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Treatment of Posttraumatic Stress Disorder

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Foa EB, Davidson JRT, Frances A. The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. J Clin Psychiatry 1999;60 (Suppl 16).

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THE JOURNAL OF
CLINICAL PSYCHIATRY

VOLUME 60 1999 SUPPLEMENT 16

SUPPLEMENT

The Expert Consensus Guideline Series

Treatment of Posttraumatic Stress Disorder

Editors for the Guidelines

Edna B. Foa, Jonathan R. T. Davidson, and Allen Frances

THE JOURNAL OF
CLINICAL PSYCHIATRY

VOLUME 60 **1999** **SUPPLEMENT 16**

The Journal of Clinical Psychiatry (ISSN 0160-6689) is owned and published monthly by Physicians Postgraduate Press, Inc., P.O. Box 752870, Memphis, TN 38175-2870. Physicians Postgraduate Press, Inc., does not hold itself responsible for statements made by contributors in the *Journal.*

The Journal of Clinical Psychiatry is indexed in Index Medicus, Excerpta Medica, Psychological Abstracts, Current Contents, Science Citation Index, Hospital Literature Index, Biological Abstracts, Cumulative Index of Allied Health and Nursing, International Nursing, Industrial Medicine, Chemical Abstracts, and Adolescent Mental Health Abstracts.

Expert Consensus Guideline Series

Treatment of Posttraumatic Stress Disorder

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Disclaimer:

Any set of guidelines can provide only general suggestions for clinical practice and practitioners must use their own clinical judgment in treating and addressing the needs of each individual patient, taking into account that patient's unique clinical situation. There is no representation of the appropriateness or validity of these guideline recommendations for any given patient. The developers of the guidelines disclaim all liability and cannot be held responsible for any problems that may arise from their use.

This project was supported by unrestricted educational grants from
Abbott Laboratories
Bristol-Myers Squibb
Eli Lilly and Co.
Janssen Pharmaceutica, Inc.
Pfizer Inc
Solvay Pharmaceuticals.

PUBLISHED BY PHYSICIANS POSTGRADUATE PRESS, INC.
For reprints of this Supplement, contact
Physicians Postgraduate Press, Inc.

THE JOURNAL OF
CLINICAL PSYCHIATRY
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Treatment of Posttraumatic Stress Disorder

GUIDELINES

SURVEY RESULTS

The Expert Consensus Panels for PTSD

The recommendations in the guidelines are derived from the statistically aggregated opinions of the groups of experts and do not necessarily reflect the opinion of each individual expert on each question.

Psychotherapy Experts

The following participants in the Psychotherapy Expert Consensus Survey were identified from several sources: recent publications, recipients of research grants, and the membership of the International Society for Traumatic Stress Studies and the American Association of Behavioral Therapists. Of the 55 experts to whom we sent the PTSD psychotherapy survey, 52 (95%) replied.

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The following participants in the Medication Expert Consensus Survey were identified from several sources: recent publications, recipients of research grants, and the membership of the International Society for Traumatic Stress Studies, the Society for Biological Psychiatry, and the American Society for Clinical Psychopharmacology. Of the 61 experts to whom we sent the PTSD medication survey, 57 (93%) replied.

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Introduction

How often have you wished that you had an expert on hand to advise you on how best to help a patient who is not responding well to treatment or is having a serious complication? Unfortunately, of course, an expert is usually not at hand, and even if a consultation were available, how would you know that any one expert opinion represents the best judgment of our entire field? This is precisely why we began the Expert Consensus Guidelines Series. Our practical clinical guidelines for treating the major mental disorders are based on a wide survey of the best expert opinion. These are meant to be of immediate help to you in your everyday clinical work. Let's begin by asking and answering four questions that will help put our effort in context.

How do these Expert Consensus Guidelines relate to (and differ from) the other guidelines that are already available in the literature?

Each of our guidelines builds upon existing guidelines but goes beyond them in a number of ways:

1. We focus our questions on the most specific and crucial treatment decisions for which detailed recommendations are usually not made in the more generic guidelines that are currently available.
2. We survey the opinions of a large number of the leading experts in each field and have achieved a remarkably high rate of survey response (over 90% for these PTSD guidelines), ensuring that our recommendations are authoritative and represent the best in current expert opinion.
3. We report the experts' responses to each question in a detailed and quantified way (but one that is easy to understand) so that you can evaluate the relative strength of expert opinion supporting the guideline recommendations.
4. The guidelines are presented in a simple format. It is easy to find where each patient's problem fits in and what the experts would suggest you do next.
5. To ensure the widest possible implementation of each of the guidelines, we are undertaking a number of educational activities and research projects, consulting with policy makers in the public sector and in managed care, and maintaining a web page (www.psychguides.com).

Why should we base current treatment decisions on expert consensus instead of the relevant treatment studies in the research literature and evidence-based guidelines?

There are three reasons why expert consensus remains an important addition:

1. Most research studies are difficult to generalize to everyday clinical practice. The typical patient who causes us the most concern usually presents with comorbid disorders, has not responded to previous treatment efforts, and/or requires a number of different treatments delivered in combination or sequentially. Such individuals are almost universally excluded from clinical trials. We need practice guidelines for help with those patients who would not meet the narrow selection criteria used in most research studies.
2. The available controlled research studies do not, and cannot possibly, address all the variations and contingencies that arise in clinical practice. Expert-generated guidelines are needed because clinical practice is so complicated that it is constantly generating far too many questions for the clinical research literature to ever answer comprehensively with systematic studies.
3. Changes in the accepted best clinical practice often occur at a much faster rate than the necessarily slower-paced research efforts that would eventually provide scientific documentation for the change. As new treatments become available, clinicians often find them to be superior for indications that go beyond the narrower indications supported by the available controlled research.

For all these reasons, the aggregation of expert opinion is a crucial bridge between the clinical research literature and clinical practice.

How valid are the expert opinions provided in these guidelines, and how much can I trust the recommendations?

We should be better able to answer this question when our current research projects on guideline implementation are completed. For now, the honest answer is that we simply don't know. Expert opinion must always be subject to the corrections provided by the advance of science. Moreover, precisely because we asked the experts about the most difficult questions facing you in clinical practice, many of their recommendations must inevitably be based on incomplete research information and may have to be revised as we learn more. Despite this, the aggregation of the universe of expert opinion is often the best tool we have to develop guideline recommendations. Certainly the quantification of the opinions of a large number of experts is likely to be much more trustworthy than the opinions of any small group of experts or of any single person.

Why should I use treatment guidelines?

First, no matter how skillful or artful any of us may be, there are frequent occasions when we feel the need for expert guidance and external validation of our clinical experience. Second, our field is becoming standardized at an ever more rapid pace. The only question is, who will be setting the standards? We believe that practice guidelines should be based on the very best in clinical and research opinion. Otherwise, they will be dominated by other less clinical and less scientific goals (e.g., pure cost reduction, bureaucratic simplicity). Third, it should be of some comfort to anyone concerned about losing clinical art under the avalanche of guidelines that the complex specificity of clinical practice will always require close attention to the individual clinical situation. Guidelines can provide useful information but are never a substitute for good clinical judgment and common sense.

Our guidelines are already being used throughout the country and seem to be helpful not only to clinicians but also to policy makers, administrators, case managers, mental health educators, patient advocates, and clinical and health services researchers. Ultimately, of course, the purpose of this whole enterprise is to do whatever we can to improve the lives of our patients. It is our hope that the expert advice provided in these guidelines will make our treatments ever more specific and effective.

Allen Frances, M.D.

How to Use the Guidelines

The *Expert Consensus Guidelines for the Treatment of Posttraumatic Stress Disorder* (PTSD) are based on surveys of 52 experts on the psychotherapy treatment and 57 experts on the medication treatment of PTSD. We thank all the experts who gave of their time and expertise in participating in the surveys.

METHOD OF DEVELOPING EXPERT CONSENSUS GUIDELINES

Creating the Surveys

We first created a skeleton algorithm based on the existing research literature and other guidelines[1] to identify key decision points in the everyday treatment of patients with PTSD. We highlighted important clinical questions that had not yet been adequately addressed or definitely answered.[2,3] We then developed two written questionnaires, one on medication treatments and one on psychotherapy treatments.

The Rating Scale

The survey questionnaires used a 9-point scale slightly modified from a format developed by the RAND Corporation for ascertaining expert consensus.[4] We presented the rating scale to the experts with the following anchor points:

Extremely Inappropriate ← **1 2 3 4 5 6 7 8 9** → Extremely Appropriate

- 9 = extremely appropriate: this is your treatment of choice
- 7–8 = usually appropriate: a 1st line treatment you would often use
- 4–6 = equivocal: a 2nd line you would sometimes use (e.g., patient/family preference or if 1st line treatment is ineffective, unavailable, or unsuitable)
- 2–3 = usually inappropriate: a treatment you would rarely use
- 1 = extremely inappropriate: a treatment you would never use

Below is Psychotherapy Survey Question 20 as an example of our question format.

20. Please rate the appropriateness of each of the following **formats** for psychotherapy sessions during the initial phase (first 3 months) of treatment for PTSD.

Individual	1 2 3 4 5 6 7 8 9
Family	1 2 3 4 5 6 7 8 9
Therapist-led PTSD group	1 2 3 4 5 6 7 8 9
Self-help PTSD group	1 2 3 4 5 6 7 8 9
Combination of individual and group therapy	1 2 3 4 5 6 7 8 9
Combination of individual and family therapy	1 2 3 4 5 6 7 8 9

Analyzing and Presenting the Results

The actual questions and results of the medication and psychotherapy treatment surveys are presented in the second half of this publication (pp. 34–68). As an example, the results of Psychotherapy Survey Question 20 are presented graphically as shown on the next page. For most questions, we present:

- the question as it was posed to the experts
- the treatment options ordered as they were rated by the experts
- a bar chart depicting the confidence intervals for each of the choices
- a table of mean scores and frequency distributions

In some cases, to save space, we present only the numerical results in a tabular form or summarize the results verbally. Complete results for these questions are available from the editors on request.

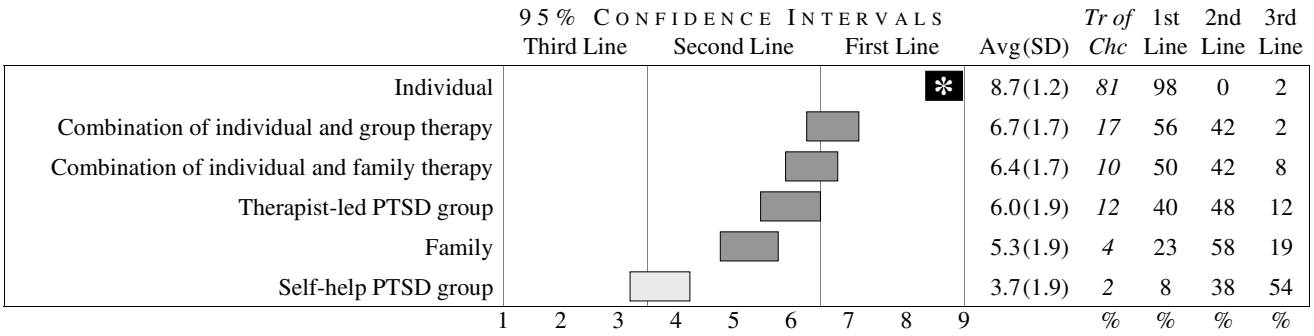
95% Confidence Intervals. In analyzing the results of the survey questions, we first calculated the mean (Avg), standard deviation (SD), and confidence interval (CI) for each item. The CI is a statistically calculated range which tells you that there is a 95% chance that the mean score would fall within that range if the survey were repeated with a similar group of experts. The CIs for each treatment option are shown as horizontal bars. When the bars do not overlap, it indicates that there is a statistically significant difference between the mean scores of the two choices.

Rating Categories. We designated a rating of first, second, or third line for each item, determined by the category into which the 95% CI of its mean score fell. In assigning a rating for each item, we followed a stringent rule to avoid chance upgrading and assigned the lowest rating into which the confidence interval fell. For example, if the bottom of the confidence interval even bordered on the next lower category, we considered the item to be in the lower group. The following graphic conventions are used to indicate the different rating categories.

- ✻ Treatments of choice (items rated "9" by at least half the experts)
- First line (the entire CI had to fall at or above a score of 6.5 or greater)
- Second line (the CI had to fall between 3.5 and 6.49)
- Third line (a portion of the CI had to fall below 3.5)

Numeric Values. Next to the chart we give a table of numeric values for the mean score (Avg) and standard deviation (SD) for each item, and the percentage of experts who rated the option treatment of choice (9), first line (7–9), second line (4–6), and third line (1–3). (Note: the percentage for treatment of choice [*Tr of Chc*] is also included in the total percentage for first line.)

20 Please rate the appropriateness of each of the following **formats** for psychotherapy sessions during the initial phase (first 3 months) of treatment for PTSD.



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Individual	8.7(1.2)	*81*	98	0	2
Combination of individual and group therapy	6.7(1.7)	*17*	56	42	2
Combination of individual and family therapy	6.4(1.7)	*10*	50	42	8
Therapist-led PTSD group	6.0(1.9)	*12*	40	48	12
Family	5.3(1.9)	*4*	23	58	19
Self-help PTSD group	3.7(1.9)	*2*	8	38	54
		%	*%*	*%*	*%*

What the Ratings Mean

First line treatments are options that the panel feels are usually appropriate as initial treatment for a given situation. Treatment of choice, when it appears, is an especially strong first line recommendation (having been rated as "9" by at least half the experts). In choosing between several first line recommendations, or deciding whether to use a first line treatment at all, clinicians should consider the overall clinical situation, including the patient's prior response to treatment, side effects, general medical problems, and patient preferences.

Second line treatments are reasonable choices for patients who cannot tolerate or do not respond to the first line choices. Alternatively, you might select a second line choice as your initial treatment if the first line options are deemed unsuitable for a particular patient (e.g., because of poor previous response, inability to follow psychotherapy instructions, inconvenient dosing regimen, particularly annoying side effects, a general medical contraindication, a potential drug-drug interaction, or if the experts don't agree on a first line treatment).

For some questions, second line ratings dominated, especially when the experts did not reach any consensus on first line options. In such cases, to differentiate within the pack, we label those items whose confidence intervals overlap with the first line category as "high second line."

Third line treatments are usually inappropriate or used only when preferred alternatives have not been effective.

From Survey Results to Guidelines

After the survey results were analyzed and ratings assigned, the next step was to turn these recommendations into user-friendly guidelines. For example, the results of Survey Question 20 presented above are shown on p. 50 and are used in *Guideline 2C: Level of Care during the Initial Phase of Treatment* (p. 13).

The graphic for Survey Question 20 shows that the experts rated individual psychotherapy sessions as first line, since the bar for this option falls entirely within the first line category. In addition, because 81% of the experts rated individual sessions as 9, they are considered the treatment format of choice (indicated by the star in the bar). The bars for a combination of individual and group or family therapy straddle the first and second line categories, resulting in a "top tier" second line designation for these two options.

Guideline 2C therefore recommends individual psychotherapy sessions as the format of choice for psychotherapy during the acute phase of treatment (first 3 months or until the patient is stabilized) and suggests that clinicians also consider a combination of individual and group or family therapy. Whenever the guideline gives more than one treatment in a rating category, we list them in the order of their mean scores.

LIMITATIONS AND ADVANTAGES OF THE GUIDELINES

These guidelines can be viewed as an expert consultation, to be weighed in conjunction with other information and in the context of each individual patient-physician relationship. The recommendations do not replace clinical judgment, which must be tailored to the particular needs of each clinical situation. We describe groups of patients and make suggestions intended to apply to the average patient in each group. ***However, individual patients will differ greatly in their treatment preferences and capacities, their history of response to previous treatments, their family history of treatment response, and their tolerance for different side effects. Therefore, the experts' first line recommendations will certainly not be appropriate in all circumstances.***

We remind readers of several other limitations of these guidelines:

1. The guidelines are based on a synthesis of the opinions of a large group of experts. From question to question, some of the individual experts would differ with the consensus view.
2. We have relied on expert opinion precisely because we are asking crucial questions that are not yet well answered by the literature. One thing that the history of medicine teaches us is that expert opinion at any given time can be very wrong. Accumulating research will ultimately reveal better and clearer answers. Clinicians should therefore stay abreast of the literature for developments that would make at least some of our recommendations obsolete. We will continue to revise the guidelines periodically based on new research information and on reassessment of expert opinion to keep them up-to-date.

3. The guidelines are financially sponsored by the pharmaceutical industry, which could possibly introduce biases. Because of this, we have made every step in guideline development transparent, report all results, and take little or no editorial liberty.
4. These guidelines are comprehensive but not exhaustive; because of the nature of our method, we omit some interesting topics on which we did not query the expert panel.

Despite these limitations, the *Expert Consensus Guideline Series*[5–9] represents a significant advance because of the guidelines' specificity, ease of use, and the credibility that comes from achieving a very high response rate from a large sample of the leading experts in the field.

SUGGESTED TOUR

The best way to use these guidelines is first to read the Table of Contents to get an overview of how the document is organized. Next, read through the individual guidelines. Finally, you may find it fascinating to compare your opinions with those of the experts on each of the questions; we strongly recommend that you use the detailed survey results presented in the second half of this publication in this way.

The guidelines are organized so that clinicians can quickly locate the experts' treatment recommendations. The recommendations are presented in 11 easy-to-use tabular guidelines that are organized into four sections:

I. Diagnosis (pp. 10–11)
II. Selecting Initial Treatment Strategies (pp. 12–23)
III. What to Do After the Initial Trial (pp. 24–29)
IV. Other Treatment Issues (pp. 30–31)

We also include a Primary Care Treatment Guide (pp. 32–33) that summarizes the key recommendations in an easy-to-use format for primary care practitioners. The guidelines are followed by a summary of the results of the treatment surveys (pp. 34–68).

Finally, we include a patient-family educational handout (pp. 69–76) that can be reproduced for distribution to families and patients. We gratefully acknowledge the Anxiety Disorders Association of America for their help in developing these educational materials.

The data supporting the recommendations given in the guidelines are referenced by means of numbered notes on the guideline pages. These notes refer to specific questions and answers in the two expert surveys that were used to develop the guideline recommendations.

Let's examine how a clinician might use the guidelines in selecting a treatment for a hypothetical patient who presents with what appears to be acute PTSD. In the table of contents, the clinician locates *Guideline 1: How to Recognize PTSD* (p. 10) and uses the information there to assist in evaluating the patient and confirming the diagnosis of PTSD. The clinician can then go to *Guideline 2: Selecting the Overall Treatment Strategy* (p. 12), for information on the appropriateness of starting treatment with psychotherapy or medication or a combination of both, depending on the age of the patient and the severity and chronicity of symptoms. Information on selecting specific psychotherapy techniques and medications for different types of presentations are covered in *Guideline 3: Selecting the Initial Psychotherapy* (p. 14) and *Guideline 4: Selecting the Initial Medication* (p. 18). If the patient does not have an adequate response to the initial treatment strategy selected, the clinician can then refer to *Section III. What to Do Next after the Initial Trial* (p. 24).

No set of guidelines can ever improve practice if read just once. These guidelines are meant to be used in an ongoing way, since each patient's status and phase of illness will require different interventions at different times. Locate your patient's problem or your question about treatment in the Table of Contents and compare your plan with the guideline recommendations. We believe the guideline recommendations will reinforce your best judgment when you are in familiar territory and help you with new suggestions when you are in a quandary.

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I. DIAGNOSIS

Guideline 1: How to Recognize PTSD

1A: The Types of Extreme Stressors That Cause PTSD

Type of stressor	Examples
Serious accident	Car, plane, boating, or industrial accident
Natural disaster	Tornado, hurricane, flood, or earthquake
Criminal assault	Being physically attacked, mugged, shot, stabbed, or held at gunpoint
Military	Serving in an active combat theater
Sexual assault	Rape or attempted rape
Child sexual abuse	Incest, rape, or sexual contact with an adult or much older child
Child physical abuse or severe neglect	Beatings, burning, restraints, starvation
Hostage/imprisonment/torture	Being kidnapped or taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, displacement as a refugee
Witnessing or learning about traumatic events	Witnessing a shooting or devastating accident, sudden unexpected death of a loved one

1B: The Impact of the Stressor

The stressor must be extreme, not just severe	The event involved actual or threatened death, serious injury, rape, or childhood sexual abuse. Would not include many frequently encountered stressors that are severe but not extreme (e.g., losing a job, divorce, failing in school, expected death of a loved one).
The stressor causes powerful subjective responses	The person experienced intense fear, helplessness, or horror.

1C: The Key Symptoms of PTSD

Key symptoms	Examples
Reexperiencing the traumatic event	• Intrusive, distressing recollections of the event • Flashbacks (feeling as if the event were recurring while awake) • Nightmares (the event or other frightening images recur frequently in dreams) • Exaggerated emotional and physical reactions to triggers that remind the person of the event
Avoidance	• Of activities, places, thoughts, feelings, or conversations related to the trauma
Emotional numbing	• Loss of interest • Feeling detached from others • Restricted emotions
Increased arousal	• Difficulty sleeping • Irritability or outbursts of anger • Difficulty concentrating • Hypervigilance • Exaggerated startle response

1D: The Duration of Symptoms

If the duration of symptoms is	The diagnosis is	Comments
Less than 1 month	Acute stress disorder (not PTSD)	These are symptoms that occur in the immediate aftermath of the stressor and may be transient and self-limited. Although not yet diagnosable as PTSD, the presence of severe symptoms during this period is a risk factor for developing PTSD.
1–3 months	Acute PTSD	Active treatment during this acute phase of PTSD may help to reduce the otherwise high risk of developing chronic PTSD.
3 months or longer	Chronic PTSD	Long-term symptoms may need longer and more aggressive treatment and are likely to be associated with a higher incidence of cormorbid disorders.

1E: The Most Common Comorbid Disorders in a Patient with PTSD

Because PTSD often co-occurs with the disorders listed below, it is useful to screen for them in any patient with PTSD and to take them into account in treatment planning. (See Guidelines 2B, 3B, and 4C for information about selecting treatments for PTSD when it is accompanied by complicating comorbidity.)

Comorbid conditions
• Substance abuse or dependence
• Major depressive disorder
• Panic disorder/agoraphobia
• Generalized anxiety disorder
• Obsessive-compulsive disorder
• Social phobia
• Bipolar disorder

II. SELECTING INITIAL TREATMENT STRATEGIES

Guideline 2: Selecting the Overall Treatment Strategy

2A: Sequencing Treatments: Whether to Start with Psychotherapy, Medication, or a Combination of Both

This guideline provides information on the sequencing of psychotherapy and medication in the treatment of PTSD. We asked the same questions of two separate groups: psychotherapy experts and medication experts. Both groups recommended psychotherapy as a first line treatment for PTSD, but the medication experts were much more likely to combine medication with psychotherapy from the start, especially for those patients with more severe or chronic problems.

Age	Severity	Acute PTSD[1]	Chronic PTSD[2]
In children and younger adolescents	Milder	Psychotherapy first	Psychotherapy first
	More severe	Psychotherapy first* *or* Combination of medication and psychotherapy*	Psychotherapy first* *or* Combination of medication and psychotherapy*
In older adolescents and adults	Milder	Psychotherapy first	Psychotherapy first† *or* Combination of medication and psychotherapy†
	More severe	Psychotherapy first* *or* Combination of medication and psychotherapy*	Psychotherapy first* *or* Combination of medication and psychotherapy*
In geriatric patients	Milder	Psychotherapy first	Psychotherapy first
	More severe	Psychotherapy first* *or* Combination of medication and psychotherapy*	Psychotherapy first* *or* Combination of medication and psychotherapy*

*On this question, the psychosocial experts preferred psychotherapy first, whereas the medication experts preferred combination treatment.

†On this question, the medication experts rated both psychotherapy and combined treatment first line, while the psychosocial experts preferred psychotherapy first.

[1]Question 1 [2]Question 2

2B: Sequencing Treatments When PTSD Presents with Psychiatric Comorbidity

When a comorbid psychiatric disorder is present, the experts recommend treating PTSD with a combination of both psychotherapy and medication from the start. It is therefore vital that questions about comorbidity and substance use should be included in the evaluation of every patient with PTSD.

Comorbid condition	**Recommended strategy**
Depressive disorder[3]	Combine psychotherapy and medication from the start
Bipolar disorder[3]	Combine psychotherapy and medication from the start
Other anxiety disorders (e.g., panic disorder, social phobia, obsessive-compulsive disorder, generalized anxiety disorder)[3]	Combine psychotherapy and medication from the start
Substance abuse or dependence[4]	
Milder problems with substance abuse	Provide treatment for both substance abuse and PTSD simultaneously
More severe problems with substance abuse	Treat substance abuse problems first *or* Provide treatment for both substance abuse and PTSD simultaneously

[3]Question 3 [4]Question 4

2C: Level of Care During the Initial Phase of Treatment (First 3 Months or Until Stabilized)

During the initial stage of treatment, the experts recommend that psychotherapy should generally be delivered weekly in individual sessions of about 60 minutes duration. Weekly medication visits are recommended for the first month, with visits every other week thereafter. Recommendations for treatment intensity during the maintenance phase are given in Guideline 8.

(***bold italics*** = treatment of choice)

	Recommended	**Also consider**
Frequency of psychotherapy sessions[5]	Weekly	Twice a week
Duration of psychotherapy sessions[5]	60 minutes*	> 60 minutes* or 45 minutes
Format of psychotherapy sessions[5]	***Individual***	Combination of individual and group or family therapy
Frequency of medication visits[6]	Weekly for the first month and every 2 weeks thereafter	Weekly for all 3 months Every 2 weeks for all 3 months

*Longer sessions may be needed for exposure therapy to allow for habituation.

[5]Questions 18–20 [6]Question 41

Guideline 3: Selecting the Initial Psychotherapy

Brief Descriptions of the Most Recommended Psychotherapy Techniques*

Anxiety management (stress inoculation training): teaching a set of skills that will help patients cope with stress:

- **Relaxation training**: teaching patients to control fear and anxiety through the systematic relaxation of the major muscle groups.
- **Breathing retraining**: teaching slow, abdominal breathing to help the patient relax and/or avoid hyperventilation with its unpleasant and often frightening physical sensations.
- **Positive thinking and self-talk**: Teaching the person how to replace negative thoughts (e.g., "I'm going to lose control") with positive thoughts (e.g., "I did it before and I can do it again") when anticipating or confronting stressors.
- **Assertiveness training**: teaching the person how to express wishes, opinions, and emotions appropriately and without alienating others.
- **Thought stopping**: distraction techniques to overcome distressing thoughts by inwardly "shouting stop."

Cognitive therapy: helping to modify unrealistic assumptions, beliefs, and automatic thoughts that lead to disturbing emotions and impaired functioning. For example, trauma victims often have unrealistic guilt related to the trauma: a rape victim may blame herself for the rape; a war veteran may feel it was his fault that his best friend was killed. The goal of cognitive therapy is to teach patients to identify their own particular dysfunctional cognitions, weigh the evidence for and against them, and adopt more realistic thoughts that will generate more balanced emotions.

Exposure therapy: helping the person to confront specific situations, people, objects, memories, or emotions that have become associated with the stressor and now evoke an unrealistically intense fear. This can be done in two ways:

- **Imaginal exposure**: the repeated emotional recounting of the traumatic memories until they no longer evoke high levels of distress.
- **In vivo exposure**: confrontation with situations that are now safe, but which the person avoids because they have become associated with the trauma and trigger strong fear (e.g., driving a car again after being involved in an accident; using elevators again after being assaulted in an elevator). Repeated exposures help the person realize that the feared situation is no longer dangerous and that the fear will dissipate if the person remains in the situation long enough rather than escaping it.

Play therapy: therapy for children employing games to allow the introduction of topics that cannot be effectively addressed more directly and to facilitate the exposure to, and the reprocessing of, the traumatic memories.

Psychoeducation: educating patients and their families about the symptoms of PTSD and the various treatments that are available for it. Reassurance is given that PTSD symptoms are normal and expectable shortly after a trauma and can be overcome with time and treatment. Also includes education about the symptoms and treatment of any comorbid disorders.

***We also asked the experts about eye movement desensitization reprocessing (EMDR), hypnotherapy, and psychodynamic psychotherapy, but they did not rate these techniques highly for the treatment of PTSD.**

3A: Preferred Psychotherapy Techniques for Different Target Symptoms[7]

Three psychotherapy techniques—exposure therapy, cognitive therapy, and anxiety management—are considered to be the most useful in the treatment of PTSD. As shown in the table below, the experts make distinctions among the techniques depending on which specific type of symptom presentation is most prominent. Psychoeducation is recommended as a high second line option for all types of target symptoms, probably reflecting the experts' belief that it is important in the treatment of every patient with PTSD, but is not by itself sufficient. Note also that the experts recommend considering play therapy for certain types of target symptoms in children.

(***bold italics*** = treatment of choice)

Most prominent symptom	Recommended techniques	Also consider
Intrusive thoughts	• ***Exposure therapy***	• Cognitive therapy • Anxiety management • Psychoeducation • Play therapy for children
Flashbacks	• ***Exposure therapy***	• Anxiety management • Cognitive therapy • Psychoeducation
Trauma-related fears, panic, and avoidance	• ***Exposure therapy*** • Cognitive therapy • Anxiety management	• Psychoeducation • Play therapy for children
Numbing/detachment from others/loss of interest	• Cognitive therapy	• Psychoeducation • Exposure therapy
Irritability/angry outbursts	• Cognitive therapy • Anxiety management	• Psychoeducation • Exposure therapy
Guilt/shame	• ***Cognitive therapy***	• Psychoeducation • Play therapy for children
General anxiety (hyperarousal, hypervigilance, startle)	• Anxiety management • Exposure therapy	• Cognitive therapy • Psychoeducation • Play therapy for children
Sleep disturbance	• Anxiety management	• Exposure therapy • Cognitive therapy • Psychoeducation
Difficulty concentrating	• Anxiety management	• Cognitive therapy • Psychoeducation

[7]Question 13

3B: Preferred Psychotherapy Techniques for PTSD with Comorbid Psychiatric Conditions[8]

The type of comorbidity accompanying PTSD affects the choice of the specific psychotherapy techniques. The experts are especially likely to recommend cognitive therapy in the treatment of PTSD when there is a comorbid mood or anxiety disorder or a cluster B personality disorder. Anxiety management is especially recommended when a comorbid anxiety disorder is present or there are substance abuse problems. Exposure therapy is also especially recommended when there is a comorbid anxiety disorder.

(***bold italics*** = treatment of choice)

Comorbid condition	Recommended techniques	Also consider
Depressive disorder	• ***Cognitive therapy***	• Exposure therapy • Psychoeducation • Anxiety management • Play therapy for children
Bipolar disorder	• Cognitive therapy	• Psychoeducation • Anxiety management
Other anxiety disorder (e.g., panic disorder, social phobia, obsessive-compulsive disorder, generalized anxiety disorder)	• Anxiety management • Cognitive therapy • Exposure therapy	• Psychoeducation
Substance abuse or dependence	• Anxiety management	• Cognitive therapy • Psychoeducation
Severe cluster B personality disorder (e.g., borderline) with impulsivity	• Cognitive therapy	• Anxiety management • Psychoeducation

[8]Question 14

3C: Selecting Psychotherapy Techniques Based on the Patient's Age[9]

To some extent, the choice of psychotherapy varies depending on the patient's age. Play therapy may be useful for children and younger adolescents. Exposure therapy is more strongly recommended for adults than for children or for geriatric patients.

(**bold** = first line)

	Preferred techniques
For children and younger adolescents	• Play therapy • Psychoeducation • Anxiety management • Cognitive therapy
For adults and older adolescents	• **Cognitive therapy** • **Exposure therapy** • **Anxiety management** • **Psychoeducation**
For geriatric patients	• **Cognitive therapy** • **Anxiety management** • **Psychoeducation** • Exposure therapy

[9]Question 16

3D: Selecting Psychotherapy Techniques Based on Effectiveness, Safety, Acceptability, and Speed of Action

The following table presents the experts' recommendations for specific psychotherapy techniques based on the overall effectiveness, speed of action, usefulness for different stressors, safety, and acceptability of these techniques. As indicated in Guidelines 3A–3C, the selection of a specific psychotherapy technique will also depend on the type of presentation of PTSD, the type of accompanying comorbidity, and the patient's age. The choice may vary with the stage of treatment, the strength of the therapeutic alliance, the therapist's clinical judgment, and the patient's preference and previous response to treatment.

	Recommended techniques	**Also consider**
Most effective techniques[10]	• Exposure therapy • Cognitive therapy	• Anxiety management
Quickest acting techniques[11]	• Exposure therapy	• Anxiety management • Cognitive therapy • Psychoeducation
Techniques preferred across all the different types of trauma[12]	• Cognitive therapy • Exposure therapy • Anxiety management	• Psychoeducation
Safest techniques[10]	• Anxiety management • Psychoeducation • Cognitive therapy	• Play therapy for children • Exposure therapy
Most acceptable techniques[10]	• Psychoeducation • Cognitive therapy • Anxiety management	• Play therapy for children
Further recommendation for combining psychotherapy techniques: The experts believe that the techniques that are effective for PTSD when used alone (anxiety management, cognitive therapy, exposure therapy, and psychoeducation) are also helpful when used in combination. They consider combinations especially appropriate for patients who have a complex presentation or who have had an inadequate response to treatment (see Guidelines 5A, 5B, 6A, and 6B). The choice of which and how many of the techniques to combine should be based on clinical judgment and patient preference. For children, the experts also consider it appropriate to combine play therapy with any of the previous four techniques.[13]		

[10]Question 15 [11]Question 17 [12]Question 25 [13]Question 26

Guideline 4: Selecting the Initial Medication

4A: Preferred Classes of Medications Based on Different Target Symptoms[14]

We asked the experts about their preferences for different classes of medication for different types of target symptoms. In nearly every case, the newer antidepressants, particularly the selective serotonin reuptake inhibitors (SSRIs), were favored regardless of the type of symptom that was prominent. Mood stabilizers may also be helpful for prominent irritability or anger. Benzodiazepines may sometimes be helpful in the short term, but must be used with caution because of the risk of substance abuse problems.

Most prominent symptom	Recommended medications[15]	Also consider
Intrusive thoughts	• SSRIs* • Nefazodone • Venlafaxine	• Tricyclic antidepressants
Flashbacks	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants
Trauma-related fears, panic, and avoidance	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Benzodiazepines (e.g., clonazepam[16])†
General anxiety (hyperarousal, hypervigilance, startle)	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Benzodiazepines† • Antiadrenergics • Buspirone
Numbing/detachment from others/loss of interest	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants
Dissociative symptoms		• SSRIs • Nefazodone • Venlafaxine • Tricyclic antidepressants
Sleep disturbance[17]	• Trazodone	• Zolpidem • Benadryl • Tricyclic antidepressants • Benzodiazepines†
Irritability/angry outbursts	• SSRIs • Nefazodone • Venlafaxine	• Mood stabilizers (e.g., divalproex[18]) • Tricyclic antidepressants • Antiadrenergics
Difficulty concentrating	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants
Guilt/shame	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants

*SSRIs = sertraline, paroxetine, fluoxetine, fluvoxamine, citalopram

†The experts recommend using caution in prescribing benzodiazepines for patients with current substance abuse problems or a history of substance abuse problems.[19]

[14]Question 27 [15]Question 35 [16]Question 37 [17]Question 56 [18]Question 36 [19]Question 38

4B: Preferred Classes of Medications Based on Different Types of Stressors[20]

We also asked about preferences for the different classes of medication in a variety of different types of stressful situation. Just as when we asked about choice of medications for different target symptoms, the newer antidepressants were favored regardless of the type of stressor. Other medications to consider are tricyclic antidepressants, mood stabilizers, and benzodiazepines.

Most prominent stressor	Recommended medications[21]	Also consider
Military combat	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Mood stabilizers (e.g., divalproex[22])
Sexual trauma as an adult	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Benzodiazepines (e.g., clonazepam[23])*
Sexual or physical abuse in childhood	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Mood stabilizers
Accidents	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Benzodiazepines*
Natural disasters	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Benzodiazepines*
Victim of violent crime or torture	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Mood stabilizers
Other trauma (e.g., witnessing a traumatic event)	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Benzodiazepines*

*The experts recommend using caution in prescribing benzodiazepines for patients with current substance abuse problems or a history of substance abuse problems.[24]

[20]Question 28 [21]Question 35 [22]Question 36 [23]Question 37 [24]Question 38

4C: Preferred Medications for PTSD with Comorbid Psychiatric Conditions[25]

The newer antidepressants are also useful in treating patients whose PTSD is accompanied by comorbid psychiatric disorders, except mania. Mood stabilizers are recommended for patients whose PTSD is accompanied by bipolar disorder, whether they are in the manic or depressed phase of the illness.

(***bold italics*** = treatment of choice)

Comorbid condition	Recommended medications[26]	Also consider
Unipolar depressive disorder	• ***SSRIs*** • ***Nefazodone*** • ***Venlafaxine*** • Tricyclic antidepressants	
Bipolar disorder, depressed phase	• SSRIs • Nefazodone • Venlafaxine • Mood stabilizers (e.g., divalproex[27])	• Tricyclic antidepressants
Bipolar disorder, manic or hypomanic phase	• ***Mood stabilizers***	• Atypical antipsychotics • Conventional antipsychotics
Obsessive-compulsive disorder	• ***SSRIs*** • ***Nefazodone*** • ***Venlafaxine***	• Tricyclic antidepressants
Panic disorder	• ***SSRIs*** • ***Nefazodone*** • ***Venlafaxine***	• Tricyclic antidepressants • Benzodiazepines (e.g., clonazepam[28])*
Social phobia	• ***SSRIs*** • ***Nefazodone*** • ***Venlafaxine***	• Tricyclic antidepressants • Benzodiazepines*
Generalized anxiety disorder	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Benzodiazepines* • Buspirone

*The experts recommend using caution in prescribing benzodiazepines for patients with current substance abuse problems or a history of substance abuse problems.[29]

[25]Question 29 [26]Question 35 [27]Question 36 [28]Question 37 [29]Question 38

4D: Preferred Medications for PTSD with Comorbid General Medical Conditions[30]

The experts also recommend the newer antidepressants for the treatment of PTSD in patients who have a variety of different general medical conditions. The second line choices vary by type of disorder.

Comorbid condition	Recommended medications[31]	Also consider
Central nervous system damage or disorder (e.g., head trauma, epilepsy, stroke)	• SSRIs • Nefazodone • Venlafaxine	• Mood stabilizers (e.g., divalproex[32])
Chronic pain	• SSRIs • Nefazodone • Venlafaxine • Tricyclic antidepressants	• Mood stabilizers
Hypertension	• SSRIs • Nefazodone • Venlafaxine	• Antiadrenergics • Mood stabilizers • Benzodiazepines (e.g., clonazepam[33])* • Tricyclic antidepressants
Cardiac disease	• SSRIs • Nefazodone • Venlafaxine	• Benzodiazepines* • Mood stabilizers
Thyroid abnormality	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Benzodiazepines* • Mood stabilizers
Diabetes	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Mood stabilizers
Respiratory disease (e.g., asthma, emphysema)	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Mood stabilizers
Gastrointestinal disease (e.g., ulcer)	• SSRIs • Nefazodone • Venlafaxine	• Tricyclic antidepressants • Benzodiazepines*
Liver disease	• SSRIs • Nefazodone • Venlafaxine	

*The experts recommend using caution in prescribing benzodiazepines for patients with current substance abuse problems or a history of substance abuse problems.[34]

[30]Question 30 [31]Question 35 [32]Question 36 [33]Question 37 [34]Question 38

4E: Selecting Medications for Women of Childbearing Age[35]

(***bold italics*** = treatment of choice)

If patient is	Recommended medications
Pregnant or breastfeeding	• The experts prefer not to use medications in women who are pregnant or breastfeeding, but when necessary they would choose an SSRI.
Woman of childbearing age	• ***SSRIs*** • Nefazodone • Venlafaxine

[35]Question 34

4F: Selecting Medications Based on Effectiveness, Safety, and Acceptability for Different Age Groups

Factor	In children	In adults/adolescents	In geriatric patients
Most effective[36]	• SSRIs • *Nefazodone** • *Venlafaxine*	• SSRIs • Nefazodone • Venlafaxine • *Tricyclic antidepressants*	• SSRIs • Nefazodone • Venlafaxine
Safest[37]	• SSRIs • *Nefazodone* • *Venlafaxine*	• SSRIs • Nefazodone • Venlafaxine • *Buspirone*	• SSRIs • *Nefazodone* • *Venlafaxine*
Most acceptable[38]	• SSRIs • *Nefazodone* • *Venlafaxine*	• SSRIs • Nefazodone • Venlafaxine • Benzodiazepines† • *Buspirone*	• SSRIs • *Nefazodone* • *Venlafaxine*

Further recommendation: In treating PTSD in older adults, the experts recommend the following strategies:[39]

- Taking a very careful history of all medications the person is taking
- Monitoring carefully for interactions with other medications
- Starting with a low dose of medication
- Increasing medication dose slowly

**italics* = top second line options

†The experts recommend using caution in prescribing benzodiazepines for patients with current substance abuse problems or a history of substance abuse problems.[40]

[36]Questions 33 & 35 [37]Questions 31& 35 [38]Questions 32 & 35 [39]Question 39 [40]Question 38

4G: Defining an Adequate Initial Medication Trial[41]

Before deciding that a patient has not responded to a medication, the clinician should be sure that the treatment trial has been adequate in dose and duration. Too often, patients have received numerous medications, but never in systematic adequate trials that enable the clinician to judge whether the medication would actually work if given appropriately. The experts recommend allowing slightly more time for patients who are showing a partial response compared to those with no response. For information on adequate doses, see Guideline 9.

	Length of time to wait before switching to or adding another medication	
	No response	**Partial response**
Antidepressant	6 weeks	8 weeks
Antipsychotic	3 weeks	4 weeks
Benzodiazepine	2 weeks	3 weeks
Buspirone	4 weeks	5 weeks
Mood stabilizer	4 weeks	6 weeks
Antiadrenergic	2 weeks	3 weeks

[41]Question 40

III. What to Do After the Initial Trial

Definitions of Terms

Remission/good response: > 75% reduction in symptoms and response maintained for at least 3 months

Partial response: 25%–75% of symptoms remain

No response: < 25% reduction in symptoms

Persistently refractory: little or no response after multiple trials of medications and psychotherapy techniques

Guideline 5: When the Patient Has Had No Response

5A. Selecting the Next Step

We asked the experts to recommend the next step when patients with PTSD have had no response to the initial treatment. Their first line recommendations were the same for patients with acute and chronic PTSD as well as for patients who also have suicidal or aggressive tendencies.

For patients receiving monotherapy (i.e., medication alone or psychotherapy alone), the experts offer two general treatment recommendations:

1. Add the type of treatment the patient has not yet received (i.e., add medication to psychotherapy or add psychotherapy to medication)

   and/or

2. Switch to a different psychotherapy technique or to a different medication.

Both of these strategies may be helpful, either separately or in combination. Clinicians should use their clinical judgment, based on the specific situation, in deciding whether to add a new treatment, switch to a different treatment, or do both.

Presentation	No response to psychotherapy alone[42]	No response to medication alone[43]	No response to combined psychotherapy and medication[44]
Acute and chronic PTSD	Add medication *and/or* Switch to other psychotherapy technique(s)	Add psychotherapy *and/or* Switch to another medication	Switch to another medication *and/or* Switch to or add other psychotherapy technique(s)

[42]Question 6 [43]Question 8 [44]Question 10

5B: Strategies for Further Psychotherapy[45]

For a patient who is not responding to one of the three preferred psychotherapy techniques, the experts recommend adding one or both of the other two techniques. Adequate psychoeducation should also always be provided.

If current psychotherapy technique is	Combine with	Also consider
Anxiety management	• Cognitive therapy • Exposure therapy	• Psychoeducation
Cognitive therapy	• Anxiety management • Exposure therapy	• Psychoeducation
Exposure therapy	• Anxiety management • Cognitive therapy	• Psychoeducation

[45]Question 26

5C: Choosing the Next Medication

For the purpose of this survey, no response to medication was defined as < 25% reduction in symptoms. If there is no response to an adequate trial of the first medication, the experts usually recommend switching to a different type of medication. Fortunately, there is a wide array of medications to choose from.

(**bold** = first line)

If initial treatment was	Switch to
An SSRI[46]	• Venlafaxine • Nefazodone • Tricyclic antidepressant • Monoamine oxidase inhibitor • A different SSRI • Mood stabilizer (e.g., divalproex[47])
Nefazodone[48]	• **SSRI** • Venlafaxine • Tricyclic antidepressant • Monoamine oxidase inhibitor • Mood stabilizer
Venlafaxine[49]	• **SSRI** • Tricyclic antidepressant • Nefazodone • Monoamine oxidase inhibitor • Mood stabilizer
A mood stabilizer given for explosive, irritable, aggressive, or violent behavior[50]	• Another mood stabilizer • SSRI • Atypical antipsychotic • Venlafaxine • Nefazodone • Tricyclic antidepressant
A mood stabilizer given for a patient with PTSD and comorbid bipolar disorder[51]	• **Continue mood stabilizer** • **Add an SSRI**
An atypical antipsychotic given for explosive, irritable, aggressive, or violent behavior[52]	• **Mood stabilizer** • Antidepressant • Another atypical antipsychotic
An atypical antipsychotic given for prominent flashbacks/dissociative symptoms/psychotic symptoms associated with PTSD[53]	• Mood stabilizer • Antidepressant • Another atypical antipsychotic • Conventional antipsychotic

[46]Question 45 [47]Question 36 [48]Question 46 [49]Question 47 [50]Question 48
[51]Question 49 [52]Question 50 [53]Question 51

Guideline 6: When the Patient Has Only a Partial Response

6A: Selecting the Next Step

Partial response was defined as 25%–75% of symptoms remaining. There is one major difference between the experts' recommendations when there is a partial response as opposed to no response. When a patient is having a partial response to treatment, the experts are more likely to recommend continuing the current treatment and adding another medication and/or adding additional psychotherapy.

(***bold italics*** = treatment of choice)

Presentation	Partial response to psychotherapy alone[54]	Partial response to medication alone[55]	Partial response to combined psychotherapy and medication[56]
Acute PTSD	Add medication *and/or* Add or switch to other psychotherapy technique(s)	Add psychotherapy	Add or switch to another medication *and/or* Add or switch to other psychotherapy technique(s)
Chronic PTSD	Add medication *and/or* Add or switch to other psychotherapy technique(s)	Add psychotherapy *and/or* Add another medication	Add or switch to another medication *or* Raise the dose of the medication to a higher than usual level *and/or* Add or switch to other psychotherapy technique(s)
PTSD with strong suicidal or aggressive tendencies	***Add medication*** *and/or* Add other psychotherapy technique(s)	Add psychotherapy *and/or* Add another medication	Add or switch to another medication *or* Raise the dose of the medication to a higher than usual level *and/or* Add or switch to other psychotherapy technique(s)

[54]Question 5 [55]Question 7 [56]Question 9

6B: Strategies for Further Psychotherapy[57]

Just as when there is no response (see Guideline 5B), if a patient is having a partial response to one of the three preferred psychotherapy techniques, the experts recommend adding one or both of the other two techniques. Adequate psychoeducation should also always be provided.

If current psychotherapy technique is	Combine with	Also consider
Anxiety management	• Cognitive therapy • Exposure therapy	• Psychoeducation
Cognitive therapy	• Anxiety management • Exposure therapy	• Psychoeducation
Exposure therapy	• Anxiety management • Cognitive therapy	• Psychoeducation

[57]Question 26

6C: Selecting Adjunctive Medications

When a patient is having a partial response to medication alone, the experts recommend adding another medication as an adjunct rather than switching to a different medication. In this table, we present the experts' recommendations for adjunctive medications. The most highly recommended adjunctive medication in the treatment of PTSD is a mood stabilizer. For recommendations for choices of medications to switch to, see Guideline 5C. (**bold** = first line)

If the initial treatment was	The following medications are recommended as adjuncts
An SSRI[58]	• Mood stabilizer (e.g., divalproex[59]) • Tricyclic antidepressant
Nefazodone[60]	• Mood stabilizer
Venlafaxine[61]	• Mood stabilizer
A mood stabilizer given for explosive, irritable, aggressive, or violent behavior[62]	• SSRI • Atypical antipsychotic • Another mood stabilizer • Trazodone • Nefazodone • Venlafaxine • Tricyclic antidepressant
A mood stabilizer given for a patient with PTSD and comorbid bipolar disorder[63]	• SSRI • Nefazodone • Venlafaxine • Atypical antipsychotic • Tricyclic antidepressant • Another mood stabilizer
An atypical antipsychotic given for explosive, irritable, aggressive, or violent behavior[64]	• **Mood stabilizer** • Antidepressant
An atypical antipsychotic given for prominent flashbacks/dissociative symptoms/psychotic symptoms associated with PTSD[65]	• Mood stabilizer • Antidepressant • Clonazepam*

*The experts recommend using caution in prescribing benzodiazepines for patients with current substance abuse problems or a history of substance abuse problems.[66]

[58]Question 45 [59]Question 36 [60]Question 46 [61]Question 47 [62]Question 48 [63]Question 49 [64]Question 50
[65]Question 51 [66]Question 38

Guideline 7: When the Patient Has Not Responded to Multiple Previous Treatments

PTSD that has been persistently refractory to treatment is defined as a course of illness in which there has been little or no response after multiple adequate trials of medication and psychotherapy. It is important not to lose hope, even when patients have not responded to previous treatments. The first step is a careful assessment to reevaluate for possible causes of nonresponse (e.g., substance abuse problems, comorbid psychiatric conditions). The experts then recommend developing a comprehensive treatment plan using combinations of medications and psychotherapy techniques to be given in systematic, sequential trials to discover which customized treatment package will work best for the particular patient. Finding the right treatment for the individual patient requires clinical art and judgment, determination, persistence, and realistic optimism.

(***bold italics*** = treatment of choice)

	Recommended
Assessment strategies[67]	• ***Assess for substance abuse problems*** • ***Reevaluate for psychiatric comorbidity*** • Assess for the presence of a complicating neurological or other general medical condition • Assess for secondary gain • Reevaluate diagnosis of PTSD
Medication interventions[68]	Combine medications: **Preferred combination: antidepressant + mood stabilizer** *Also consider* Antidepressant + antipsychotic *or* Antidepressant + antipsychotic + mood stabilizer *or* Two antidepressants *or* Adjunctive benzodiazepine* or trazodone
Psychosocial interventions[69]	Combine psychotherapy techniques (see Guidelines 5B and 6B) *and/or* Add special rehabilitation programs (e.g., social skills training, vocational rehabilitation) *and/or* Add family therapy
Indications for hospitalization[70]	***Risk of suicide*** ***Risk of harm to others***

*The experts recommend using caution in prescribing benzodiazepines for patients with current substance abuse problems or a history of substance abuse problems.[71]

[67]Question 11 [68]Questions11 & 52 [69]Question 11 [70]Question 54 [71]Question 38

Guideline 8: When the Patient Has a Remission or Good Response: Strategies for the Maintenance Phase

8A. Psychotherapy Issues

See Guideline 2C for level of care recommendations for the initial phase of treatment (first 3 months or until stabilized). This guideline presents the experts' recommendations for the duration and the intensity of psychotherapy treatment during the maintenance phase after the patient has achieved a good response to treatment.

How long to continue psychotherapy after a good response[72]	• Acute PTSD: continue for up to 3 more months, with booster sessions every 2–4 weeks • Chronic PTSD: continue for up to 6 more months, with booster sessions every 2–4 weeks initially and then less frequently as needed after that, depending on the level of recovery
Indications for continuing booster sessions[73]	• Current life stressors • Poor social supports • High suicide risk in the past • History of violence • Persistence of some symptoms • Poor functioning when symptomatic • Presence of comorbid Axis I disorder(s) • Presence of comorbid Axis II disorder(s)

[72]Questions 21 & 22 [73]Question 23

8B. Medication Issues

See Guideline 2C for level of care recommendations for the initial phase of treatment (first 3 months or until stabilized). This guideline presents the experts' recommendations for the duration and the intensity of medication treatment during the maintenance phase after the patient has achieved a good response to treatment.

Duration of treatment before considering tapering medication[74]	• Acute PTSD: 6–12 months • Chronic PTSD with excellent response: 12–24 months • Chronic PTSD with residual symptoms: usually at least 24 months and possibly longer, especially if the indications listed below are present
Indications for continuing medication treatment for a longer period[75]	• Current life stressors • Poor social supports • Persistence of some symptoms • High suicide risk in the past • History of violence • Presence of comorbid Axis I disorder(s) • Long duration of PTSD symptoms • Poor functioning when symptomatic • History of severe PTSD symptoms
Frequency of medication visits[76]	• Months 3–6: monthly • Months 6–12: every 1–2 months • After 12 months: every 3 months
Recommended method of tapering medication[77]	• To avoid discontinuation/withdrawal syndrome: Taper medication over 2 weeks–1 month, except for the benzodiazepines, which experts recommend tapering over 1 month or longer • To lessen the likelihood of relapse in a patient with risk factors for relapse: Taper medication over a longer period, 4–12 weeks, except for the benzodiazepines, for which experts recommend tapering for longer than 12 weeks

[74]Question 43 [75]Question 44 [76]Question 42 [77]Questions 57 & 58

IV. Other Treatment Issues

Guideline 9: Medication Dosing[78]

The following table summarizes the experts' dosing recommendations. These are a rough guide, and it is advisable to consult the *Physicians' Desk Reference* and other standard pharmacology texts for more information on recommended doses. Clinical judgment is necessary in selecting doses for the specific patient, especially for children, the elderly, those with comorbid medical conditions, and those receiving combinations of medications.

Medication	Acute phase*				
	Adult starting dose (mg/day)	Average target dose (mg/day)			Highest target dose (mg/day)†
		Adult	Child	Older adult	
SSRIs					
citalopram (Celexa)	20	20–40	20	20	60
fluoxetine (Prozac)	10–20	20–50	10–20	20	80
fluvoxamine (Luvox)	50	100–250	50	100	300
paroxetine (Paxil)	10–20	20–50	20	20	50
sertraline (Zoloft)	25–50	50–150	50	75	200
Other antidepressants					
nefazodone (Serzone)	100	300–500	200	250	600
venlafaxine (Effexor XR)	75	75–225	50	150	225
Mood stabilizers					
divalproex (Depakote)	500	500–1500	750	750	2000
Antipsychotics					
haloperidol (Haldol)	2	2–10	1.5	3	20
risperidone (Risperdal)	1	2–6	1.5	2.5	8
olanzapine (Zyprexa)	5	5–15	5	7.5	20
quetiapine (Seroquel)	50	100–400	—‡	150	800
Anti-anxiety medications					
buspirone (BuSpar)	15	20–60	20	30	60
alprazolam (Xanax)§	1	1–4	1	1.5	4
clonazepam (Klonopin)§	1	1–4	1.5	1.5	4

*Recommended maintenance doses were generally equivalent to acute phase doses.

†Based on package insert.

‡The experts did not make any dosing recommendations for quetiapine in children.

§The experts recommend using caution in prescribing benzodiazepines for patients with current substance abuse problems or a history of substance abuse problems.[79]

[78]Question 55 [79]Question 38

Guideline 10: Enhancing Compliance[80]

Facilitating full patient cooperation with treatment is often the crucial factor in successful treatment. The following table presents the experts' recommendations for improving the therapeutic relationship and enhancing the patient's role in the treatment process.

Type of Strategy	Recommendation
General	• Psychoeducation • Frequently review with patient the rationale for the treatment intervention • Take patient preference into account in selecting treatments • Involve a relative or significant other at an early stage
Programmatic	• Evaluate for and treat substance abuse problems • Ensure easy and prompt access to treatment
For patients receiving medication	• Select medications based on side effect tolerance • Start low and go slow to avoid side effects

[80]Questions 24 & 53

Guideline 11: Prevention of PTSD and Avoiding Chronicity[81]

An ounce of prevention is often worth a pound of cure. Helping people deal effectively with their immediate reaction to an extreme stressor may well avoid PTSD altogether or at least shorten the duration of symptoms. The experts recommend providing education, normalization, guilt relief, and emotional catharsis for everyone who develops symptoms after an extreme stressor. If the symptoms last longer than 1 month, the experts recommend adding specific psychotherapy techniques and considering medication to avoid chronicity.

(***bold italics*** = treatment of choice)

	To prevent PTSD in patients with acute stress disorder	To prevent chronic symptoms in patients with acute PTSD
Recommended	• ***Provide psychoeducation*** • ***Normalize the reaction to the event*** • Relieve irrational guilt • Facilitate emotional recalling and retelling of the event	• ***Provide psychoeducation*** • Relieve irrational guilt • Normalize the reaction to the event • Facilitate emotional recalling and retelling of the event • Cognitive therapy • Exposure therapy • Anxiety management techniques
Also consider	• Anxiety management techniques • Provide group crisis intervention • Cognitive therapy	• Start treatment with an antidepressant

[81]Question 12

V. PRIMARY CARE TREATMENT GUIDE FOR POSTTRAUMATIC STRESS DISORDER

I. RECOGNITION

The diagnosis of PTSD requires exposure to an extreme stressor and a characteristic set of symptoms that have lasted for at least 1 month.

What is an extreme stressor?

Examples include

- Serious accident or natural disaster
- Rape or criminal assault
- Combat exposure
- Child sexual or physical abuse or severe neglect
- Hostage/imprisonment/torture/displacement as refugee
- Witnessing a traumatic event
- Sudden unexpected death of a loved one

The person has the following three main types of symptoms:

Re-experiencing of the traumatic event as indicated by

- Intrusive distressing recollections of the event
- Flashbacks (feeling as if the event were recurring while awake)
- Nightmares (the event or other frightening images recur frequently in dreams)
- Exaggerated emotional and physical reactions to triggers that remind the person of the event

Avoidance and emotional numbing as indicated by

- Extensive avoidance of activities, places, thoughts, feelings, or conversations related to the trauma
- Loss of interest
- Feeling detached from others
- Restricted emotions

Increased arousal as indicated by

- Difficulty sleeping
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- An exaggerated startle response

Ask about possible trauma and resulting symptoms in patients who present with depression, anxiety, or substance abuse problems, since these often co-occur with PTSD.

II. EARLY INTERVENTION AND PREVENTION

What to do immediately after exposure to an extreme stressor or trauma:

- Help the patient understand that it is normal to be upset and have distressing symptoms shortly after a trauma.
- Provide education about acute stress reactions and PTSD (you may want to give the patient a copy of the "Guide for Patients and Families" that begins on p. 69).
- Encourage the patient to talk with family and friends about the trauma and experience the feelings associated with it.
- Educate family and significant others about the importance of listening and being tolerant of the person's emotional reactions.
- Help the patient and family accept the need for repeated retelling of the event in order to facilitate recovery.
- Provide emotional support.
- Relieve irrational guilt.
- Refer to peer support group or trauma counseling.
- Consider short-term sleep medication for insomnia.

III. TREATMENT SELECTION

If symptoms have lasted for at least 1 month without significant improvement:

1. Offer or refer for psychological treatment

2. Also prescribe medication if:

- Symptoms are severe and/or persistent.
- Daily functioning is severely disrupted.
- Patient has severe insomnia.
- Patient has another psychiatric problem (e.g., depression, anxiety, suicidal thoughts).
- Patient is experiencing a lot of stress.
- Patient has already been receiving psychotherapy and is still having significant symptoms.

IV. RECOMMENDED MEDICATIONS

Start with a selective serotonin reuptake inhibitor (SSRI) for at least an 8-week treatment trial. Evaluate response every 1–2 weeks and increase dose as needed.

After 8 weeks of SSRI trial:

- ***If no response***, switch to nefazodone or venlafaxine.
- ***If partial response***, add a mood stabilizer such as divalproex.

If patient has other significant problems, consider:

- ***For severe insomnia***, short-term treatment with trazodone.
- ***For significant anxiety***, short-term treatment with a benzodiazepine* or longer term treatment with buspirone.
- ***For comorbid bipolar disorder, prominent irritability or anger, or aggressive behavior***, adding a mood stabilizer.

*Note: benzodiazepines should be avoided or used very cautiously in patients who have current substance abuse problems or a history of substance abuse problems.

V. RECOMMENDED PSYCHOLOGICAL TREATMENTS

- ***Anxiety management:*** relaxation training, breathing retraining, positive thinking and self-talk, assertiveness training, and thought stopping
- ***Cognitive therapy:*** correcting irrational beliefs, especially unrealistic guilt about the trauma
- ***Exposure therapy:*** desensitizing the anxiety caused by reminders of the trauma by progressive exposure to them

VI. RECOMMENDED MEDICATION DOSES FOR ADULTS (mg/day)

Medication	Starting	Average	Max
SSRIs			
sertraline (Zoloft)	25–50	50–150	200
paroxetine (Paxil)	10–20	20–50	50
fluoxetine (Prozac)	10–20	20–50	60
fluvoxamine (Luvox)	50	100–250	300
citalopram (Celexa)	20	20–40	60
Other Antidepressants			
nefazodone (Serzone)	100	300–500	600
venlafaxine (Effexor XR)	75	75–225	225
Mood Stabilizers			
divalproex (Depakote)	500	500–1500	2000
Anti-anxiety Medications			
buspirone (BuSpar)	15	20–60	60
alprazolam (Xanax)	1	1–4	4
clonazepam (Klonopin)	1	1–4	4

VII. WHEN TO REFER FOR SPECIALIZED PSYCHIATRIC CARE

Primary care clinicians may decide to refer for specialized psychiatric care at any point, depending on how comfortable they are treating PTSD, the particular needs and preferences of the patient, and the availability of other services. However, referral for specialized care is often necessary in the following situations:

- Patient has persistent impairing PTSD symptoms that have not responded to at least one systematic medication trial adequate in dose and duration.
- Patient has suicidal thoughts/behavior.
- Patient has had persistent problems with medication side effects.
- Patient has other serious psychiatric problems (e.g., depression, anxiety) that are not improving with treatment.
- Patient has substance abuse problems.
- Patient is experiencing other life stressors and/or has limited social support.

Survey Questions Answered by All the Experts

1 It is important for clinicians and patients to decide how to sequence treatments. Please rate each method for starting the initial treatment(s) for **acute PTSD (**1–3 months posttrauma) for both a patient with milder PTSD and a patient with more severe PTSD (i.e., with severe agitation, impulsivity, violence, suicidal behavior, or significant functional impairment). Assume that the patient will be receiving the most appropriate type of psychotherapy or medication.

	Psychotherapy experts						**Medication experts**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
In children and younger adolescents												
MILDER PTSD												
Psychotherapy for PTSD first	8.6(0.9)	Chc	*73*	98	2	0	8.2(1.2)	Chc	*50*	94	4	2
Combined psychotherapy and medication from the start	3.7(2.0)	3rd	*0*	8	35	56	5.2(2.0)	2nd	*6*	27	50	23
Medication for PTSD first	2.8(1.6)	3rd	*0*	2	29	69	4.1(1.8)	2nd	*0*	13	45	43
MORE SEVERE PTSD												
Psychotherapy for PTSD first	7.8(1.4)	1st	*45*	83	17	0	6.5(2.4)	2nd	*23*	62	23	15
Combined psychotherapy and medication from the start	6.0(2.0)	2nd	*13*	48	41	11	7.8(1.2)	1st	*36*	85	15	0
Medication for PTSD first	4.8(1.9)	2nd	*2*	17	55	28	6.2(1.7)	2nd	*6*	47	43	11
In adults and older adolescents												
MILDER PTSD												
Psychotherapy for PTSD first	8.8(0.5)	Chc	*80*	100	0	0	7.9(1.5)	1st	*44*	87	9	4
Combined psychotherapy and medication from the start	4.4(2.1)	2nd	*2*	12	46	42	6.0(1.9)	2nd	*11*	38	55	8
Medication for PTSD first	3.4(1.8)	3rd	*0*	6	37	57	4.6(1.7)	2nd	*2*	15	57	28
MORE SEVERE PTSD												
Psychotherapy for PTSD first	7.8(1.3)	1st	*42*	84	16	0	6.0(2.2)	2nd	*17*	46	37	17
Combined psychotherapy and medication from the start	6.7(1.8)	2nd	*22*	61	33	6	8.1(1.2)	1st	*48*	88	12	0
Medication for PTSD first	5.1(1.9)	2nd	*0*	26	54	20	6.6(1.7)	2nd	*15*	52	44	4
In geriatric patients												
MILDER PTSD												
Psychotherapy for PTSD first	8.5(1.0)	Chc	*69*	96	4	0	7.8(1.4)	1st	*40*	85	13	2
Combined psychotherapy and medication from the start	4.9(2.2)	2nd	*4*	26	49	26	6.2(1.9)	2nd	*8*	46	44	10
Medication for PTSD first	3.6(2.0)	3rd	*0*	10	33	56	5.0(1.8)	2nd	*0*	27	51	22
MORE SEVERE PTSD												
Psychotherapy for PTSD first	7.6(1.3)	1st	*33*	78	22	0	6.0(2.3)	2nd	*17*	52	27	21
Combined psychotherapy and medication from the start	6.5(1.9)	2nd	*22*	50	43	7	7.8(1.6)	1st	*46*	85	13	2
Medication for PTSD first	5.0(1.8)	2nd	*0*	27	51	22	6.8(1.7)	2nd	*17*	60	38	2
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

2 Now please rate each method for starting the initial treatment(s) for **chronic PTSD.**

	Psychotherapy experts						Medication experts					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
In children and younger adolescents												
MILDER PTSD												
Psychotherapy for PTSD first	8.5(0.9)	Chc	*70*	96	4	0	7.8(1.5)	1st	*43*	84	14	2
Combined psychotherapy and medication from the start	4.5(2.3)	2nd	*2*	26	33	41	6.7(2.0)	2nd	*13*	69	22	9
Medication for PTSD first	3.4(1.8)	3rd	*0*	2	42	56	5.2(1.8)	2nd	*2*	27	53	20
MORE SEVERE PTSD												
Psychotherapy for PTSD first	7.9(1.4)	1st	*46*	87	13	0	6.7(2.0)	2nd	*20*	65	26	9
Combined psychotherapy and medication from the start	6.1(2.1)	2nd	*18*	44	44	11	8.3(1.0)	Chc	*51*	93	7	0
Medication for PTSD first	4.6(2.0)	2nd	*0*	14	55	32	6.5(1.5)	2nd	*7*	53	40	7
In adults and older adolescents												
MILDER PTSD												
Psychotherapy for PTSD first	8.5(0.9)	Chc	*73*	96	4	0	7.3(1.8)	1st	*33*	73	23	4
Combined psychotherapy and medication from the start	5.2(2.3)	2nd	*4*	36	40	24	7.1(1.8)	1st	*21*	68	28	4
Medication for PTSD first	3.9(2.0)	3rd	*0*	6	53	41	5.6(1.8)	2nd	*6*	34	53	13
MORE SEVERE PTSD												
Psychotherapy for PTSD first	7.9(1.5)	1st	*49*	84	14	2	5.9(2.3)	2nd	*12*	50	29	21
Combined psychotherapy and medication from the start	6.8(2.0)	2nd	*26*	62	30	8	8.4(0.9)	Chc	*62*	96	4	0
Medication for PTSD first	5.1(1.9)	2nd	*2*	20	58	22	6.7(1.4)	2nd	*8*	59	37	4
In geriatric patients												
MILDER PTSD												
Psychotherapy for PTSD first	8.3(1.1)	Chc	*64*	91	9	0	7.1(1.9)	1st	*26*	70	22	8
Combined psychotherapy and medication from the start	5.2(2.1)	2nd	*0*	31	47	22	6.8(2.0)	2nd	*22*	63	29	8
Medication for PTSD first	4.0(2.1)	3rd	*0*	6	53	40	5.8(2.0)	2nd	*8*	37	49	14
MORE SEVERE PTSD												
Psychotherapy for PTSD first	7.7(1.3)	1st	*37*	80	20	0	5.8(2.2)	2nd	*9*	50	31	19
Combined psychotherapy and medication from the start	6.6(2.1)	2nd	*26*	55	36	9	8.0(1.3)	1st	*47*	92	6	2
Medication for PTSD first	5.0(1.9)	2nd	*2*	22	57	22	6.8(1.6)	2nd	*11*	64	32	4
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

3 Now please rate each method for starting the initial treatment(s) for PTSD when it is complicated by the following **comorbid conditions.** Assume that PTSD is the primary diagnosis. ***Note: results from psychotherapy and medication experts are combined.***

	95% Confidence Intervals Third Line / Second Line / First Line	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
PTSD + depressive disorder						
Combined psychotherapy and medication from the start		7.7(1.5)	*39*	81	15	3
Psychotherapy for PTSD first		6.5(2.2)	*22*	56	31	12
Medication for PTSD first		5.9(2.2)	*10*	47	35	17
PTSD + bipolar disorder						
Combined psychotherapy and medication from the start		7.7(1.8)	*49*	81	13	5
Medication for PTSD first		6.4(2.4)	*27*	58	28	13
Psychotherapy for PTSD first		4.8(2.6)	*8*	31	36	34
PTSD + other anxiety disorder (e.g., obsessive-compulsive disorder, social phobia, panic disorder, generalized anxiety disorder)						
Combined psychotherapy and medication from the start		7.1(2.1)	*33*	69	23	8
Psychotherapy for PTSD first		6.8(2.2)	*30*	63	27	10
Medication for PTSD first		5.7(2.3)	*9*	41	38	20
PTSD + severe cluster B personality disorder (e.g., borderline) with impulsivity						
Combined psychotherapy and medication from the start		6.9(2.2)	*32*	63	27	9
Psychotherapy for PTSD first		6.8(2.2)	*28*	63	24	13
Medication for PTSD first		5.4(2.3)	*5*	38	36	25
	1 2 3 4 5 6 7 8 9		%	%	%	%

4 Now please rate the appropriateness of the following treatment strategies for PTSD complicated by substance abuse problems. ***Note: results from psychotherapy and medication experts are combined.***

	95% Confidence Intervals Third Line / Second Line / First Line	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Milder substance abuse						
Provide combined treatment for substance abuse and PTSD simultaneously		7.8(1.4)	*42*	82	17	1
Treat PTSD first		6.0(2.2)	*12*	46	38	15
Treat substance abuse problems first		5.9(2.0)	*7*	46	38	15
More severe substance abuse						
Treat substance abuse problems first		7.5(1.8)	*38*	79	18	3
Provide combined treatment for substance abuse and PTSD simultaneously		7.1(2.0)	*38*	68	26	7
Treat PTSD first		4.2(1.9)	*1*	9	54	37
	1 2 3 4 5 6 7 8 9		%	%	%	%

5 A patient with PTSD has had an adequate trial of ***psychotherapy alone*** but has achieved only ***a partial response***. Please rate the appropriateness of the following strategies as a next step. Assume that you will either provide the treatment or can make an appropriate referral for treatment.

	Psychotherapy experts						**Medication experts**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
In acute PTSD												
Add other psychotherapy techniques	7.8(1.5)	1st	*35*	88	10	2	5.8(2.1)	2nd	*4*	50	37	13
Add medication	7.0(1.7)	1st	*27*	67	29	4	8.1(1.0)	1st	*42*	94	6	0
Switch to other psychotherapy techniques	6.8(1.8)	2nd	*21*	60	35	6	5.1(1.8)	2nd	*2*	17	63	19
Stop psychotherapy. Start medication	3.0(2.2)	3rd	*2*	8	20	73	3.6(2.1)	3rd	*0*	16	29	55
In chronic PTSD												
Add other psychotherapy techniques	7.6(1.5)	1st	*33*	85	13	2	5.7(2.0)	2nd	*4*	46	38	15
Add medication	7.4(1.7)	1st	*33*	75	21	4	8.4(0.9)	Chc	*56*	98	2	0
Switch to other psychotherapy techniques	7.0(1.5)	1st	*19*	62	37	2	5.2(1.7)	2nd	*2*	15	65	19
Stop psychotherapy. Start medication	2.9(2.1)	3rd	*2*	8	23	69	3.9(2.2)	3rd	*0*	18	31	51
In PTSD with strong suicidal or aggressive tendencies												
Add medication	7.8(1.9)	Chc	*55*	82	12	6	8.5(0.8)	Chc	*69*	98	2	0
Add other psychotherapy techniques	7.7(1.7)	1st	*37*	84	12	4	5.5(2.5)	2nd	*14*	43	33	24
Switch to other psychotherapy techniques	6.7(2.0)	2nd	*24*	59	29	12	4.8(2.3)	2nd	*6*	22	49	29
Stop psychotherapy. Start medication	2.7(2.3)	3rd	*4*	8	16	76	3.4(2.3)	3rd	*2*	14	20	67
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

6 A patient with PTSD has had an adequate trial of ***psychotherapy alone*** but has had ***no response***. Please rate the appropriateness of the following strategies as a next step. Assume that you will either provide the treatment or can make an appropriate referral for treatment.

	Psychotherapy experts						**Medication experts**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
In acute PTSD												
Switch to other psychotherapy techniques	7.8(1.5)	1st	*40*	85	13	2	5.9(1.9)	2nd	*6*	46	40	13
Add medication	7.4(1.6)	1st	*29*	79	19	2	8.1(1.2)	1st	*45*	94	4	2
Add other psychotherapy techniques	6.8(2.0)	2nd	*25*	65	25	10	5.2(2.4)	2nd	*4*	33	42	25
Stop psychotherapy. Start medication	4.2(2.6)	3rd	*8*	19	40	40	5.1(2.3)	2nd	*4*	35	38	27
In chronic PTSD												
Switch to other psychotherapy techniques	7.7(1.7)	1st	*39*	78	20	2	5.6(2.1)	2nd	*8*	35	46	19
Add medication	7.7(1.4)	1st	*35*	85	12	4	8.2(1.1)	Chc	*53*	94	4	2
Add other psychotherapy techniques	6.7(2.0)	2nd	*24*	62	26	12	4.9(2.3)	2nd	*4*	29	42	29
Stop psychotherapy. Start medication	4.0(2.6)	3rd	*6*	19	38	42	5.2(2.5)	2nd	*6*	38	29	33
In PTSD with strong suicidal or aggressive tendencies												
Add medication	7.9(1.8)	Chc	*57*	90	6	4	8.5(1.1)	Chc	*70*	94	4	2
Switch to other psychotherapy techniques	7.6(1.9)	1st	*44*	82	12	6	5.4(2.3)	2nd	*4*	40	37	23
Add other psychotherapy techniques	6.7(2.3)	2nd	*29*	61	22	16	4.9(2.6)	2nd	*10*	31	40	29
Stop psychotherapy. Start medication	3.9(2.9)	3rd	*10*	22	29	49	4.7(2.7)	2nd	*6*	33	27	40
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

7 A patient with PTSD has had an adequate trial (i.e., duration and dose) of ***medication alone*** but has achieved only ***a partial response***. Please rate the appropriateness of the following strategies as a next step. Assume that you will either provide the treatment or can make an appropriate referral for treatment.

	Psychotherapy experts						**Medication experts**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
In acute PTSD												
Add psychotherapy	8.3(1.3)	Chc	*64*	96	2	2	8.1(1.0)	1st	*45*	96	4	0
Switch medication. Start psychotherapy	5.7(2.5)	2nd	*11*	47	34	19	5.6(2.2)	2nd	*4*	35	47	18
Switch to another medication	5.3(1.9)	2nd	*0*	32	47	21	5.9(1.8)	2nd	*6*	42	48	10
Raise the dose of the medication to a higher than usual level	4.9(2.4)	2nd	*9*	29	38	33	5.9(2.2)	2nd	*12*	50	35	15
Add another medication	4.9(2.1)	2nd	*2*	26	43	30	6.5(1.8)	2nd	*10*	58	37	6
Stop medication. Start psychotherapy	4.7(2.7)	2nd	*14*	26	38	36	2.9(1.9)	3rd	*0*	10	19	71
In chronic PTSD												
Add psychotherapy	8.2(1.7)	Chc	*65*	94	2	4	7.9(1.3)	1st	*41*	88	12	0
Switch medication. Start psychotherapy	5.9(2.6)	2nd	*15*	50	29	21	5.8(2.3)	2nd	*4*	47	31	22
Switch to another medication	5.6(1.8)	2nd	*0*	36	47	17	6.3(1.8)	2nd	*8*	54	38	8
Add another medication	5.3(2.0)	2nd	*4*	30	48	22	7.2(1.6)	1st	*17*	71	27	2
Raise the dose of the medication to a higher than usual level	5.2(2.3)	2nd	*9*	33	40	27	6.6(2.0)	2nd	*17*	65	25	10
Stop medication. Start psychotherapy	4.5(2.5)	2nd	*8*	22	36	42	2.6(1.7)	3rd	*0*	4	19	77
In PTSD with strong suicidal or aggressive tendencies												
Add psychotherapy	8.1(1.7)	Chc	*63*	92	4	4	7.8(1.5)	1st	*44*	84	14	2
Switch medication. Start psychotherapy	6.0(2.7)	2nd	*19*	58	21	21	5.8(2.3)	2nd	*10*	39	43	18
Switch to another medication	5.9(1.8)	2nd	*2*	47	40	13	6.2(1.9)	2nd	*10*	51	37	12
Raise the dose of the medication to a higher than usual level	5.6(2.6)	2nd	*13*	47	27	27	6.7(2.0)	2nd	*24*	61	31	8
Add another medication	5.3(2.1)	2nd	*4*	39	39	22	7.4(1.3)	1st	*18*	78	22	0
Stop medication. Start psychotherapy	3.8(2.5)	3rd	*6*	20	20	60	2.2(1.8)	3rd	*0*	6	10	85
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

8 A patient with PTSD has had an adequate trial (i.e., duration and dose) of ***medication alone*** but has achieved ***no response***. Please rate the appropriateness of the following strategies as a next step. Assume that you will either provide the treatment or can make an appropriate referral for treatment.

	Psychotherapy experts						**Medication experts**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
In acute PTSD												
Add psychotherapy	8.0(1.6)	Chc	*61*	84	12	4	6.7(2.4)	2nd	*27*	63	21	15
Switch medication. Start psychotherapy	6.6(2.4)	2nd	*22*	67	20	12	7.2(1.8)	1st	*21*	77	17	6
Switch to another medication	6.1(2.2)	2nd	*13*	54	31	15	7.5(1.7)	1st	*31*	79	17	4
Stop medication. Start psychotherapy	6.0(2.7)	2nd	*24*	51	27	22	3.9(2.4)	3rd	*2*	19	27	54
Add another medication	4.2(2.4)	2nd	*2*	20	41	39	5.5(2.4)	2nd	*13*	38	33	29
Raise the dose of the medication to a higher than usual level	3.8(2.4)	3rd	*2*	16	36	49	4.2(2.5)	2nd	*8*	21	37	42
In chronic PTSD												
Add psychotherapy	7.8(1.7)	Chc	*57*	82	14	4	6.6(2.4)	2nd	*29*	60	25	15
Switch medication. Start psychotherapy	6.6(2.4)	2nd	*24*	60	28	12	7.3(1.9)	1st	*29*	76	18	6
Switch to another medication	6.3(1.9)	2nd	*13*	54	35	11	7.6(1.6)	1st	*29*	85	12	4
Stop medication. Start psychotherapy	5.9(2.6)	2nd	*20*	49	27	24	3.7(2.2)	3rd	*2*	13	33	54
Add another medication	4.5(2.4)	2nd	*4*	22	42	36	5.9(2.5)	2nd	*13*	48	29	23
Raise the dose of the medication to a higher than usual level	3.9(2.5)	3rd	*5*	18	32	50	4.8(2.5)	2nd	*10*	31	37	33
In PTSD with strong suicidal or aggressive tendencies												
Add psychotherapy	7.9(1.7)	Chc	*56*	85	12	4	6.7(2.4)	2nd	*27*	62	27	12
Switch medication. Start psychotherapy	6.8(2.4)	2nd	*26*	70	18	12	7.4(2.0)	1st	*38*	75	19	6
Switch to another medication	6.4(2.2)	2nd	*19*	57	28	15	7.4(1.7)	1st	*31*	75	21	4
Stop medication. Start psychotherapy	5.3(2.7)	2nd	*16*	37	35	29	3.0(2.4)	3rd	*4*	12	23	65
Add another medication	4.5(2.4)	2nd	*4*	22	40	38	6.3(2.5)	2nd	*21*	58	23	19
Raise the dose of the medication to a higher than usual level	3.9(2.6)	3rd	*4*	22	24	53	4.7(2.4)	2nd	*8*	29	40	31
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

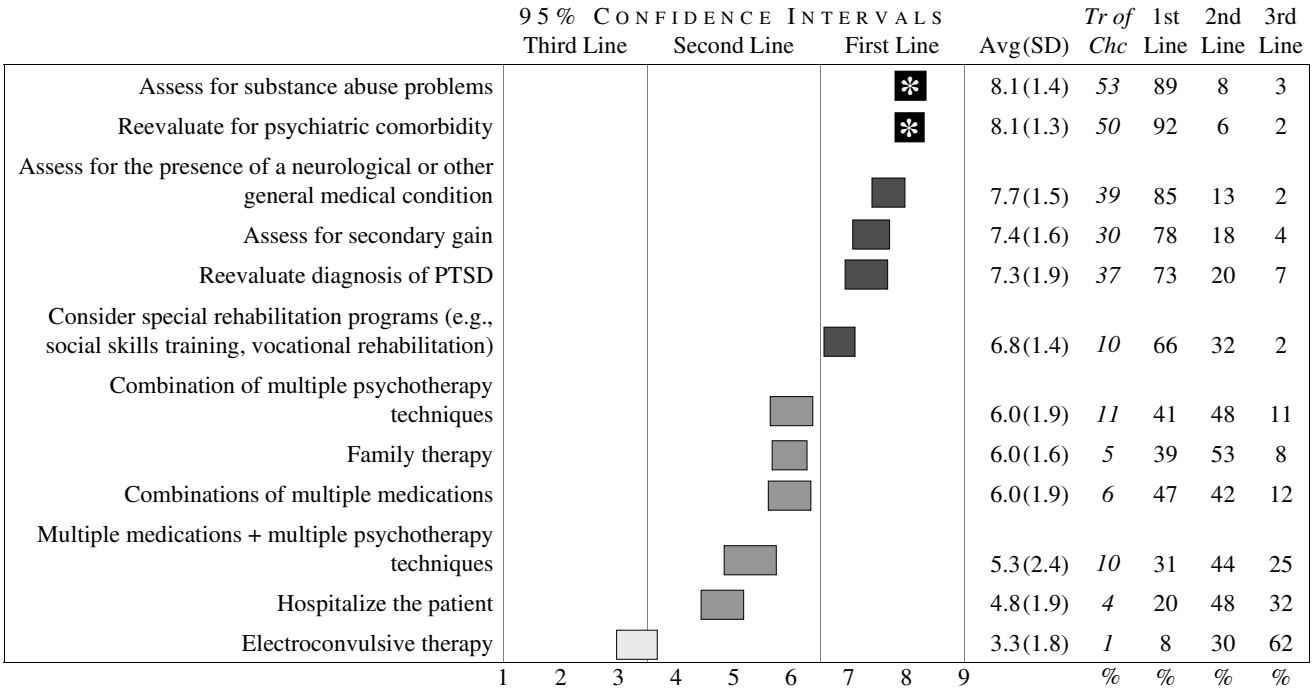
9 A patient with PTSD has had an adequate initial trial of a ***combination of the psychotherapy you thought would be most effective and an appropriate medication at an adequate dose***, but has had only ***a partial response***. Please rate the appropriateness of the following strategies as a next step. Assume that you will either provide the treatment or can make an appropriate referral for treatment.

	Psychotherapy experts						**Medication experts**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
In acute PTSD												
Add another psychotherapy technique	7.1(2.1)	1st	*29*	77	15	8	5.8(2.0)	2nd	*4*	48	41	11
Switch to another psychotherapy technique	6.9(1.5)	2nd	*19*	65	33	2	5.7(1.7)	2nd	*4*	37	57	6
Switch to another medication	6.4(1.7)	2nd	*8*	56	35	8	6.8(1.5)	2nd	*17*	61	37	2
Raise the dose of the medication to a higher than usual level	5.4(2.3)	2nd	*4*	40	36	24	6.3(2.1)	2nd	*15*	52	37	11
Add another medication	5.3(2.0)	2nd	*2*	30	48	22	6.9(1.7)	2nd	*19*	63	33	4
Stop medication. Continue psychotherapy	4.0(2.3)	3rd	*6*	14	37	49	2.7(1.6)	3rd	*0*	2	26	72
Stop psychotherapy. Continue medication	2.8(1.8)	3rd	*2*	2	31	67	3.2(1.7)	3rd	*0*	6	30	65
In chronic PTSD												
Add another psychotherapy technique	7.1(2.0)	1st	*29*	75	17	8	5.6(2.0)	2nd	*4*	43	44	13
Switch to another psychotherapy technique	6.8(1.5)	2nd	*15*	62	38	0	5.8(1.7)	2nd	*4*	33	57	9
Switch to another medication	6.4(1.8)	2nd	*9*	60	30	11	6.8(1.4)	2nd	*13*	57	41	2
Add another medication	5.4(2.0)	2nd	*7*	27	56	18	7.3(1.5)	1st	*20*	78	19	4
Raise the dose of the medication to a higher than usual level	5.4(2.5)	2nd	*9*	38	40	22	6.8(1.8)	2nd	*17*	69	24	7
Stop medication. Continue psychotherapy	3.5(2.0)	3rd	*2*	4	43	53	2.5(1.6)	3rd	*0*	2	23	75
Stop psychotherapy. Continue medication	2.7(1.8)	3rd	*2*	2	27	71	3.2(1.7)	3rd	*0*	6	30	65
In PTSD with strong suicidal or aggressive tendencies												
Add another psychotherapy technique	7.1(2.1)	1st	*33*	71	21	8	5.6(2.2)	2nd	*4*	43	39	19
Switch to another psychotherapy technique	6.8(1.6)	2nd	*20*	55	43	2	5.7(1.9)	2nd	*6*	37	46	17
Switch to another medication	6.8(1.6)	2nd	*10*	73	21	6	7.0(1.5)	1st	*19*	64	32	4
Add another medication	5.9(2.0)	2nd	*9*	41	46	13	7.8(1.1)	1st	*28*	91	9	0
Raise the dose of the medication to a higher than usual level	5.8(2.5)	2nd	*11*	51	31	18	6.9(1.9)	2nd	*17*	70	20	9
Stop medication. Continue psychotherapy	3.1(1.9)	3rd	*2*	6	25	69	2.1(1.4)	3rd	*0*	2	13	85
Stop psychotherapy. Continue medication	2.6(1.8)	3rd	*2*	2	24	75	2.7(1.8)	3rd	*0*	6	22	72
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

10 A patient with PTSD has had an adequate initial trial of a ***combination of the psychotherapy you thought would be most effective and an appropriate medication at an adequate dose,*** but has had ***no response***. Please rate the appropriateness of the following strategies as a next step. Assume that you will either provide the treatment or can make an appropriate referral for treatment.

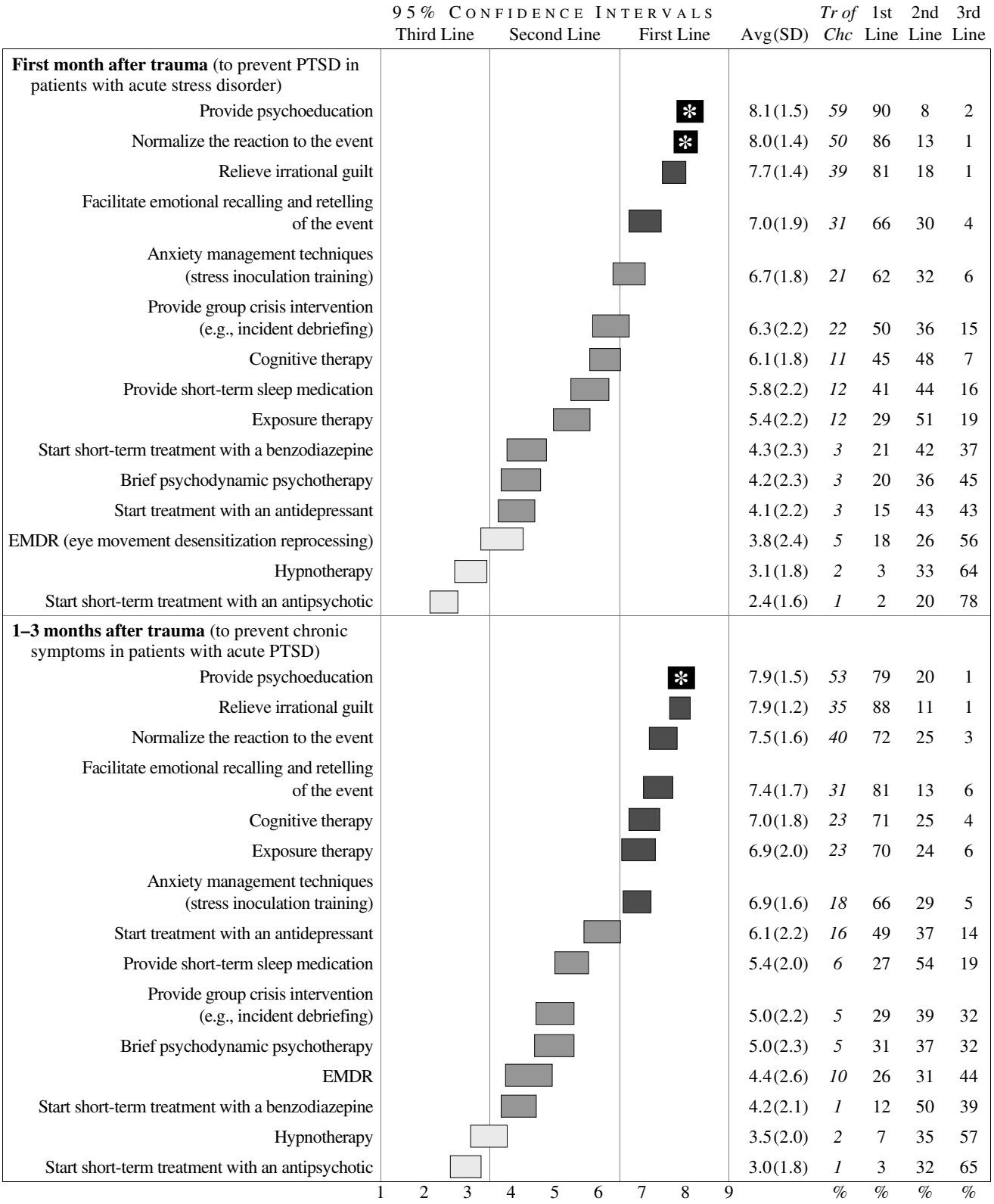
	Psychotherapy experts						**Medication experts**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
In acute PTSD												
Switch to another psychotherapy technique	7.3(1.8)	1st	*33*	75	21	4	6.2(2.0)	2nd	*11*	55	32	13
Switch to another medication	6.8(2.1)	2nd	*24*	69	22	8	7.7(1.2)	1st	*33*	85	15	0
Add another psychotherapy technique	6.7(2.1)	2nd	*21*	62	31	8	5.3(2.3)	2nd	*6*	36	40	25
Add another medication	5.1(2.5)	2nd	*9*	28	41	30	6.0(2.2)	2nd	*13*	48	37	15
Raise the dose of the medication to a higher than usual level	4.3(2.5)	2nd	*4*	24	31	44	5.1(2.4)	2nd	*10*	27	42	31
Stop medication. Continue psychotherapy	4.0(2.4)	3rd	*2*	16	37	47	2.8(1.8)	3rd	*0*	4	23	74
Stop psychotherapy. Continue medication	2.7(1.7)	3rd	*2*	2	25	73	2.7(1.6)	3rd	*0*	2	21	77
In chronic PTSD												
Switch to another psychotherapy technique	7.2(1.9)	1st	*31*	71	24	6	6.1(2.1)	2nd	*8*	53	34	13
Switch to another medication	7.0(1.8)	1st	*22*	71	27	2	7.8(1.1)	1st	*30*	89	11	0
Add another psychotherapy technique	6.6(2.2)	2nd	*24*	63	25	12	5.4(2.3)	2nd	*6*	40	38	23
Add another medication	5.4(2.3)	2nd	*11*	28	48	24	6.4(2.1)	2nd	*15*	57	30	13
Raise the dose of the medication to a higher than usual level	4.6(2.5)	2nd	*7*	27	38	36	5.7(2.3)	2nd	*9*	38	42	21
Stop medication. Continue psychotherapy	3.7(2.1)	3rd	*2*	6	44	50	2.7(1.7)	3rd	*0*	2	21	77
Stop psychotherapy. Continue medication	2.7(1.8)	3rd	*2*	2	26	72	2.8(1.7)	3rd	*0*	2	25	74
In PTSD with strong suicidal or aggressive tendencies												
Switch to another medication	7.3(1.6)	1st	*24*	80	16	4	8.0(1.1)	1st	*38*	89	11	0
Switch to another psychotherapy technique	7.2(1.8)	1st	*29*	76	18	6	5.9(2.0)	2nd	*4*	49	34	17
Add another psychotherapy technique	6.7(2.1)	2nd	*22*	65	25	10	5.5(2.4)	2nd	*9*	40	34	26
Add another medication	5.8(2.3)	2nd	*17*	35	48	17	6.8(2.0)	2nd	*19*	65	25	10
Raise the dose of the medication to a higher than usual level	4.8(2.6)	2nd	*9*	33	29	38	5.7(2.6)	2nd	*13*	44	29	27
Stop medication. Continue psychotherapy	3.3(2.0)	3rd	*2*	4	35	60	2.1(1.5)	3rd	*0*	2	8	91
Stop psychotherapy. Continue medication	2.7(1.9)	3rd	*2*	2	27	71	2.6(1.8)	3rd	*0*	4	13	83
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

11 Rate the appropriateness of the following interventions for a patient with chronic PTSD who has been persistently refractory to treatment. Assume that the patient has received an adequate course of a number of the usual psychotherapy and medication treatments either alone or in combination. ***Note: results from psychotherapy and medication experts are combined.***



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Assess for substance abuse problems	8.1(1.4)	*53*	89	8	3
Reevaluate for psychiatric comorbidity	8.1(1.3)	*50*	92	6	2
Assess for the presence of a neurological or other general medical condition	7.7(1.5)	*39*	85	13	2
Assess for secondary gain	7.4(1.6)	*30*	78	18	4
Reevaluate diagnosis of PTSD	7.3(1.9)	*37*	73	20	7
Consider special rehabilitation programs (e.g., social skills training, vocational rehabilitation)	6.8(1.4)	*10*	66	32	2
Combination of multiple psychotherapy techniques	6.0(1.9)	*11*	41	48	11
Family therapy	6.0(1.6)	*5*	39	53	8
Combinations of multiple medications	6.0(1.9)	*6*	47	42	12
Multiple medications + multiple psychotherapy techniques	5.3(2.4)	*10*	31	44	25
Hospitalize the patient	4.8(1.9)	*4*	20	48	32
Electroconvulsive therapy	3.3(1.8)	*1*	8	30	62
		%	%	%	%

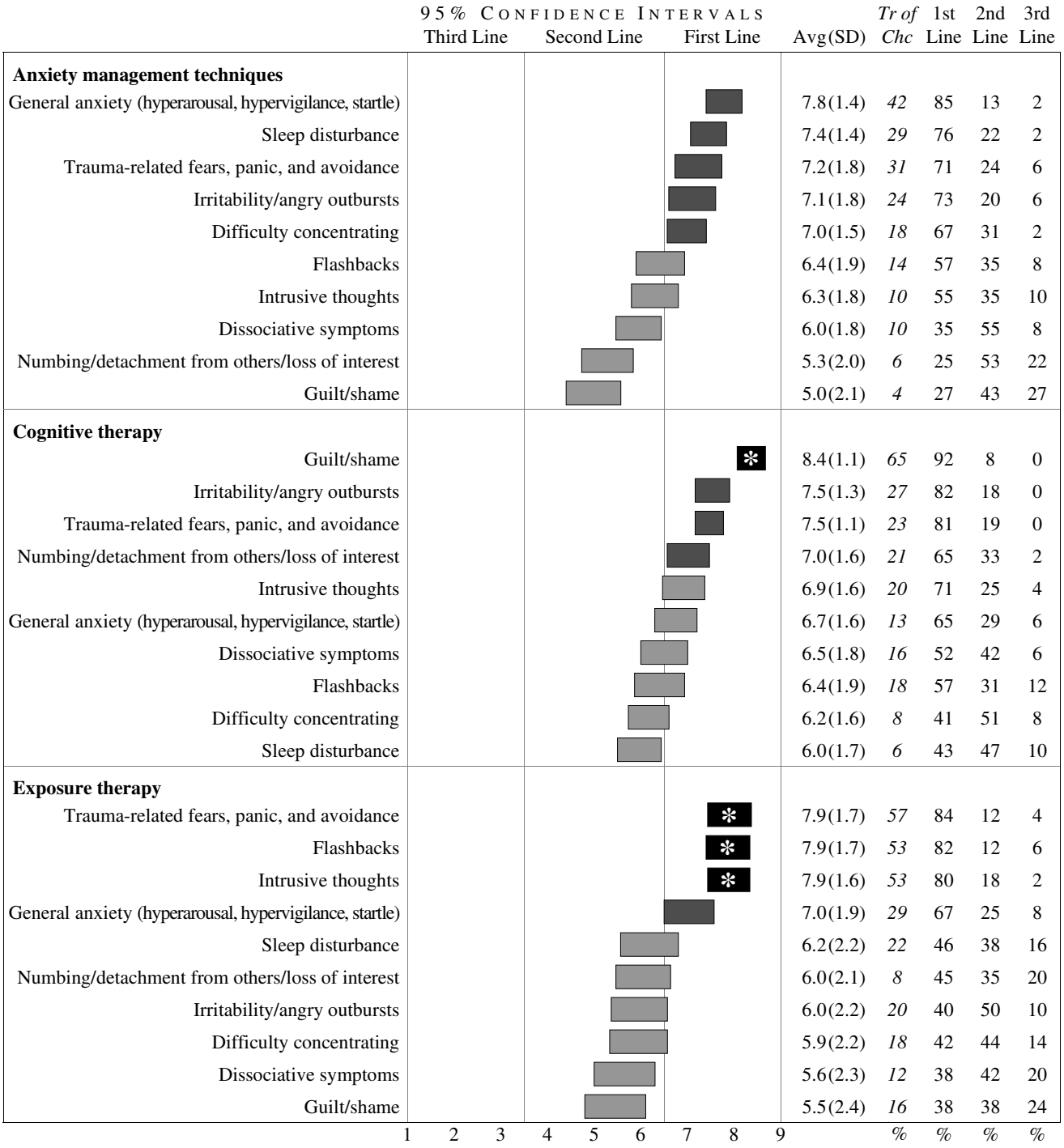
12 Please rate the appropriateness of the following prevention strategies during the first month after the trauma and in the period from 1 to 3 months after the trauma. ***Note: results from psychotherapy and medication experts are combined.***



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
First month after trauma (to prevent PTSD in patients with acute stress disorder)					
Provide psychoeducation	8.1(1.5)	*59*	90	8	2
Normalize the reaction to the event	8.0(1.4)	*50*	86	13	1
Relieve irrational guilt	7.7(1.4)	*39*	81	18	1
Facilitate emotional recalling and retelling of the event	7.0(1.9)	*31*	66	30	4
Anxiety management techniques (stress inoculation training)	6.7(1.8)	*21*	62	32	6
Provide group crisis intervention (e.g., incident debriefing)	6.3(2.2)	*22*	50	36	15
Cognitive therapy	6.1(1.8)	*11*	45	48	7
Provide short-term sleep medication	5.8(2.2)	*12*	41	44	16
Exposure therapy	5.4(2.2)	*12*	29	51	19
Start short-term treatment with a benzodiazepine	4.3(2.3)	*3*	21	42	37
Brief psychodynamic psychotherapy	4.2(2.3)	*3*	20	36	45
Start treatment with an antidepressant	4.1(2.2)	*3*	15	43	43
EMDR (eye movement desensitization reprocessing)	3.8(2.4)	*5*	18	26	56
Hypnotherapy	3.1(1.8)	*2*	3	33	64
Start short-term treatment with an antipsychotic	2.4(1.6)	*1*	2	20	78
1–3 months after trauma (to prevent chronic symptoms in patients with acute PTSD)					
Provide psychoeducation	7.9(1.5)	*53*	79	20	1
Relieve irrational guilt	7.9(1.2)	*35*	88	11	1
Normalize the reaction to the event	7.5(1.6)	*40*	72	25	3
Facilitate emotional recalling and retelling of the event	7.4(1.7)	*31*	81	13	6
Cognitive therapy	7.0(1.8)	*23*	71	25	4
Exposure therapy	6.9(2.0)	*23*	70	24	6
Anxiety management techniques (stress inoculation training)	6.9(1.6)	*18*	66	29	5
Start treatment with an antidepressant	6.1(2.2)	*16*	49	37	14
Provide short-term sleep medication	5.4(2.0)	*6*	27	54	19
Provide group crisis intervention (e.g., incident debriefing)	5.0(2.2)	*5*	29	39	32
Brief psychodynamic psychotherapy	5.0(2.3)	*5*	31	37	32
EMDR	4.4(2.6)	*10*	26	31	44
Start short-term treatment with a benzodiazepine	4.2(2.1)	*1*	12	50	39
Hypnotherapy	3.5(2.0)	*2*	7	35	57
Start short-term treatment with an antipsychotic	3.0(1.8)	*1*	3	32	65
		%	*%*	*%*	*%*

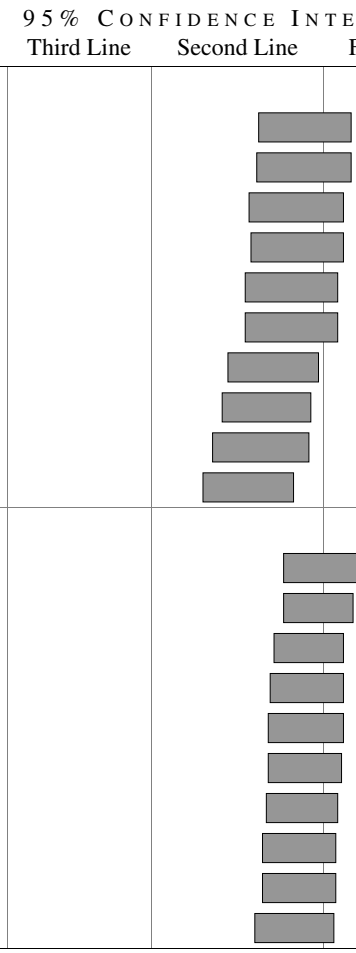
Survey Questions Answered Only by Psychotherapy Experts

13 Rate the appropriateness of each of the different psychotherapy techniques for each PTSD symptom assuming that it is the most prominent target of treatment. Consider each technique independently.



	Avg (SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Anxiety management techniques					
General anxiety (hyperarousal, hypervigilance, startle)	7.8 (1.4)	*42*	85	13	2
Sleep disturbance	7.4 (1.4)	*29*	76	22	2
Trauma-related fears, panic, and avoidance	7.2 (1.8)	*31*	71	24	6
Irritability/angry outbursts	7.1 (1.8)	*24*	73	20	6
Difficulty concentrating	7.0 (1.5)	*18*	67	31	2
Flashbacks	6.4 (1.9)	*14*	57	35	8
Intrusive thoughts	6.3 (1.8)	*10*	55	35	10
Dissociative symptoms	6.0 (1.8)	*10*	35	55	8
Numbing/detachment from others/loss of interest	5.3 (2.0)	*6*	25	53	22
Guilt/shame	5.0 (2.1)	*4*	27	43	27
Cognitive therapy					
Guilt/shame	8.4 (1.1)	*65*	92	8	0
Irritability/angry outbursts	7.5 (1.3)	*27*	82	18	0
Trauma-related fears, panic, and avoidance	7.5 (1.1)	*23*	81	19	0
Numbing/detachment from others/loss of interest	7.0 (1.6)	*21*	65	33	2
Intrusive thoughts	6.9 (1.6)	*20*	71	25	4
General anxiety (hyperarousal, hypervigilance, startle)	6.7 (1.6)	*13*	65	29	6
Dissociative symptoms	6.5 (1.8)	*16*	52	42	6
Flashbacks	6.4 (1.9)	*18*	57	31	12
Difficulty concentrating	6.2 (1.6)	*8*	41	51	8
Sleep disturbance	6.0 (1.7)	*6*	43	47	10
Exposure therapy					
Trauma-related fears, panic, and avoidance	7.9 (1.7)	*57*	84	12	4
Flashbacks	7.9 (1.7)	*53*	82	12	6
Intrusive thoughts	7.9 (1.6)	*53*	80	18	2
General anxiety (hyperarousal, hypervigilance, startle)	7.0 (1.9)	*29*	67	25	8
Sleep disturbance	6.2 (2.2)	*22*	46	38	16
Numbing/detachment from others/loss of interest	6.0 (2.1)	*8*	45	35	20
Irritability/angry outbursts	6.0 (2.2)	*20*	40	50	10
Difficulty concentrating	5.9 (2.2)	*18*	42	44	14
Dissociative symptoms	5.6 (2.3)	*12*	38	42	20
Guilt/shame	5.5 (2.4)	*16*	38	38	24
		%	*%*	*%*	*%*

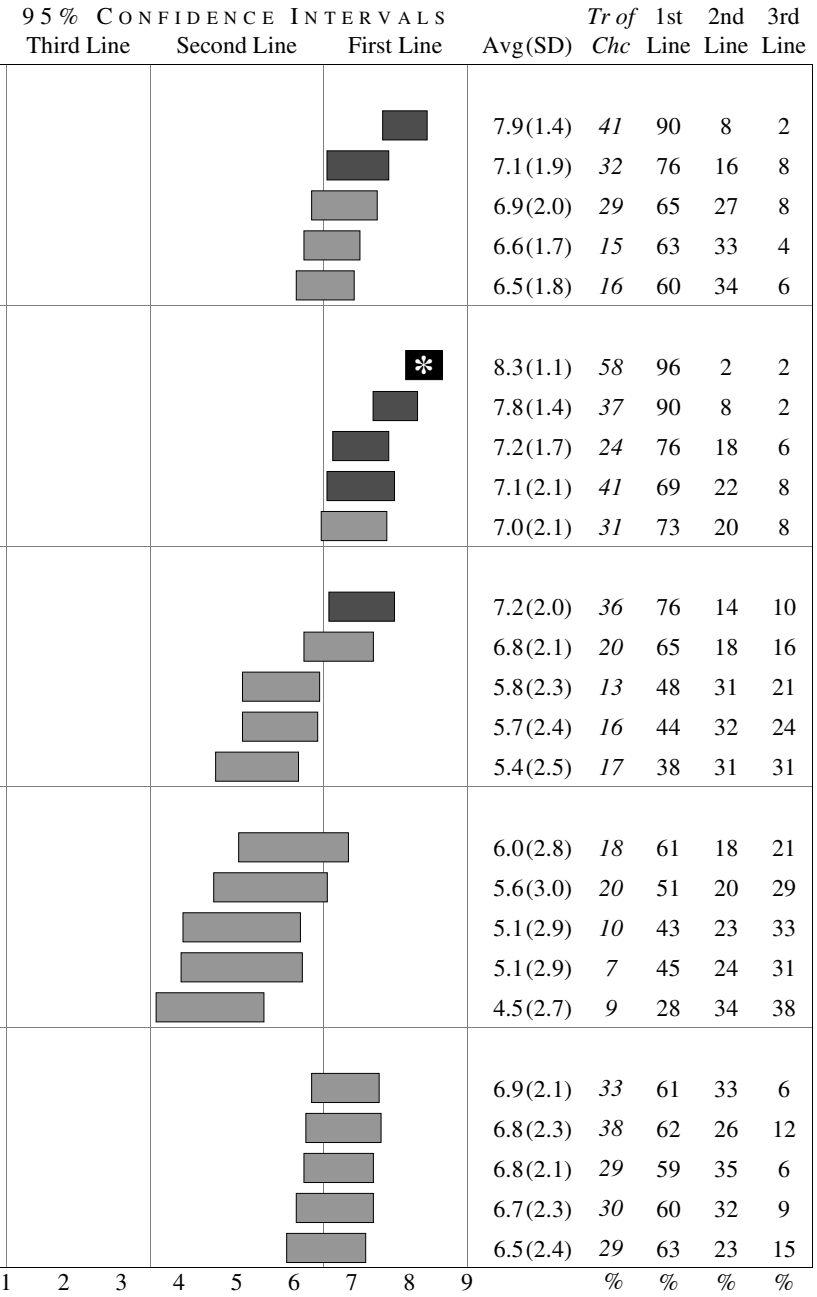
13. *Continued.*



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Play therapy for children					
General anxiety (hyperarousal, hypervigilance, startle)	6.2(2.4)	*19*	58	25	17
Trauma-related fears, panic, and avoidance	6.2(2.5)	*22*	59	24	16
Guilt/shame	6.0(2.5)	*19*	57	27	16
Intrusive thoughts	6.0(2.5)	*16*	54	30	16
Irritability/angry outbursts	5.9(2.5)	*14*	51	35	14
Flashbacks	5.9(2.5)	*14*	54	30	16
Numbing/detachment from others/loss of interest	5.6(2.4)	*11*	43	38	19
Sleep disturbance	5.4(2.3)	*8*	39	44	17
Dissociative symptoms	5.4(2.6)	*8*	41	32	27
Difficulty concentrating	5.2(2.4)	*8*	35	43	22
Psychoeducation					
Trauma-related fears, panic, and avoidance	6.4(2.3)	*26*	52	38	10
General anxiety (hyperarousal, hypervigilance, startle)	6.4(2.2)	*24*	52	38	10
Irritability/angry outbursts	6.2(2.2)	*22*	51	35	14
Intrusive thoughts	6.2(2.3)	*24*	51	33	16
Flashbacks	6.2(2.4)	*25*	51	29	20
Guilt/shame	6.2(2.3)	*20*	51	31	18
Difficulty concentrating	6.1(2.3)	*20*	49	33	18
Numbing/detachment from others/loss of interest	6.1(2.3)	*22*	47	37	16
Dissociative symptoms	6.1(2.3)	*22*	43	41	16
Sleep disturbance	6.0(2.5)	*20*	49	31	20
		%	*%*	*%*	*%*

The mean ratings for these three techniques were below 5.5	**EMDR** Avg(SD)	**Hypnotherapy** Avg(SD)	**Psychodynamic psychotherapy** Avg(SD)
Intrusive thoughts	4.8(2.8)	3.7(2.3)	4.2(2.3)
Flashbacks	4.7(2.7)	3.7(2.4)	3.9(2.2)
Trauma-related fears, panic, and avoidance	4.5(2.7)	3.8(2.2)	4.2(2.3)
General anxiety (hyperarousal, hypervigilance, startle)	4.3(2.6)	3.9(2.3)	4.1(2.2)
Numbing/detachment from others/loss of interest	3.8(2.3)	3.5(2.1)	4.8(2.6)
Dissociative symptoms	3.7(2.4)	4.1(2.5)	4.5(2.6)
Sleep disturbance	3.7(2.6)	3.9(2.2)	3.9(2.3)
Irritability/angry outbursts	3.7(2.7)	3.4(2.0)	4.5(2.5)
Difficulty concentrating	3.8(2.4)	3.5(2.0)	4.0(2.4)
Guilt/shame	4.0(2.7)	3.6(2.2)	5.4(2.8)

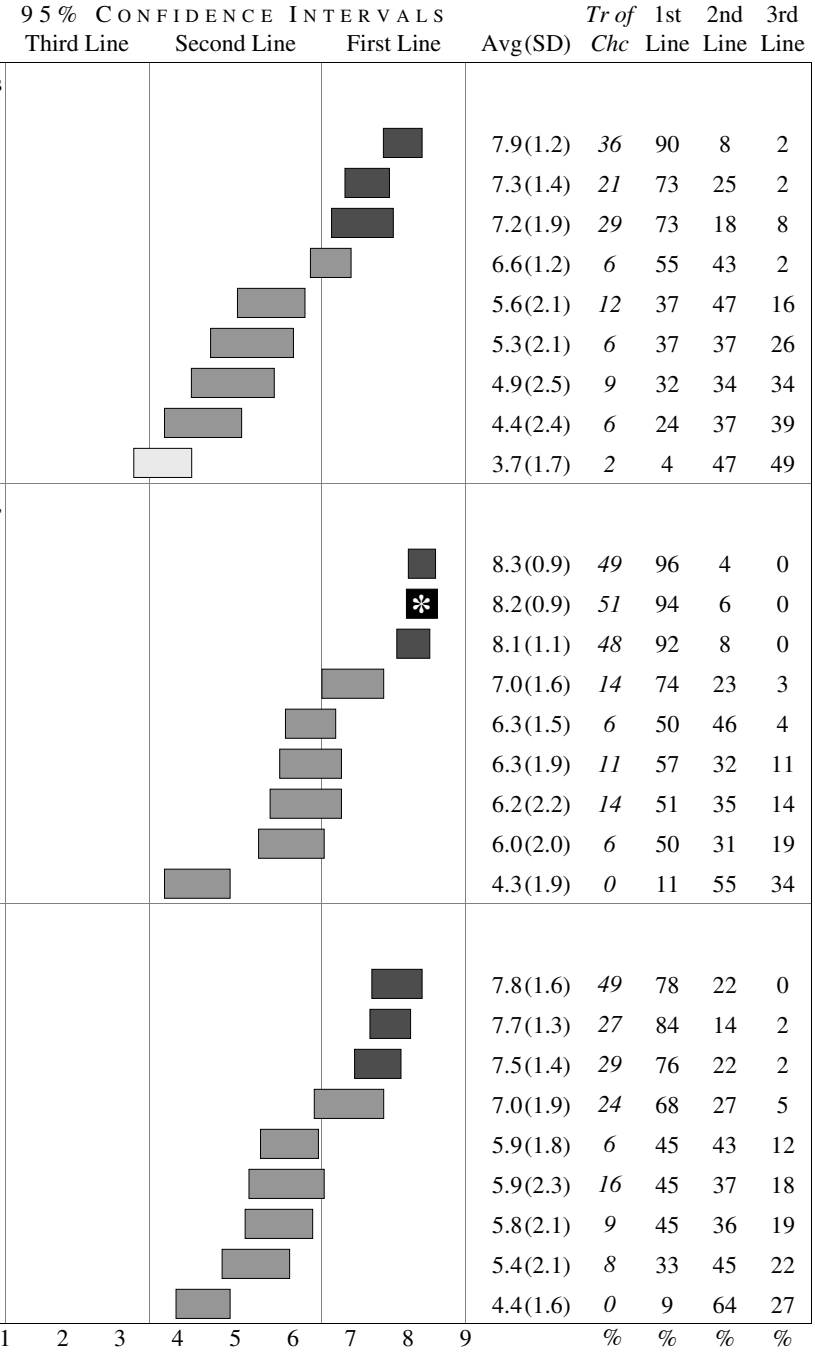
14 How does the presence of a comorbid psychiatric disorder affect your choice of psychotherapy techniques in treating PTSD? Please rate the appropriateness of each of the following psychotherapy techniques for a patient whose PTSD is complicated by the following conditions. Assume that PTSD is the primary diagnosis. Consider each technique independently.



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Anxiety management techniques					
Other anxiety disorder	7.9(1.4)	*41*	90	8	2
Substance abuse or dependence	7.1(1.9)	*32*	76	16	8
Severe cluster B personality disorder	6.9(2.0)	*29*	65	27	8
Bipolar disorder	6.6(1.7)	*15*	63	33	4
Depressive disorder	6.5(1.8)	*16*	60	34	6
Cognitive therapy					
Depressive disorder	8.3(1.1)	*58*	96	2	2
Other anxiety disorder	7.8(1.4)	*37*	90	8	2
Bipolar disorder	7.2(1.7)	*24*	76	18	6
Severe cluster B personality disorder	7.1(2.1)	*41*	69	22	8
Substance abuse or dependence	7.0(2.1)	*31*	73	20	8
Exposure therapy					
Other anxiety disorder	7.2(2.0)	*36*	76	14	10
Depressive disorder	6.8(2.1)	*20*	65	18	16
Bipolar disorder	5.8(2.3)	*13*	48	31	21
Substance abuse or dependence	5.7(2.4)	*16*	44	32	24
Severe cluster B personality disorder	5.4(2.5)	*17*	38	31	31
Play therapy for children					
Depressive disorder	6.0(2.8)	*18*	61	18	21
Other anxiety disorder	5.6(3.0)	*20*	51	20	29
Bipolar disorder	5.1(2.9)	*10*	43	23	33
Severe cluster B personality disorder	5.1(2.9)	*7*	45	24	31
Substance abuse or dependence	4.5(2.7)	*9*	28	34	38
Psychoeducation					
Other anxiety disorder	6.9(2.1)	*33*	61	33	6
Substance abuse or dependence	6.8(2.3)	*38*	62	26	12
Depressive disorder	6.8(2.1)	*29*	59	35	6
Bipolar disorder	6.7(2.3)	*30*	60	32	9
Severe cluster B personality disorder	6.5(2.4)	*29*	63	23	15
		%	*%*	*%*	*%*

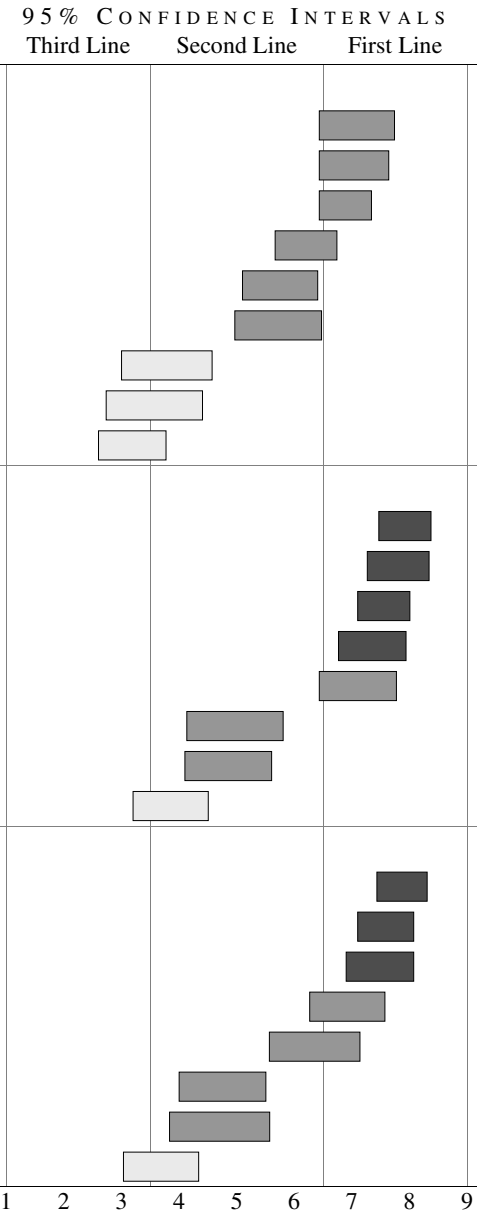
The mean ratings for these three techniques were below 5.0	**EMDR** Avg(SD)	**Hypnotherapy** Avg(SD)	**Psychodynamic psychotherapy** Avg(SD)
Depressive disorder	3.8(2.6)	3.2(1.8)	4.8(2.7)
Bipolar disorder	3.6(2.4)	2.8(1.6)	3.8(2.4)
Other anxiety disorder	4.0(2.6)	3.5(2.1)	4.3(2.5)
Substance abuse or dependence	3.6(2.6)	2.9(1.8)	3.9(2.6)
Severe cluster B personality disorder	3.3(2.5)	2.9(2.0)	4.8(2.8)

15 Please rate the overall effectiveness, safety, and acceptability of each of the following psychotherapy techniques for a patient with PTSD. Give your highest ratings to those techniques you consider most effective, safe, or acceptable.



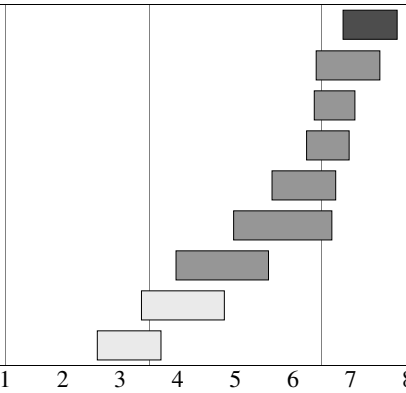
	Avg (SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Effectiveness (likely to decrease PTSD symptoms by 75% and improve general functioning)					
Imaginal exposure	7.9 (1.2)	*36*	90	8	2
Cognitive therapy	7.3 (1.4)	*21*	73	25	2
In vivo exposure	7.2 (1.9)	*29*	73	18	8
Anxiety management techniques	6.6 (1.2)	*6*	55	43	2
Psychoeducation	5.6 (2.1)	*12*	37	47	16
Play therapy for children	5.3 (2.1)	*6*	37	37	26
EMDR	4.9 (2.5)	*9*	32	34	34
Psychodynamic psychotherapy	4.4 (2.4)	*6*	24	37	39
Hypnotherapy	3.7 (1.7)	*2*	4	47	49
Safety (unlikely to increase severity of symptoms, agitation, or suicidality)					
Anxiety management techniques	8.3 (0.9)	*49*	96	4	0
Psychoeducation	8.2 (0.9)	*51*	94	6	0
Cognitive therapy	8.1 (1.1)	*48*	92	8	0
Play therapy for children	7.0 (1.6)	*14*	74	23	3
Imaginal exposure	6.3 (1.5)	*6*	50	46	4
EMDR	6.3 (1.9)	*11*	57	32	11
Psychodynamic psychotherapy	6.2 (2.2)	*14*	51	35	14
In vivo exposure	6.0 (2.0)	*6*	50	31	19
Hypnotherapy	4.3 (1.9)	*0*	11	55	34
Acceptability (likely to promote engagement, responsiveness, and retention in treatment)					
Psychoeducation	7.8 (1.6)	*49*	78	22	0
Cognitive therapy	7.7 (1.3)	*27*	84	14	2
Anxiety management techniques	7.5 (1.4)	*29*	76	22	2
Play therapy for children	7.0 (1.9)	*24*	68	27	5
Imaginal exposure	5.9 (1.8)	*6*	45	43	12
Psychodynamic psychotherapy	5.9 (2.3)	*16*	45	37	18
EMDR	5.8 (2.1)	*9*	45	36	19
In vivo exposure	5.4 (2.1)	*8*	33	45	22
Hypnotherapy	4.4 (1.6)	*0*	9	64	27
		%	*%*	*%*	*%*

16 How does the age of the patient affect your choice of psychotherapy techniques in treating PTSD? Please rate the overall appropriateness of each of the following psychotherapy techniques for a patient with PTSD in each of the following age groups.



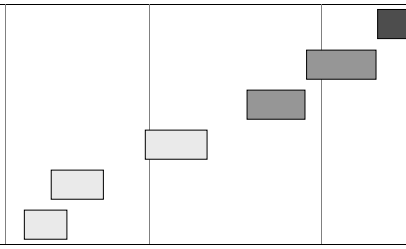
	Avg (SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Children and younger adolescents					
Play therapy	7.1 (2.1)	*32*	71	22	7
Psychoeducation	7.0 (2.1)	*37*	65	28	7
Anxiety management techniques	6.9 (1.6)	*15*	64	32	4
Cognitive therapy	6.2 (1.9)	*15*	48	43	9
Imaginal exposure	5.8 (2.2)	*13*	44	29	27
In vivo exposure	5.7 (2.5)	*20*	48	25	27
Psychodynamic psychotherapy	3.8 (2.6)	*9*	19	28	53
EMDR	3.6 (2.7)	*5*	20	25	55
Hypnotherapy	3.2 (1.9)	*3*	5	30	65
Adults and older adolescents					
Cognitive therapy	7.9 (1.6)	*48*	88	10	2
Imaginal exposure	7.8 (1.9)	*49*	88	4	8
Anxiety management techniques	7.5 (1.6)	*32*	82	14	4
Psychoeducation	7.4 (2.1)	*46*	70	24	6
In vivo exposure	7.1 (2.3)	*43*	72	15	13
EMDR	5.0 (2.9)	*13*	40	22	38
Psychodynamic psychotherapy	4.9 (2.6)	*11*	30	32	38
Hypnotherapy	3.8 (2.2)	*5*	9	39	52
Geriatric patients					
Cognitive therapy	7.9 (1.5)	*42*	89	9	2
Anxiety management techniques	7.6 (1.7)	*36*	82	13	4
Psychoeducation	7.5 (2.1)	*47*	72	21	6
Imaginal exposure	6.9 (2.2)	*30*	73	16	11
In vivo exposure	6.4 (2.6)	*31*	55	29	17
Psychodynamic psychotherapy	4.8 (2.5)	*9*	26	35	40
EMDR	4.7 (2.8)	*8*	33	28	40
Hypnotherapy	3.7 (2.1)	*0*	8	41	51
		%	*%*	*%*	*%*

17 Which of the following psychotherapy techniques acts most quickly? Please give your highest ratings to those techniques you think have the fastest effect.



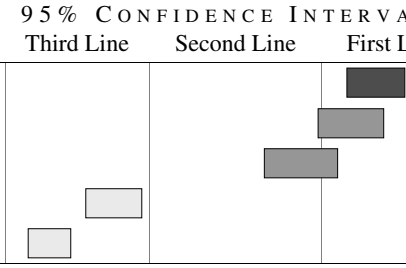
	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Imaginal exposure	7.3(1.7)	*26*	82	16	2
In vivo exposure	7.0(1.9)	*25*	71	25	4
Anxiety management techniques	6.7(1.3)	*6*	62	38	0
Cognitive therapy	6.6(1.4)	*10*	54	44	2
Psychoeducation	6.2(2.0)	*15*	46	46	8
EMDR	5.8(2.9)	*26*	53	16	30
Play therapy for children	4.8(2.5)	*11*	24	43	32
Hypnotherapy	4.1(2.4)	*5*	17	33	50
Psychodynamic psychotherapy	3.2(2.0)	*0*	6	33	60
		%	*%*	*%*	*%*

18 **Frequency of visits: initial treatment phase.** Please rate the appropriateness of the following ***frequencies*** of psychotherapy sessions during the initial phase (first 3 months) of treatment for PTSD.



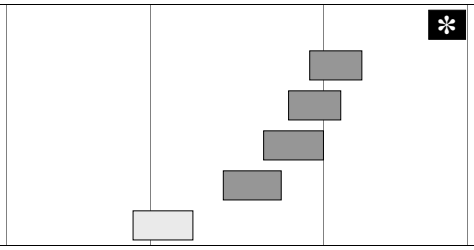
	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Weekly throughout	7.9(1.5)	*36*	94	2	4
Twice a week	6.8(2.2)	*29*	61	31	8
Weekly for first month and every 2 weeks thereafter	5.7(1.8)	*2*	34	52	14
Every 2 weeks	4.0(1.9)	*2*	8	52	40
Monthly	2.2(1.6)	*2*	2	12	86
Every 2 months	1.7(1.3)	*2*	2	2	96
		%	*%*	*%*	*%*

19 Please rate the appropriateness of the following **durations** of psychotherapy sessions during the initial phase (first 3 months) of treatment for PTSD.



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
60 minutes	7.5(1.8)	*29*	82	12	6
> 60 minutes	7.0(2.1)	*31*	69	23	8
45 minutes	6.1(2.3)	*16*	50	36	14
30 minutes	2.9(1.8)	*2*	4	23	73
15 minutes	1.8(1.3)	*2*	2	4	94
		%	*%*	*%*	*%*

20 Please rate the appropriateness of each of the following **formats** for psychotherapy sessions during the initial phase (first 3 months) of treatment for PTSD.



	Avg (SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Individual	8.7 (1.2)	*81*	98	0	2
Combination of individual and group therapy	6.7 (1.7)	*17*	56	42	2
Combination of individual and family therapy	6.4 (1.7)	*10*	50	42	8
Therapist-led PTSD group	6.0 (1.9)	*12*	40	48	12
Family	5.3 (1.9)	*4*	23	58	19
Self-help PTSD group	3.7 (1.9)	*2*	8	38	54
		%	%	%	%

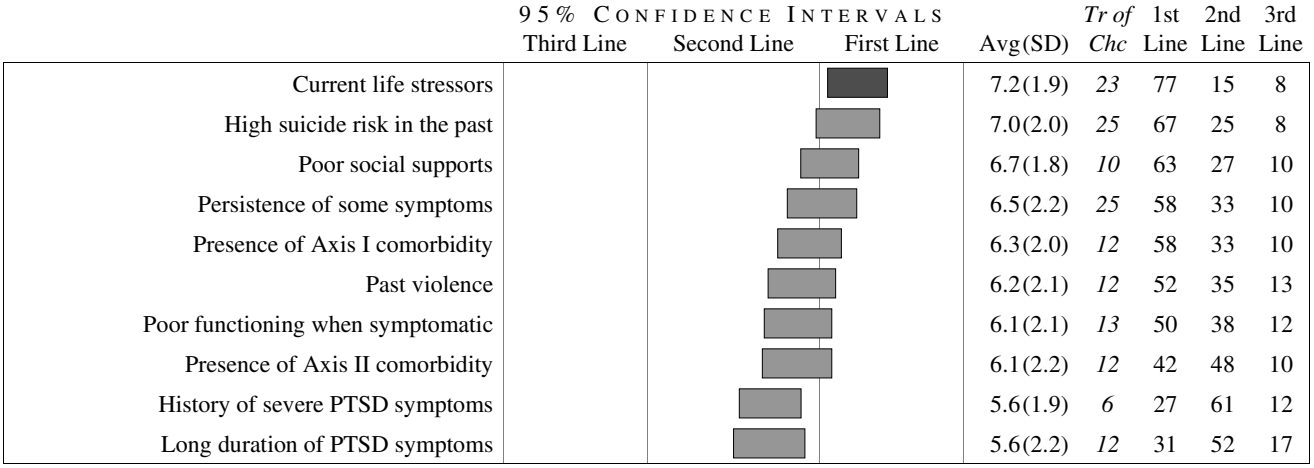
21 **Frequency of visits: maintenance phase.** What frequency of psychotherapy visits makes sense in the maintenance phase? Assume that a patient with PTSD has already had a good response after 3 months of treatment and continues to do well. Rate the appropriateness of the following frequencies of psychotherapy follow-up visits for each subsequent time period.

	3–6 months						**6–12 months**						**After 12 months**					
	Avg (SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg (SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg (SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
Once a week	4.6 (2.7)	2nd	*13*	28	36	36	3.3 (2.5)	3rd	*6*	12	27	61	2.4 (2.2)	3rd	*6*	8	10	82
Every 2 weeks	5.8 (2.3)	2nd	*6*	51	31	18	3.9 (2.5)	3rd	*2*	27	18	55	2.6 (2.1)	3rd	*2*	8	16	76
Once a month	6.5 (2.2)	2nd	*14*	67	20	12	5.3 (2.4)	2nd	*8*	37	39	24	3.3 (2.3)	3rd	*4*	8	35	57
Every 2 months	5.2 (1.8)	2nd	*0*	27	54	19	5.0 (2.3)	2nd	*6*	22	53	24	3.7 (2.5)	3rd	*6*	18	29	53
Every 3 months	4.3 (2.3)	2nd	*8*	13	52	35	5.0 (2.4)	2nd	*4*	33	39	29	3.9 (2.5)	3rd	*2*	20	31	49
Every 6 months	3.6 (2.2)	3rd	*2*	11	34	55	4.5 (2.4)	2nd	*4*	27	39	35	4.7 (2.7)	2nd	*4*	35	29	37
No more visits	3.4 (2.7)	3rd	*4*	21	13	67	5.3 (3.1)	2nd	*22*	44	18	38	6.4 (3.0)	2nd	*41*	61	16	24

22 On average, how long would you continue the psychotherapy before trying to taper and discontinue it in each of the following situations?

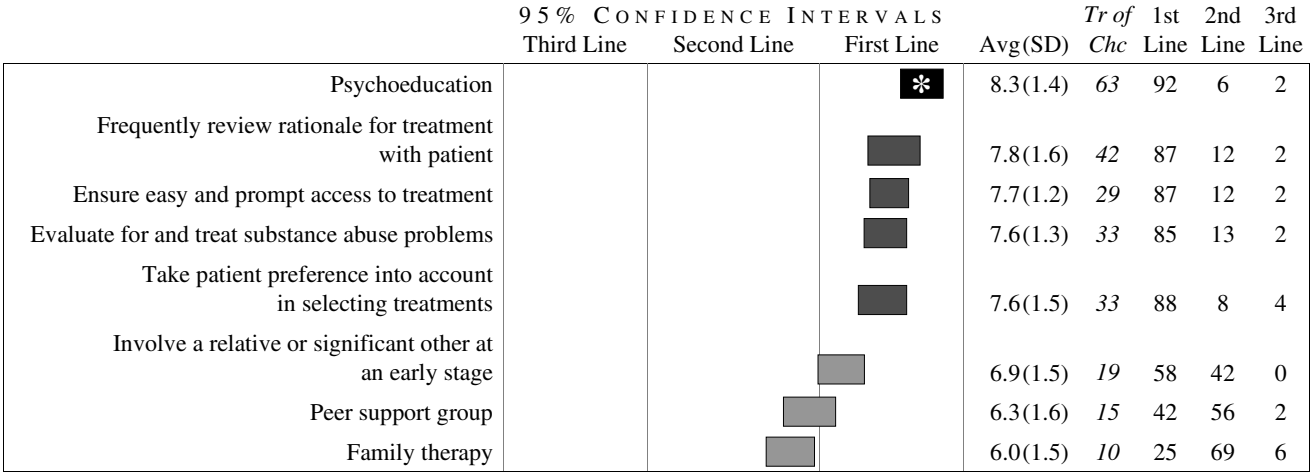
	Acute PTSD, remission						**Chronic PTSD, remission**						**Chronic PTSD, residual symptoms**					
	Avg (SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg (SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg (SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
3 months	7.9 (1.9)	Chc	*54*	90	4	6	6.8 (2.5)	2nd	*37*	61	27	12	6.5 (2.4)	2nd	*27*	63	24	14
6 months	5.9 (2.2)	2nd	*10*	46	36	18	6.6 (2.3)	2nd	*16*	73	8	18	6.7 (2.1)	2nd	*18*	68	18	14
12 months	3.7 (2.0)	3rd	*2*	6	46	48	5.5 (2.3)	2nd	*13*	29	52	19	5.9 (2.3)	2nd	*16*	45	39	16
24 months	2.4 (1.6)	3rd	*2*	2	20	78	3.9 (2.2)	3rd	*4*	13	38	49	4.3 (2.3)	2nd	*6*	16	42	42
> 24 months	1.7 (1.3)	3rd	*2*	2	0	98	2.9 (2.1)	3rd	*2*	6	25	69	3.0 (2.0)	3rd	*2*	6	30	64

23 Assume that a patient with PTSD is doing well in the maintenance phase (in remission for 6–12 months) and you are considering discontinuing psychotherapy, but are concerned about the possibility of relapse. Give your highest ratings to those factors that would support ***continuing*** psychotherapy for a longer time.



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Current life stressors	7.2(1.9)	*23*	77	15	8
High suicide risk in the past	7.0(2.0)	*25*	67	25	8
Poor social supports	6.7(1.8)	*10*	63	27	10
Persistence of some symptoms	6.5(2.2)	*25*	58	33	10
Presence of Axis I comorbidity	6.3(2.0)	*12*	58	33	10
Past violence	6.2(2.1)	*12*	52	35	13
Poor functioning when symptomatic	6.1(2.1)	*13*	50	38	12
Presence of Axis II comorbidity	6.1(2.2)	*12*	42	48	10
History of severe PTSD symptoms	5.6(1.9)	*6*	27	61	12
Long duration of PTSD symptoms	5.6(2.2)	*12*	31	52	17
		%	*%*	*%*	*%*

24 Please rate the appropriateness of the following strategies for enhancing compliance with psychotherapy treatment.



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Psychoeducation	8.3(1.4)	*63*	92	6	2
Frequently review rationale for treatment with patient	7.8(1.6)	*42*	87	12	2
Ensure easy and prompt access to treatment	7.7(1.2)	*29*	87	12	2
Evaluate for and treat substance abuse problems	7.6(1.3)	*33*	85	13	2
Take patient preference into account in selecting treatments	7.6(1.5)	*33*	88	8	4
Involve a relative or significant other at an early stage	6.9(1.5)	*19*	58	42	0
Peer support group	6.3(1.6)	*15*	42	56	2
Family therapy	6.0(1.5)	*10*	25	69	6
		%	*%*	*%*	*%*

Because of space limitations, we could not present the complete results of the following questions. Results are available on request.

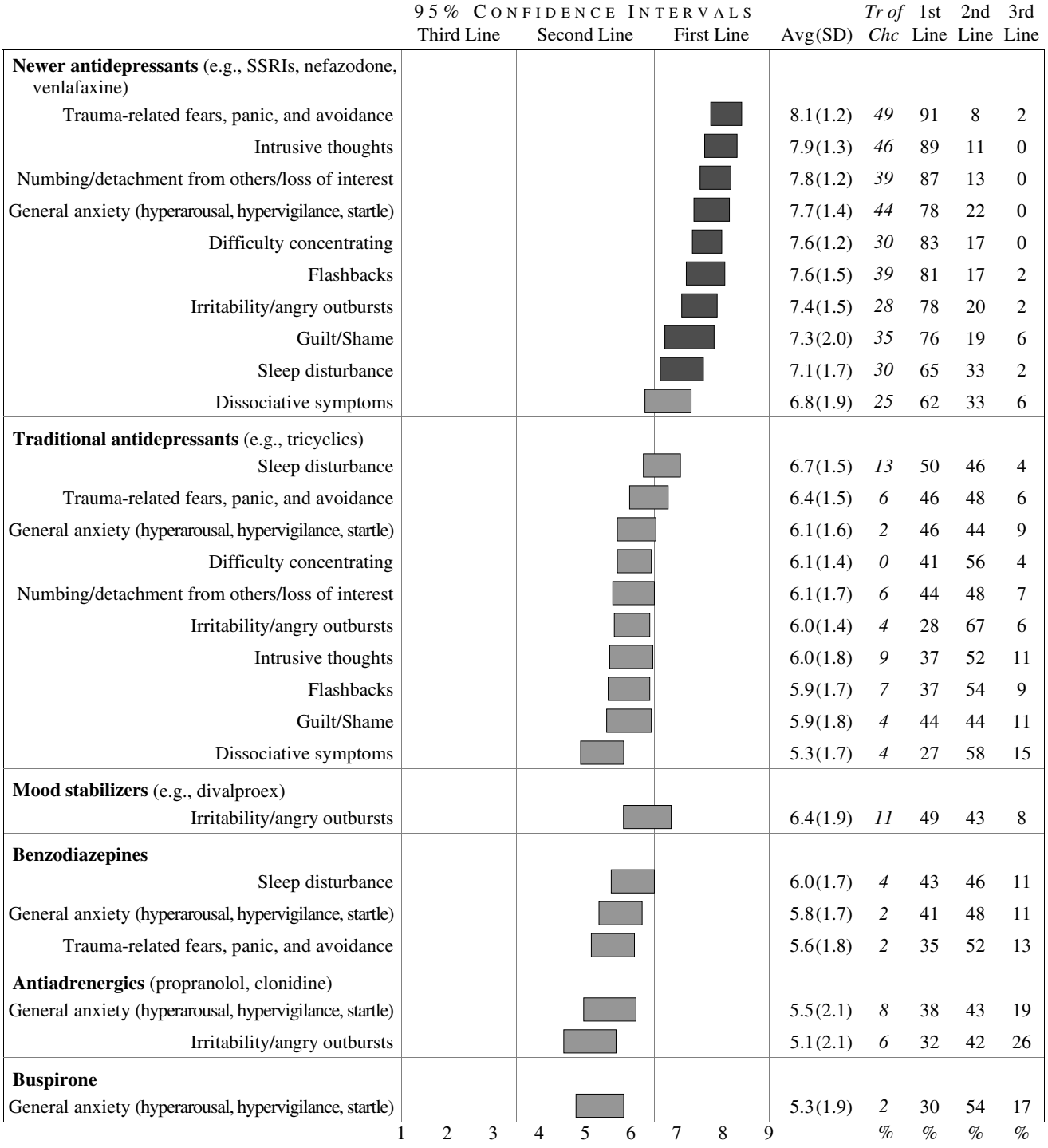
25 Does the type of stressful event affect your choice of psychotherapy techniques? Please rate the appropriateness of each of the following psychotherapy techniques for the treatment of PTSD that is associated with each of the following types of stressors. ***Cognitive therapy, exposure therapy, anxiety management, and psychoeducation received the highest ratings for all the different types of stressors.***

26 How well do the different psychotherapy techniques go together ***at the outset of treatment*** and also for a patient who is ***not having an adequate response to a single psychotherapy technique***? ***The four techniques preferred for use alone—anxiety management techniques, cognitive therapy, exposure therapy, and psychoeducation—are also recommended in combination with one another.***

Survey Questions Answered Only by Medication Experts

In questions 27–30, we asked about the appropriateness of the following classes of medications: newer antidepressants, traditional antidepressants, mood stabilizers, benzodiazepines, antiadrenergics, buspirone, and atypical and conventional antipsychotics. Due to space limitations, we report here only the situations for which the mean rating for a given class of medication was 5.0 or higher. Complete results are available on request.

27 Rate the appropriateness of the different classes of medication for each PTSD symptom assuming that it is the most prominent target of treatment.

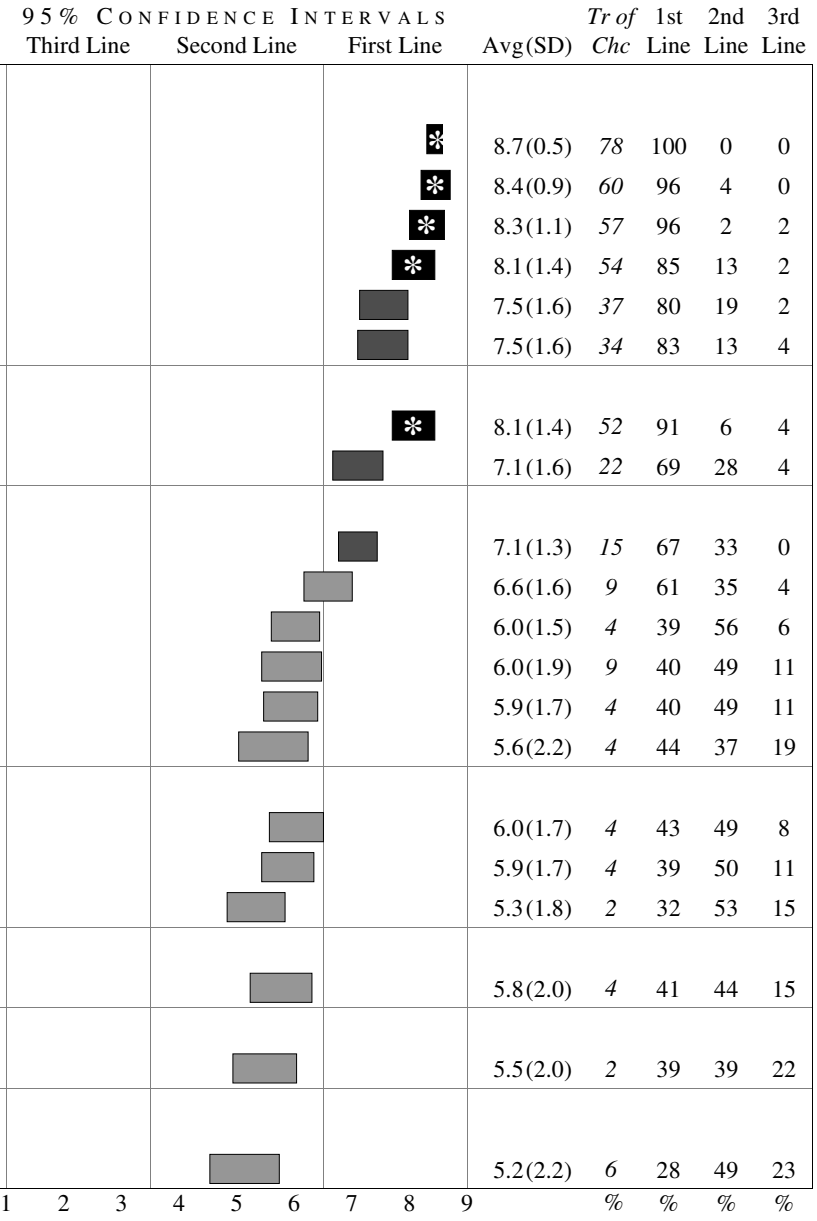


	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Newer antidepressants (e.g., SSRIs, nefazodone, venlafaxine)					
Trauma-related fears, panic, and avoidance	8.1(1.2)	*49*	91	8	2
Intrusive thoughts	7.9(1.3)	*46*	89	11	0
Numbing/detachment from others/loss of interest	7.8(1.2)	*39*	87	13	0
General anxiety (hyperarousal, hypervigilance, startle)	7.7(1.4)	*44*	78	22	0
Difficulty concentrating	7.6(1.2)	*30*	83	17	0
Flashbacks	7.6(1.5)	*39*	81	17	2
Irritability/angry outbursts	7.4(1.5)	*28*	78	20	2
Guilt/Shame	7.3(2.0)	*35*	76	19	6
Sleep disturbance	7.1(1.7)	*30*	65	33	2
Dissociative symptoms	6.8(1.9)	*25*	62	33	6
Traditional antidepressants (e.g., tricyclics)					
Sleep disturbance	6.7(1.5)	*13*	50	46	4
Trauma-related fears, panic, and avoidance	6.4(1.5)	*6*	46	48	6
General anxiety (hyperarousal, hypervigilance, startle)	6.1(1.6)	*2*	46	44	9
Difficulty concentrating	6.1(1.4)	*0*	41	56	4
Numbing/detachment from others/loss of interest	6.1(1.7)	*6*	44	48	7
Irritability/angry outbursts	6.0(1.4)	*4*	28	67	6
Intrusive thoughts	6.0(1.8)	*9*	37	52	11
Flashbacks	5.9(1.7)	*7*	37	54	9
Guilt/Shame	5.9(1.8)	*4*	44	44	11
Dissociative symptoms	5.3(1.7)	*4*	27	58	15
Mood stabilizers (e.g., divalproex)					
Irritability/angry outbursts	6.4(1.9)	*11*	49	43	8
Benzodiazepines					
Sleep disturbance	6.0(1.7)	*4*	43	46	11
General anxiety (hyperarousal, hypervigilance, startle)	5.8(1.7)	*2*	41	48	11
Trauma-related fears, panic, and avoidance	5.6(1.8)	*2*	35	52	13
Antiadrenergics (propranolol, clonidine)					
General anxiety (hyperarousal, hypervigilance, startle)	5.5(2.1)	*8*	38	43	19
Irritability/angry outbursts	5.1(2.1)	*6*	32	42	26
Buspirone					
General anxiety (hyperarousal, hypervigilance, startle)	5.3(1.9)	*2*	30	54	17
		%	*%*	*%*	*%*

28 Does the type of stressful event affect your choice of medications? Please rate the appropriateness of the different classes of medication for the treatment of PTSD that is associated with each of the following types of stressors.

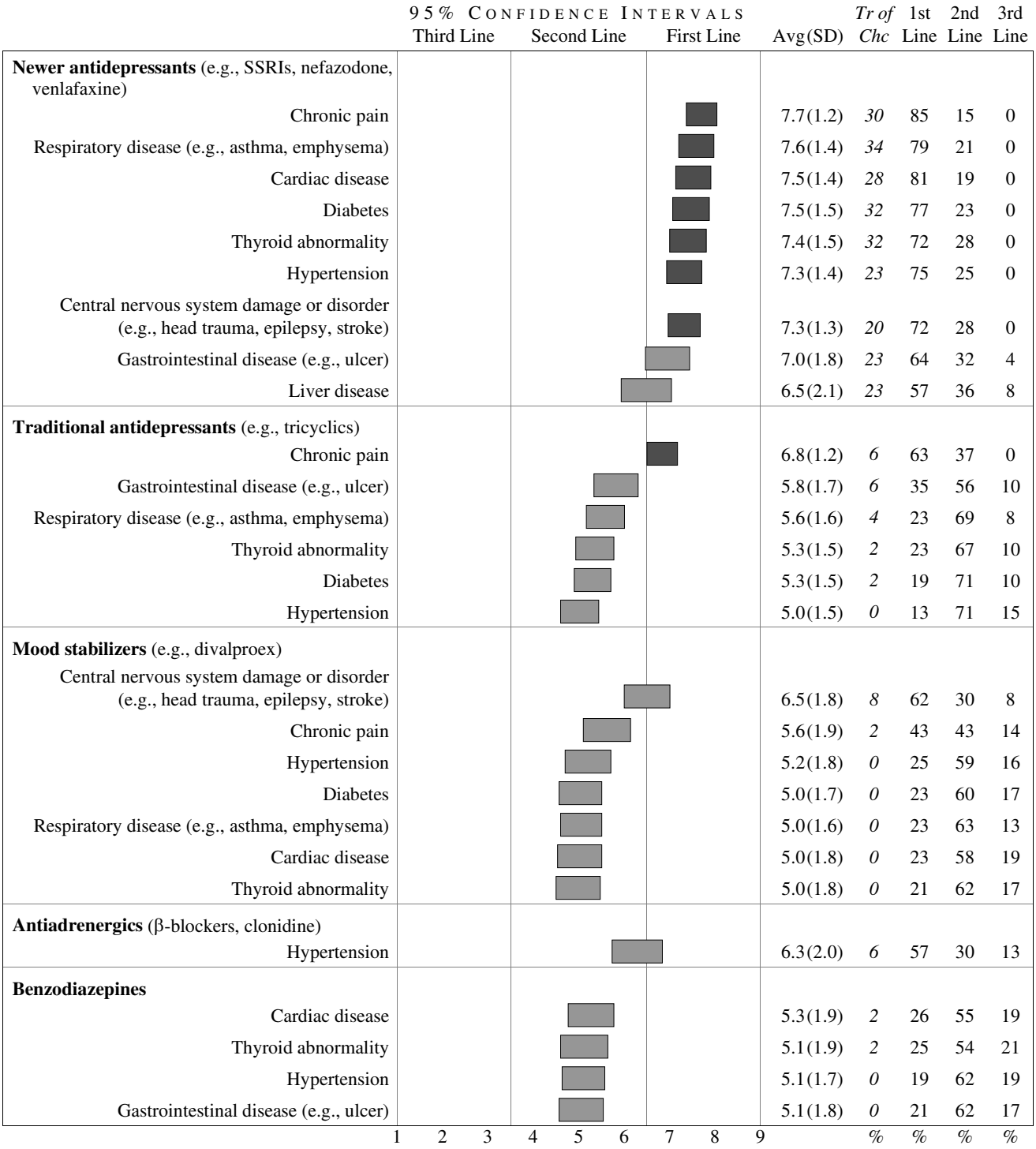
	95% Confidence Intervals (Third Line / Second Line / First Line)	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Newer antidepressants (e.g., SSRIs, nefazodone, venlafaxine)						
Sexual trauma as an adult		8.0(1.2)	*40*	96	2	2
Victim of violent crime or torture		8.0(1.2)	*42*	96	2	2
Military combat		8.0(1.2)	*40*	94	4	2
Sexual or physical abuse in childhood		8.0(1.2)	*40*	96	2	2
Natural disasters		7.9(1.2)	*34*	94	4	2
Other trauma (e.g., being diagnosed with a life-threatening illness, witnessing a traumatic event)		7.9(1.4)	*38*	94	4	2
Accidents		7.9(1.3)	*36*	94	4	2
Traditional antidepressants (e.g., tricyclics)						
Military combat		6.3(1.6)	*8*	44	54	2
Sexual trauma as an adult		6.2(1.5)	*8*	34	64	2
Victim of violent crime or torture		6.1(1.5)	*4*	38	58	4
Accidents		6.1(1.5)	*6*	38	58	4
Sexual or physical abuse in childhood		6.0(1.5)	*6*	34	64	2
Natural disasters		6.0(1.5)	*4*	36	60	4
Other trauma (e.g., being diagnosed with a life-threatening illness, witnessing a traumatic event)		5.9(1.5)	*4*	36	58	6
Mood stabilizers (e.g., divalproex)						
Military combat		5.2(1.9)	*2*	27	55	18
Sexual or physical abuse in childhood		5.2(1.8)	*0*	24	55	20
Victim of violent crime or torture		5.0(1.7)	*0*	16	65	18
Benzodiazepines						
Accidents		5.2(1.9)	*4*	27	57	16
Natural disasters		5.2(1.9)	*4*	26	56	18
Sexual trauma as an adult		5.1(1.8)	*2*	22	59	18
Other trauma (e.g., being diagnosed with a life-threatening illness, witnessing a traumatic event)		5.0(1.9)	*4*	26	53	21
	1 2 3 4 5 6 7 8 9		*%*	*%*	*%*	*%*

29 How does the presence of a comorbid psychiatric disorder affect your choice of medications in treating PTSD? Please rate the appropriateness of the different classes of medication for a patient whose PTSD is complicated by the following conditions. Assume that PTSD is the primary diagnosis.



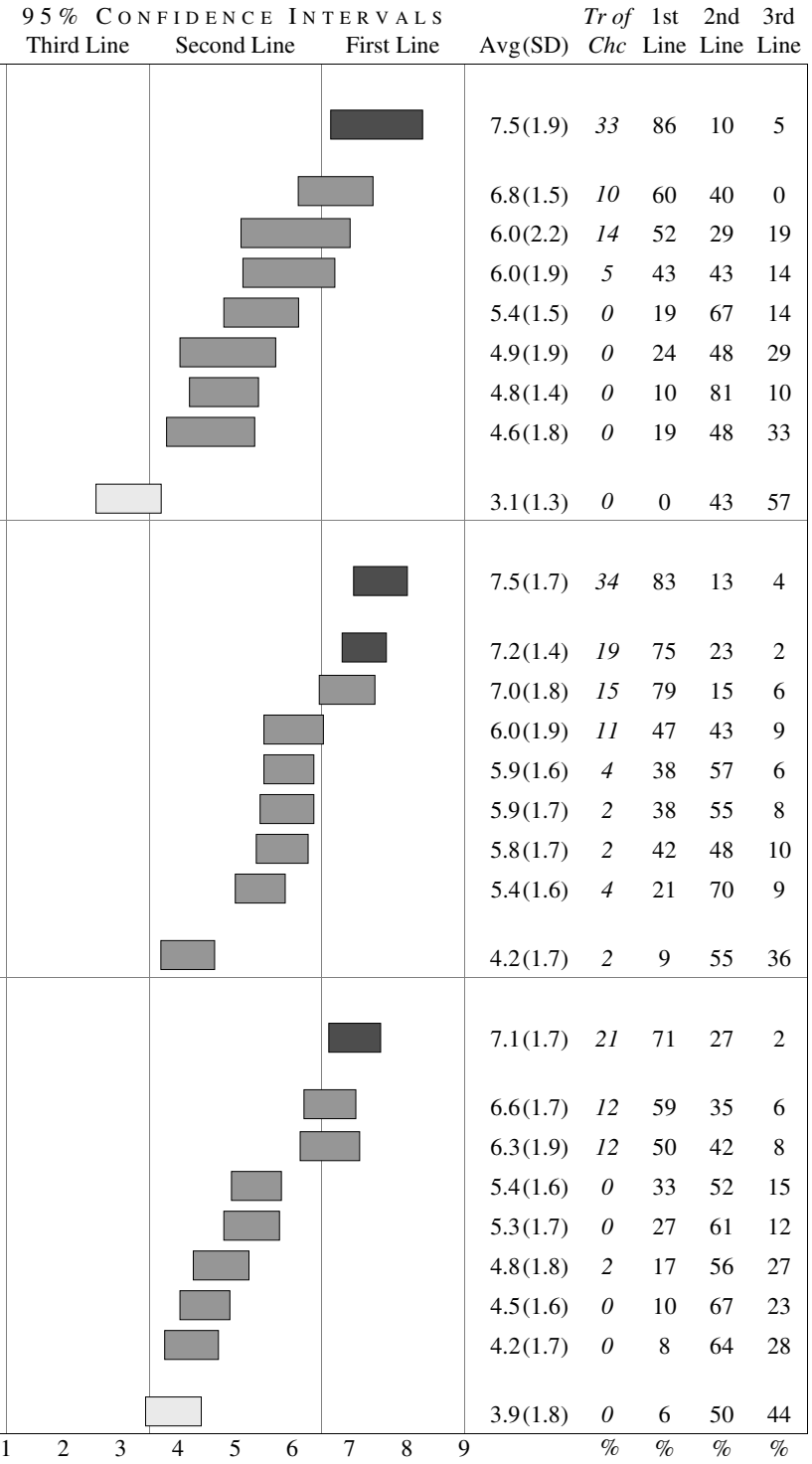
	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Newer antidepressants (e.g., SSRIs, nefazodone, venlafaxine)					
Unipolar depressive disorder	8.7(0.5)	*78*	100	0	0
Obsessive-compulsive disorder	8.4(0.9)	*60*	96	4	0
Panic disorder	8.3(1.1)	*57*	96	2	2
Social phobia	8.1(1.4)	*54*	85	13	2
Generalized anxiety disorder	7.5(1.6)	*37*	80	19	2
Bipolar disorder, depressed phase	7.5(1.6)	*34*	83	13	4
Mood stabilizers (e.g., divalproex)					
Bipolar disorder, manic/hypomanic phase	8.1(1.4)	*52*	91	6	4
Bipolar disorder, depressed phase	7.1(1.6)	*22*	69	28	4
Traditional antidepressants (e.g., tricyclics)					
Unipolar depressive disorder	7.1(1.3)	*15*	67	33	0
Panic disorder	6.6(1.6)	*9*	61	35	4
Generalized anxiety disorder	6.0(1.5)	*4*	39	56	6
Bipolar disorder, depressed phase	6.0(1.9)	*9*	40	49	11
Social phobia	5.9(1.7)	*4*	40	49	11
Obsessive-compulsive disorder	5.6(2.2)	*4*	44	37	19
Benzodiazepines					
Panic disorder	6.0(1.7)	*4*	43	49	8
Generalized anxiety disorder	5.9(1.7)	*4*	39	50	11
Social phobia	5.3(1.8)	*2*	32	53	15
Buspirone					
Generalized anxiety disorder	5.8(2.0)	*4*	41	44	15
Atypical antipsychotics					
Bipolar disorder, manic/hypomanic phase	5.5(2.0)	*2*	39	39	22
Conventional antipsychotics (e.g., haloperidol, thioridazine)					
Bipolar disorder, manic/hypomanic phase	5.2(2.2)	*6*	28	49	23
		%	*%*	*%*	*%*

30 How does the presence of a comorbid general medical condition affect your choice of medications in treating PTSD? Please rate the appropriateness of the different classes of medication for a patient whose PTSD is complicated by the following conditions.



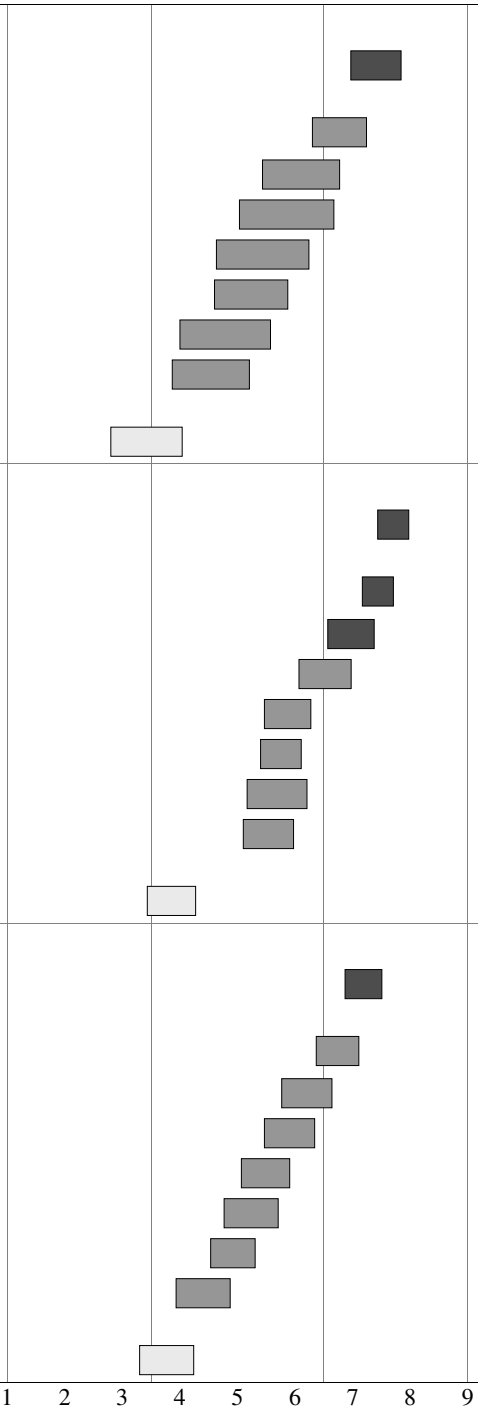
	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Newer antidepressants (e.g., SSRIs, nefazodone, venlafaxine)					
Chronic pain	7.7(1.2)	*30*	85	15	0
Respiratory disease (e.g., asthma, emphysema)	7.6(1.4)	*34*	79	21	0
Cardiac disease	7.5(1.4)	*28*	81	19	0
Diabetes	7.5(1.5)	*32*	77	23	0
Thyroid abnormality	7.4(1.5)	*32*	72	28	0
Hypertension	7.3(1.4)	*23*	75	25	0
Central nervous system damage or disorder (e.g., head trauma, epilepsy, stroke)	7.3(1.3)	*20*	72	28	0
Gastrointestinal disease (e.g., ulcer)	7.0(1.8)	*23*	64	32	4
Liver disease	6.5(2.1)	*23*	57	36	8
Traditional antidepressants (e.g., tricyclics)					
Chronic pain	6.8(1.2)	*6*	63	37	0
Gastrointestinal disease (e.g., ulcer)	5.8(1.7)	*6*	35	56	10
Respiratory disease (e.g., asthma, emphysema)	5.6(1.6)	*4*	23	69	8
Thyroid abnormality	5.3(1.5)	*2*	23	67	10
Diabetes	5.3(1.5)	*2*	19	71	10
Hypertension	5.0(1.5)	*0*	13	71	15
Mood stabilizers (e.g., divalproex)					
Central nervous system damage or disorder (e.g., head trauma, epilepsy, stroke)	6.5(1.8)	*8*	62	30	8
Chronic pain	5.6(1.9)	*2*	43	43	14
Hypertension	5.2(1.8)	*0*	25	59	16
Diabetes	5.0(1.7)	*0*	23	60	17
Respiratory disease (e.g., asthma, emphysema)	5.0(1.6)	*0*	23	63	13
Cardiac disease	5.0(1.8)	*0*	23	58	19
Thyroid abnormality	5.0(1.8)	*0*	21	62	17
Antiadrenergics (β-blockers, clonidine)					
Hypertension	6.3(2.0)	*6*	57	30	13
Benzodiazepines					
Cardiac disease	5.3(1.9)	*2*	26	55	19
Thyroid abnormality	5.1(1.9)	*2*	25	54	21
Hypertension	5.1(1.7)	*0*	19	62	19
Gastrointestinal disease (e.g., ulcer)	5.1(1.8)	*0*	21	62	17
		%	*%*	*%*	*%*

31 Please rate the safety of each of the following classes of medication for treating a patient with PTSD (9 = least likely to cause serious problems or drug interactions). If you do not have experience with treating children and younger adolescents, please cross this column out.



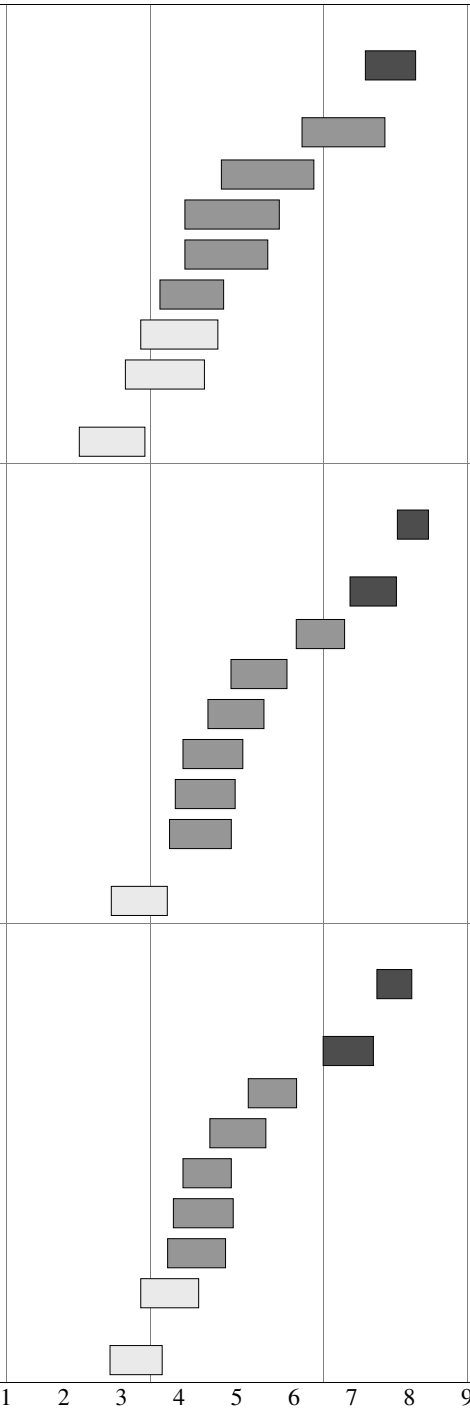
	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
In children and younger adolescents					
SSRIs	7.5(1.9)	*33*	86	10	5
Other newer antidepressants (e.g., nefazodone, venlafaxine)	6.8(1.5)	*10*	60	40	0
Buspirone	6.0(2.2)	*14*	52	29	19
Antiadrenergics (e.g., propranolol, clonidine)	6.0(1.9)	*5*	43	43	14
Mood stabilizers (e.g., divalproex)	5.4(1.5)	*0*	19	67	14
Atypical antipsychotics	4.9(1.9)	*0*	24	48	29
Traditional antidepressants (e.g., tricyclics)	4.8(1.4)	*0*	10	81	10
Benzodiazepines	4.6(1.8)	*0*	19	48	33
Conventional antipsychotics (e.g., haloperidol, thioridazine)	3.1(1.3)	*0*	0	43	57
In adults/older adolescents					
SSRIs	7.5(1.7)	*34*	83	13	4
Other newer antidepressants (e.g., nefazodone, venlafaxine)	7.2(1.4)	*19*	75	23	2
Buspirone	7.0(1.8)	*15*	79	15	6
Benzodiazepines	6.0(1.9)	*11*	47	43	9
Antiadrenergics (e.g., propranolol, clonidine)	5.9(1.6)	*4*	38	57	6
Mood stabilizers (e.g., divalproex)	5.9(1.7)	*2*	38	55	8
Atypical antipsychotics	5.8(1.7)	*2*	42	48	10
Traditional antidepressants (e.g., tricyclics)	5.4(1.6)	*4*	21	70	9
Conventional antipsychotics (e.g., haloperidol, thioridazine)	4.2(1.7)	*2*	9	55	36
In geriatric patients					
SSRIs	7.1(1.7)	*21*	71	27	2
Other newer antidepressants (e.g., nefazodone, venlafaxine)	6.6(1.7)	*12*	59	35	6
Buspirone	6.3(1.9)	*12*	50	42	8
Mood stabilizers (e.g., divalproex)	5.4(1.6)	*0*	33	52	15
Atypical antipsychotics	5.3(1.7)	*0*	27	61	12
Benzodiazepines	4.8(1.8)	*2*	17	56	27
Traditional antidepressants (e.g., tricyclics)	4.5(1.6)	*0*	10	67	23
Antiadrenergics (e.g., propranolol, clonidine)	4.2(1.7)	*0*	8	64	28
Conventional antipsychotics (e.g., haloperidol, thioridazine)	3.9(1.8)	*0*	6	50	44
		%	*%*	*%*	*%*

32 Please rate the patient acceptability (tolerability and adherence) of each of the following classes of medication for treating a patient with PTSD.



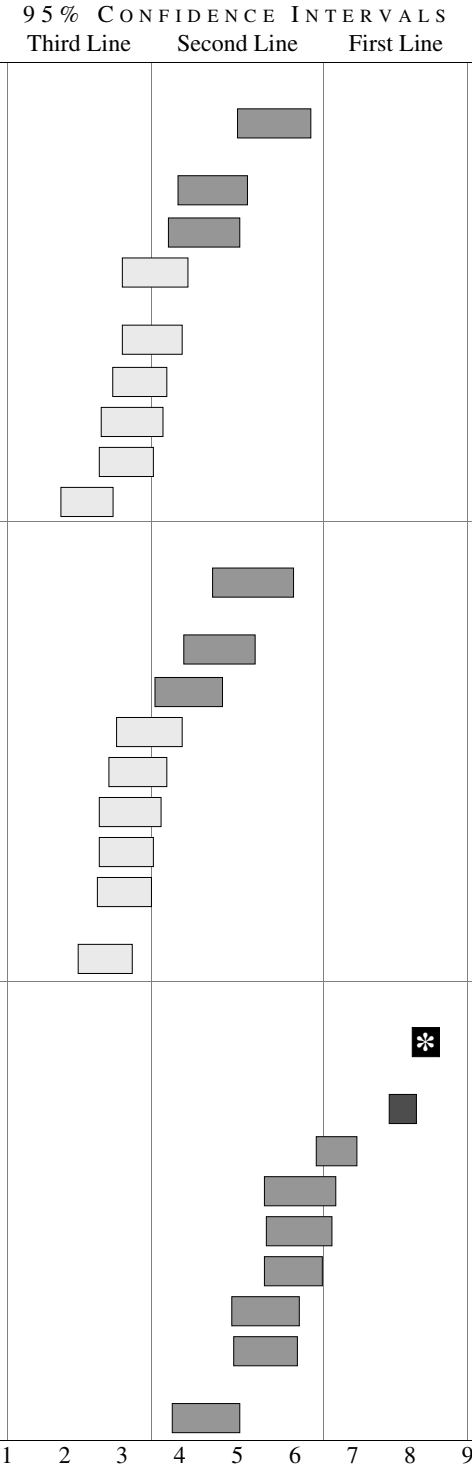
	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
In children and younger adolescents					
SSRIs	7.4(1.1)	*18*	77	23	0
Other newer antidepressants (e.g., nefazodone, venlafaxine)	6.8(1.1)	*0*	62	38	0
Buspirone	6.1(1.6)	*0*	43	52	5
Antiadrenergics (e.g., propranolol, clonidine)	5.9(2.0)	*0*	41	45	14
Benzodiazepines	5.4(1.9)	*0*	38	43	19
Mood stabilizers (e.g., divalproex)	5.2(1.5)	*0*	18	68	14
Atypical antipsychotics	4.8(1.8)	*0*	14	62	24
Traditional antidepressants (e.g., tricyclics)	4.5(1.6)	*0*	5	76	19
Conventional antipsychotics (e.g., haloperidol, thioridazine)	3.4(1.5)	*0*	5	41	55
In adults/older adolescents					
SSRIs	7.7(1.0)	*21*	87	13	0
Other newer antidepressants (e.g., nefazodone, venlafaxine)	7.4(1.0)	*15*	83	17	0
Benzodiazepines	7.0(1.5)	*11*	72	26	2
Buspirone	6.5(1.7)	*4*	60	34	6
Mood stabilizers (e.g., divalproex)	5.9(1.5)	*2*	36	58	6
Traditional antidepressants (e.g., tricyclics)	5.8(1.3)	*4*	21	75	4
Antiadrenergics (e.g., propranolol, clonidine)	5.7(1.9)	*2*	38	49	13
Atypical antipsychotics	5.5(1.6)	*2*	25	63	12
Conventional antipsychotics (e.g., haloperidol, thioridazine)	3.9(1.6)	*0*	4	47	49
In geriatric patients					
SSRIs	7.2(1.2)	*15*	77	23	0
Other newer antidepressants (e.g., nefazodone, venlafaxine)	6.7(1.3)	*8*	61	39	0
Buspirone	6.2(1.6)	*4*	54	42	4
Benzodiazepines	5.9(1.6)	*2*	37	58	6
Mood stabilizers (e.g., divalproex)	5.5(1.5)	*2*	29	67	4
Atypical antipsychotics	5.3(1.7)	*2*	22	63	16
Traditional antidepressants (e.g., tricyclics)	4.9(1.4)	*0*	12	71	18
Antiadrenergics (e.g., propranolol, clonidine)	4.4(1.7)	*0*	10	58	33
Conventional antipsychotics (e.g., haloperidol, thioridazine)	3.8(1.7)	*0*	10	40	50
		%	*%*	*%*	*%*

33 Please rate the effectiveness of each of the following classes of medication for treating a patient with PTSD.



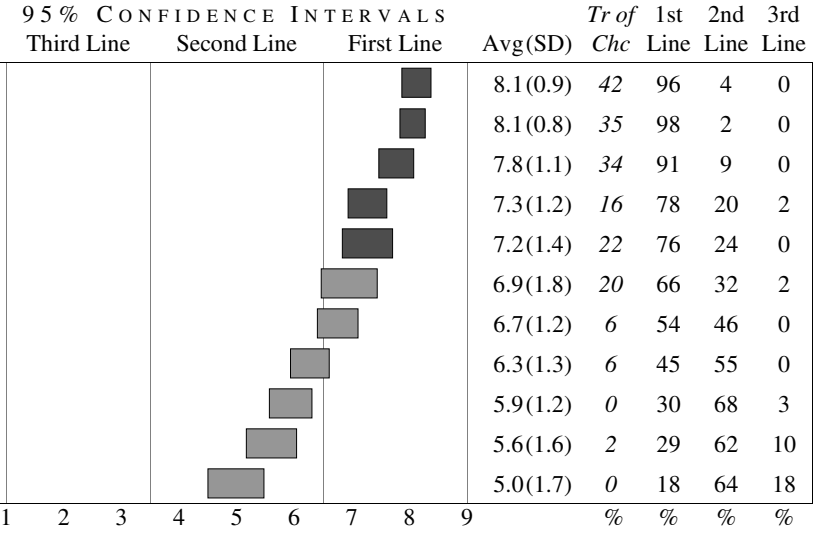
	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
In children and younger adolescents					
SSRIs	7.7(1.1)	*24*	84	16	0
Other newer antidepressants (e.g., nefazodone, venlafaxine)	6.9(1.8)	*9*	70	26	4
Traditional antidepressants (e.g., tricyclics)	5.5(2.0)	*0*	36	52	12
Antiadrenergics (e.g., propranolol, clonidine)	4.9(2.1)	*4*	20	48	32
Mood stabilizers (e.g., divalproex)	4.8(1.8)	*0*	21	50	29
Benzodiazepines	4.2(1.4)	*0*	8	56	36
Buspirone	4.0(1.7)	*0*	8	52	40
Atypical antipsychotics	3.8(1.7)	*0*	8	33	58
Conventional antipsychotics (e.g., haloperidol, thioridazine)	2.8(1.4)	*0*	0	25	75
In adults/older adolescents					
SSRIs	8.1(1.0)	*42*	90	10	0
Other newer antidepressants (e.g., nefazodone, venlafaxine)	7.4(1.5)	*22*	75	24	2
Traditional antidepressants (e.g., tricyclics)	6.5(1.5)	*8*	46	52	2
Mood stabilizers (e.g., divalproex)	5.4(1.8)	*2*	27	58	15
Benzodiazepines	5.0(1.8)	*4*	23	50	27
Atypical antipsychotics	4.6(1.9)	*2*	20	43	37
Antiadrenergics (e.g., propranolol, clonidine)	4.4(1.9)	*2*	12	56	33
Buspirone	4.4(2.0)	*4*	15	52	33
Conventional antipsychotics (e.g., haloperidol, thioridazine)	3.4(1.8)	*0*	4	38	58
In geriatric patients					
SSRIs	7.7(1.1)	*29*	85	15	0
Other newer antidepressants (e.g., nefazodone, venlafaxine)	6.9(1.6)	*12*	68	30	2
Traditional antidepressants (e.g., tricyclics)	5.6(1.6)	*2*	31	60	10
Mood stabilizers (e.g., divalproex)	5.0(1.7)	*2*	21	58	21
Benzodiazepines	4.5(1.6)	*0*	12	60	29
Buspirone	4.4(1.9)	*4*	12	58	31
Atypical antipsychotics	4.3(1.8)	*0*	14	45	41
Antiadrenergics (e.g., propranolol, clonidine)	3.8(1.8)	*0*	10	42	48
Conventional antipsychotics (e.g., haloperidol, thioridazine)	3.2(1.6)	*0*	4	38	58
		%	*%*	*%*	*%*

34 Which of the following classes of medication are you most comfortable using in women of childbearing age? Give higher ratings to the classes of medications you consider safest to use during each of the following phases.



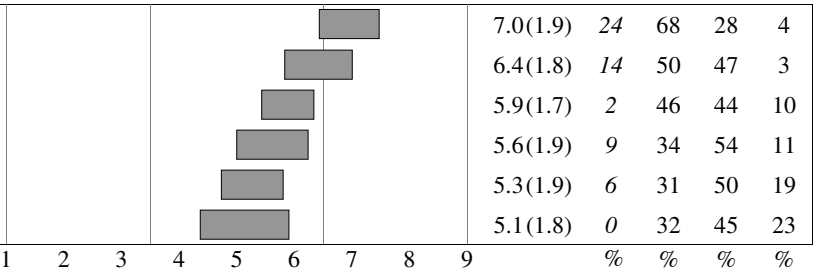
	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Pregnant					
SSRIs	5.6(2.3)	*12*	42	36	22
Other newer antidepressants (e.g., nefazodone, venlafaxine)	4.6(2.1)	*0*	22	46	33
Traditional antidepressants (e.g., tricyclics)	4.4(2.2)	*2*	26	38	36
Buspirone	3.6(2.0)	*2*	10	38	52
Conventional antipsychotics (e.g., haloperidol, thioridazine)	3.5(1.9)	*0*	6	34	60
Benzodiazepines	3.3(1.7)	*0*	4	38	58
Antiadrenergics (e.g., propranolol, clonidine)	3.2(1.9)	*0*	6	35	59
Atypical antipsychotics	3.1(1.7)	*0*	2	27	71
Mood stabilizers (e.g., divalproex)	2.4(1.6)	*0*	2	14	84
Breastfeeding					
SSRIs	5.3(2.5)	*10*	35	39	27
Other newer antidepressants (e.g., nefazodone, venlafaxine)	4.7(2.2)	*0*	20	52	28
Traditional antidepressants (e.g., tricyclics)	4.1(2.1)	*0*	17	46	38
Buspirone	3.5(2.0)	*2*	7	35	59
Antiadrenergics (e.g., propranolol, clonidine)	3.3(1.8)	*0*	4	40	56
Mood stabilizers (e.g., divalproex)	3.1(1.9)	*0*	6	34	60
Benzodiazepines	3.1(1.7)	*0*	2	33	65
Atypical antipsychotics	3.0(1.6)	*0*	2	34	64
Conventional antipsychotics (e.g., haloperidol, thioridazine)	2.7(1.6)	*0*	2	21	77
Not pregnant					
SSRIs	8.3(0.9)	*50*	98	2	0
Other newer antidepressants (e.g., nefazodone, venlafaxine)	7.9(0.9)	*24*	96	4	0
Traditional antidepressants (e.g., tricyclics)	6.7(1.3)	*8*	54	46	0
Buspirone	6.1(2.3)	*12*	60	25	15
Benzodiazepines	6.1(2.1)	*12*	52	35	13
Mood stabilizers (e.g., divalproex)	6.0(1.8)	*6*	43	49	8
Atypical antipsychotics	5.5(2.1)	*4*	40	40	19
Antiadrenergics (e.g., propranolol, clonidine)	5.5(2.0)	*4*	37	40	23
Conventional antipsychotics (e.g., haloperidol, thioridazine)	4.5(2.2)	*2*	23	38	38
		%	*%*	*%*	*%*

35 Assume that you have decided to use an antidepressant to treat a patient with PTSD. Please give your highest ratings to the antidepressants you believe have the best combination of effectiveness, safety, and tolerability.



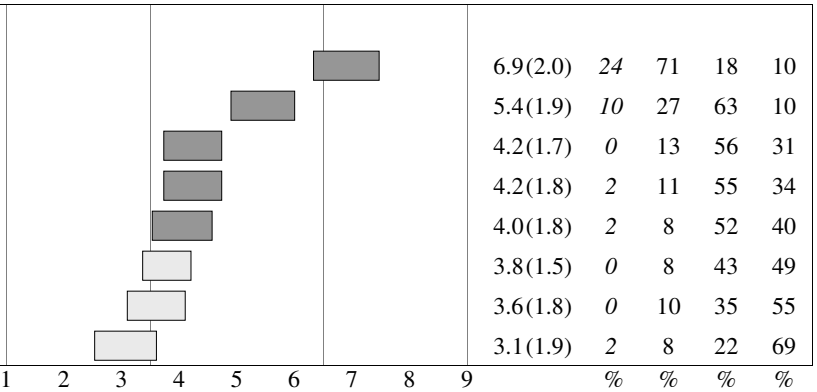
	95% Confidence Intervals Third Line / Second Line / First Line	Avg (SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Sertraline (Zoloft)		8.1 (0.9)	*42*	96	4	0
Paroxetine (Paxil)		8.1 (0.8)	*35*	98	2	0
Fluoxetine (Prozac)		7.8 (1.1)	*34*	91	9	0
Fluvoxamine (Luvox)		7.3 (1.2)	*16*	78	20	2
Citalopram (Celexa)		7.2 (1.4)	*22*	76	24	0
Nefazodone (Serzone)		6.9 (1.8)	*20*	66	32	2
Venlafaxine (Effexor)		6.7 (1.2)	*6*	54	46	0
Tricyclic antidepressant		6.3 (1.3)	*6*	45	55	0
Mirtazapine (Remeron)		5.9 (1.2)	*0*	30	68	3
Monoamine oxidase inhibitor (Nardil, Parnate)		5.6 (1.6)	*2*	29	62	10
Bupropion (Wellbutrin)		5.0 (1.7)	*0*	18	64	18
1 2 3 4 5 6 7 8 9				%	%	%	%

36 Assume that you have decided to use a mood stabilizer to treat a patient with PTSD. Please give your highest ratings to the mood stabilizers you believe have the best combination of effectiveness, safety, and tolerability.



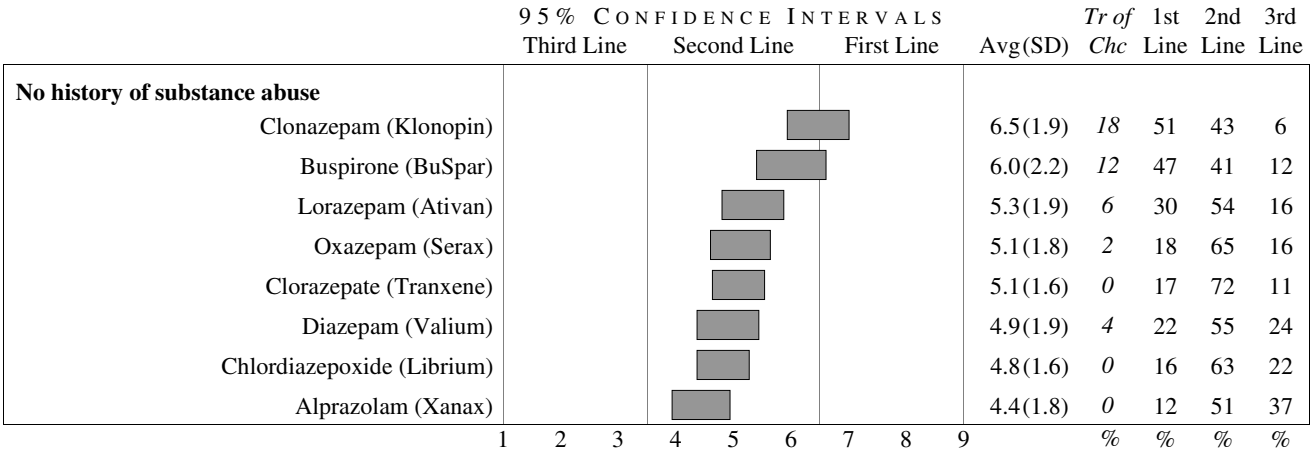
	95% Confidence Intervals Third Line / Second Line / First Line	Avg (SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Divalproex (Depakote)		7.0 (1.9)	*24*	68	28	4
Gabapentin (Neurontin)		6.4 (1.8)	*14*	50	47	3
Carbamazepine (Tegretol)		5.9 (1.7)	*2*	46	44	10
Lamotrigine (Lamictal)		5.6 (1.9)	*9*	34	54	11
Lithium		5.3 (1.9)	*6*	31	50	19
Topiramate (Topamax)		5.1 (1.8)	*0*	32	45	23
1 2 3 4 5 6 7 8 9			%	%	%	%

37 Assume that you have decided to use an antianxiety medication to treat a patient with PTSD. Please give your highest ratings to the antianxiety medications you believe are most effective, best tolerated, and least likely to cause addiction and withdrawal symptoms.

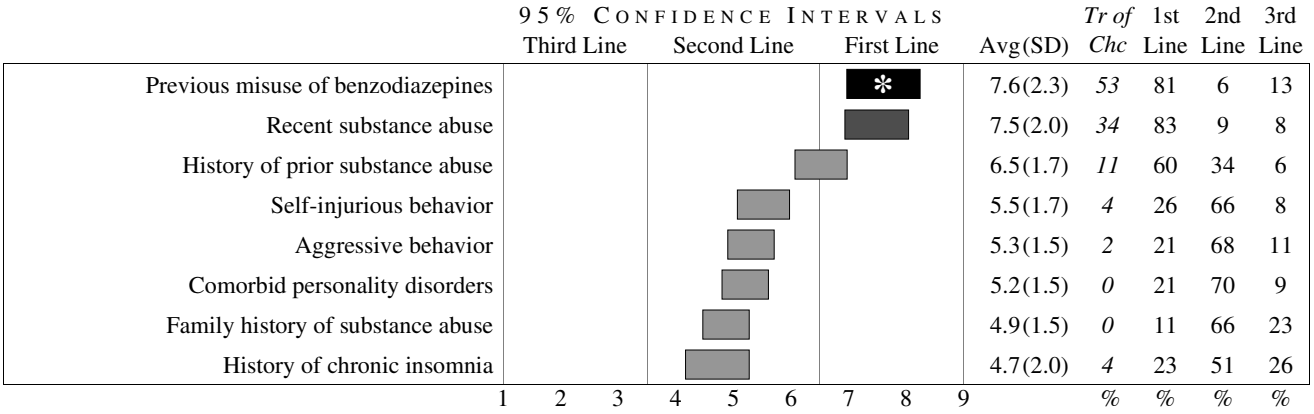


	95% Confidence Intervals Third Line / Second Line / First Line	Avg (SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
History of substance abuse						
Buspirone (BuSpar)		6.9 (2.0)	*24*	71	18	10
Clonazepam (Klonopin)		5.4 (1.9)	*10*	27	63	10
Clorazepate (Tranxene)		4.2 (1.7)	*0*	13	56	31
Oxazepam (Serax)		4.2 (1.8)	*2*	11	55	34
Lorazepam (Ativan)		4.0 (1.8)	*2*	8	52	40
Chlordiazepoxide (Librium)		3.8 (1.5)	*0*	8	43	49
Diazepam (Valium)		3.6 (1.8)	*0*	10	35	55
Alprazolam (Xanax)		3.1 (1.9)	*2*	8	22	69
1 2 3 4 5 6 7 8 9			%	%	%	%

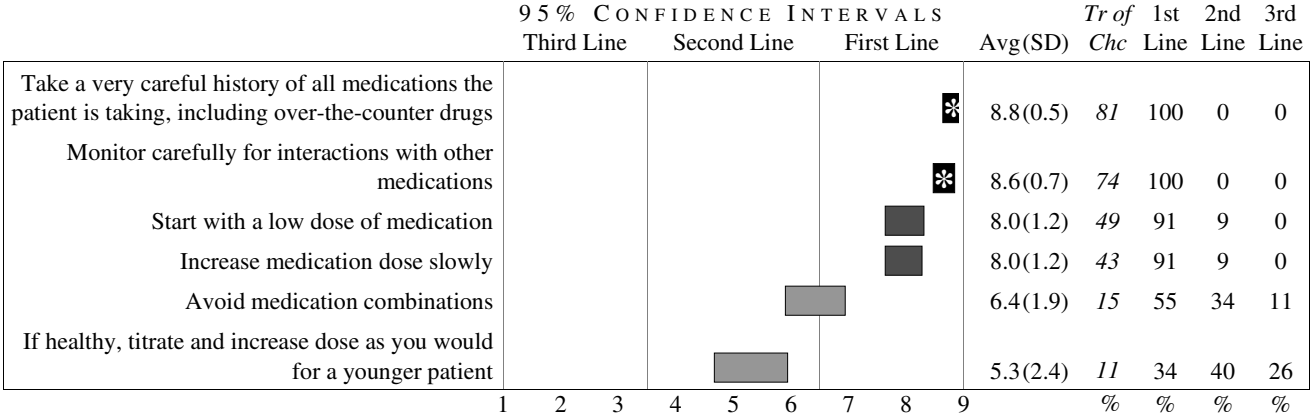
37. *continued*



38 Please rate the following possible contraindications to using benzodiazepines in a patient with PTSD. Give your highest ratings to the situations in which you would definitely ***not*** use a benzodiazepine.



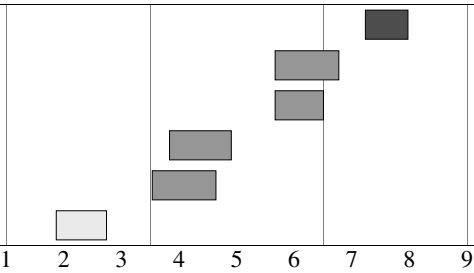
39 Please rate the appropriateness of the following strategies in treating PTSD in older adults (65 years and older).



40 **Length of adequate trial.** Assume you are treating a patient with PTSD with a medication. If the patient is having an inadequate response to the first medication you have selected, how long would you wait **in weeks** before switching to or adding another medication?

	Partial response (weeks)		**No response (weeks)**	
	Milder PTSD Avg(SD)	**More severe PTSD** Avg(SD)	**Milder PTSD** Avg(SD)	**More severe PTSD** Avg(SD)
Newer antidepressant (e.g., SSRI, nefazodone, venlafaxine)	7.8(2.9)	7.1(2.9)	5.8(2.3)	5.0(2.5)
Traditional antidepressant (e.g., tricyclics)	7.2(2.7)	6.6(2.8)	5.4(2.3)	4.9(2.4)
Atypical antipsychotic	4.5(2.8)	3.7(2.3)	3.3(2.0)	2.9(1.7)
Conventional antipsychotic (e.g., haloperidol, thioridazine)	4.1(2.6)	3.3(2.1)	3.3(2.2)	2.8(1.8)
Mood stabilizer (e.g., divalproex)	5.8(2.7)	5.2(2.6)	4.4(2.3)	3.9(2.0)
Buspirone	5.2(3.1)	4.7(2.6)	4.2(2.3)	3.8(1.9)
Benzodiazepine	2.8(1.9)	2.6(2.0)	2.2(1.5)	2.1(1.6)
Antiadrenergic (e.g., propranolol, clonidine)	3.0(1.8)	2.8(1.9)	2.3(1.5)	2.2(1.7)

41 **Frequency of visits: initial treatment phase.** Rate the appropriateness of the following frequencies of medication visits during the initial phase (first 3 months) of treatment for PTSD.



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Weekly for 1st month and every 2 weeks thereafter	7.6(1.4)	*35*	75	25	0
Weekly throughout	6.2(2.0)	*12*	50	42	8
Every 2 weeks	6.1(1.5)	*2*	42	54	4
Twice a week	4.4(1.9)	*2*	14	51	35
Monthly	4.1(2.0)	*2*	13	40	46
Every 2 months	2.3(1.6)	*0*	2	13	85
		%	%	%	%

42 **Frequency of visits: maintenance phase.** What frequency of medication visits makes sense in the maintenance phase? Assume that a patient with PTSD has already had a good response after 3 months of treatment and continues to do well. Rate the appropriateness of the following frequencies of medication follow-up visits for each subsequent time period.

	3–6 months						**6–12 months**						**After 12 months**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
Once a week	3.5(2.2)	3rd	*2*	13	26	60	2.8(1.8)	3rd	*0*	8	23	70	2.2(1.5)	3rd	*0*	4	11	85
Every 2 weeks	4.9(2.3)	2nd	*9*	25	45	30	3.8(2.2)	3rd	*2*	13	36	51	2.9(1.8)	3rd	*0*	4	26	70
Once a month	7.6(1.5)	1st	*38*	81	19	0	6.4(2.3)	2nd	*26*	58	30	11	5.2(2.3)	2nd	*9*	28	51	21
Every 2 months	5.6(2.1)	2nd	*4*	45	34	21	6.8(1.8)	2nd	*15*	68	25	8	6.1(2.0)	2nd	*8*	53	36	11
Every 3 months	4.2(2.1)	2nd	*0*	17	46	37	6.0(2.2)	2nd	*13*	49	36	15	7.0(1.9)	2nd	*21*	72	23	6
Every 6 months	2.6(1.5)	3rd	*0*	2	23	75	3.7(1.7)	3rd	*0*	4	45	51	5.2(2.3)	2nd	*8*	34	40	26
No more visits	1.2(0.5)	3rd	*0*	0	0	100	1.4(0.9)	3rd	*0*	0	4	96	2.2(2.2)	3rd	*4*	9	9	81

43 On average, how long would you continue a medication before trying to taper and discontinue it in each of the following situations?

	Acute PTSD, remission						**Chronic PTSD, remission**						**Chronic PTSD, residual symptoms**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
3 months	4.0(2.3)	3rd	*6*	20	25	55	2.3(1.4)	3rd	*0*	2	10	88	2.5(1.8)	3rd	*0*	4	17	79
6 months	6.1(2.3)	2nd	*16*	45	41	14	4.0(2.2)	3rd	*2*	19	29	52	3.6(2.3)	3rd	*0*	21	21	58
12 months	7.0(1.8)	2nd	*22*	68	26	6	6.9(2.0)	2nd	*25*	62	30	8	5.9(2.5)	2nd	*15*	46	37	17
24 months	5.4(2.1)	2nd	*2*	35	43	22	6.7(1.8)	2nd	*9*	70	23	8	6.3(2.3)	2nd	*8*	62	25	13
> 24 months	4.0(2.3)	3rd	*2*	16	33	51	6.1(2.3)	2nd	*17*	46	38	15	6.3(2.7)	2nd	*29*	62	17	21

44 Assume that a patient with PTSD is doing well in the maintenance phase (in remission for 6–12 months) and you are considering discontinuing medication, but are concerned about the possibility of relapse. Give your highest ratings to those factors that would support ***continuing*** medication for a longer time.

	95% Confidence Intervals													
	Third Line			Second Line			First Line			Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Current life stressors										7.8(1.3)	*36*	87	11	2
Persistence of some symptoms										7.7(1.2)	*30*	87	13	0
High suicide risk in the past										7.6(1.4)	*36*	87	11	2
Presence of Axis I comorbidity										7.5(1.2)	*25*	87	13	0
Long duration of PTSD symptoms										7.5(1.6)	*30*	77	19	4
Poor functioning when symptomatic										7.3(1.4)	*25*	77	21	2
History of severe PTSD symptoms										7.3(1.4)	*21*	75	23	2
Past violence										7.2(1.5)	*19*	75	23	2
Poor social supports										7.1(1.5)	*17*	74	25	2
Presence of Axis II comorbidity										6.1(1.4)	*2*	43	51	6
	1	2	3	4	5	6	7	8	9		%	%	%	%

45 After an adequate trial (dose and duration) of an **SSRI**, a patient with PTSD has had either ***a partial response*** or ***no response***, and you believe a further medication intervention is warranted. Rate the appropriateness of the following medication strategies as your next choice.

	Partial response: Add						**No response: Switch to**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
A different SSRI	2.2(1.5)	3rd	*0*	2	18	80	5.7(2.4)	2nd	*12*	42	31	27
Atypical antipsychotic	4.2(2.1)	2nd	*0*	20	41	39	3.5(1.7)	3rd	*0*	4	38	58
Benzodiazepine	4.9(2.0)	2nd	*0*	29	48	23	3.4(1.7)	3rd	*0*	4	38	58
Buspirone (BuSpar)	4.9(2.1)	2nd	*2*	25	49	25	3.8(1.8)	3rd	*0*	8	51	41
Monoamine oxidase inhibitor	1.6(1.3)	3rd	*0*	2	6	92	5.8(2.1)	2nd	*8*	47	37	16
Mood stabilizer	5.8(2.2)	2nd	*10*	46	37	17	5.3(1.9)	2nd	*2*	32	48	20
Nefazodone (Serzone)	3.9(2.4)	3rd	*2*	16	29	55	6.7(1.6)	2nd	*14*	61	35	4
Tricyclic antidepressant	5.1(2.2)	2nd	*0*	37	37	27	6.7(1.5)	2nd	*15*	50	48	2
Venlafaxine (Effexor)	3.4(2.1)	3rd	*2*	4	40	56	6.8(1.6)	2nd	*18*	64	30	6
			%	%	%	%			%	%	%	%

46 After an adequate trial (dose and duration) of **nefazodone**, a patient with PTSD has had either ***a partial response*** or ***no response***, and you believe a further medication intervention is warranted.

	Partial response: Add						**No response: Switch to**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
Atypical antipsychotic	4.2(2.0)	2nd	*0*	16	47	37	3.3(1.8)	3rd	*0*	4	32	64
Benzodiazepine	4.6(2.2)	2nd	*0*	24	46	30	3.7(1.8)	3rd	*0*	4	44	52
Buspirone (BuSpar)	4.6(2.2)	2nd	*4*	22	47	31	4.0(1.8)	3rd	*0*	8	53	39
Monoamine oxidase inhibitor	1.6(1.0)	3rd	*0*	0	4	96	6.1(1.8)	2nd	*8*	46	46	8
Mood stabilizer	5.5(2.1)	2nd	*6*	40	42	18	5.4(1.8)	2nd	*0*	31	47	22
SSRI	4.2(2.7)	3rd	*10*	29	20	51	7.9(1.5)	1st	*44*	90	8	2
Tricyclic antidepressant	4.0(2.1)	3rd	*0*	13	40	47	6.6(1.2)	2nd	*6*	44	54	2
Venlafaxine (Effexor)	3.6(2.2)	3rd	*0*	13	33	54	6.8(1.6)	2nd	*21*	56	40	4
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

47 After an adequate trial (dose and duration) of **venlafaxine**, a patient with PTSD has had either ***a partial response*** or ***no response***, and you believe a further medication intervention is warranted.

	Partial response: Add						**No response: Switch to**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
Atypical antipsychotic	4.4(2.1)	2nd	*0*	21	45	34	3.6(2.0)	3rd	*0*	8	33	59
Benzodiazepine	4.8(2.0)	2nd	*2*	23	56	21	3.7(2.1)	3rd	*2*	10	41	49
Buspirone (BuSpar)	4.5(2.4)	2nd	*6*	26	38	36	3.8(2.0)	3rd	*2*	6	55	38
Monoamine oxidase inhibitor	1.4(0.8)	3rd	*0*	0	2	98	5.9(2.1)	2nd	*6*	51	33	16
Mood stabilizer	5.5(2.3)	2nd	*10*	44	35	21	5.7(1.9)	2nd	*2*	40	44	17
Nefazodone (Serzone)	3.8(2.3)	3rd	*2*	9	42	49	6.4(1.9)	2nd	*10*	54	35	10
SSRI	3.6(2.5)	3rd	*0*	21	21	57	7.4(2.0)	1st	*35*	82	12	6
Tricyclic antidepressant	3.8(2.1)	3rd	*2*	9	38	53	6.4(1.3)	2nd	*4*	47	51	2
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

48 A patient with PTSD characterized by explosive, irritable, aggressive, or violent behavior has had either ***a partial response*** or ***no response*** to an adequate trial (dose and duration) of a **mood stabilizer**, and you believe a further medication intervention is warranted.

	Partial response: Add						**No response: Switch to**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
Another mood stabilizer	5.4(2.3)	2nd	*6*	38	36	26	6.9(1.8)	2nd	*24*	58	40	2
Atypical antipsychotic	6.2(1.8)	2nd	*4*	46	46	8	6.4(1.8)	2nd	*10*	51	39	10
Benzodiazepine	3.9(2.1)	3rd	*2*	12	41	47	3.3(2.0)	3rd	*0*	8	37	55
Buspirone (BuSpar)	4.4(2.3)	2nd	*4*	22	41	37	3.5(2.1)	3rd	*2*	8	40	52
Monoamine oxidase inhibitor	3.3(2.0)	3rd	*0*	6	33	60	4.2(2.0)	2nd	*2*	16	40	44
Nefazodone (Serzone)	5.1(2.3)	2nd	*6*	30	43	28	5.6(1.8)	2nd	*2*	34	52	14
SSRI	6.6(2.2)	2nd	*24*	61	29	10	6.7(1.9)	2nd	*16*	72	20	8
Trazodone (Desyrel)	5.3(1.8)	2nd	*2*	29	58	13	4.6(1.7)	2nd	*0*	17	59	24
Tricyclic antidepressant	5.0(1.9)	2nd	*0*	24	57	18	5.2(1.6)	2nd	*2*	16	69	14
Venlafaxine (Effexor)	5.1(2.0)	2nd	*2*	33	48	20	5.6(1.8)	2nd	*4*	36	53	11
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

49 A patient with PTSD and comorbid bipolar disorder has received an adequate trial (dose and duration) of a **mood stabilizer**. The bipolar disorder is adequately controlled, but there has been either ***a partial response*** or ***no response*** in the PTSD symptoms, and you believe a further medication intervention is warranted.

	Partial response: Add						**No response: Add**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
Another mood stabilizer	5.0(2.3)	2nd	*2*	26	45	30	4.8(2.2)	2nd	*4*	23	44	33
Atypical antipsychotic	5.2(2.1)	2nd	*2*	29	46	25	5.1(2.1)	2nd	*0*	37	35	29
Benzodiazepine	4.5(1.7)	2nd	*0*	10	63	27	4.3(1.9)	2nd	*0*	10	57	33
Buspirone (BuSpar)	4.1(2.1)	3rd	*0*	13	45	43	4.2(2.0)	2nd	*0*	13	46	42
Monoamine oxidase inhibitor	3.8(2.1)	3rd	*0*	12	35	53	4.4(2.3)	2nd	*2*	26	34	40
Nefazodone (Serzone)	5.6(2.0)	2nd	*6*	41	47	12	5.8(2.1)	2nd	*4*	50	36	14
SSRI	7.0(1.9)	2nd	*20*	76	18	6	7.2(1.8)	1st	*26*	76	20	4
Trazodone (Desyrel)	4.7(1.7)	2nd	*2*	11	64	25	5.0(1.6)	2nd	*2*	18	68	14
Tricyclic antidepressant	5.0(1.7)	2nd	*2*	16	63	20	5.4(1.7)	2nd	*2*	24	59	16
Venlafaxine (Effexor)	5.5(1.9)	2nd	*4*	36	47	17	5.8(1.8)	2nd	*4*	42	46	13
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

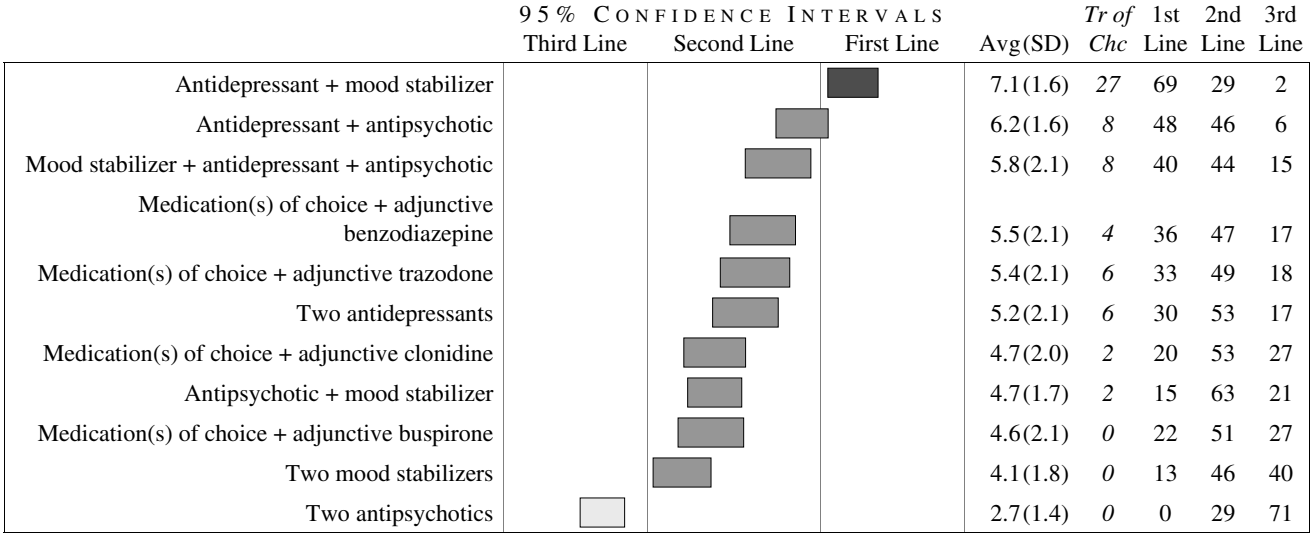
50 A patient with PTSD characterized by explosive, irritable, aggressive, or violent behavior has had either ***a partial response*** or ***no response*** to an adequate trial (dose and duration) of an **atypical antipsychotic**, and you believe a further medication intervention is warranted.

	Partial response: Add						**No response: Switch to**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
Another atypical antipsychotic	2.7(1.9)	3rd	*0*	6	18	76	5.2(2.5)	2nd	*12*	38	38	24
Antiadrenergic	4.9(1.9)	2nd	*2*	18	57	24	4.2(2.1)	2nd	*4*	12	50	38
Antidepressant	6.5(1.9)	2nd	*10*	60	30	10	6.1(2.1)	2nd	*12*	47	39	14
Benzodiazepine	4.1(2.0)	2nd	*0*	10	48	42	3.2(2.0)	3rd	*0*	4	44	52
Buspirone (BuSpar)	4.3(2.0)	2nd	*0*	10	54	35	3.5(2.2)	3rd	*2*	10	31	58
Conventional antipsychotic	3.1(2.1)	3rd	*0*	12	18	70	4.6(2.3)	2nd	*0*	22	44	34
Mood stabilizer	7.3(1.5)	1st	*28*	72	24	4	7.4(1.4)	1st	*32*	68	32	0
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

51 A patient with prominent flashbacks, dissociative symptoms, and/or psychotic symptoms associated with PTSD has had either ***a partial response*** or ***no response*** to an adequate trial (dose and duration) of an **atypical antipsychotic**, and you believe a further medication intervention is warranted.

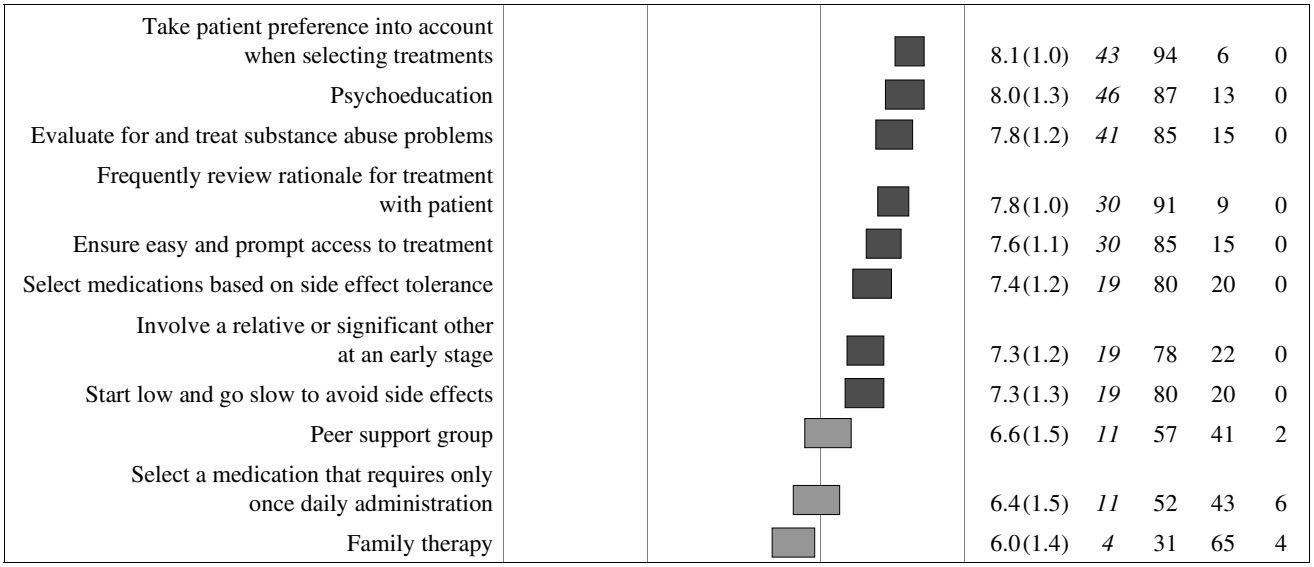
	Partial response: Add						**No response: Switch to**					
	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line	Avg(SD)	Rank	*Tr of Chc*	1st Line	2nd Line	3rd Line
Another atypical antipsychotic	3.2(2.2)	3rd	*2*	10	25	65	5.7(2.6)	2nd	*17*	48	29	23
Antiadrenergic	4.3(1.9)	2nd	*2*	15	50	35	3.6(2.0)	3rd	*2*	6	44	50
Antidepressant	6.4(1.8)	2nd	*14*	63	31	6	5.8(2.2)	2nd	*15*	42	42	17
Clonazepam (Klonopin)	5.1(1.7)	2nd	*0*	21	60	19	4.4(2.0)	2nd	*0*	12	55	33
Buspirone (BuSpar)	4.0(1.9)	3rd	*0*	15	38	47	3.2(1.8)	3rd	*0*	4	29	67
Conventional antipsychotic	3.3(2.3)	3rd	*4*	15	19	67	5.4(2.4)	2nd	*6*	42	33	25
Mood stabilizer	6.6(1.9)	2nd	*18*	61	33	6	6.1(2.2)	2nd	*16*	43	45	12
			%	*%*	*%*	*%*			*%*	*%*	*%*	*%*

52 Understanding that there are different clinical profiles that influence the choice of medication combinations for a patient with chronic PTSD who has been persistently refractory to treatment, give your highest ratings to the combinations that are most commonly used in your practice for such patients.



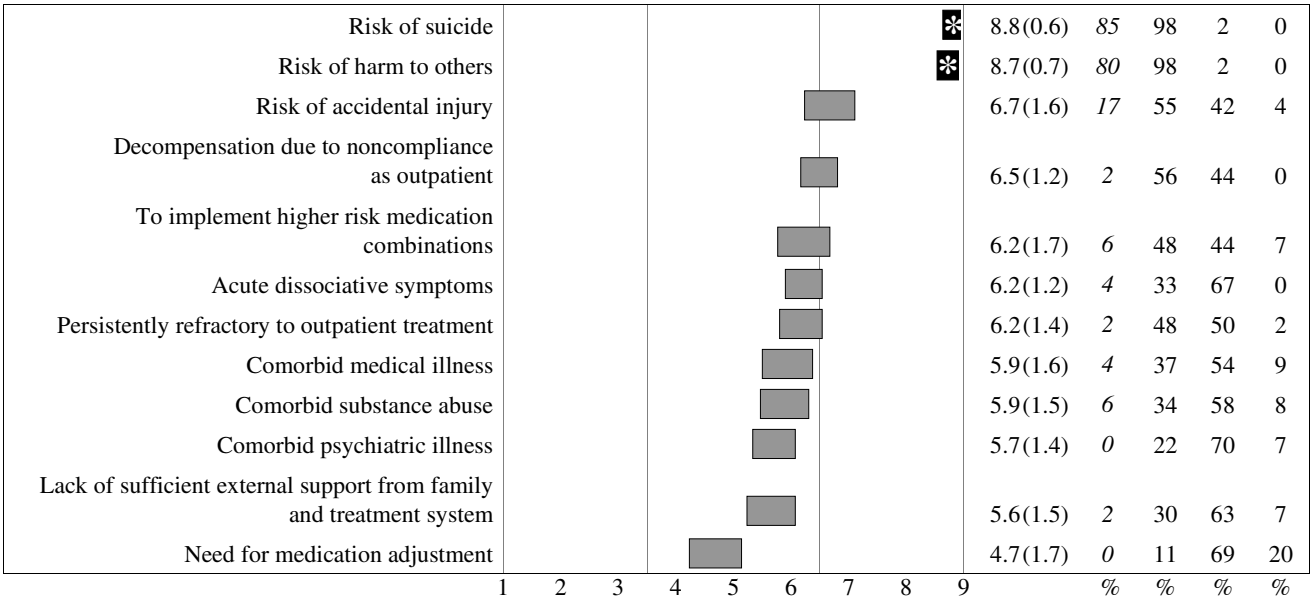
	95% Confidence Intervals: Third Line / Second Line / First Line	Avg (SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Antidepressant + mood stabilizer		7.1 (1.6)	*27*	69	29	2
Antidepressant + antipsychotic		6.2 (1.6)	*8*	48	46	6
Mood stabilizer + antidepressant + antipsychotic		5.8 (2.1)	*8*	40	44	15
Medication(s) of choice + adjunctive benzodiazepine		5.5 (2.1)	*4*	36	47	17
Medication(s) of choice + adjunctive trazodone		5.4 (2.1)	*6*	33	49	18
Two antidepressants		5.2 (2.1)	*6*	30	53	17
Medication(s) of choice + adjunctive clonidine		4.7 (2.0)	*2*	20	53	27
Antipsychotic + mood stabilizer		4.7 (1.7)	*2*	15	63	21
Medication(s) of choice + adjunctive buspirone		4.6 (2.1)	*0*	22	51	27
Two mood stabilizers		4.1 (1.8)	*0*	13	46	40
Two antipsychotics		2.7 (1.4)	*0*	0	29	71
	1 2 3 4 5 6 7 8 9		%	%	%	%

53 Please rate the appropriateness of the following strategies for enhancing compliance with medication treatment.



	95% Confidence Intervals: Third Line / Second Line / First Line	Avg (SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Take patient preference into account when selecting treatments		8.1 (1.0)	*43*	94	6	0
Psychoeducation		8.0 (1.3)	*46*	87	13	0
Evaluate for and treat substance abuse problems		7.8 (1.2)	*41*	85	15	0
Frequently review rationale for treatment with patient		7.8 (1.0)	*30*	91	9	0
Ensure easy and prompt access to treatment		7.6 (1.1)	*30*	85	15	0
Select medications based on side effect tolerance		7.4 (1.2)	*19*	80	20	0
Involve a relative or significant other at an early stage		7.3 (1.2)	*19*	78	22	0
Start low and go slow to avoid side effects		7.3 (1.3)	*19*	80	20	0
Peer support group		6.6 (1.5)	*11*	57	41	2
Select a medication that requires only once daily administration		6.4 (1.5)	*11*	52	43	6
Family therapy		6.0 (1.4)	*4*	31	65	4
	1 2 3 4 5 6 7 8 9		%	%	%	%

54 Rate the appropriateness of the following indications for hospitalizing a patient with PTSD.



	Avg(SD)	*Tr of Chc*	1st Line	2nd Line	3rd Line
Risk of suicide	8.8(0.6)	*85*	98	2	0
Risk of harm to others	8.7(0.7)	*80*	98	2	0
Risk of accidental injury	6.7(1.6)	*17*	55	42	4
Decompensation due to noncompliance as outpatient	6.5(1.2)	*2*	56	44	0
To implement higher risk medication combinations	6.2(1.7)	*6*	48	44	7
Acute dissociative symptoms	6.2(1.2)	*4*	33	67	0
Persistently refractory to outpatient treatment	6.2(1.4)	*2*	48	50	2
Comorbid medical illness	5.9(1.6)	*4*	37	54	9
Comorbid substance abuse	5.9(1.5)	*6*	34	58	8
Comorbid psychiatric illness	5.7(1.4)	*0*	22	70	7
Lack of sufficient external support from family and treatment system	5.6(1.5)	*2*	30	63	7
Need for medication adjustment	4.7(1.7)	*0*	11	69	20
		%	*%*	*%*	*%*

55 **Appropriate Dose.** Please write in the dose range (total mg per 24 hours) you recommend for each of the following medications to ensure an adequate trial in a patient with PTSD during both acute and maintenance treatment. If you do not have experience with treating children, please cross out the column for child doses.

		Average target dose for acute treatment				
	Adult starting dose (mg/day)	**Children/ younger adolescents (mg/day)**	**Adults/ older adolescents (mg/day)**	**Geriatric patients (mg/day)**	**Highest potential adult final dose (mg/day)**	**Average maintenance dose (mg/day)**
	Avg(SD)	Avg(SD)	Avg(SD)	Avg(SD)	Avg(SD)	Avg(SD)
SSRIs						
citalopram (Celexa)	17.0(4.6)	18.0(8.4)	34.1(13.4)	25.4(10.6)	62.1(11.0)	33.0(9.7)
fluoxetine (Prozac)	15.8(5.0)	15.0(7.1)	32.1(15.3)	21.0(10.6)	77.5(19.6)	31.8(11.4)
fluvoxamine (Luvox)	46.6(18.1)	61.9(52.3)	153.8(74.5)	114.9(63.9)	287.1(87.5)	163.4(63.6)
paroxetine (Paxil)	15.3(5.1)	16.7(7.1)	30.8(11.3)	21.7(10.4)	60.4(16.0)	31.8(10.4)
sertraline (Zoloft)	42.0(14.3)	58.0(31.6)	117.5(48.8)	81.7(42.4)	224.6(60.0)	119.0(41.8)
Other antidepressants						
nefazodone (Serzone)	106.7(54.2)	200.0(111.8)	353.4(142.8)	247.0(121.6)	595.5(116.0)	387.8(97.3)
venlafaxine (Effexor)	71.0(90.9)	52.1(25.5)	170.5(89.8)	132.6(95.3)	318.3(87.6)	182.3(81.4)
Mood stabilizers						
divalproex (Depakote)	459.9(227.1)	679.2(955.0)	1169.2(613.8)	784.6(511.0)	2094.4(1142.9)	1271.9(507.7)
Antipsychotics						
haloperidol (Haldol)	2.2(2.2)	1.6(1.4)	5.5(3.8)	2.9(2.1)	19.8(17.7)	4.9(3.3)
risperidone (Risperdal)	1.4(0.7)	1.5(1.3)	3.8(1.8)	2.6(1.7)	8.3(3.6)	3.9(1.4)
olanzapine (Zyprexa)	5.2(2.0)	4.3(1.9)	11.5(5.4)	7.3(4.1)	23.1(9.1)	10.3(3.1)
quetiapine (Seroquel)	44.1(25.0)	—	295.3(181.9)	169.1(123.9)	526.5(243.7)	248.5(149.3)
Anti-anxiety medications						
alprazolam (Xanax)	0.9(0.5)	1.0(0.9)	2.4(1.4)	1.5(1.0)	6.0(2.8)	2.4(1.0)
buspirone (BuSpar)	16.2(6.5)	20.0(10.7)	37.3(17.6)	27.1(13.6)	67.5(25.7)	38.3(14.1)
clonazepam (Klonopin)	1.0(0.7)	1.3(1.9)	2.7(1.9)	1.7(1.7)	6.3(4.1)	3.0(3.2)

Because of space limitations, we could not present the complete results of the following questions. Results are available on request.

56 Give your highest ratings to the sedative hypnotics you believe are most effective and best tolerated for sleep disturbances in PTSD. ***Results available on request. Trazodone was rated first line both with and without a history of substance abuse. Zolpidem and benadryl were higher second line. For patients without a history of substance abuse, benzodiazepines were also rated higher second line. For patients with a history of substance abuse, benzodiazepines were rated third line.***

57 You have decided to discontinue long-term treatment with one of the following medications. Rate the appropriateness of each of the following discontinuation schedules for preventing discontinuation/withdrawal syndrome. Assume the patient was receiving an average dose of the medication for the treatment of PTSD. ***Results available on request. To avoid discontinuation/withdrawal syndrome, the experts recommend tapering medication over 2 weeks–1 month, except for the benzodiazepines, for which the experts recommend tapering over 1 month or longer.***

58 You have decided to discontinue long-term treatment with one of the following medications, but the patient has risk factors for relapse. Rate the appropriateness of each of the following discontinuation schedules for preventing relapse. Assume the patient was receiving an average dose of the medication for the treatment of PTSD. ***Results available on request. To lessen the likelihood of relapse in a patient with risk factors for relapse, the experts recommend tapering medication over 4–12 weeks, except for the benzodiazepines, for which the experts recommend tapering for longer than 12 weeks.***

Expert Consensus Treatment Guidelines For Posttraumatic Stress Disorder:

A Guide For Patients and Families

If you or someone you care about has been diagnosed with posttraumatic stress disorder (PTSD), you may feel that your problem is rare and that you have to face it alone. This is not the case. There are many people in a similar situation, and lots of help is available. As many as 70% of adults in the United States have experienced at least one major trauma in their lives, and many of them have suffered from the emotional reactions that are called PTSD. It is estimated that 5% of the population currently have PTSD, and that 8% have had PTSD at some point in their lives. Women are twice as likely to have PTSD as men. Fortunately, very effective treatments for PTSD are now available to help you or your loved one overcome this problem and get back to a normal life. This guide is designed to answer the most commonly asked questions about PTSD based on answers to a recent survey of 100 experts.

WHAT IS POSTTRAUMATIC STRESS DISORDER?

The diagnosis of PTSD requires exposure to an extreme stressor and a characteristic set of symptoms that have lasted for at least 1 month.

What is an extreme stressor?

Examples include

- Serious accident or natural disaster
- Rape or criminal assault
- Combat exposure
- Child sexual or physical abuse or severe neglect
- Hostage/imprisonment/torture/displacement as refugee
- Witnessing a traumatic event
- Sudden unexpected death of a loved one

Other kinds of severe (but not extreme) stress can be very upsetting but generally do not cause PTSD (such as losing a job, divorce, failing in school, the expected death of an elderly parent).

This Guide was prepared by Edna B. Foa, Ph.D., Jonathan R. T. Davidson, M.D., Allen Frances, M.D., and Ruth Ross, M.A. The guide includes recommendations contained in the *Expert Consensus Treatment Guidelines for Posttraumatic Stress Disorder*. The Editors gratefully acknowledge the Anxiety Disorders Association of America (ADAA) for their generous help and permission to adapt their written materials. Abbott Laboratories, Bristol-Myers Squibb, Eli Lilly, Janssen Pharmaceutica, Pfizer Inc, and Solvay Pharmaceuticals provided unrestricted educational grants in support of this project.

A person with PTSD has three main types of symptoms:

Re-experiencing of the traumatic event as indicated by

- Intrusive distressing recollections of the event
- Flashbacks (feeling as if the event were recurring while awake)
- Nightmares (the event or other frightening images recur frequently in dreams)
- Exaggerated emotional and physical reactions to triggers that remind the person of the event

Avoidance and emotional numbing as indicated by

- Extensive avoidance of activities, places, thoughts, feelings, or conversations related to the trauma
- Loss of interest
- Feeling detached from others
- Restricted emotions

Increased arousal as indicated by

- Difficulty sleeping
- Irritability or outbursts of anger
- Difficulty concentrating
- Hypervigilance
- An exaggerated startle response

What other problems are associated with PTSD?

The three types of symptoms of PTSD described above are the most typical reactions to traumas. However, there are other problems that are also common. Many of these will improve when the PTSD symptoms are successfully treated, but some may require additional treatment on their own.

Panic attacks

Individuals who have experienced a trauma may have panic attacks when exposed to something that reminds them of the trauma (e.g., encountering a man who looks like the rapist; riding in a car again after having had a bad accident, hearing a storm blow up after being in a destructive hurricane). A panic attack involves intense feelings of fear or discomfort that are accompanied by physical or psychological symptoms. Physical symptoms include pounding or racing heart, sweating, trembling or shaking, a feeling of shortness of breath or choking, chest pain, nausea, dizziness, chills, hot flushes, numbness, or tingling. The person may also experience psychological symptoms such as feeling unreal or detached or fearing that he is going crazy, dying, or is having a heart attack.

Severe avoidant behavior

Avoidance of reminders of the trauma is one of the characteristic symptoms of PTSD. However, sometimes the avoidance begins to extend far beyond reminders of the original trauma to all sorts of situations in everyday life. This can become so severe that the person becomes virtually housebound or is able to go out only if accompanied by someone else.

Depression

Many people become depressed after experiencing a trauma and no longer take interest or pleasure in things they used to enjoy before. They may also develop unjustified feelings of guilt and self-blame and feel that the experience was their fault, even when this is clearly not true. For example, a rape victim may blame herself for having walked in the parking lot alone early in the evening; a victim of industrial disaster may blame himself for not having noticed an imperceptible noise in the engine that preceded the explosion.

Suicidal thoughts and feelings

Sometimes the depression can become so severe that people feel that life is no longer worth living. Studies show that as many as 50% of rape victims report suicidal thoughts. If you or your loved one is having suicidal thoughts following a traumatic event, it is very important to consult a professional right away and get the help you need to overcome this.

Substance abuse

People with PTSD may turn to alcohol or drugs to try to deaden their pain. They may also misuse prescription or over-the-counter drugs. Although this may seem to be an understandable reaction, inappropriate substance use greatly aggravates the person's symptoms and makes successful treatment much more difficult. Alcohol and drugs can provide only temporary relief and, in the long run, make a bad situation much worse. Facing the problem without alcohol or drugs will help you get over it sooner and with fewer problems.

Feelings of alienation and isolation

People with PTSD need increased social support, but they often feel very alone and isolated by their experience and find it very difficult to reach out to others for help. They find it especially hard to believe that other people will be able to understand what they have gone through. PTSD symptoms may also make it difficult to function socially. For example, someone who has been assaulted by a stranger may develop a fear of all strangers. Marital and family misunderstandings are also common after a severe trauma.

Feelings of mistrust and betrayal

After going through a terrible experience, you may lose faith in other people and feel that you have been betrayed or cheated by the world, by fate, or by God. However, getting better requires reaching out and taking the chance that other people will understand. A good alliance with your therapist and/or spiritual counselor can go a long way towards helping you reconnect.

Anger and irritability

Anger and irritability are common reactions among trauma survivors. Of course, anytime we have been treated wrongly, and especially when we have been assaulted, anger is a natural and justified reaction. However, extreme anger can interfere with recovery and make it hard for a person to get along with others at home, at work, and in treatment.

Severe impairment in daily functioning

Some people with PTSD have very severe problems functioning both socially and at work or school for a long period of time after the trauma. For example, an assault victim may refuse to leave the house alone after dark, thus severely curtailing social and leisure activities. A person may lose his ability to concentrate and be unable to fulfill his obligations at work. A rape victim may become too fearful to stay alone and have to move back into her parents' home after 10 years of independent living. Prompt treatment is crucial because it helps prevent these problems from ever developing.

Strange beliefs and perceptions

Occasionally, someone who has undergone a severe trauma may temporarily develop strange ideas or perceptions (e.g., believing that that they can communicate with or actually see a dead parent). Although these symptoms are scary and resemble delusions and hallucinations, they are usually temporary and often go away on their own.

What is the usual course after exposure to an extreme stressor?

How long psychological disturbances last after a trauma can vary greatly. Some people have few or no long-lasting effects, whereas others may continue to have problems for months or even years after the trauma and will not get better unless treated by a professional. The range of possible responses to a trauma are described below in order of severity.

Only a mild and brief response to a stressor

Although some people may have no problems at all after a terrible experience, it is more common to have at least some symptoms after a trauma. Often these go away quickly without any treatment.

Acute stress disorder

Acute stress disorder is diagnosed when symptoms last for less than 1 month, but are more severe than what most people have. This is too brief to be considered PTSD but increases the risk of later developing PTSD.

Acute PTSD

When the symptoms last for longer than 1 month and are seriously interfering with the person's ability to function, the diagnosis is changed to PTSD. If symptoms have lasted only 1–3 months, this is called acute PTSD. Anyone who continues to have severe symptoms for longer than a month after a trauma should consult a health professional.

Chronic PTSD

If symptoms continue for longer than 3 months, this is called chronic PTSD. Once PTSD becomes established, it is less likely to improve without treatment and you should definitely get help right away.

Delayed PTSD

Although the symptoms of PTSD usually begin immediately after (or within a few weeks of) the trauma, they sometimes appear only several months or even years later. This is more likely to happen on the anniversary of the traumatic event or if another trauma is experienced, especially if it reminds the person of the original event.

Why do some people recover from a trauma while others don't?

We do not know exactly why one person may have little difficulty after a trauma, while someone else may suffer for years afterwards. However, the following factors appear to make it more likely that the person will develop PTSD:

- the more severe the trauma
- the longer it lasted
- the closer the person was to it
- the more dangerous it seemed
- the more times the person has been traumatized
- the trauma was inflicted by other people (e.g., rape)
- the person gets negative reactions from friends and relatives

For example, if you actually see someone being shot or are shot at yourself, it is more likely that you will get PTSD than if you just heard the shots and found out about the murder afterward. A rape victim whose life was in danger is more likely to develop chronic PTSD than a rape victim who did not believe she was likely to be killed. People are much more likely to get PTSD after being raped or tortured than after being in an earthquake or hurricane. The boyfriend of a rape victim might blame her for not being careful enough, or friends may refuse to listen sympathetically to the victim, instead strongly urging her to "forget about it and get on with life."

Guilt and intense anger may also interfere with recovery. Failing to process the traumatic event by sharing it with significant others can make it difficult to get over its effects. Finally, substance use makes it more likely that people will have a hard time dealing with the aftermath of a trauma.

THE TREATMENT OF PTSD

Two types of treatment are helpful for PTSD: psychotherapy and medication. Some people recover from PTSD with psychotherapy alone, while others need a combination of psychotherapy and medication, and some need only medication. You and your doctor will discuss what is best for you.

Psychotherapy alone may be best for you if

- Your symptoms are milder
- You are pregnant or breastfeeding
- You prefer not to take medication
- You have a medical condition that medication might interfere with

Medication is often needed if

- Your symptoms are severe or have lasted a long time
- You have another psychiatric problem (e.g., depression or anxiety) that is making it harder for you to recover from PTSD
- You are thinking about suicide
- You are experiencing a lot of stress in your life
- You are having a very hard time functioning
- You have been receiving psychotherapy alone and are still having many disturbing PTSD symptoms

PSYCHOTHERAPY

The experts on PTSD believe that three types of psychotherapy are especially effective in treating it—anxiety management, cognitive therapy, exposure therapy. Play therapy may be useful in the treatment of children with PTSD.

Anxiety management

In anxiety management, the therapist will teach you the following skills to help you cope better with the symptoms of PTSD:

- **Relaxation training:** you learn to control fear and anxiety by systematically relaxing your major muscle groups.

- **Breathing retraining:** you learn slow, abdominal breathing to relax and/or avoid hyperventilation with its unpleasant and often frightening physical sensations (e.g., palpitations, dizziness, tingling).

- **Positive thinking and self-talk:** you learn to replace negative thoughts (e.g., "I'm going to lose control") with positive thoughts (e.g., "I did it before and I can do it again") when facing reminders of a stressor.

- **Assertiveness training:** you learn how to express your wishes, opinions, and emotions without alienating others.

- **Thought stopping:** you learn how to use distraction to overcome distressing thoughts (inwardly "shouting stop").

Cognitive therapy

The therapist helps you change the irrational beliefs that may be disturbing your emotions and making it hard for you to function. For example, trauma victims often feel unrealistically guilty as if they had brought about the trauma: a crime victim may blame himself for not being more careful, or a war veteran may feel it was his fault that his best friend was killed. The goal of cognitive therapy is to teach you how to identify your own particular upsetting thoughts, weigh the evidence for and against them, and then to adopt more realistic thoughts that can help you achieve more balanced emotions.

Exposure therapy

In exposure therapy, the therapist helps you confront specific situations, people, objects, memories, or emotions that remind you of the trauma and now evoke an unrealistically intense fear in your everyday life. This can be done in two ways:

- **Exposure in the imagination:** the therapist asks you to repeatedly retell the traumatic memories until they no longer evoke high levels of distress.

- **Exposure in reality:** the therapist helps you to confront the situations in your life that are now safe but which you want to avoid because they trigger strong fear (e.g., driving a car again after being involved in an accident, using elevators after being assaulted in an elevator, going back home after being robbed there). Your fear will gradually begin to dissipate if you force yourself to remain in the situation rather than trying to escape it. Repeated exposures will help you to realize that the feared situation is no longer dangerous and that you can handle it.

Play therapy

Play therapy is used to treat children with PTSD. The therapist uses games to introduce topics that cannot be dealt with more directly. This can help children confront and reprocess traumatic memories.

Education and supportive counseling

The experts consider it very important for people with PTSD (and their families) to learn about the symptoms of PTSD and the various treatments that are available for it. Even if you have had PTSD symptoms for a long time, the first step in finally getting control of them is to understand the problem and what can be done to help it.

Other types of psychotherapy

A number of other types of psychotherapy (eye movement desensitization reprocessing [EMDR], hypnotherapy, and psychodynamic psychotherapy) have been used in the treatment of PTSD and may sometimes be helpful for some people. However, the group of experts we surveyed did not rate the effectiveness of these treatments nearly as highly as those that were described in detail above.

MEDICATION TREATMENT

A number of different types of medication can be used to treat PTSD.

SSRI antidepressants

The experts consider the selective serotonin reuptake inhibitor (SSRI) antidepressant medications to be the best first choice for treating the symptoms of PTSD. There are currently five SSRIs available in the United States:

- Zoloft (sertraline)
- Paxil (paroxetine)
- Prozac (fluoxetine)
- Luvox (fluvoxamine)
- Celexa (citalopram)

Other newer antidepressants

The experts also thought highly of two other newer antidepressants and one of these would be the next choice if the SSRI antidepressant did not work or caused side effects that required a switch to a different class of medication:

- Serzone (nefazodone)
- Effexor (venlafazine)

Your doctor may sometimes recommend other types of medication, particularly if you have not responded to treatment with one of the newer antidepressants listed above.

Tricyclic antidepressants

The tricyclic antidepressants (e.g., imipramine, amitriptyline [Elavil]) are helpful in PTSD. However, they are not generally first-choice drugs because they have more side effects than the newer antidepressants.

Mood stabilizers

The experts recommend adding a mood stabilizer, such as divalproex (Depakote), to the antidepressant if the person is having only a partial response. Mood stabilizers are the usual treatment for bipolar disorder (manic-depressive illness) and they are recommended for treating people who have both bipolar disorder and PTSD. They are also used especially for certain types of PTSD symptoms (such as prominent irritability or anger).

Anti-anxiety medications

Benzodiazepines are a type of medication used to reduce anxiety, usually only on a short-term or intermittent basis. They include

- Valium (diazepam)
- Xanax (alprazolam)
- Klonopin (clonazepam)
- Ativan (lorazepam)

Your doctor should not prescribe a benzodiazepine for you if you have current problems with substance abuse or a history of such problems, because of the risk of developing dependence on them.

BuSpar (buspirone) is another medication that is used to treat anxiety on a more long-term basis, since it takes several weeks to start working. It has the great advantage of not being addictive.

Sequencing and combining medications

Most of the time, one of the SSRIs will be the first-choice medication. If this does not help, your doctor may then suggest a different type of drug, probably nefazodone or venlafaxine. As a third choice, you may be given one of the older tricyclic antidepressants. Your doctor may also try combining another kind of medication, particularly a mood stabilizer, with the antidepressant if your PTSD symptoms have responded only partially to treatment with a single medication. The doctor might also try adding an anti-anxiety drug, such as BuSpar or a benzodiazepine, to the antidepressant.

How long is medication usually needed?

For acute PTSD (when your symptoms have lasted less than 3 months), most experts recommend continuing your medication for 6–12 months. For chronic PTSD (when your symptoms have lasted longer than 3 months), it is recommended that you continue to take your medication for at least 12–24 months and perhaps even longer if you are still having significant symptoms.

What are the side effects of the medications used to treat PTSD?

Any medication can have side effects, especially early in the course of taking it. If you stay on the medication, you will usually get used to it and the side effects will often go away by themselves. Sometimes the dose may need to be lowered to achieve this. Be sure to tell your doctor about any side effects you are having so that your medication dosage can be adjusted to help the problem. ***Don't stop your medication on your own.***

The newer antidepressants can cause nausea and bowel symptoms, weight loss or gain, impaired sexual functioning, sleep disturbances, and increased nervousness. In addition to the side effects listed above, the older antidepressants are more likely to cause dry mouth, constipation, dizziness, sleepiness, and altered heart rate. Benzodiazepines can cause sedation, tiredness, forgetfulness, unsteadiness, impaired attention and reactions in driving, and physical dependence.

Selecting medication for relapses

If you start to have troublesome PTSD symptoms again after stopping medication, your doctor will probably suggest restarting the medicine that helped you before. If you start to relapse while you are still taking medication, then the doctor will probably try switching you to the next medication in the sequence described above (see "Sequencing and combining medications") or he might try adding another medication to the one you are taking.

TREATMENT OF ASSOCIATED PROBLEMS

Sometimes people with PTSD develop depressive symptoms that are severe enough to require additional treatment. It is especially important to seek treatment if you are having suicidal thoughts or feelings. Your doctor may recommend psychotherapy or medication treatment or a combination of both, depending on how severe your depression is. Two kinds of psychotherapy, cognitive-behavioral therapy and interpersonal therapy, may be especially helpful for depression. You doctor may also prescribe an antidepressant medication if you are not already taking one.

Sometimes people with PTSD have other anxiety symptoms, such as panic disorder, that may require additional treatment. Your doctor may recommend that you be taught special anxiety management techniques and/or may prescribe a medication to reduce your symptoms.

It is fortunate that the antidepressant medications that have been found to be most effective for treating PTSD are also the ones used to treat anxiety or depression. This means that your doctor can often treat your PTSD symptoms and any associated anxiety or depression you have with just one medication. It also means that if you do have a lot of anxiety or depression, you are much more likely to need an antidepressant medication.

People with PTSD frequently turn to drugs or alcohol for comfort. However, substance abuse only makes it harder to recover from PTSD, since it is necessary to face the memories of the trauma in order to get over it. If you are having substance use problems that are interfering with your recovery, your doctor may recommend that you enroll in a special treatment program for substance problems.

WHY DO MANY PEOPLE NOT RECEIVE APPROPRIATE TREATMENT FOR PTSD?

People with PTSD often do not seek professional help. This may be because they do not realize that they have a problem or that the problem can be treated. There is also a natural tendency to avoid dealing with the unpleasant feelings associated with the trauma. The very symptoms of PTSD—withdrawal, feelings of guilt or mistrust—may make it difficult for some people to seek help and get treatment.

Fortunately, our knowledge of PTSD has grown greatly over the last 10 years and the disorder has received extensive research and media attention. This has increased the chances that people will recognize their PTSD symptoms and seek treatment for them. There are many effective treatment approaches that can be used and chances of improvement with treatment are very good.

ARE THERE WAYS TO PREVENT PTSD?

People have a natural tendency to avoid inflicting pain on themselves and it certainly *is* painful to stay in touch with traumatic memories. However, if you try to push the memories of the trauma away, PTSD symptoms are likely to become more severe and last longer. It is therefore important to face the memories, feel the emotions, and try to work through them. It can also be very helpful to reach out to other people who can provide support and share your feelings about what happened. It is common and natural to feel guilty after a trauma, but it is also irrational and not helpful. Revealing your sense of guilt to other people you trust can help you see that what happened was not your fault. Try to get back to doing the things you've always done as soon as possible.

WHAT CAN I DO TO HELP MY RECOVERY?

There are a number of things you can to do to help yourself recover from PTSD:

- Learn about your disorder
- Talk about the problem to others
- Expose yourself to situations that remind you of the trauma
- Seek treatment
- If medication is prescribed, be sure to take it in the recommended doses and report any side effects you have
- Avoid alcohol or illicit drugs
- Don't quit your treatment and don't give up hope
- Join a support group

WHAT CAN FAMILIES AND FRIENDS DO TO HELP?

Provide emotional support and be a good listener

It can be very painful for friends and family members to watch a loved one suffer after a severe trauma. Unfortunately, common sense reactions are often counterproductive and may make the person feel even more isolated and hopeless. Undoubtedly, you will be tempted time and again to encourage the person to stop reliving and simply forget about the trauma and get on with life. Unfortunately, this seemingly reasonable advice is usually not helpful in this situation and is likely to make things worse.

In the long run, the person's chances of recovery and regaining a good quality of life are enhanced when he or she is encouraged to share the pain and memories associated with the traumatic experience. The person may need to talk about the traumatic events over and over again, and one of the best things family members and friends can do is to be patient and sympathetic listeners. Being able to share the feelings and pain can help the person feel less alone. Friends and family members can provide important emotional support and can also try to help the person let go of any unrealistic guilt they feel about what they have been through. One of the most important things you can do is to give the message: "You are not to blame—and you are not alone." It is also important to have realistic expectations while the person is recovering and not to expect too much or too little from the person.

Encourage your loved one to join a PTSD support group. Participating in a group with others who have experienced extreme trauma can help people to understand that they are not alone and to learn how to cope with their symptoms and work towards their own recovery.

Learn about the disorder

If you have a family member or friend with PTSD, learn all you can about the illness and its treatment. This will help you understand behavior that might otherwise seem frustrating or difficult to deal with. A number of educational books are listed at the end of this guide.

Encourage the person to stick with treatment

During treatment, the therapist may try to help your loved one get in touch with feelings about the trauma. This can be very difficult and there may be a temporary increase in symptoms and distress. Emotional support from family and friends can be especially helpful during this period. Sometimes you can help the person perform the exposure tasks that are part of the therapy (e.g., driving a car after a serious accident, revisiting the street where a mugging occurred).

It can be hard for your loved one to stick with treatment, especially when the therapist is asking him to face emotionally frightening and upsetting memories. Your encouragement and support can make a big difference if your loved one is tempted to quit treatment.

Consider family counseling

If a member of your family is having PTSD symptoms that are seriously interfering with the functioning of your family, you may want to ask the therapist about family counseling. Such counseling can improve communications and help return the family to normal.

FINAL THOUGHTS

No matter how long you have been suffering from PTSD, something can be done to help you get over it and dramatically improve your life. It is important to accept that the treatment will also ask something of you—you may need to revisit painful experiences you would rather avoid, and you may need to take medication that might have some side effects. But if you commit yourself to the treatment and stick with it, there is a good chance that you will soon begin to feel better and regain your quality of life. PTSD is painful—but fortunately it is a treatable condition, and you can get better.

ORGANIZATIONS YOU SHOULD KNOW ABOUT

Anxiety Disorders Association of American (ADAA) maintains a national network of 165 self-help support groups, has a catalogue bookstore of educational materials for consumers and professionals, and publishes a list of therapists to help people locate specialists where they live. Contact them at
11900 Parklawn Drive, Suite 100
Rockville, MD 20852-2624
301-231-9350
Website: www.adaa.org

The following organizations can also provide information and support.

National Organization for Victim Assistance (NOVA)
1757 Park Road, NW
Washington, DC 20010
202-232-6682
Website: www.try-nova.org

National Victim Center
2111 Wilson Boulevard, Suite 300
Arlington, VA 22201
800-394-2255
Website: www.nvc.org

Trauma Survivors Anonymous
2022 Fifteenth Avenue
Columbus, VA 31901
706-649-6500

International Society for Traumatic Stress Studies (ISTSS)
60 Revere Drive, Suite 500
Northbrook, IL 60062
847-480-9028
Website: www.istss.org

National Depressive and Manic-Depressive Association (NDMDA)
730 N. Franklin St., Suite 501
Chicago IL, 60610-3526
800-82-NDMDA (800-826-3632)
Website: www.ndmda.org

National Mental Health Association (NMHA)
National Mental Health Information Center
1021 Prince Street
Alexandria, VA 22314-2971
800-969-6642
Website: www.nmha.org

The National Mental Health Consumer Self Help Clearinghouse
1211 Chestnut St., 11th Floor
Philadelphia, PA 19107
800-688-4226
website: www.mentalhelp.net

FOR MORE INFORMATION

The following materials provide more information on PTSD. Unless otherwise indicated, they are available from ADAA. To order or to obtain a complete ADAA publications list, call 301-231-9350.

Allen JG. Coping with Trauma: A Guide to Self Understanding. American Psychiatric Press, 1995

Brooks B, Siegel PM. The Scared Child: Helping Kids Overcome Traumatic Events. John Wiley, 1996 (to order, call 732-469-4400)

Coffey R. Unspeakable Truths and Happy Endings: Human Cruelty and the New Trauma Therapy. Sidran Press, 1998

Davidson JRT, Foa EB, eds. Posttraumatic Stress Disorder: DSM-IV and Beyond. American Psychiatric Press, 1993 (to order, call 800-368-5777)

Finney LD. Clear Your Past: Change Your Future. New Harbinger, 1997

Foa EB, Rothbaum BO. Treating the Trauma of Rape: Cognitive-Behavioral Therapy for PTSD. Guilford, 1998 (to order, call 800-365-7006)

Frances AF, First MB. Your Mental Health, Scribner, 1999 (available at bookstores)

Gorman J. The Essential Guide to Psychiatric Drugs. St. Martin's, 1995

Herman JL. Trauma and Recovery. Basic Books, 1997 (to order, call 800-386-5656)

Matsakis A. Trust after Trauma: A Guide to Relationships for Survivors and Those Who Love Them. New Harbinger, 1998

Porterfield KM. Straight Talk about Post-traumatic Stress Disorder: Coping with the Aftermath of Trauma. Facts on File, 1996 (to order, call 800-322-8755)

Rothbaum B, Foa E. Reclaiming Your Life after Rape. Psychological Corporation, 1999 (to order, call 800-211-8378)

To request more copies of this handout, please contact ADAA at 301-231-9350. You can also download the text of this handout on the Internet at:

www.psychguides.com

HOW CAN I TELL IF I HAVE PTSD?*

PTSD is a serious, yet treatable, medical disorder. It is not a sign of personal weakness. If you think you may have PTSD, answer the following questions and show this checklist to your health care professional.

Yes or No?

❑ ❑ *Yes No* Have you experienced or witnessed a life-threatening event that caused intense fear, helplessness, or horror?

Do you re-experience the event in at least one of the following ways?

❑ ❑ *Yes No* Repeated, distressing memories and/or dreams?

❑ ❑ *Yes No* Acting or feeling as if the event were happening again (flashbacks or a sense of reliving it)?

❑ ❑ *Yes No* Intense physical and/or emotional distress when you are exposed to things that remind you of the event?

Do you avoid reminders of the event and feel numb, compared to the way you felt before, in three or more of the following ways?

❑ ❑ *Yes No* Avoiding thoughts, feelings, or conversation about it?

❑ ❑ *Yes No* Avoiding activities, places, or people who remind you of it?

❑ ❑ *Yes No* Being unable to remember important parts of it?

❑ ❑ *Yes No* Losing interest in significant activities in your life?

❑ ❑ *Yes No* Feeling detached from other people?

❑ ❑ *Yes No* Feeling that your range of emotions is restricted?

❑ ❑ *Yes No* Feeling as if your future has shrunk (for example, you don't expect to have a career, marriage, children, or a normal life span)?

Are you troubled by two or more of the following?

❑ ❑ *Yes No* Problems sleeping?

❑ ❑ *Yes No* Irritability or outbursts of anger?

❑ ❑ *Yes No* Problems concentrating?

❑ ❑ *Yes No* Feeling "on guard"?

❑ ❑ *Yes No* An exaggerated startle response?

❑ ❑ *Yes No* Do your symptoms interfere with your daily life?

❑ ❑ *Yes No* Have your symptoms lasted at least 1 month?

Having more than one illness at the same time can make it more difficult to diagnose and treat the different conditions. Illnesses that sometimes complicate PTSD include depression and substance abuse. To see if you have other problems that may need treatment, please complete the following questions.

❑ ❑ *Yes No* Have you experienced changes in sleeping or eating habits?

More days than not, do you feel

❑ ❑ *Yes No* Sad or depressed?

❑ ❑ *Yes No* Uninterested in life?

❑ ❑ *Yes No* Worthless or guilty?

During the last year, has the use of alcohol or drugs

❑ ❑ *Yes No* Resulted in your failure to fulfill responsibilities related to work, school, or family?

❑ ❑ *Yes No* Placed you in a dangerous situation, such as driving a car under the influence?

❑ ❑ *Yes No* Gotten you arrested?

❑ ❑ *Yes No* Continued despite causing problems for you and/or your loved ones?

* Symptoms listed here are based on criteria for posttraumatic stress disorder, major depressive disorder, and substance use disorders in the *Diagnostic and Statistical Manual of Mental Disorders,* Fourth Edition. Washington, DC: American Psychiatric Association; 1994. Checklist reprinted by permission of the Anxiety Disorders Association of America.

Other Published Expert Consensus Guidelines

McEvoy JP, Scheifler PL, Frances A. The Expert Consensus Guideline Series: **Treatment of Schizophrenia 1999**. J Clin Psychiatry 1999;60(suppl 11).

Alexopoulos GS, Silver JM, Kahn DA, Frances A, Carpenter D. The Expert Consensus Guideline Series: **Treatment of Agitation in Older Persons with Dementia**. Postgraduate Medicine Special Report April 1998.

March JS, Frances A, Carpenter D, Kahn DA. The Expert Consensus Guideline Series: **Treatment of Obsessive-Compulsive Disorder**. J Clin Psychiatry 1997;58(suppl 4).

McEvoy JP, Weiden PJ, Smith TE, Carpenter D, Kahn DA, Frances A. The Expert Consensus Guideline Series: **Treatment of Schizophrenia**. J Clin Psychiatry 1996;57(suppl 12B).

Kahn DA, Carpenter D, Docherty JP, Frances A. The Expert Consensus Guideline Series: **Treatment of Bipolar Disorder**. J Clin Psychiatry 1996;57(suppl 12A).

Expert Consensus Guidelines are in preparation for:

Psychiatric and Behavioral Problems in Mental Retardation

Attention-Deficit/Hyperactivity Disorder

Bipolar Disorder 1999

Treatment of Depression in Women

Guidelines can be downloaded from our web site: **www.psychguides.com**