The 2017 Revised Clinical Practice Guideline for PTSD: Why It Matters for Primary Care and What Resources are Available

Nancy Bernardy, PhD
Associate Director for Clinical Networking, Executive Division, National Center for PTSD
Associate Professor, Geisel School of Medicine at Dartmouth

Andrew Pomerantz, MD
National Mental Health Director, Integrated Services Office of Mental Health and Suicide Prevention, VHA
Associate Professor, Geisel School of Medicine at Dartmouth

PTSD Consultation Lecture Series, November, 2017
1. Review revised PTSD guideline recommendations relevant to Primary Care – including Patient Aligned Care Team (PACT) and Primary Care Mental Health Integration (PCMHI)

2. Briefly discuss clinical implications and practice changes

3. Provide resources available to support Primary Care
Keeping up with the rapidly expanding evidence base for various disorders represents a nearly impossible challenge for most Primary Care clinicians.

The VA/DoD PTSD guideline is designed to support clinical decision making with evidence-based recommendations; not to define VA/DoD standards of care or policy.

www.healthquality.va.gov/guidelines/MH/PTSD
WHAT DO WE MEAN WHEN WE SAY THESE ARE EVIDENCE-BASED RECOMMENDATIONS?

• Methodology for 2017 based on *Guide for Guidelines* and is as rigorous for mental health as medical guidelines

• What does it mean when we say a treatment is evidence-based?
  
  – **Evidence-based treatments** give patients the best chance for recovery and are the foundation for evidence-based practice.
  
  – Review of evidence takes 3 things into account:
    
    • # of studies,
    
    • quality of those studies, and
    
    • experts agree the treatment works

• **1 in 10** Veterans receiving care in VA have a diagnosis of PTSD

• Among OEF/OIF Veterans who use VA care, **1 in 4** men and **1 in 5** women have PTSD

(Greenberg, Greg; and Hoff, Rani. 2016 Veterans with PTSD Data Sheet: National, VISN, and VAMC Tables. West Haven, CT: Northeast Program Evaluation Center. Annual (2014-Present)

• **1 in 5** patients with PTSD will only see PCP for treatment – refuse MH referral.

• Among those patients referred to MH, older veterans less likely to follow through with referral (3 studies).

• Of 5000+ positive PTSD screens in VISN 20, about 60% had no MH visits in the following year.

• Treating Veterans with PTSD in primary care improves engagement in care.
REASONS TO TREAT PTSD IN PRIMARY CARE: PATIENT PREFERENCE

- Of those who accept referral to MH, more than half want PCP to be involved in their MH care anyway.
- About 1 in 3 older Veterans prefer PTSD treatment with PCP.
- About 1 in 4 Veterans who are racial/ethnic minority Veterans with PTSD prefer to have treatment by PCP.
- Patients who have negative experiences with MH providers may return to primary care untreated.
- Patient satisfaction, and possibly treatment engagement and outcome, improve if the patient is treated by the preferred provider.
REASONS TO TREAT PTSD IN PRIMARY CARE: IMPROVED MEDICAL HEALTH OUTCOMES

- PTSD patients may present with physical symptoms rather than emotional distress (headaches, insomnia, pain)
- PTSD associated with increased rates and earlier onset of chronic diseases (e.g. HTN, DMII, Alzheimer's, Osteoarthritis)
- PTSD is associated with increases in inflammatory markers and increased all cause mortality.
- More outpatient healthcare use and worse response to treatments for many conditions (e.g., pain).
- Treating PTSD in PC is integral to improving medical outcomes.
SCREENING STARTS IN PRIMARY CARE

No diagnosis of PTSD

Periodic screening for PTSD – repeated to assess for delayed onset as well as impact of new stressors

Use quantitative self-report measure:

| PC-PTSD-5 | PTSD Checklist – 5 (PCL-5) |

Diagnosis of PTSD

Use of quantitative self-report measure of PTSD severity (i.e., PCL-5)

Measurement-Based Care

Initial treatment planning | Screening | Monitor treatment progress

PCL-5 and PC-PTSD-5 are available at: www.ptsd.va.gov/professional/assessment/DSM_5_Validated_Measures.asp
Hypertension management (blood pressure), Diabetes (A1c), COPD (pulmonary function tests)

Mental Health is actually late to measurement-based care

Large initiative now in Mental Health to do it with standardized outcome measures such as the PCL-5, the PHQ9, and the BAM-R regardless of presenting diagnosis

Patient-reported outcome measures carry the same weight as laboratory tests

Bottom line: Measurement-based care saves money, resources, and improves patient outcomes
WHAT DO PATIENTS WANT TO KNOW ABOUT PTSD TREATMENT?

• How well the treatments work
• How long the benefits will last
• What the “side effects” of psychotherapy are
  – Will it cause them to have increases in symptoms such as nightmares or flashbacks?
  – Will it interfere with functioning while going through it?
  – Will it help with functioning after treatment?
• Will they be asked to talk about their trauma?
• Will they be asked to do homework?
WHAT DO PROVIDERS WANT TO KNOW ABOUT PTSD TREATMENT?

• What do I do when someone screens positive?
• What do I do when someone mentions traumatic nightmares?
• How do I decide when to send someone to the PTSD specialty clinic versus using PCMHI?
• What can I do myself?
• What do I do when someone will not go to MH for care?
  • What do I do when I’ve sent someone to MH and they come back saying it didn’t help or they didn’t like it?
Tell your patient trauma-focused psychotherapy works

- Explain that untreated PTSD can impact health and enjoyment of life
- Point out that with no treatment, symptoms are unlikely to get better and may get worse
- Be a myth-buster: Trauma-focused psychotherapy for PTSD is not laying on a couch, won’t go on indefinitely, and is not the same as talking to a support group.
- Explore why a patient is declining referral
- Know the recommended treatments, not just for PTSD but also for the common symptoms that you treat
- Acknowledge that there are side effects to psychotherapy; it is hard work and symptoms may worsen initially
WHERE TO START?

• Start with your PCMHI colleagues
  – If your patient has a positive PTSD screen, have PCMHI then help make the diagnosis.

• Learn what treatments are available in PCMHI
  – Effective brief treatment such as Problem-Solving Training (PST)
  – We are testing and piloting brief versions of Cognitive Behavioral Therapy for Insomnia (CBT-I), Cognitive Behavioral Therapy for Chronic Pain (CBT-CP)
  – We’re working to make brief Prolonged Exposure (PE) available

• Collaborate beyond Primary Care
  – Ask PCMHI to invite your Local Evidence-Based Psychotherapy Coordinator or your PTSD Clinical Team Director to come to a PACT training to discuss referral processes, available treatments and barriers you face in getting patients the care they need
  – List of EBP Coordinators is available at http://vaww.mentalhealth.va.gov/ebp/coordinator.asp
VA CENTER FOR INTEGRATED HEALTHCARE (CIH)

- CIH is a VA Center of Excellence devoted to improving health care for Veterans through research, education, and implementation support focused on Primary Care-Mental Health Integration (PCMHI), including enhanced implementation of brief EBPs
- Center personnel are available to provide individualized program consultation related to PCMHI fidelity, training, dissemination, and implementation of brief evidence-based interventions appropriate for the PCMHI setting
- Brief treatments for PCMHI (currently available and under development):
  - Problem Solving Training (PST)
  - Behavioral Activation
  - Brief CBT for Chronic Pain
  - Brief Alcohol Interventions
  - Pilot for Brief Prolonged Exposure for PTSD
  - Referral Management
  - Unified Protocol
  - Tobacco Use Cessation
  - Pilot for Brief CBT for Depression
  - Pilot for Brief CBT-I

Please contact our consultation team at CIHConsultation@va.gov
Visit our website at https://www.mirecc.va.gov/cih-visn2/clinical_resources.asp
Questions about prescribing for PTSD?
Our experts can help.

PTSDconsult@va.gov
(866) 948-7880
www.ptsd.va.gov/consult

Matthew Friedman, MD, PhD
PTSD Senior Advisor
1. *We recommend* engaging patients in shared decision making (SDM), which includes educating patients about effective treatment options.

**Shared Decision Making (SDM)** is an approach in which providers and patients communicate together using the best available evidence to make decisions.

The patient’s goals may not lead to the treatment decision you think is best.
9. *We recommend* individual, manualized trauma focused psychotherapy over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD.

10. When individual trauma focused psychotherapy is not readily available or not preferred, *we recommend* pharmacotherapy or individual non-trauma-focused psychotherapy. There is *insufficient* evidence to recommend one over the other.
11. *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 Therapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure.
For every 100 people who receive the treatment, how many will no longer have PTSD after 3 months?

- CPT/PE/EMDR: 53
- SSRIs: 42
- No Treatment: 9

Both medication and psychotherapy are effective but trauma-focused psychotherapies are better.

### Effect Size

<table>
<thead>
<tr>
<th></th>
<th>8-12 wk pre/post</th>
<th>9 month pre/post</th>
<th>9m. Between Group</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SSRI/SNRI</strong></td>
<td>1.43 (1.36 to 1.51)</td>
<td>2.51 (2.14-2.82)</td>
<td>.30 (.12-.47)</td>
</tr>
<tr>
<td><strong>PE+CPT+EMDR</strong></td>
<td>2.74 (2.50-2.97)</td>
<td>4.54 (4.16-4.91)</td>
<td>.80 (.57-1.03)</td>
</tr>
</tbody>
</table>
Effects of Trauma Focused Cognitive Psychotherapy Last

**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

If individual trauma-focused psychotherapy is not readily available or not preferred, then recommend:

<table>
<thead>
<tr>
<th>Pharmacotherapy:</th>
<th>Manualized individual non-trauma-focused psychotherapy</th>
</tr>
</thead>
<tbody>
<tr>
<td>– Sertraline</td>
<td>– Present-Centered Therapy (PCT)</td>
</tr>
<tr>
<td>– Paroxetine</td>
<td>– Stress Inoculation Training (SIT)</td>
</tr>
<tr>
<td>– Fluoxetine</td>
<td>– Interpersonal Psychotherapy (IPT)</td>
</tr>
<tr>
<td>– Venlafaxine</td>
<td></td>
</tr>
</tbody>
</table>

There is insufficient evidence to recommend one over the other.
• Important to consider the reasons for and impact of prescribing medication
• Antidepressants don’t work as well as the trauma-focused psychotherapies
• What if a prescription prevents someone from benefiting from a first-line psychotherapy?
• Many patients with comorbidities such as depression or insomnia show improvement after psychotherapy, not just in PTSD but the comorbidity
• Are there barriers to talk therapy that could be solved?
17. *We recommend* the following specific medications as monotherapy for PTSD for patients diagnosed with PTSD who choose not to engage in or are unable to access trauma-focused psychotherapy:

- Sertraline
- Paroxetine
- Fluoxetine
- Venlafaxine
AVOID PTSD PRESCRIBING PITFALLS

- Medications focused on insomnia and anxiety carry risk and do not address underlying PTSD
- Symptom-focused medications can actually lead to worse PTSD outcomes
- If patient wants to focus treatment on insomnia or anxiety, discuss advantages of psychotherapy approaches
- Shared decision-making can help.
We suggest against treatment of PTSD with the following medications as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks.

- Quetiapine, Olanzapine, and other Second Generation Antipsychotics (except for Risperidone, which is a Strong Against)
- Citalopram
- Amitriptyline
- Lamotrigine
- Topiramate
20. *We recommend against* treating PTSD with the following medications as monotherapy due to the lack of strong evidence for their efficacy and/or known adverse effect profiles and associated risks.

- Divalproex
- Tiagabine
- Guanfacine
- Risperidone
- Benzodiazepines
- Ketamine
- Hydrocortisone
- D-Cycloserine
21. *We recommend against* treating PTSD with cannabis or cannabis derivatives due to the lack of evidence for their efficacy, known adverse effects, and associated risks.

- Preliminary evidence that cannabis could improve PTSD symptoms, particularly nightmares, is offset by the significant side effects.
- The lack of well-designed RCTs evaluating the efficacy of cannabis in large samples of patients with PTSD combined with the serious side effects, does not support the use of natural or synthetic cannabinoids as a treatment for PTSD.
<table>
<thead>
<tr>
<th>Quality of Evidence</th>
<th>Recommend For</th>
<th>Suggest For</th>
<th>Suggest Against</th>
<th>Recommend Against</th>
<th>No Recommendation For or Against</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Moderate</strong></td>
<td>Sertraline(^\wedge)</td>
<td>Prazosin (excluding the treatment of PTSD associated nightmares)</td>
<td>Prazosin for the treatment of PTSD associated nightmares</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Paroxetine(^\wedge)</td>
<td>Fluoxetine Venlafaxine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Low</strong></td>
<td>Nefazodone</td>
<td>Quetiapine Olanzapine Citalopram Amitriptyline</td>
<td>Divalproex Tiagabine Guanfacine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Very Low</strong></td>
<td>Imipramine Phenelzine</td>
<td>Lamotrigine Topiramate</td>
<td>Risperidone Benzodiazepines D-cycloserine D-serine Escitalopram Mirtazapine</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>No Data+</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*The Work Group determined there was no high quality evidence regarding medication monotherapy.
\(^\wedge\)FDA approved for PTSD
\(\pm\)Serious potential toxicity, should be managed carefully
\(\dagger\)No data were captured in the evidence review (based on the criteria outlined in Conducting the Systematic Review) and were not considered in development of this table
\(\ddagger\)Studies of these drugs did not meet the inclusion criteria for the systematic evidence review due to poor quality

(VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder, page 53)
<table>
<thead>
<tr>
<th>Quality of Evidence</th>
<th>Recommend For</th>
<th>Suggest For</th>
<th>Suggest Against</th>
<th>Recommend Against</th>
<th>No Recommendation For or Against</th>
</tr>
</thead>
<tbody>
<tr>
<td>Moderate</td>
<td></td>
<td>Prazosin (excluding the treatment of PTSD associated nightmares)</td>
<td>Risperidone</td>
<td>Prazosin for the treatment of PTSD associated nightmares</td>
<td></td>
</tr>
<tr>
<td>Low</td>
<td>Topiramate</td>
<td>Divalproex Olanzapine</td>
<td>Hydrocortisone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Very Low</td>
<td>Baclofen Pregabalin D-cycloserine†</td>
<td>Mirtazapine and Sertraline^</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No Data+</td>
<td></td>
<td>Other atypical antipsychotics</td>
<td>Any drug not listed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Combination means treatments are started simultaneously; augmentation means one treatment is started after another treatment (all treatments are augmentation unless otherwise noted)
±The Work Group determined there was no high quality evidence regarding medication augmentation and combination therapy
†Outside of a research setting
^Combination treatment
‡No data were captured in the evidence review (based on the criteria outlined in Conducting the Systematic Review) and were not considered in development of this table

RECOMMENDATIONS FOR PRAZOSIN

28a. For global symptoms of PTSD, *we suggest against* the use of prazosin as mono- or augmentation therapy.

28b. For nightmares associated with PTSD, there is *insufficient evidence* to recommend for or against the use of prazosin as mono- or augmentation therapy.

- This was a painful recommendation. Basically no difference between prazosin and placebo on any sleep measure.
- If you have a patient who has benefited from prazosin, then by all means, continue with that treatment plan.
- Research suggests those PTSD patients with adrenergic arousal may be a subgroup that benefits from prazosin. (Raskind, et al., 2016)
25. *We recommend against* using the following medications as augmentation therapy for the treatment of PTSD due to low quality evidence or the absence of studies and their association with known adverse effects.

- Second Generation Antipsychotics
- Benzodiazepines
- Divalproex
29. In partial- or non-responders to psychotherapy, there is insufficient evidence to recommend for or against augmentation with pharmacotherapy.

30. In partial- or non-responders to pharmacotherapy, there is insufficient evidence to recommend for or against augmentation with psychotherapy.

31. There is insufficient evidence to recommend for or against starting patients with PTSD on combination pharmacotherapy and psychotherapy.
32. There is *insufficient evidence* to recommend for or against the following somatic therapies:

- Repetitive transcranial magnetic stimulation (rTMS)
- Electroconvulsive therapy (ECT)
- Hyperbaric oxygen therapy (HBOT)
- Stellate ganglion block (SGB)
- Vagal nerve stimulation (VNS)
WHAT ABOUT COMORBIDITIES, TECHNOLOGY, AND COMPLIMENTARY AND INTEGRATIVE HEALTH?

NANCY BERNARDY
37. *We recommend* that the presence of a co-occurring disorder(s) not prevent patients from receiving other VA/DoD guideline-recommended treatments.

38. *We recommend* VA/DoD guideline-recommended treatments for PTSD in the presence of co-occurring substance use disorder (SUD).

39. *We recommend* an independent assessment of co-occurring sleep disturbance in patients with PTSD, particularly when sleep problems pre-date PTSD onset or remain following successful completion of a course of treatment.

40. *We recommend* Cognitive Behavioral Therapy for Insomnia (CBT-I) for insomnia in patients with PTSD unless an underlying medical or environmental etiology is identified or severe sleep deprivation warrants the immediate use of medications to prevent harm.
35. **We suggest** internet-based cognitive behavioral therapy (iCBT) with feedback provided by a qualified facilitator as an alternative to no treatment.

36. **We recommend** using trauma-focused psychotherapies that have demonstrated efficacy using secure video teleconferencing (VTC) modality when PTSD treatment is delivered via VTC.
32. There is *insufficient evidence* to recommend any complementary and integrative health (CIH) practice, such as meditation (including mindfulness), yoga, acupuncture, and mantram meditation, as a primary treatment for PTSD.

- Important to clarify that we are not recommending against these treatments but are saying that at this time, the research does not support the use of any CIH practice for the primary treatment of PTSD. **Recognize their value to improve wellness and promote recovery.**

- Complicated by the heterogeneity of the types of acupuncture or meditation, for instance, that have been assessed.

- No studies evaluating the use of animal-assisted therapy met the threshold for inclusion.
2. We suggest collaborative care interventions, for patients with PTSD who are treated in Primary Care, that facilitate active engagement in evidence-based treatments.

- Interventions that facilitate **active engagement** in evidence-based PTSD treatments appear to increase patient follow-through with treatment, improve patient satisfaction, and potentially reduce premature dropout from treatment.

- Effective elements include:
  - Weekly telephone coaching in problem solving, behavioral activation
  - Stepped psychosocial treatment options including online tools, problem solving, and individual psychotherapy with collected outcomes
  - Central telepsychiatry assistance

- Care management alone was not effective for PTSD, whereas the stepped care aspects of the models evaluated did appear to improve outcomes.
SUMMARY

• There is growing evidence that specific psychotherapies are more effective than medications as treatment for PTSD and the common symptoms seen in Primary Care.

• Innovative brief treatment psychotherapy approaches that are available in PCMHI offer promise as a way to re-engage Veterans in their lives and promote recovery.

• Think of this presentation like writing a consult note, which the receiving clinician reads backwards, starting with “what do I do,” and then looking at the “why” when you have time and curiosity.

• We hope we have given you information for both the what and the why and want to share valuable resources to help.
PRIMARY CARE: The Best PTSD Care Anywhere Starts with You!

Primary Care teams have an important role in treating Veterans with PTSD. Know the facts about recommended PTSD treatments to provide the best care to your patients.

Did You Know?

1 in 10 Veterans receiving care in VA have PTSD

Among OEF/OIF Veterans who use VA care, 1 in 4 men and 1 in 5 women have PTSD

PTSD does not have to be a chronic disorder. With treatment, recovery is possible

Trauma-focused psychotherapies—not medication—are the best treatment option

Plan Ahead for Resistance

You can challenge common misconceptions about PTSD therapy and mental health treatment.

TIPS: STANDING UP TO STIGMA

- Tell your patient trauma-focused psychotherapy works.
- Talk openly about mental health issues.
- Explain that untreated PTSD can impact overall health and enjoyment of life.
- Explore why a patient is declining referral.
- Be a myth-buster: Effective therapy is focused and time-limited.

WHAT ELSE CAN YOU DO?

- Think twice before you prescribe. Is medication going to prevent your patient from trying psychotherapy?
- Emphasize that without treatment, symptoms are unlikely to get better and may get worse.
- Start with your Primary Care Mental Health Integration team. Brief, effective treatments are available.

What Works

Connect your patient to effective PTSD treatments. When placing a consult, indicate you want your patient to receive trauma-focused psychotherapy, the first-line treatment for PTSD.

Trauma-focused psychotherapies with the strongest evidence

- Cognitive Processing Therapy (CPT)
- Prolonged Exposure (PE)
- Eye Movement Desensitization and Reprocessing (EMDR)

Antidepressants are another option

Through less effective than trauma-focused psychotherapies, antidepressant medication is another treatment option for PTSD. Prescribing medication for PTSD is the same as prescribing medication to treat depression.

Antidepressants with the strongest evidence:

- Sertraline
- Paroxetine
- Fluoxetine
- Venlafaxine

To track clinical progress, use the PTSD Checklist (PCL-5).

Remember: For the best outcome, keep the focus on treating PTSD. Focusing on symptoms like anxiety or insomnia is not as effective.

There is strong evidence against the following:

- Benzodiazepines
- Cannabis

Ask an expert about your PTSD-related questions through the PTSD Consultation Program: call (866) 948-7880 or email PTSDconsult@va.gov

Find a full list of recommended treatments in the VA/DoD 2017 PTSD Clinical Practice Guidelines: www.healthquality.va.gov/guidelines/Min/ptsd

Help patients learn more about PTSD treatment options and choose what's best for them with the PTSD Treatment Decision Aid: www ptsdva.gov/apps/decisionaid/
A new online tool to help patients learn about and compare evidence-based PTSD treatments

www.ptsd.va.gov/decisionaid
Prolonged Exposure

What type of treatment is this?

Prolonged Exposure (PE) is one type of trauma-focused psychotherapy for PTSD. 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 actually keeps you from recovering from PTSD. PE works by helping you face your fears. By talking about the details of the trauma and by confronting safe situations that you have been avoiding, you can decrease your PTSD symptoms and regain more control of your life.

What can I expect?

Your provider will start by giving you an overview of treatment and getting to know more about your past experiences. You will also learn a breathing technique to help you manage anxiety. Around your second session, you will work with your provider to make a list of people, places, or activities that you have stayed away from since your trauma. Over the course of therapy, you will work through your list step-by-step, practicing in vivo exposure.

This means that you will gradually confront these situations. With time, you will find that you can feel comfortable in these situations — and you will not need to avoid them anymore. After a few sessions, you will begin to talk through the details of your trauma with your provider. This is called imaginal exposure. Talking about the trauma can help with emotions like fear, anger, and sadness. You will listen to recordings of your imaginal exposure between sessions. By confronting the details of the trauma in therapy, you will find that you have fewer unwanted memories at other times.

Is it effective?

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

How long does treatment last?

PE usually takes 8-15 weekly sessions, so treatment lasts about 3 months. Sessions are 1.5 hours each. You may start to feel better after a few sessions. And the benefits of PE often last long after your final session with your provider.

What are the risks?

The risks of doing PE are mild to moderate discomfort when engaging in new activities and when talking about trauma-related memories. These feelings are usually mild and people tend to feel better as they keep doing PE. There is also a slight risk that someone could listen to a therapy session without your permission if the recording was not secure. You and your provider can discuss ways to secure your personal information related to this program. Most people who complete PE find that the benefits outweigh any initial discomfort.

Will I talk in detail about my trauma?

Yes, around your third session, you will start talking in detail about your trauma. Your provider will guide you through it, keep track of your anxiety level as you talk, and will make sure you take things at your own pace. You will listen to a recording of this part of your session at home between sessions.

Group or individual?

PE is an individual therapy. You will meet one-to-one with your provider for each session.

Will I have homework?

Yes, you will practice doing some of the things you have avoided since your trauma. You will start with activities that are manageable for you, and you will work up to activities that are more challenging. You will also listen to a recording of your therapy sessions, including your imaginal exposure recording. Practicing these skills between sessions helps you get the most out of PE.

How available is this in VA?

Almost all VA Medical Centers offer PE in their specialized PTSD programs and more than 2,000 VA providers are trained in PE. Smaller VA facilities that do not offer PE may be able to use videoteleconferencing to have you receive PE from a provider at another location.

See what Veterans have to say:

Now that I have had PE, I can do the things that I used to avoid, I can rejoin my family and continue to go to crowded places. I can drive a car. I can be around people, my friends, and family.

— Valentina Oronde

I had a problem believing that this therapy, me actually facing the trauma over and over was going to help me. But as I did more and more and more, the therapy, it worked. I listened to it and I listened to it and eventually, you're controlling the memory versus it controlling you.

— Arthur Jefferson

I had to spend at least 30 minutes in a restaurant, which was, at first, it was very difficult, but now, I'm up to, at least, I can go and have dinner and not have to worry about getting out of there in a sweat.

— Curtis Cedarbaum
ABOUTFACE VIDEO GALLERY

Learn about posttraumatic stress disorder (PTSD) from Veterans who've experienced it. Hear their stories. Find out how treatment turned their lives around.

VETERANS  CLINICIANS  FAMILY

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

www ptsd va gov/aboutface
NCPTSD has partnered with a number of organizations to develop a variety of mobile apps.

Apps are focused on PTSD, related health problems (e.g., insomnia, alcohol use, etc.), or general well-being.

There are apps for patients, providers, and for use with patient-provider dyads.

MOBILE APP USE IN PCMHI
Previously in the PTSD Consultation Program Monthly Lecture Series

**The 2017 Revised Clinical Practice Guideline for PTSD:**

**Recommendations for Psychotherapy**
Jessica Hamblen, PhD  
Recorded September 20  [Slides (PDF)](https://example.com/slides)  [Audio (MP4)](https://example.com/audio)

**Recommendations for Medications**
Matthew Friedman, MD, PhD  
Recorded October 18  [Slides (PDF)](https://example.com/slides)  [Audio (MP4)](https://example.com/audio)

Click on the Lecture Series tab and scroll down.
CONTINUING EDUCATION COURSES

- Over 50 hours of web-based courses for professionals.
- All courses are free.
- Most offer continuing education for multiple disciplines.

Available to Anyone  For VA Staff

www ptsd va gov/professional/continuing ed/index asp
Are you treating Veterans with PTSD?

Consult with expert PTSD clinicians for FREE

PTSDconsult@va.gov
(866) 948-7880
www ptsd va gov consult

PTSD Consultation Program
For Providers Who Treat Veterans
VA Participants in the PTSD CPG Work Group

Nancy C. Bernardy, PhD (Champion)
Director, PTSD Mentoring Program
Associate Director for Clinical Networking, VA National Center for PTSD
Associate Professor of Psychiatry
Geisel School of Medicine at Dartmouth
White River Jct, VT

Matthew J. Friedman, MD, PhD (Champion)
Senior Advisor, VA National Center for PTSD
Professor of Psychiatry
Geisel School of Medicine at Dartmouth
White River Jct, VT

Sonya Norman, PhD
Director, PTSD Consultation Program
VA National Center for PTSD
VA San Diego Healthcare System
Professor, University California San Diego School of Medicine
San Diego, CA

Matthew Jeffreys, MD
Telehealth Psychiatrist
VA Texas Valley Coastal Bend Healthcare System
Associate Professor of Psychiatry
University of Texas Health Science Center
San Antonio, TX

Mary Jo Pugh, RN, PhD, FACMPH
National Quality Assurance Director, VA Epilepsy Centers of Excellence
Research Health Scientist, Veterans Evidence-based Research, Dissemination, and Implementation Center
Professor, Department of Epidemiology and Biostatistics
Co-Director, Research to Advance Community Health (ReACH) Center
University of Texas Health Science Center San Antonio, TX

Kathleen M. Chard, PhD
Associate Chief of Staff for Research
Director, Trauma Recovery Center
Cincinnati VA Medical Center
Professor of Psychiatry and Behavioral Neuroscience
University of Cincinnati
Cincinnati, OH

Lori Davis, MD
Associate Chief of Staff for Research and Development
Tuscaloosa VA Medical Center
Clinical Professor of Psychiatry
The University of Alabama at Birmingham
Tuscaloosa, AL

Bradford Felker, MD
Director, Telemental Health Program
VA Puget Sound Health Care System
Professor, Department of Psychiatry and Behavioral Sciences
University of Washington
Seattle, WA

Paula P. Schnurr, PhD (Champion)
Executive Director, VA National Center for PTSD
Research Professor of Psychiatry
Geisel School of Medicine at Dartmouth
White River Jct, VT

Sheila A.M. Rauch, PhD, ABPP
Director, Mental Health Research and Program Evaluation
Atlanta VAMC Clinical Director, Emory Healthcare Veterans Program
Associate Professor of Psychiatry and Behavioral Sciences
Emory University School of Medicine
Atlanta, GA

Todd P. Semla, MS, PharmD, BCPS, FCCP, AGSF
National PBM Clinical Pharmacy Program Manager
Mental Health & Geriatrics
National Pharmacy Benefits Management Services
US Department of Veterans Affairs
Feinberg School of Medicine
Northwestern University
Chicago, IL

Jessica Hamblen, PhD
Acting Deputy Executive Director, VA National Center for PTSD
Associate Professor, Department of Psychiatry
Geisel School of Medicine at Dartmouth
White River Jct, VT
DoD Participants in the PTSD CPG Work Group

**Charles S. Hoge, MD (Champion)**  
Senior Scientist, Walter Reed Army Institute of Research  
Neuropsychiatric Consultant, Office of the Army Surgeon General  
Attending Psychiatrist, Walter Reed National Military Medical Center  
Bethesda, MD

**David Riggs, PhD (Champion)**  
Professor and Chair, Department of Medical and Clinical Psychology  
Executive Director, Center for Deployment Psychology  
Uniform Services University of the Health Sciences  
Bethesda, MD

**Megan J. Ehret, PharmD, MS, BCPP**  
Fort Belvoir, VA

**Elaine Stuffel, RN, NSN, MHA**  
Fort Sam Houston, TX

**Joel T. Foster, PhD MAJ, USAF, BSC**  
Falls Church, VA

**Lisa Teegarden, PsyD, COL, MS, USA**  
Bethesda, MD

**Shawn F. Kane, MD, FAAFP, FACSM, COL, MC, MFS, DMO**  
Fort Bragg, NC

**Meena Vythilingham, MD CDR, USPHS**  
Arlington, VA

**Kate McGraw, PhD**  
Silver Spring, MD

**Wendi M. Waits, MD, COL., MC USA**  
Fort Belvoir, VA

**Jeffery Millegan, MD, MPH, FAPA, CDR MC USN**  
San Diego, CA

**Jonathon Wolf, MD**  
Bethesda, MD
Acknowledgements

• Michele Spoont, PhD
• Laura Wray, PhD
• Macgregor Montañó, PharmD
• Claire Collie, PhD
• Todd McKee and the NCPTSD staff
OTHER QUESTIONS?

Nancy.Bernardy@va.gov

Andrew.Pomerantz@va.gov
Please enter your questions in the Q&A box and be sure to include your email address.

The lines are muted to avoid background noise.
Welcome users of VHA TRAIN!
To obtain continuing education credit please return to www.vha.train.org after the lecture.

TRAIN help desk: VHATRAIN@va.gov
Registration —> Attendance —> Evaluation —> Certificate

Register in TRAIN.

Listen to the lecture.

Return to TRAIN for evaluation.

Follow the directions to print certificate.

TRAIN help desk: VHATRAIN@va.gov

(866) 948-7880 or PTSDconsult@va.gov
CEU Process (for VA employees)

Registration

Register in TMS.
(See link under “Web Links” on right here if you have not registered.)

Attendance

Join via TMS and listen to the lecture.

Posttest

Posttest is no longer required for this lecture.

Evaluation

Return to TMS and complete evaluation found in your “To-Do List.”

Certificate

Print certificate from the “Completed Work” section of TMS.
PTSD Consultation Program
FOR PROVIDERS WHO TREAT VETERANS

PTSDconsult@va.gov
(866) 948-7880
www.ptsd.va.gov/consult
**PTSD Consultation Program**

FOR PROVIDERS WHO TREAT VETERANS

(866) 948-7880 or PTSDconsult@va.gov

### UPCOMING TOPICS

**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>December 20</td>
<td>Present Centered Therapy for PTSD</td>
<td>Paula Schnurr, PhD &amp; Tracie Shea, PhD</td>
</tr>
<tr>
<td>January 17</td>
<td>Balancing Clinical Flexibility while Preserving Efficacy in Delivering EBPs for PTSD</td>
<td>Tara Galovski, PhD</td>
</tr>
<tr>
<td>February 21</td>
<td>PTSD Treatment Via Telehealth</td>
<td>Leslie Morland, PhD</td>
</tr>
<tr>
<td>March 21</td>
<td>What We Know about PTSD and Opioids</td>
<td>Elizabeth Oliva, PhD &amp; Jodie Trafton, PhD</td>
</tr>
<tr>
<td>April 18</td>
<td>Written Exposure Therapy for PTSD</td>
<td>Denise Sloan, PhD</td>
</tr>
<tr>
<td>May 16</td>
<td>Brief Prolonged Exposure for PTSD</td>
<td>Sheila Rauch, PhD</td>
</tr>
<tr>
<td>June 20</td>
<td>What the Latest Research Tells Us about Treating PTSD Nightmares</td>
<td>Philip Gehrman, PhD</td>
</tr>
<tr>
<td>July 18</td>
<td>[To be announced]</td>
<td></td>
</tr>
<tr>
<td>August 15</td>
<td>An Evidence-Informed Approach to Helping Clients after Disaster or Mass Violence: Skills for Psychological Recovery</td>
<td>Patricia Watson, PhD</td>
</tr>
<tr>
<td>September 19</td>
<td>PTSD and Women’s Mental Health</td>
<td>Suzanne Pineles, PhD</td>
</tr>
</tbody>
</table>

For more information and to subscribe to announcements and reminders go to [www.ptsd.va.gov/consult](http://www.ptsd.va.gov/consult)