misusing diagnostic and screening tests. *Journal of Personality Assessment*, *81*(3), 209–219. https://doi.org/10.1207/S15327752JPA8103_03

Swift, J. K., Callahan, J. L., Cooper, M., & Parkin, S. R. (2018). The impact of accommodating client preference in psychotherapy: A meta-analysis. *Journal of Clinical Psychology*, *74*(11), 1924–1937. https://doi.org/10.1002/jclp.22680

Tan, L., Strudwick, J., Deady, M., Bryant, R., & Harvey, S. B. (2023). Mind–body exercise interventions for prevention of posttraumatic stress disorder in trauma-exposed populations: A systematic review and meta-analysis. *BMJ Open*, *13*(7), Article e064758. http://doi.org/10.1136/bmjopen-2022-064758

Tripp, J. C., Haller, M., Trim, R. S., Straus, E., Bryan, C. J., Davis, B. C., Lyons, R., Hamblen, J. L., & Norman, S. B. (2021). Does exposure exacerbate symptoms in veterans with PTSD and alcohol use disorder? *Psychological Trauma: Theory, Research, Practice, and Policy*, *13*(8), 920–928. https://doi.org/10.1037/tra0000634

U.S. Department of Veterans Affairs/Department of Defense. (n.d.). *VA/DoD clinical practice guidelines*. https://www.healthquality.va.gov/

U.S. Department of Veterans Affairs/Department of Defense. (2017). *Clinical practice guideline for the management of posttraumatic stress disorder and acute stress disorder*. https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGFinal012418.pdf

U.S. Department of Veterans Affairs/Department of Defense. (2019). *Assessment and management of patients at risk for suicide*. https://www.healthquality.va.gov/guidelines/MH/srb/index.asp

U.S. Department of Veterans Affairs/Department of Defense. (2023). *VA/DoD clinical practice guidelines: Management of posttraumatic stress disorder and acute stress disorder 2023*. https://www.healthquality.va.gov/guidelines/MH/ptsd/

U.S. Department of Veterans Affairs/Department of Defense Health Executive Committee. (2017). *Evidence-based practice work group charter*. www.healthquality.va.gov/documents/EvidenceBasedPracticeWGCharter123020161.pdf

Van Houtert, E. A., Endenburg, N., Wijnker, J. J., Rodenburg, B., & Vermetten, E. (2018). The study of service dogs for veterans with post-traumatic stress disorder: A scoping literature review. *European Journal of Psychotraumatology*, *9*(sup3), Article 1503523. https://doi.org/10.1080/20008198.2018.1503523

Vitte, P., Bragg, K., Graham, D., Davidson, J., Bratten, T., & Angus-Leppan, G. (2021). The role of canines in the treatment of posttraumatic stress disorder: A systematic review. *Psychological Trauma: Theory, Research, Practice, and Policy*, *13*(8), 899–906. https://doi.org/10.1037/tra0001074

Watts, B. V., Schnurr, P. P., Mayo, L., Young-Xu, Y., Weeks, W. B., & Friedman, M. J. (2013). Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *Journal of Clinical Psychiatry*, *74*(6), e541–e550. https://doi.org/10.4088/jcp.12r08225

Watts, B. V., Schnurr, P. P., Zayed, M., Young-Xu, Y., Stender, P., & Llewellyn-Thomas, H. (2015). A randomized controlled clinical trial of a patient decision aid for posttraumatic stress disorder. *Psychiatric Services*, *66*(2), 149–154. https://doi.org/10.1176/appi.ps.201400062

Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)*. https://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp

Weathers, F. W., Litz, B. T., Keane, T. M., Palmier, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5)*. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Wilkinson, S. T., Radhakrishnan, R., & D'Souza, D. C. (2016). A systematic review of the evidence for medical marijuana in psychiatric indications. *Journal of Clinical Psychiatry*, *77*(8), 1050–1064. https://doi.org/10.4088/JCP.15r10036

Williams, T., Phillips, N. J., Stein, D. J., & Ipser, J. C. (2022). Pharmacotherapy for posttraumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews*, *3*(3), Article CD002795. https://doi.org/10.1002/14651858.CD002795.pub3

Zoellner, L. A., Roy-Byrne, P. P., Mavissakalian, M., & Feeny, N. C. (2019). Doubly randomized preference trial of prolonged exposure versus sertraline for treatment of PTSD. *American Journal of Psychiatry*, *176*(4), 287–296. https://doi.org/10.1176/appi.ajp.2018.17090995

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