NEJM Journal Watch

Managing Post-Traumatic Stress Disorder

A new guideline carefully separates validated treatments from those with weak or insufficient evidence and recommends a screening tool for primary care.

Sponsoring Organization: U.S. Veterans Affairs/U.S. Department of Defense (VA/DOD)

Background

This guideline on post-traumatic stress disorder (PTSD), written by the VA/DOD Evidence Based Practice Work Group, provides 37 assessment and treatment recommendations, based on the quality and strength of evidence for effectiveness and safety, along with consideration of feasibility and patient perspectives. The authors believe that this guideline can apply to both military and civilian patients.

Key Recommendations

- A 5-item tool (the PC-PTSD-5) is recommended for primary care screening. For positive screens, a clinician-rated structured clinical assessment should be used to confirm PTSD diagnosis.
- Psychotherapies are recommended over pharmacotherapy due to greater efficacy, fewer adverse effects, and patient greater preference, despite feasibility and patient-engagement challenges.
- For specific psychotherapies, recommendations are strongest for cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), and prolonged exposure (PE). Various other therapies are rated as weaker or as having insufficient evidence. The authors recommend against group, marital, or family therapy formats. Delivery by teletherapy is acceptable.
- For medications, paroxetine, sertraline, and venlafaxine are recommended; evidence is insufficient for all other antidepressants and psychedelic drugs (with or without psychotherapy); the authors recommend against divalproex, prazosin, ketamine, risperidone, benzodiazepines, and cannabis.
- Evidence is insufficient for a variety of nonpharmacologic biologic treatments, including transcranial magnetic or direct current stimulation. The authors recommend against electroconvulsive therapy.
- Among complementary and alternative treatments, only mindfulness is recommended.
- For nightmares, prazosin is given a "weak" recommendation; evidence is insufficient for various other proposed treatments for PTSD-associated nightmares.
- Comorbid conditions should not delay PTSD treatment but occasionally might alter recommendations; for example, ketamine might be appropriate if comorbid depression is present.

COMMENT

A striking aspect of this guideline is its long list of interventions that have been proposed for PTSD treatment but lack sufficient supporting evidence. The guideline's recommendations *against* treatments often are based on single negative clinical trials or reflect clear evidence of risks and harms (e.g., benzodiazepines, cannabis). Popular enthusiasm for psychedelics is tempered by limited studies and concern about harms, resulting in no recommendation.

The recommended 5-item screener (the PC-PTSD-5) can be accessed with an online tool; a cutoff score of 3 or 4 appears to optimize sensitivity and specificity (*JAMA Network Open* 2021; 4:e2036733). The authors note that primary care providers are well positioned to screen patients for PTSD, provide

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medication, use self-rated checklists to monitor treatment, and counsel both in favor of specific psychotherapies and against certain potentially harmful interventions such as benzodiazepines or cannabis. **— *Peter Roy-Byrne, MD***

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Schnurr PP et al. 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. **Ann Intern Med** *2024 Feb 27; [e-pub]. (https://doi.org/10.7326/M23-2757)*