Posttraumatic Stress and Substance Use Disorder Comorbidity

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Agenda

• Prevalence and Correlates of Co-occurring PTSD and SUD
• Treatment Guidelines and Research
• Clinical Implications
PTSD and Substance Use Disorder

(Brown, et al., 1995; Dansky, et al., 1995), Farley, et al., 2004; Kessler, et al., 1995; Breslau, et al., 1997; Triffleman et al., 1995)
Fiscal Year (FY) 2013 Prevalence of Co-Occurring Conditions in Veterans Seeking Treatment in Veterans Health Administration (VHA)

- **PTSD**
  - N=535,506 (up 52%)
  - PTSD & SUD: 26.5%
  - N=142,163 (up 76%)

- **SUD**
  - N=516,095 (up 33%)

- **Major Depressive Disorder (MDD)**

- **Schizophrenia**

- **Bipolar(BP)**
Alcohol and Drug Use Disorder Trends in VHA Fiscal Years 2002 to 2014

- Alcohol Only DX
- Both Alc and Drug DX
- Cocaine
- Opioids
- Cannabis
- Amphetamines

Number of Patients

FY02 FY03 FY04 FY05 FY06 FY07 FY08 FY09 FY10 FY11 FY12 FY13 FY14
Trends in SUD Diagnoses in Patients with SUD and PTSD

Trends in SUD Diagnoses Among Veterans with PTSD and SUD

- Alcohol Only DX
- Drug Only DX
- Both Alc and Drug DX

FY06 FY07 FY08 FY09 FY10 FY11 FY12 FY13 FY14
Trends in Drug Use Disorders in Veterans with PTSD and SUD

Trends in Drug Use Disorder Diagnoses for Veterans with PTSD and SUD

- Cocaine
- Opioids
- Cannabis
- Amphetamines
Comorbidity Associated with Worse:

- Treatment outcomes
- Additional medical and psychiatric diagnoses
- Work functioning
- Legal problems
- Medical problems

- HIV risk
- Social support
- Suicidality
- Risk of future trauma
- Risk of aggression
Impact of PTSD on SUD treatment

- Relapse is quicker
- PTSD is a significant predictor of relapse
- Remission of PTSD is associated with better SUD outcomes but remission from substances is NOT associated with improved PTSD
- Patients with PTSD benefit less from SUD treatment than pts w/o PTSD
A Little History

• Sequential Treatment

• Some length of abstinence (~90 days) before Veterans eligible for PTSD treatment
VA/DoD Clinical Practice Guidelines

Available at [www.healthquality.va.gov](http://www.healthquality.va.gov)

PTSD

The guideline is formatted in three modules (algorithms), with 40 evidence-based recommendations:

• Module A
  - Acute Stress Reaction/Disorder
• Module B
  - Assessment and Diagnosis of Posttraumatic Stress Disorder
• Module C
  - Management of Posttraumatic Stress Disorder

SUD

The guideline is formatted as two algorithms and 36 evidence-based recommendations:

• Module A
  - Screening and Treatment
• Module B
  - Stabilization
## GRADE system

<table>
<thead>
<tr>
<th>Four Domains to Assess Strength of Recommendation</th>
<th>Confidence in the quality of the evidence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balance of desirable and undesirable outcomes</td>
<td></td>
</tr>
<tr>
<td>Values and preferences</td>
<td>Other implications, e.g.:</td>
</tr>
<tr>
<td></td>
<td>Resource Use</td>
</tr>
<tr>
<td></td>
<td>Equity</td>
</tr>
<tr>
<td></td>
<td>Acceptability</td>
</tr>
<tr>
<td></td>
<td>Feasibility</td>
</tr>
<tr>
<td></td>
<td>Subgroup considerations</td>
</tr>
</tbody>
</table>

### Balance = Benefit - Harm

<table>
<thead>
<tr>
<th>Balance Level</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SUBSTANTIAL</strong></td>
<td>The intervention substantially improves important health outcomes; benefits substantially outweigh harm</td>
</tr>
<tr>
<td><strong>MODERATE</strong></td>
<td>The intervention improves health outcomes for some and the benefits outweigh harm</td>
</tr>
<tr>
<td><strong>SMALL</strong></td>
<td>The intervention can improve health outcomes – small benefit may involve potential harm</td>
</tr>
<tr>
<td><strong>ZERO-Negative</strong></td>
<td>The intervention provides no benefit and/or may cause harm</td>
</tr>
</tbody>
</table>
Recommendations are explicitly linked to the supporting evidence and graded according to the strength of that evidence.
Quality of the Evidence

**GOOD**
*(High)*
- Further research is unlikely to change confidence in the estimate of effect.

**FAIR**
*(Moderate)*
- Further research is likely to have important impact on our confidence in the estimate of effect and may change the estimate.

**POOR**
*(Low/Very Low)*
- Confidence in the estimate of effect and is likely to change with further research. Any estimate of effect is very uncertain.
Strength of a Recommendation

- Recommendations based on the strength and quality of the evidence
- Strength of a recommendation on a continuum:
  - Strong For (or “We recommend offering this option …”)
  - Weak For (or “We suggest offering this option …”)
  - Weak Against (or “We suggest not offering this option …”)
  - Strong Against (or “We recommend against offering this option …”)
  - Inconclusive – cannot recommend for or against use

### General Clinical Management

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Strength</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. We recommend engaging patients in shared decision making (SDM), which includes educating patients about effective treatment options.</td>
<td>Strong</td>
<td>Not Reviewed, Amended</td>
</tr>
<tr>
<td>Recommendation</td>
<td>Strength</td>
<td>Category</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------</td>
<td>--------------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>Treatment of PTSD with Co-occurring Conditions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>36. We recommend that the presence of co-occurring disorder(s) not prevent patients from receiving other VA/DoD guideline-recommended treatments for PTSD.</td>
<td>Strong for</td>
<td>Reviewed, New-added</td>
</tr>
<tr>
<td>37. We recommend VA/DoD guideline-recommended treatments for PTSD in the presence of co-occurring substance use disorder (SUD).</td>
<td>Strong for</td>
<td>Reviewed, New-replaced</td>
</tr>
</tbody>
</table>
### Treatment of PTSD

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Strength</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>9. We recommend individual, manualized trauma-focused psychotherapy (see Recommendation 11) over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD.</td>
<td>Strong for</td>
<td>Reviewed, New-added</td>
</tr>
<tr>
<td>10. When individual trauma-focused psychotherapy is not readily available or not preferred, we recommend pharmacotherapy (see Recommendation 17) or individual non-trauma-focused psychotherapy (see Recommendation 12). With respect to pharmacotherapy and non-trauma-focused psychotherapy, there is insufficient evidence to recommend one over the other.</td>
<td>Strong for</td>
<td>Reviewed, New-added</td>
</tr>
</tbody>
</table>
11. For patients with PTSD, we recommend individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Strength</th>
<th>Category</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Psychotherapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment of PTSD (cont.)</td>
<td>Strong for</td>
<td>Reviewed, New-replaced</td>
</tr>
</tbody>
</table>
# PTSD Consultation Program Monthly Lecture Series

**SAVE THE DATE: Third Wednesday of the Month from 2-3PM (ET)**

<table>
<thead>
<tr>
<th>Date</th>
<th>Topic</th>
<th>Speaker(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>September 20</td>
<td>The 2017 Revised Clinical Practice Guideline for PTSD: Recommendations for Psychotherapy</td>
<td>Jessica Hamblen, PhD</td>
</tr>
<tr>
<td>October 18</td>
<td>The 2017 Revised Clinical Practice Guideline for PTSD: Recommendations for Medications</td>
<td>Matthew Friedman, MD, PhD</td>
</tr>
<tr>
<td>November 15</td>
<td>The 2017 Revised Clinical Practice Guideline for PTSD: Why It Matters for Primary Care Providers and What Resources are Available</td>
<td>Andrew Pomerantz, MD and Nancy Bernardy, PhD</td>
</tr>
</tbody>
</table>

For more information and to subscribe to announcements and reminders go to [www.ptsd.va.gov/consult](https://www.ptsd.va.gov/consult)
<table>
<thead>
<tr>
<th>#</th>
<th>Recommendation</th>
<th>Strength*</th>
<th>Category†</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>Among patients in early recovery from substance use disorders or following relapse, we suggest prioritizing other needs through shared decision-making (e.g., related to other mental health conditions, housing, supportive recovery environment, employment, or related recovery-relevant factors) among identified biopsychosocial problems and arranging services to address them.</td>
<td>Weak For</td>
<td>Not reviewed, Amended</td>
</tr>
</tbody>
</table>
Searched literature up to Jan 10, 2014

RCT’s of individual or group psychotherapy with PTSD/SUD participants, compared with waiting list, usual care, or other psychotherapy

14 studies included

Meta-analysis with over 1400 participants total

Main comparison was CBT with trauma processing v. CBT without trauma focus (coping skills)
Prolonged Exposure (PE)

In PE you confront situations you have been avoiding until distress decreases.
In CPT you examine and challenge thoughts about the trauma until you can change the way you feel.
CBT works

Prolonged Exposure

- Pre-Treatment
- Post-Treatment
- 9 Month Follow-up
- 5-10 Years

Cognitive Processing Therapy

- Pre-Treatment
- Post-Treatment
- 9 Month Follow-up
- 5-10 Years

Results – Individual Trauma Focused Interventions w/Concurrent or Integrated SUD Treatment

- PTSD symptoms
  - More effective than TAU or min intervention reduction at post-treatment and f/u

- Substance use
  - No diffs at post-tx but more effective at 5-7 month f/u

- Higher drop out rate than TAU
Results – Non-Trauma Focused Interventions

• Most conducted in group
• No effect on PTSD symptoms or SUD compared to TAU
• Full course Seeking Safety more effective at post-tx but not by f/u
• Drop out rate comparable to TAU
Other Findings

- High drop out rate across all studies
- Review based on small number of studies, some small or poorly designed
- Need for further study given low to very low quality of research
- Need to interpret results with caution
Critical Review

Posttraumatic Stress Disorder and Alcohol Use Disorder: A Critical Review of Pharmacologic Treatments

Ismene L. Petrakis and Tracy L. Simpson

Critical Review

No Wrong Doors: Findings from a Critical Review of Behavioral Randomized Clinical Trials for Individuals with Co-Occurring Alcohol/Drug Problems and Posttraumatic Stress Disorder

Tracy L. Simpson, Keren Lehavot, and Ismene L. Petrakis
Promising Directions
In Progress

• Over 44 trials
• PE, CPT, other CBT, prazosin, topiramate...
• Examples...
What is COPE?

- PE + Relapse Prevention – 2 evidence based treatments
- Imaginal is shortened to about 25-30 minutes
- Last 15 minutes of session are focused on RP skills
<table>
<thead>
<tr>
<th>Session</th>
<th>PE</th>
<th>RP</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 - Intro</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Common reactions</td>
<td>Cravings</td>
</tr>
<tr>
<td>3</td>
<td>In-Vivo hierarchy</td>
<td>Craving mgmt</td>
</tr>
<tr>
<td>4</td>
<td>Initiate imageinals</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Continue exposures</td>
<td>Planning for emergencies</td>
</tr>
<tr>
<td>6</td>
<td></td>
<td>Awareness of high risk thoughts</td>
</tr>
<tr>
<td>7</td>
<td></td>
<td>Managing high risk thoughts</td>
</tr>
<tr>
<td>8</td>
<td></td>
<td>Refusal skills</td>
</tr>
<tr>
<td>9</td>
<td></td>
<td>Seemingly irrelevant decisions</td>
</tr>
<tr>
<td>10</td>
<td></td>
<td>Anger awareness</td>
</tr>
<tr>
<td>11</td>
<td></td>
<td>Anger management</td>
</tr>
<tr>
<td>12</td>
<td>Review and termination</td>
<td>Review and termination</td>
</tr>
</tbody>
</table>
Prolonged Exposure With Veterans in a Residential Substance Use Treatment Program

Sonya B. Norman, VA San Diego Healthcare System, National Center for PTSD, University of California, San Diego, VA Center of Excellence for Stress and Mental Health
Brittany C. Davis, VA San Diego Healthcare System
Peter J. Colvonen, VA San Diego Healthcare System, VA Center of Excellence for Stress and Mental Health
Moira Haller, VA San Diego Healthcare System
Ursula S. Myers, VA San Diego Healthcare System and San Diego State University/University of California, San Diego Joint Doctoral Program in Clinical Psychology
Ryan S. Trim, VA San Diego Healthcare System and University of California, San Diego University of California, San Diego
Rebecca Bogner, VA San Diego Healthcare System
Shannon K. Robinson, VA San Diego Healthcare System, University of California, San Diego
Aims

• Assess Feasibility, acceptability, and preliminary efficacy of PE in residential SUD treatment
  – First study of
    • Veteran sample with combat and MST traumas
    • In a hospital setting
    • All SUDs, not just alcohol use disorder
  – Comparison condition that received TAU only
Results

- All completed PE
- Satisfaction scores: 30.83/32 for PE v. 28.00/32 for TAU: NS
Conclusions

- Possible to conduct PE in residential substance use treatment unit with minimal modifications
  - 3x/wk, reminder to use skills, final session includes relapse prevention
- Can conduct exposures around hospital and on leave
- Need buy-in from multiple levels
- Very severe patients benefited
- Some patients may need this level of structure for trauma focused treatment
- Benefits continue post-discharge
Where Are We Now?

• Concurrent or integrated treatment is considered best practice
• Trauma focused (evidence based) PTSD treatments are tolerable and perform as well or better than other treatment
• Consider level of care
  – Outpatient? Intensive? Residential?
A Lot Left to Do...

- Most research to date with AUD
- More needed that is substance specific
- More combination medication/therapy
- More on different levels of care
- How to improve engagement and retention?
Clinical Implications
### Measurement: Brief Addiction Monitor (BAM)

<table>
<thead>
<tr>
<th>Substance Use</th>
<th>Risk Factors</th>
<th>Protective Factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any alcohol use</td>
<td>Physical health</td>
<td>Self-efficacy</td>
</tr>
<tr>
<td>Heavy alcohol use</td>
<td>Sleep problems</td>
<td>Self-help</td>
</tr>
<tr>
<td>Drug use</td>
<td>Mood/Angry/Upset</td>
<td>Religion/spirituality</td>
</tr>
<tr>
<td>Craving</td>
<td>Risky situations</td>
<td>Work, school</td>
</tr>
<tr>
<td>Family/social conflict</td>
<td>Satisfied with Recovery</td>
<td>Income/Housing</td>
</tr>
<tr>
<td>Satisfied with Recovery</td>
<td></td>
<td>Social supports for recovery</td>
</tr>
</tbody>
</table>
BAM: Use items

4. In the past 30 days, how many days did you drink ANY alcohol?  
(If 00, Skip to #6)  

5. How many days did you have at least (5-men, 4-women) drinks?  
[One drink is considered one shot of hard liquor (1.5 oz.) or 12-ounce can/bottle of beer or 5 ounce glass of wine.]  

6. In the past 30 days, how many days did you use any illegal/street drugs or abuse any prescription medications?  
(If 00, Skip to #8)  

7. What did you take?  
   A  ○  Marijuana  
   B  ○  Sedatives/Tranquilizers (benzos, Valium, Xanax, Ativan, Ambien, "barbs" Phenobarbitol, downers, etc.)  
   C  ○  Cocaine/Crack  
   D  ○  Other Stimulants (amphetamine, methamphetamine, Dexadrine, Ritalin, Adderall, "speed", "crystal meth", "ice", "crank", etc.)  
   E  ○  Opiates (Heroin, Morphine, Dilaudid, Demerol, Oxycontin ["oxcy"], codeine [Tylenol 2,3,4], Percocet, Vicodin, Fentanyl, etc.)  
   F  ○  Other Drugs (Steroids, non-prescription sleep/diet pills, Benadryl, Ephedra, other over-the-counter medications, etc.)
Case Example

USE: Alcohol & Drugs
RISK for USE
PROTECTION from USE

Intake
30-day
90-day
180-day
Treatment Planning

• Integrated or concurrent preferred
• Plan developed collaboratively with patient
• Focus on pt goals, safety, and recovery
  – Psychotherapy
  – Goals and treatment around substance use
  – Medication management
  – Other comorbidities and conditions?
Continuum of Care

Primary Care
- Engagement
- Triage
- Brief Interventions

General Outpatient Mental Health (BHIP)
- Engagement & Triage
- Initial Treatment
- Continuing Care

Specialty Care (PCT)
- Intensive PTSD treatment

Residential (PTSD RRTP)
- 24/7 Treatment Setting
- Higher level of care than outpatient care
- Co-occurring treatment needs

Inpatient
- Acute level of care
- Engagement
- Stabilization

The remaining SIPUs and EBPTUs are currently converting to PTSD RRTPs

Veterans may move along the continuum with expectation that Veterans will spend a briefer amount of time in the more intensive treatment settings.
VA-DoD Clinical Practice Guideline for Management of Substance Use Disorders: Key Recommendations

- Screening and brief alcohol intervention
- Treatment (pharmacotherapy and psychosocial interventions)
  - Alcohol use disorder
  - Opioid use disorder
  - Cannabis use disorder
  - Stimulant use disorder
- Promoting group mutual help involvement (e.g. AA, NA, Smart Recovery)
- Address co-occurring mental health conditions and psychosocial problems
- Continuing care guided by ongoing assessment
- Stabilization and withdrawal

<table>
<thead>
<tr>
<th>SUD</th>
<th>Medications</th>
<th>Psychosocial Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Acamprosate, Disulfiram, Naltrexone, Topiramate, Gabapentin*</td>
<td>BCT, CBT-SUD, CRA, MET, TSF</td>
</tr>
<tr>
<td>Opioid</td>
<td>Buprenorphine, Methadone, ER-Injectable, Naltrexone*</td>
<td>Medical Management**, CM/IDC**</td>
</tr>
<tr>
<td>Cannabis</td>
<td></td>
<td>CBT/MET</td>
</tr>
<tr>
<td>Stimulant</td>
<td></td>
<td>CBT/CRA/GDC +/- CM</td>
</tr>
</tbody>
</table>

*suggested  **recommended only with medication

http://www.healthquality.va.gov/guidelines/MH/sud/
When to Offer PTSD Treatment?

• No metric yet
• Case by case decision with pts using collaborative approach
• Abstinent or willing to cut down?
  – Willing not to use in a way that would disrupt treatment
• Motivated for treatment
• What supports are in place?
Introducing Treatment

• Do patients want treatments?
• Continue to use motivational strategies
Learn about posttraumatic stress disorder (PTSD) from Veterans who live with it every day. Hear their stories. Find out how treatment turned their lives around.

VETERANS CLINICIANS

Who I am
How I knew I had PTSD
How PTSD affects the people you love
Why I didn’t ask for help right away
When I knew I needed help
What treatment was like for me
How treatment helps me
My advice to you
PTSD
TREATMENT DECISION AID:
THE CHOICE IS YOURS

LEARN
Learn about PTSD and how this decision aid can help

COMPARE
Compare effective PTSD treatment options

ACT
Take action to start treatment
Treatments Included in this Decision Aid

This decision aid focuses only on evidence-based treatments that are proven to work. Treatments in this decision aid received a strong recommendation in the 2017 guideline published by the Department of Veterans Affairs and Department of Defense (VA/DoD).

To treat PTSD, the VA/DoD guideline strongly recommends the use of trauma-focused psychotherapies or specific SSRIs and SNRIs (types of antidepressants). Trauma-focused psychotherapies are the most highly recommended type of treatment.
Prolonged Exposure

What type of treatment is this?

Prolonged Exposure (PE) is a psychotherapy for PTSD. It is one specific type of Cognitive Behavioral Therapy. PE teaches you to gradually approach trauma-related memories, feelings, and situations that you have been avoiding since your trauma. By confronting these challenges, you can actually decrease your PTSD symptoms.

How does it work?

People with PTSD often try to avoid anything that reminds them of the trauma. This can help you feel better in the moment, but not in the long term. Avoiding these feelings and situations can actually make it harder to overcome your PTSD. PE helps you gradually face these challenges, in a safe and controlled way, to help you overcome your trauma.
# Treatment Comparison Chart

## Psychotherapy

<table>
<thead>
<tr>
<th>What type of treatment is this?</th>
<th>How does it work?</th>
<th>What will I do?</th>
<th>Is it effective?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Processing Therapy</td>
<td>Teaches you to reframe negative thoughts about the trauma</td>
<td>Talk about your thoughts, Writing assignments and worksheets</td>
<td>Yes, 53 out of every 100 people who receive a trauma-focused therapy (such as Cognitive Processing Therapy) will no longer have PTSD</td>
</tr>
<tr>
<td>Eye Movement Desensitization &amp; Reprocessing</td>
<td>Helps you process and make sense of your trauma</td>
<td>Call the trauma to mind while focusing on an external motion or sound</td>
<td>Yes, 53 out of every 100 people who receive a trauma-focused therapy (such as Eye Movement Desensitization and Reprocessing) will no longer have PTSD</td>
</tr>
<tr>
<td>Prolonged Exposure</td>
<td>Teaches you how to gain control by facing your fears</td>
<td>• Talk about the trauma&lt;br&gt;• Start doing safe things you have been avoiding</td>
<td>Yes, 53 out of every 100 people who receive Prolonged Exposure will no longer have PTSD</td>
</tr>
</tbody>
</table>

## Medication

| SSRI/SNRI | Restores the balance of naturally occurring chemicals in your brain | Yes, 42 out of every 100 people who receive this treatment will no longer have PTSD |

### Antidepressant medications:
- **SSRI:** Prozac, Paxil & Zoloft
- **SNRI:** Effexor
Cognitive Processing Therapy

Is it effective?

Yes, trauma-focused psychotherapy (including Cognitive Processing Therapy) is one of the most effective types of treatment for PTSD.

53

For every 100 people with PTSD who receive a trauma-focused therapy (such as Cognitive Processing Therapy), 53 will no longer have PTSD after about three months.

What do these figures mean?
How did we calculate this number?
Show me the studies.
Example of personalized summary

I COMPARED different PTSD treatments

Based on what I liked about different treatments, the following treatments might be a good fit for me:

- Prolonged Exposure
- Cognitive Processing Therapy
- Eye Movement Desensitization and Reprocessing

**MY TREATMENT PREFERENCES**
Here is a summary of the number of things you liked about each of the treatment options.

<table>
<thead>
<tr>
<th>Treatment Options</th>
<th>Number of Likes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cognitive Processing Therapy</td>
<td>High</td>
</tr>
<tr>
<td>Prolonged Exposure</td>
<td>Medium</td>
</tr>
<tr>
<td>Eye Movement Desensitization and Reprocessing</td>
<td>Low</td>
</tr>
</tbody>
</table>

I would like to discuss these treatments with my provider:
- Prolonged Exposure

I took steps to ACT on a treatment that seems right to me

**My goals for treatment:**
- Sleep through the night
- Stop getting angry over little things
- Have fewer nightmares
- Get back into old hobbies

**My questions:**
- Will a provider who has not had similar experiences be able to help me?
- Can I get PTSD treatment if I am drinking or using drugs?

**My plans:**
- Discuss my thoughts about PTSD treatment with a friend or family member

The graph shows which treatments best align with your patient’s preferences.

Your patient is interested in this treatment! Ask what they liked about it and what questions they have. Tell them whether this treatment is easily available.

This information can be useful to you when you create your patient’s treatment plan.

Be sure to make time to talk through these questions together.

Ask if your patient has accomplished this task yet, or ask how you can support them in getting this done.
PTSD Treatment Decision Aid:  
www.ptsd.va.gov/decisionaid

Clinician’s User Guide:  
www.ptsd.va.gov/apps/decisionaid/resources/PTSDDecisionAid_providerguide.pdf

Printable flyers/handouts:  
www.ptsd.va.gov/professional/treatment/pdf/decisionaid_flyer.pdf

https://www.ptsd.va.gov/professional/treatment/pdf/decisionaid_rackcard.pdf
During Treatment

• Continue to use motivational strategies
• Continue to use measurement based approach
• Continue to assess progress, safety, and goals