



# Workers' Compensation Board

January 13, 2022

# Workers' Compensation Board's New York Post-Traumatic Stress Disorder and Acute Stress Disorder Medical Treatment Guidelines

A Training Module Developed by the Medical Director's Office

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medical Care

- Medical care and treatment required as a result of a work-related injury should be focused on restoring the patient's functional ability to perform their daily and work activities with a focus on return to work, while striving to restore the patient's health to its pre-injury status in so far as is feasible.
- Any medical provider rendering services to a workers' compensation patient must utilize the Workers' Compensation Board's *New York Medical Treatment Guidelines (MTGs)* as provided for with respect to all work-related injuries and/or illnesses.

## Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

- Positive results are defined primarily as functional gains that can be objectively measured. Objective functional gains include, but are not limited to, positional tolerances, range of motion, strength, endurance, activities of daily living (ADL), cognition, psychological behavior, and efficiency/velocity measures that can be quantified. Subjective reports of pain and function may be considered and given relative weight when the pain has anatomic and physiologic correlation in proportion to the injury.

## Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

- If a given treatment or modality is not producing positive results within a well-defined time frame, the provider should either modify or discontinue the treatment regime. The provider should evaluate the efficacy of the treatment or modality two to three weeks after the initial visit and three to four weeks thereafter. These time frames may be slightly longer in the context of conditions that are inherently mental health issues, and shorter for other non-musculoskeletal medical conditions (e.g., pulmonary, dermatologic etc.). Recognition that treatment failure is at times attributable to an incorrect diagnosis, a failure to respond should prompt the clinician to reconsider the diagnosis in the event of an unexpected poor response to an otherwise rational intervention.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

- Education of the patient and family, as well as the employer, insurer, policy makers and the community, should be a primary emphasis in the treatment of a work-related injury or illness. Practitioners should develop and implement effective educational strategies and skills. An education-based paradigm should always start with communication providing reassuring information to the patient. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention of future injury.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Acuity

- Acute, subacute and chronic are generally defined as time frames for disease stages:
  - Acute – Less than one month
  - Subacute – One to three months, and
  - Chronic – Longer than three months

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Time Frames

- Diagnostic time frames for conducting diagnostic testing commence on the date of injury.
- Treatment time frames for specific interventions commence once treatments have been initiated, not on the date of injury.
- Clinical judgment may substantiate the need to accelerate or decelerate the time frames discussed in this training module.
- Specific durations of treatments and number of treatment visits (e.g., physical therapy/occupational therapy (PT/OT)) are beyond the scope of this training module and the provider should refer to the recommendations in the *MTGs*.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Delayed Recovery

- For those patients who fail to make expected progress 6-12 weeks after an injury and whose subjective symptoms do not correlate with objective signs and tests, reexamination in order to confirm the accuracy of the diagnosis and reevaluation of the treatment program should be performed. When addressing a clinical issue that is not inherently a mental health issue, assessment for potential barriers to recovery (yellow flags/psychological issues) should be ongoing throughout the care of the patient. At 6-12 weeks, alternate treatment programs, including formal psychological or psychosocial evaluation should be considered. Clinicians must be vigilant for any pre-existing mental health issues or subsequent, consequential mental health issues that may be impacting recovery.



# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Delayed Recovery

- For issues that are clearly and inherently mental health issues from the outset (i.e., when it is evident that there is an underlying, work-related, mental health disorder as part of the claim at issue), referral to a mental health provider can and should occur much sooner. Referrals to mental health providers for the evaluation and management of delayed recovery do not indicate or require the establishment of a psychiatric or psychological condition. The evaluation and management of delayed recovery does not require the establishment of a psychiatric or psychological claim.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Active Interventions

- Active interventions emphasizing patient responsibility, such as therapeutic exercise and/or functional treatment, are generally emphasized over passive modalities, especially as treatment progresses. Generally, passive and palliative interventions are viewed as a means to facilitate progress in an active rehabilitation program with concomitant attainment of objective functional gains.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Diagnostic Imaging and Testing Procedures

- Clinical information obtained by history taking and physical examination should be the basis for selection of imaging procedures and interpretation of results.
- It may be of value to repeat diagnostic procedures (e.g., imaging studies) during the course of care to reassess or stage the pathology when there is progression of symptoms or findings, prior to surgical interventions and therapeutic injections when clinically indicated, and post-operatively to follow the healing process.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Surgical Interventions

- Consideration of surgery should be within the context of expected functional outcome. The concept of "cure" with respect to surgical treatment by itself is generally a misnomer. All operative interventions must be based upon positive correlation of clinical findings, clinical course, imaging, and other diagnostic tests.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Surgical Interventions

- For surgery to be performed to treat pain, there must be clear correlation between the pain symptoms and objective evidence of its cause. In all cases, shared decision making with the patient is advised.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Pre-Authorization

- All diagnostic imaging, testing procedures, non-surgical and surgical therapeutic procedures within the criteria of the *MTGs* and based on a correct application of the *MTGs* are considered authorized, with the exception of the procedures listed in section 324.3(1)(a) of Title 12 NYCRR.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Pre-Authorization

- Second or subsequent procedures (the repeat performance of a surgical procedure due to failure of, or incomplete success from, the same surgical procedure performed earlier, if the *MTGs* do not specifically address multiple procedures) also require pre-authorization.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Personality/Psychological/Psychosocial Evaluations

- In select patients, mental health evaluations are essential to make, secure or confirm a diagnosis. Of course, the extent and duration of evaluations and/or interventions by mental health professionals may vary, particularly based on whether: the underlying clinical issue in the claim is inherently a mental health issue; there is a mental health issue that is secondary or consequential to the medical injury or illness that is at issue in the claim in question; or there is a pre-existing, unrelated mental health issue that has been made worse by, and/or is impeding the recovery from the medical injury or illness that is at issue in the claim in question.



# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Personality/Psychological/Psychosocial Evaluations

- When assessing for a pre-existing, unrelated mental health issue that has been made worse by and/or is impeding the recovery from a work-related, medical injury or illness, then a one-time visit for initial psychiatric/psychological encounter should be sufficient, as care would normally be continued by the prior treating provider.
- If psychometric testing is indicated by findings in the initial encounter, time for such testing should not exceed an additional three hours of professional time.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Personality/Psychological/Psychosocial Evaluations

- For conditions in which a mental health issue is a central part of the initial claim, or in which there is a mental health issue that is secondary or consequential to the work-related, medical injury or illness, that is part of the claim in question, then more extensive diagnostic and therapeutic interventions may be clinically indicated and are discussed in detail in the *MTGs* for such mental health conditions.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Functional Capacity Evaluation (FCE)

- Functional capacity evaluation is a comprehensive or more restricted evaluation of the various aspects of function as they relate to the patient's ability to return to work.
  - In most cases, the question of whether a patient can return to work can be answered without an FCE.
  - An FCE may be considered at time of maximum medical improvement (MMI), following reasonable prior attempts to return to full duty throughout course of treatment, when the treating physician is unable to make a clear determination on work status on case closure. An FCE is not indicated early during a treatment regime for any reason including one to support a therapeutic plan.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Functional Capacity Evaluation (FCE)

- When an FCE is being used to determine return to a specific job site, the treating provider is responsible for understanding and considering the job duties. FCEs cannot be used in isolation to determine work restrictions. The authorized treating provider must interpret the FCE in light of the individual patient's presentation and medical and personal perceptions. FCEs should not be used as the sole criteria to diagnose malingering.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Functional Capacity Evaluation (FCE)

- An FCE may be considered at time of MMI, following reasonable prior attempts to return to full duty throughout the course of treatment, when the treating provider is unable to make a clear determination on work status on case closure.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Return To Work

- For purposes of the *MTGs*, return to work is defined as any work or duty that the patient is able to perform safely. It may not be the patient's regular work. Ascertaining a return-to-work status is part of medical care and should be included in the treatment and rehabilitation plan. It is normally addressed at every outpatient visit.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Return To Work

- A description of the patient's status and task limitations is part of any treatment plan and should provide the basis for restriction of work activities when warranted. Early return to work should be a prime goal in treating occupational injuries. The emphasis within the *MTGs* is to move patients along a continuum of care and return to work, since the likelihood of returning an injured worker to work drops progressively the longer the worker has been out of work.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Return To Work

- When returning to work at the patient's previous job task/setting is not feasible given the clinically determined restrictions on the patient's activities, inquiry should be made about modified duty work settings.



## Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

- **The Post-Traumatic Stress Disorder and Acute Stress Disorder MTGs address common and potentially work-related injuries. It encompasses assessment (including identification of “red flags” or indicators of potentially serious injury or disease); diagnosis; diagnostic studies for identification of clinical pathology; work-relatedness; and management, including modified duty and activity, return to work, and an approach to delayed recovery.**
  - Red flags include negative mood, dissociative symptoms, avoidance symptoms, arousal symptoms, anxiety disorders, depression, substance use disorders and risk of suicide.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ History Taking and Physical Examination

- History taking and physical examination establish the foundation/basis for and dictate subsequent stages of diagnostic and therapeutic procedures. When findings of clinical evaluations and those of other diagnostic procedures are not consistent with each other, the objective clinical findings should have preference.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ History of Present Injury

- **Mechanism of injury:** PTSD and ASD are psychiatric disorders that can occur in people who have experienced or witnessed a traumatic or terrifying event. The types of trauma commonly associated with PTSD and ASD include experiencing an actual or potential severe injury, life threatening circumstances, a physical assault or other extreme social or natural events.
- **Relationship to work:** This includes a statement of the probability that the illness or injury is work-related.
- **Prior occupational and non-occupational injuries**
- **Ability to perform job duties** and activities of daily living.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Past History

- Past medical history includes, but is not limited to, neoplasm, gout, arthritis, and diabetes;
- Review of systems includes, but is not limited to, symptoms of rheumatologic, neurologic, endocrine, neoplastic, and other systemic diseases;
- Smoking history;
- Vocational and recreational pursuits;
- Prior imaging studies; and
- Past surgical history.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Return To Work

- Certain findings, or red flags, raise suspicion of potentially serious medical conditions. In PTSD and ASD, these findings or indicators may include: negative mood, dissociative symptoms, avoidance symptoms, arousal symptoms, anxiety disorders, depression, substance use disorders and risk of suicide.
- The Post-Traumatic Stress Disorder and Acute Stress Disorder MTGs incorporate changes in clinical management triggered by the presence of red flags.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Diagnostic Criteria and Differential Diagnosis

- ASD and PTSD each have unique diagnostic criteria. The Diagnostic and Statistical Manual of Mental Health Disorders 5 (DSM-5) defines ASD when symptoms persist for 3 to 30 days after a traumatic event. DSM 5 defines a PTSD diagnosis if symptoms persist or occur more than 30 days after a traumatic event. Furthermore, the symptoms must significantly affect important areas of life, such as family and work. Differential diagnosis may include: head injury during the trauma, epilepsy, alcohol-use disorders, substance related disorders, acute intoxication or withdrawal from some substances, panic disorders and generalized anxiety disorder.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Diagnostic Testing and Procedures

- One diagnostic procedure may provide the same or distinctive information as obtained by other procedures. Therefore, prudent choice of procedure(s) for a single diagnostic procedure, a complementary procedure in combination with other procedures(s), or a proper sequential order in multiple procedures will ensure maximum diagnostic accuracy, minimize adverse effect to patients and promote cost effectiveness by avoiding duplication or redundancy.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Diagnostic Testing and Procedures

- When a diagnostic procedure, in conjunction with clinical information, provides sufficient information to establish an accurate diagnosis, a second diagnostic procedure will be redundant if it is performed only for diagnostic purposes. At the same time, a subsequent diagnostic procedure can be a complementary diagnostic procedure if the first or preceding procedures, in conjunction with clinical information, cannot provide an accurate diagnosis.



# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Diagnostic Testing

- It is recognized that repeat testing may be warranted by the clinical course and to follow the progress of treatment in some cases. It may be of value to repeat testing during the course of care to reassess or stage the pathology when there is progression of symptoms or findings.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Acute Stress Disorder (ASD) Diagnostic Criteria DSM-5 criteria

- **Criterion A.** Exposure to actual or threatened death, serious injury, or sexual violence in one(or more) of the following ways:
  1. Directly experiencing the traumatic event.
  2. Witnessing in person the event(s) as it occurred to others.
  3. Learning that the event(s) occurred to a close family member or close friend.

Note: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responder collecting human remains, police officer repeatedly exposed to details of child abuse).

Note: This does not apply to exposure through electronic media, TV, movies or pictures, unless exposure is work related.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Acute Stress Disorder (ASD) Diagnostic Criteria DSM-5 criteria

- **Criterion B.** Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:
- **Intrusion Symptoms:** Recurrent, involuntary and intrusive distressing memories of the traumatic event(s). Recurrent distressing dreams in which content and/or affect of the dream are related to the traumatic event. Dissociative reactions (e.g., flashbacks) in which the person feels or acts as if the event were recurring (most extreme expression of this being a complete loss of awareness of present surroundings).
- Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- **Negative Mood:** Persistent inability to experience positive emotions e.g., happiness, satisfaction, loving feelings.
- **Dissociative Symptoms:** Altered sense of reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing). Inability to remember an important aspect of the event(s) typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs.
- **Avoidance Symptoms:** Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). Efforts to avoid external reminders (e.g., people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- **Arousal Symptoms:** Sleep disturbance (falling or staying asleep, restless sleep), irritable behavior and angry outbursts, typically expressed as verbal or physical aggression toward people or objects with little or no provocation, hypervigilance, difficulty concentrating, exaggerated startle response.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Acute Stress Disorder (ASD) Diagnostic Criteria DSM-5 criteria

- **Criterion C:** Duration of the disturbance (symptoms in criterion B) is three days and up to one month after trauma exposure.
- **Note:** Symptoms typically begin immediately after the trauma, but persistence for at least three days and up to one month is needed to meet this disorder criteria.
- **Criterion D:** The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- **Criterion E:** The disturbance is not attributable to the physiological effects of a substance (e.g., medications or alcohol) or another medical condition (e.g., mild traumatic brain injury)) and is not better explained by brief psychotic disorder.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Post-Traumatic Stress Disorder (PTSD) Diagnostic Criteria DSM-5 criteria

- **Criterion A.** Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
  1. Directly experiencing the traumatic event.
  2. Witnessing, in person the event(s) as it occurred to others.
  3. Learning that the event(s) occurred to a close family member or close friend.

**Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.

4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responder collecting human remains, police officer repeatedly exposed to details of child abuse).

Note: This does not apply to exposure through electronic media, TV, movies, or pictures, unless exposure is work related.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Post-Traumatic Stress Disorder (PTSD) Diagnostic Criteria DSM-5 criteria

- **Criterion B:** Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred.
  1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
  2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
  3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (such reactions may occur on a continuum with the most extreme expression being a complete loss of awareness of present surroundings).
  4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
  5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- **Criterion C:** Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:
  1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about, or closely associated with, the traumatic event(s).
  2. Avoidance or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about, or closely associated with, the traumatic event(s).

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Post-Traumatic Stress Disorder (PTSD) Diagnostic Criteria DSM-5 criteria

- **Criterion D:** Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after traumatic event(s) occurred as evidenced by two or more of the following:
  1. Inability to recall an important aspect of the traumatic event(s) typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs.
  2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., “I am permanently ruined”).
  3. Persistent distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
  4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, shame).
  5. Markedly diminished interest or participation in significant activities.
  6. Feeling of detachment or estrangement from others.
  7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, loving feelings).

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Post-Traumatic Stress Disorder (PTSD) Diagnostic Criteria DSM-5 criteria

- **Criterion E:** Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
  1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
  2. Reckless or self-destructive behavior
  3. Hypervigilance
  4. Exaggerated startle response
  5. Problems with concentration
- **Criterion F:** Duration of the disturbance (symptoms in Criteria B, C, D, and E) is more than one month.
- **Criterion G:** The disturbance causes clinically significant distress or impairment in social, occupation, or other important areas of functioning.



# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ ASD Prognosis

- The diagnosis of ASD is not intended to predict subsequent PTSD, but rather to describe people with elevated distress in the initial month who may benefit from mental health services. The diagnosis is only a modest predictor of PTSD; at least half of people who develop PTSD do not initially meet the criteria for ASD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ PTSD Prognosis

- PTSD is a complex phenomenon. While the impact of PTSD on the lives of affected persons is significant, there is a notable body of evidence that indicates that PTSD may be successfully treated using established, evidenced-based methods. Despite the complexities of PTSD, the prognosis is good with the vast majority of people recovering to lead productive lives. A minority (approximately 4-22%) develop chronic PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ PTSD/ASD Treatment Overview

- **Acute Stress Disorder (ASD)** – This diagnosis does not accurately predict chronic PTSD. It describes recently trauma-exposed people with severe distress. Provisions of Cognitive Behavioral Therapy (CBT) in the acute phase is the best available strategy to limit subsequent PTSD.
- **Not Recommended** – Pharmacological management of ASD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ PTSD/ASD Treatment Overview

- **PTSD Psychological Management**
  - The primary initial intervention is CBT, which may include any or multiple of several methods or techniques. Exposure therapy (e.g., prolonged/exposure therapy, virtual reality training, Eye Movement Desensitization and Reprocessing (EMDR)) is often incorporated as part of CBT and also has evidence of efficacy, although it is less frequently prescribed.
  - For all psychological/psychiatric interventions, there must be an assessment and treatment plan with measurable behavioral goals, time frames and specific interventions planned.
- **PTSD Pharmacological Management**
  - Recommended – The primary non-psychological interventions are medications, and the strongest evidence is for elective serotonin reuptake inhibitors (SSRIs) and serotonin – norepinephrine reuptake inhibitor (SNRI) antidepressants.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ History and Psychological/Psychiatric Examination

- **The Psychological Examination of PTSD:**
  - **An event** is psychologically traumatic to the extent that it is cognitively disorienting and emotionally profound. Psychological trauma has been defined as involving “the loss of the assumptive world.” The “assumptive world” is the belief system reflecting all that a person assumes to be true about life, the world, the self and others. These assumptions are grounded on previous experience and are the basis for what a person believes to be true or real, and provide a sense of values, direction and purpose in life. A traumatic event is one that in an instant can invalidate all of these cognitive assumptions, leaving the patient feeling profound disorientation. A traumatic event is also one that elicits profound emotions, including overwhelming feelings of loss, terror, horror, rage, or guilt.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Types of Measures for PTSD Screening and Testing

- There are three basic types of psychological measures: (i) screening tools (ii) outcome measures and (iii) psychometric testing batteries (psychological inventories).
- (i.) Screening tools – Attempt to determine if there are symptoms/signs that a diagnosis might be present, and if so, supports the need for referral to a mental health/behavioral health professional to determine if the condition is present. A screening assessment is not definitive, but rather serves as an indication that further clinical evaluation is needed prior to making a definitive diagnosis.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Types of Measures for PTSD Screening and Testing

- (ii.) **An outcome measure** tracks changeable features of a condition which could potentially respond to treatment. After screening, patients who are thought to potentially have PTSD requiring treatment may be evaluated with a comprehensive evaluation and treated based on that evaluation. Some may undergo psychometric testing with psychological inventories.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Types of Measures for PTSD Screening and Testing

- (iii.) Psychological inventories are multi-dimensional measures intended to provide a broad description of the patient, by measuring a constellation of traits deemed to be relevant to the psychological examination.
- \*\*For a history and psychological examination, the mental health/behavioral health professional may use the interview and one or more psychological/biopsychological inventories to assess personality traits, general signs of psychiatric syndromes, physical and psychological coping styles and social support and conflicts.



# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Screening and Testing

- There are numerous screening and psychometric testing batteries. Although these instruments may suggest a diagnosis, neither screening nor psychometric tests are capable of making a diagnosis. The diagnosis should only be made after careful analysis of all available data, including from a thorough history and clinical interview.
- Each test must have a specific target and avoid duplication or overlap. Tests may be administered to monitor a patient's condition and progress. However, routine repeat testing is not indicated when the clinical documentation supports improved outcomes. The testing report should integrate the test data with the specific treatment goals of the client.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Screening and Testing

- **Psychological/Psychiatric Evaluation**
- **Recommended** – For all patients with potential ASD or PTSD.
- **Indications** – Mental health evaluations are essential to make, secure and/or confirm a diagnosis. They also set the stage for subsequent treatment plans.
- Evaluation should especially include focus on ASD/PTSD, anxiety disorder(s), depression, substance use disorder(s) and risk of suicide.
- **Frequency/Dose/Duration** – Initial evaluation to diagnose. Subsequent visits for treatment include performance and interpretation of screening and diagnostic testing.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Screening and Testing

- **Psychological/Psychiatric Evaluation**
- **ASD/PTSD Screening Tools**
- **Recommended** – For the evaluation of patients with ASD and/or for potential of PTSD.
- **Indications** – Patients with ASD and/or potential for PTSD (those who have sustained an at-risk event).
- **Benefits** – Earlier identification of potential PTSD, with referral of the patient to appropriate mental health services that include diagnostic confirmation.
- **Frequency/Dose/Duration** – One screening visit. Since PTSD is a disorder with a fluctuating course for many individuals, repeat screening may be clinically indicated based upon delayed or changing symptoms. However, routine screening is not recommended. Screening tools may include: PTSD Checklist, Primary Care PTSD Screen, and the Post-Traumatic Adjustment Scale.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Screening and Testing

- **Psychological/Psychiatric Evaluation**
- **Functional MRI**
- **Not Recommended** – For the diagnosis of PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Treatment Recommendations

- **Behavioral and Psychological Interventions**
- For all psychological/psychiatric interventions, there must be an assessment and treatment plan with measurable behavioral goals, time frames and specific interventions planned.
- Psychological Intervention: Optimum duration three to six months.
- **Maximum duration:** nine to twelve months.
- For select patients, longer supervision may be required and if further counseling is indicated, documentation of the nature of the psychological factors, as well as projecting a realistic functional prognosis should be provided by the treating practitioner every four weeks during treatment.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Treatment Recommendations

- **Behavioral and Psychological Interventions**
- Cognitive behavioral therapy (CBT) has been used to treat PTSD. It includes a variety of component therapies including cognitive therapy, and various types of exposure therapy.
- Mind-body interventions are reviewed separately, although they are often used with CBT; mind-body interventions attempt to achieve stress relief by encompassing a variety of techniques designed to use the mind to impact physical functioning and improve health.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Treatment Recommendations

- **Behavioral and Psychological Interventions**
- **Trauma-Focused Psychotherapies**
  - Trauma-focused psychotherapy is defined as any therapy that uses cognitive, emotional or behavioral techniques to facilitate processing a traumatic experience and in which the trauma focus is a central component of the therapeutic process.
- **Cognitive Behavioral Therapy**
  - (including Cognitive Processing Therapy, Imagery Rehearsal Training, Brief Eclectic Psychotherapy, Narrative Exposure therapy and EMDR)
  - **Recommended** – For the treatment of patients with ASD and PTSD.
  - **Frequency/Dose/Duration** – Weekly to twice-weekly sessions of 60-100 min., generally a minimum of six weeks and up to three months.
  - **Indications for Discontinuation** – Resolution of PTSD symptoms, noncompliance, lack of efficacy, or adverse effects.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Treatment Recommendations

- **Behavioral and Psychological Interventions**
- Exposure Therapy and Prolonged Exposure Therapy
- Exposure therapy involves the use of a variety of exercises which make a patient confront a traumatic memory and reorganize it. This often includes: 1) introducing the visual confrontation of the trauma and 2) repeatedly visiting the trauma memory. Exposure therapies are often combined with CBT. This may be done through virtual reality exposure, imaginal exposure, narrative exposure, in vivo exposure to a traumatic event, and/or virtual reality exposure (reviewed separately). Prolonged Exposure Therapy (PE) is a treatment that involves forced visual confrontation of trauma-related stimuli.
- **Recommended** – For the treatment of patients with PTSD.
  - Indications – PTSD symptoms sufficient to require therapy.
  - Benefits – Improvement in PTSD symptoms and reduced emotional response to traumatic stimuli and to help emotionally process a traumatic experience.
  - Frequency/Dose/Duration – Weekly 90-minute sessions for 10 weeks with reevaluation every four weeks with documented efficacy in terms of improved PTSD symptoms and functional improvement.
- **Indications for Discontinuation** – Resolution of symptoms, noncompliance, lack of efficacy or adverse events.



# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Treatment Recommendations

- **Behavioral and Psychological Interventions**
- **Virtual Reality Exposure Therapy**
  - **Recommended** – In the treatment of patients with PTSD.
  - **Indications** – PTSD symptoms sufficient to require therapy.
  - **Frequency/Dose/Duration** – Once to twice weekly 90 minute sessions for five weeks with reevaluation every four weeks with documented efficacy in terms of improved PTSD symptoms and functional improvement.
  - **Indications for Discontinuation** – Resolution of symptoms, noncompliance, adverse effects or lack of efficacy for PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Treatment Recommendations

- **Behavioral and Psychological Interventions**
- **Eye Movement Desensitization and Reprocessing (EMDR): Exposure Therapy and CBT Components of Treatment**
  - Recommended – For the treatment of patients with PTSD.
  - Rationale – EMDR includes multiple therapies, or co-interventions, including those known to be effective (e.g., CBT, exposure therapy).

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Treatment Recommendations

- Behavioral and Psychological Interventions
- Mind /Body Interventions
  - Mind/body interventions have been used for PTSD patients to attempt to relieve stress and encompass techniques such as guided imagery and mindfulness designed to use the mind to impact physical functioning.
  - Yoga
    - **Recommended** – In select patients with PTSD as second-line treatment.
    - **Indications** – PTSD sufficient to require alternate therapies after first-line PTSD psychotherapy. CBT should generally be tried first. Often yoga is used in combination as an adjunct with other therapies such as CBT and/or medication.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Treatment Recommendations

- **Behavioral and Psychological Interventions**
- **Non-Trauma Focused Psychotherapy**
- Although evidence supports the use of trauma-focused psychotherapies for the treatment of PTSD, not all patients are willing to participate in treatments that may focus on their trauma to any extent. As a result, some practitioners utilize non- trauma-focused therapies. Non-trauma-focused therapies for patients diagnosed with PTSD include: Interpersonal Psychotherapy (IPT), Stress Inoculation Training (SIT), and Present-Centered Therapy (PCT).
- **Interpersonal Psychotherapy**
  - **Recommended** – For the treatment of patients with chronic PTSD.
  - **Indications** – Chronic PTSD sufficiently symptomatic to require treatment.
  - **Frequency/Dose/Duration** – Weekly interpersonal psychotherapy for 14 weeks; 50 minutes per weekly session with reevaluation every four weeks with documented efficacy in terms of improved PTSD symptoms and functional improvement.
  - **Indications for Discontinuation** – Completion of a course of treatment, sufficient resolution of symptoms and/or non-compliance.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Treatment Recommendations

- **Behavioral and Psychological Interventions**
- **Recommended** – Stress inoculation training
- **Not Recommended** – Seeking safety
- **Not Recommended** – Dialectical behavioral therapy

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Selective Serotonin Reuptake Inhibitors (SSRIs)

- Sertraline
  - **Recommended** – For the treatment of patients with PTSD.
  - **Indications** – PTSD symptoms sufficient to require medication.
  - **Indications for Discontinuation** – Lack of efficacy, adverse effects, resolution of PTSD sufficiently to not require medication.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Selective Serotonin Reuptake Inhibitors (SSRIs)

- Paroxetine
  - **Recommended** – For the treatment of patients with PTSD.
  - **Indications** – PTSD symptoms sufficient to require medications.
  - **Indications for Discontinuation** – Lack of efficacy, adverse effects, non-compliance, resolution of PTSD sufficiently to not require medication.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Selective Serotonin Reuptake Inhibitors (SSRIs)

- Fluoxetine
  - **Recommended** – For the treatment of patients with PTSD.
  - **Indications** – PTSD symptoms sufficiently severe to require medications although main efficacy may be relapse prevention.
  - **Indications for Discontinuation** – Lack of efficacy, adverse effects, noncompliance, resolution of PTSD sufficiently to not require medication
- Fluvoxamine
  - **Not Recommended** – For the treatment of PTSD.



# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Selective Serotonin Reuptake Inhibitors (SSRIs)

- Escitalopram
  - **Recommended** – For the treatment of patients with PTSD as a second line medication for patients who have not responded to sertraline.
  - **Indications** – PTSD symptoms sufficient to require medication. Second line medication for patients with PTSD who have not responded to sertraline.
  - **Indications for Discontinuation** – Lack of efficacy, adverse effects, non-compliance, resolution of PTSD sufficiently to not require medication.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Selective Serotonin Reuptake Inhibitors (SSRIs)

- Citalopram
  - **Recommended** – For the treatment of patients with PTSD as a second-line medication for patients who have not responded to sertraline.
  - **Indications** – PTSD symptoms sufficient to require medication and not have responded to sertraline.
  - **Indications for Discontinuation** – Lack of efficacy, adverse effects, noncompliance, resolution of PTSD sufficient to not require medication.
- Vilazodone
  - **Not Recommended** – For the treatment of patients with PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Serotonin–Norepinephrine Reuptake Inhibitors (SNRIs)

- Venlafaxine
  - **Recommended** – For the treatment of patients with PTSD.
  - **Indications** – PTSD symptoms sufficient to require medications.
  - **Indications for Discontinuation** – Lack of efficacy, adverse effects, non-compliance, resolution of PTSD sufficient to not require medication.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Tricyclic Antidepressants (TCAs)

- Amitriptyline
  - **Not Recommended** – In the treatment of patients with PTSD.
- Desipramine
  - **Not Recommended** – In the treatment of patients with PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Tricyclic Antidepressants (TCAs)

- Imipramine
  - **Recommended** – As second-line treatment in patients for the treatment of PTSD.
  - **Indications** – May be recommended after first-line PTSD psychotherapies and/or other pharmacotherapy have been tried and found to be ineffective or not tolerated.
- Nortriptyline
  - **Not Recommended** – In the treatment of patients with PTSD.
- Mirtazapine
  - **Recommended** – As second-line treatment in patients with PTSD.
  - **Indications** – PTSD sufficient to require medications. Generally, sertraline, venlafaxine and paroxetine would all be preferable initial medication recommendations.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Monoamine Oxidase Inhibitors (MAOIs)

- Phenzelzine
  - **Recommended** – As second-line treatments in patients with PTSD.
  - **Indications** – PTSD sufficient to require medications. Phenzelzine may be recommended after first-line PTSD psychotherapies and/or other pharmacotherapy with greater evidence of efficacy (such as Sertraline) are tried and found to be ineffective or not tolerated.
  - (NOTE: Phenzelzine has potentially serious toxicities and should be managed carefully.)

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Atypical Antidepressants

- Trazodone
  - **Not Recommended** – For the treatment of patients with PTSD.
- Nefazodone
  - **Recommended** – As second-line treatment for patients with PTSD.
  - **Indications** – Nefazodone may be recommended after first-line PTSD psychotherapies and/or other pharmacotherapy with greater evidence of efficacy (such as SSRIs) are tried and found to be ineffective or not tolerated.
  - **(NOTE: Nefazodone has potentially serious toxicities and should be managed carefully.)**
  - **Indications for Discontinuation** – Lack of efficacy, adverse effects, noncompliance, resolution of PTSD sufficient to not require medication.
- Bupropion
  - **Not Recommended** – In the treatment of patients with PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Benzodiazepines

- **Not Recommended** – In the treatment of patients with PTSD.



# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medications-Anticonvulsants

- Gabapentin
  - **Not Recommended** – In the treatment of patients with PTSD.
- Lamotrigine
  - **Not Recommended** – In the treatment of patients with PTSD.
- Topiramate
  - **Not Recommended** – In the treatment of patients with PTSD.
- Valproic Acid
  - **Not Recommended** – In the treatment of patients with PTSD.
- Tiagabine
  - **Not Recommended** – In the treatment of patients with PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medication-Antipsychotics

- Aripiprazole
  - **Not Recommended** – In the treatment of patients with PTSD.
- Quetiapine
  - **Not Recommended** – In the treatment of patients with PTSD.
- Risperidone
  - **Not Recommended** – In the treatment of patients with PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medication-Antipsychotics

- Olanzapine
  - **Recommended** – In the treatment of select patients with PTSD who experience flashbacks and nightmares.
  - **Indications** – Olanzapine may be recommended after first-line PTSD psychotherapies and/or other pharmacotherapy are tried and found to be ineffective or not tolerated.
  - However, adverse effects suggest other medications are generally indicated prior to trying Olanzapine.
  - **Indications for Discontinuation** – Lack of efficacy, adverse effects, noncompliance, resolution of PTSD sufficiently to not require medication.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medication-Adrenergic Inhibitors

- Propranolol
  - **Not Recommended** – In the treatment of patients with PTSD.
  - Evidence for the Use of Propranolol
- Prazosin
  - **Not Recommended** – For treatment of global PTSD symptoms.
  - **Recommended** – In the treatment of select patients with PTSD with prominent nightmares and/or sleep disturbances.
  - **Indications for Discontinuation** – Lack of efficacy, adverse effects, non-compliance, resolution of PTSD sufficient to not require medication.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medication-Adrenergic Inhibitors

- Guanfacine
  - **Not Recommended** – In the treatment of patients with PTSD.
- Clonidine
  - **Not Recommended** – In the treatment of patients with PTSD.
- Doxazosin
  - **Not Recommended** – In the treatment of patients with PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medication-Steroids

- Hydrocortisone
  - **Not Recommended** – In the treatment of patients with PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Medication-Alternative Therapies

- Nutraceuticals
  - **Not Recommended** – In the treatment of patients with PTSD.
- Omega-3 Fatty Acids
  - **Not Recommended** – In the treatment of patients with PTSD.

# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Neuromodulation Therapies

- Transcranial Magnetic Stimulation (TMS) and Repetitive Transcranial Magnetic Stimulation (rTMS)
  - **Not Recommended** – In the treatment of patients with PTSD.
  - **Not Recommended** – In the treatment of patients with PTSD Vagal Nerve Stimulation.
  - **Not Recommended** – In the treatment of patients with PTSD Cranial Electrotherapy Stimulation.
  - **Not Recommended** – In the treatment of patients with PTSD.



# Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

## ■ Allied Health Interventions

- Massage
  - **Not Recommended** – In the treatment of patients with PTSD.
- Acupuncture
  - **Not Recommended** – In the treatment of patients with PTSD.

## Post-Traumatic Stress Disorder (PTSD) and Acute Stress Disorder (ASD) Training Module

- For additional questions, please email [MTGTrainings@wcb.ny.gov](mailto:MTGTrainings@wcb.ny.gov).

# Thank You