FOR PHYSICIANS & NURSE PRACTITIONERS · BRITISH COLUMBIA

Trauma & Stressor-Related Disorders
First-line treatment

A guideline-referenced summary for primary care and referring clinicians — what to start, what to avoid, what to do while a referral is pending, and when psychiatry adds value.

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GUIDELINES CURRENT TO AUGUST 2026

The central message of the current evidence base is that trauma-focused psychotherapy — not pharmacotherapy — is the first-line treatment for PTSD, and that the 2023 VA/DoD guideline now recommends it over medication with a Strong rating. In BC, where access to trained CPT, PE, and EMDR therapists is the binding constraint, that recommendation puts referral pathways and interim management at the centre of the problem rather than at the edge of it.

THE SHORT VERSION

- **Screen** with PC-PTSD-5; confirm and track with PCL-5.
- **Refer for trauma-focused psychotherapy** — CPT, PE, or EMDR. This is the first-line treatment.
- **Start an SSRI/SNRI** where therapy is unavailable, declined, delayed, or where MDD is co-primary. Sertraline, paroxetine, or venlafaxine XR.
- **Do not prescribe benzodiazepines.** Recommended against with the guideline's strongest rating.
- **Comorbidity — including active SUD — is not a reason to defer** trauma-focused treatment.
- **Do not offer single-session debriefing** after an acute event. Ineffective and potentially harmful.

SECTION 01

Case finding and measurement

INSTRUMENT	USE	NOTES
PC-PTSD-5	Screen	5 items, primary-care validated. Suitable for routine use in patients with unexplained somatic presentations, refractory insomnia, substance use, or chronic pain.

PCL-5	Track	20 items, self-report. Repeat at 4, 8, and 12 weeks. Per National Center for PTSD guidance, a 5–10 point change represents reliable change and a 10–20 point change represents clinically meaningful change — use 5 and 10 respectively as minimum thresholds. Serial PCL-5 scores are the single most useful thing you can include in a referral.
CAPS-5	Confirm	Structured clinician interview, the diagnostic reference standard. Not expected in primary care.
PHQ-9, AUDIT-C	Comorbidity	Depression and alcohol use are the two comorbidities that most change management.

Trauma exposure is not a diagnosis, and a positive screen is not PTSD. Equally, the absence of acute stress disorder in the first month does not predict who will go on to develop PTSD — on average only about 46% of those who later developed PTSD had met ASD criteria in the first month (McNally 2003; Bryant 2011), so a well patient at two weeks warrants review at one month regardless.

SECTION 02

PTSD — psychotherapy

Individual, manualized, trauma-focused. Roughly 8–15 sessions.

> STRONG FOR — VA/DOD 2023, ISTSS 2019, APA 2017, NICE NG116
>
> **Cognitive Processing Therapy · Prolonged Exposure · EMDR**
> Also strong in ISTSS: cognitive therapy for PTSD (Ehlers), individual trauma-focused CBT.

> STRONG FOR — VA/DOD 2023, RECOMMENDATION 7
>
> **Individual trauma-focused psychotherapy is recommended over pharmacotherapy** for PTSD — on the basis of larger effect size and greater durability after treatment ends. This is the substantive change from the 2017 iteration.

In network meta-analysis (Mavranezouli 2020; 90 RCTs, 6,560 participants), effect versus waitlist was largest for EMDR (SMD −2.07), then combined somatic/cognitive therapies (−1.69) and trauma-focused CBT (−1.46), with sustained effect at 1–4 month follow-up. Head-to-head, CPT, PE, EMDR, and cognitive therapy do not separate meaningfully. Selection should follow patient preference, comorbidity, and — realistically — availability.

LOWER-BURDEN OPTIONS

MODALITY	EVIDENCE AND ROLE
Written Exposure Therapy	5 sessions. Non-inferior to 12-session CPT with markedly lower attrition (6.4% vs 39.7%; Sloan 2018, JAMA Psychiatry). VA/DoD 2023 weak for. A strong option where completion is the limiting factor.
Present-Centered Therapy	Non-trauma-focused. ISTSS Standard; VA/DoD weak for. Lower efficacy than trauma-focused work but substantially lower dropout (~16%). Appropriate where the patient declines trauma processing.
STAIR	Phase-based skills work preceding trauma processing. VA/DoD 2023 rates it insufficient evidence as a standalone, but it is widely used where affect dysregulation is prominent.
Narrative Exposure Therapy	ISTSS Standard. Suited to multiple/sequential trauma and refugee populations.

ATTRITION IS THE PRACTICAL PROBLEM, AND IT IS PARTLY ADDRESSABLE

Meta-analytic dropout runs 34.0% for CPT and 28.7% for PE (Varker 2021), and 38.5–51% in routine care (a range compiled from Kehle-Forbes 2016 and Meis 2019, not a pooled estimate). Twice-weekly PE reduces dropout to 21.0% from 34.0% (OR 0.52). Intensive or massed outpatient formats do better still (CPT 8.5%, PE 5.5%). The granular military-population figures come from a 2025 meta-analysis (Penix-Smith et al., Psychological Trauma; overall weighted dropout 25.6%), not from Varker; the twice-weekly finding is an association, not a causal estimate. When making a referral, asking about session frequency is not a minor scheduling detail — it is one of the few modifiable predictors of completion.

Telehealth delivery of CPT and PE carries a Strong for recommendation (VA/DoD 2023) and is non-inferior to in-person. For BC geography this materially widens the referral field.

SECTION 03

PTSD — pharmacotherapy

AGENT	DOSE RANGE	STATUS
Sertraline	50–200 mg daily	VA/DoD 2023 Strong for. Health Canada indication for PTSD.
Paroxetine	20–60 mg daily	VA/DoD 2023 Strong for. Health Canada indication for PTSD. Anticholinergic burden, discontinuation symptoms, avoid in perinatal and older patients.
Venlafaxine XR	75–225 mg daily	VA/DoD 2023 Strong for. Monitor blood pressure at higher doses.
Fluoxetine	20–60 mg daily	**Guideline divergence.** APA 2017 conditional for; VA/DoD 2023 downgraded to insufficient evidence. Reasonable but no longer uniformly endorsed.

Trial adequacy: 8–12 weeks at an adequate dose before declaring non-response. **Duration:** continue at least 12 months in responders — continuation and maintenance treatment reduces relapse, and the British Association for Psychopharmacology guideline (Baldwin et al. 2014) supports longer-term treatment. Efficacy expectations should be set honestly: response rates under 60% and remission in roughly 20–30% on medication alone, which is the arithmetic behind the psychotherapy-first recommendation.

NIGHTMARES

Prazosin, titrated from 1 mg qhs toward 10–15 mg. The evidence is genuinely split: multiple positive early RCTs (Raskind 2003, 2007, 2013) against a negative large multi-site trial (PACT; Raskind, NEJM 2018, n=304, all endpoints non-significant). VA/DoD 2023 resolves this as weak for nightmares and weak against global PTSD. Higher baseline or standing blood pressure has been proposed as a marker of response — a partially supported hypothesis rather than an established predictor. Counsel on first-dose orthostasis. Imagery Rehearsal Therapy is an effective non-pharmacological alternative and is under-used, though note the divergence: the AASM endorses IRT for nightmare disorder while VA/DoD 2023 (Rec 33) rated nightmare-focused psychotherapies as insufficient evidence under its stricter GRADE bar.

STRONG AGAINST — VA/DOD 2023

Benzodiazepines. No benefit for core PTSD symptoms; misuse liability; associated with worse outcomes and reduced efficacy of trauma-focused therapy. Evidence that peri-traumatic administration increases PTSD incidence. Where a patient is already established on one, plan a structured taper rather than an abrupt stop, and ideally sequence it with initiation of definitive treatment.

STRONG AGAINST — VA/DOD 2023

Cannabis and cannabis derivatives. Frequently self-initiated for sleep and hyperarousal; recommended against.

SUGGESTED AGAINST — VA/DOD 2023

Atypical antipsychotic augmentation (quetiapine, risperidone, aripiprazole, olanzapine) — Recommendation 22. The VA Cooperative Study #504 risperidone augmentation RCT was negative (Krystal, JAMA 2011; CAPS mean difference 3.74, 95% CI −0.86 to 8.35, P=.11); metabolic and cardiac harms are not offset. Note the distinction: as monotherapy, quetiapine and olanzapine are rated insufficient evidence rather than weak against. NICE permits risperidone only as a last-resort adjunct for disabling psychotic-spectrum symptoms unresponsive to other treatment. **Ketamine** is also weak against for PTSD itself, though it retains a role for comorbid treatment-resistant depression. Divalproex, guanfacine, tiagabine, and vortioxetine: weak against.

WHERE THE FIELD CURRENTLY STANDS ON NOVEL AGENTS

MDMA-assisted psychotherapy — two positive phase-3 trials, but the FDA issued a Complete Response Letter in August 2024 requesting a further phase-3 trial. The June 2024 advisory committee voted 2–9 against the data showing effectiveness, and 1–10 against benefits outweighing risks, citing functional unblinding, expectancy effects, and data-integrity concerns. The CRL was publicly released in September 2025 and recommended an independent third-party data audit; no resubmission based on a new phase 3 trial had been completed as of 2026. Not approved in the US, and not authorized by Health Canada — Canadian access remains limited to clinical trials and case-by-case Special Access Program requests. **Psilocybin and other psychedelics, rTMS, stellate ganglion block, tDCS, and neurofeedback** — all rated insufficient evidence. Mindfulness-based stress reduction carries a weak for recommendation.

SECTION 04

Acute stress disorder and the first month

DO NOT OFFER

Single-session psychological debriefing / CISD. Ineffective and potentially harmful — a consistent finding across NICE, WHO, and Cochrane. Still routinely deployed by workplaces and organizations after critical incidents; worth naming explicitly when asked to endorse it.

- **No pharmacological agent has evidence for preventing PTSD.** VA/DoD 2023: insufficient evidence. Do not initiate prophylactically. Peri-traumatic benzodiazepines carry a signal for increased PTSD incidence.
- **Psychological First Aid** — safety, practical need, connection to supports. Universally endorsed, never rigorously proven. Offer it; do not count it as treatment.
- **Trauma-focused CBT** where ASD is diagnosed with functional impairment, typically deferred about two weeks to allow natural recovery (VA/DoD weak for; NICE recommends; WHO "should be considered").
- **Reassess at one month.** Persistence beyond one month means re-diagnosing as PTSD and moving to that algorithm.

SECTION 05

Adjustment disorders and prolonged grief

Adjustment disorders

Brief, time-limited psychotherapy is first-line — CBT-based, problem-solving, solution-focused, or IPT, typically 4–10 sessions. Activating, work-focused CBT has the strongest functional evidence, particularly for return-to-work outcomes. Pharmacotherapy is adjunctive only, reserved for moderate-to-severe or persistent symptoms, and always alongside psychotherapy. No dedicated high-grade guideline exists; recommendations rest on small trials and consensus.

Two cautions. First, address the stressor itself — treatment that leaves the precipitant untouched underperforms. Second, the "mild" framing of this diagnosis is misleading: there is a meaningful rate of impulsive self-harm, and suicidality warrants

active screening and monitoring. If criteria for MDD, GAD, or PTSD are met, that diagnosis takes precedence and changes management.

Prolonged grief disorder

Added to DSM-5-TR in 2022; requires at least 12 months post-loss in adults (6 months in children and adolescents), which diverges from the ICD-11 threshold of 6 months — worth noting when reading the literature.

Grief-targeted psychotherapy is first-line: Complicated Grief Treatment / Prolonged Grief Disorder Therapy (Shear), roughly 16 sessions integrating loss-focused exposure, restoration goals, and imaginal revisiting. It outperforms IPT in randomized trials; generic supportive counselling and standard depression protocols underperform. **No agent is first-line** — Shear 2016 (JAMA Psychiatry; 4-site RCT, n=395) found citalopram added to grief-targeted psychotherapy did not improve grief outcomes over psychotherapy plus placebo, improving comorbid depressive symptoms only. Response was 82.5% for CGT plus placebo versus 54.8% for placebo alone. Access to trained CGT/PGDT clinicians is the practical bottleneck in BC.

Differentiate from MDD — yearning and preoccupation with the deceased rather than pervasive anhedonia — and from PTSD following a traumatic death, which can co-occur and requires both to be treated.

SECTION 06

Comorbidity and special populations

SITUATION	APPROACH
Substance use disorder	Concurrent, not sequential. VA/DoD 2023 supports treating PTSD and SUD together; historical practice of requiring sobriety first is not supported. No benzodiazepines. Integrated protocols (COPE, Seeking Safety) where available.
Major depression	SSRI/SNRI with dual coverage. Watch for anhedonia and inertia interfering with therapy homework.
Traumatic brain injury	Does not preclude CPT or PE. Extend session count, simplify and shorten between-session tasks.
Psychosis or bipolar disorder	Stabilize first; trauma-focused work remains deliverable once stable and should not be permanently withheld.
Insomnia and nightmares	CBT-I and Imagery Rehearsal Therapy alongside. Residual sleep symptoms predict relapse.
Perinatal	Sertraline commonly preferred; avoid paroxetine. Weigh untreated-illness morbidity explicitly. Birth trauma is under-detected — ask directly.
Older adults	SIADH, falls, anticholinergic burden. Prazosin: orthostasis and first-dose syncope.
Military, veteran, first responder	Effect sizes are smaller and dropout higher than in civilian samples; EMDR has a thin military-specific evidence base. Moral injury responds poorly to fear-extinction models and better to meaning- and values-based work.
Refugee and multiple trauma	NET, interpreter-mediated delivery. Address ongoing threat and status insecurity before expecting treatment response.
Complex PTSD (ICD-11)	Same first-line pharmacotherapy; no separate agent. **Genuinely contested:** ISTSS position papers and expert consensus have historically favoured phase-based treatment with stabilization first, while accumulating RCT and meta-analytic evidence indicates standard trauma-focused therapy remains effective in many complex presentations and that a mandatory stabilization phase is not always necessary. Treat as an open question rather than settled.

SECTION 07

Non-response sequence

1. **Verify the trial was adequate.** Full dose, full duration for medication. For psychotherapy, confirm it was actually trauma-focused and actually completed — a substantial share of apparent treatment failure is unrecognized attrition.
2. **Switch modality** — CPT ⇄ PE ⇄ EMDR — or add a first-line medication to psychotherapy.
3. **Switch within, then between, SSRI and SNRI class.** Use venlafaxine XR if not yet trialed.
4. **Re-examine the diagnosis and the context.** Undetected SUD, TBI, obstructive sleep apnea, chronic pain, ongoing threat or unsafe housing, active litigation, moral injury. Ongoing exposure to threat is the most common reason good treatment fails.
5. **Treatment-resistant PTSD with comorbid MDD** — ketamine may be considered for the depressive component (per the 2022 VA/DoD MDD guideline), not for PTSD itself.

SECTION 08

What to do while a referral is pending

Wait times are the practical reality. This period is not neutral.

- **Start the SSRI/SNRI** rather than holding it for the psychiatrist. Twelve weeks of trial data makes the eventual consultation far more useful.
- **Track with serial PCL-5.** Send the scores with the referral.
- **Taper benzodiazepines** if present, deliberately and slowly.
- **Treat insomnia** in its own right — CBT-I is accessible and does not require the trauma work to have started.
- **Address alcohol and cannabis** directly, without making abstinence a precondition for trauma treatment.
- **Consider WorkSafeBC** where the trauma is occupational — and note that an accepted claim opens access to WorkSafeBC's PTSD Program, a contracted network delivering PE, CPT, EMDR, and TF-CBT. This is one of the few publicly funded routes to trauma-focused psychotherapy in BC.
  Any worker may claim; presumptive coverage expanded on 10 June 2024 to 11 further occupations including social workers, shelter and transition-house workers, victim-service and harm-reduction workers, respiratory therapists, coroners, and parole and probation officers — on top of first responders, correctional officers, dispatchers, nurses, and care aides. Teachers and bus drivers remain non-presumptive.
- **Mobilize the social layer.** Psychoeducation for the patient and, where appropriate, for family — reducing accommodation and avoidance by well-meaning relatives improves the odds that treatment is completed. Occupational accommodation and return-to-work planning. Peer support where available. These are ungraded across guidelines but clinically load-bearing.
- **Route to funded care where it exists.** Beyond WorkSafeBC: the **Crime Victim Assistance Program** (Ministry of Public Safety and Solicitor General; 1-866-660-3888) funds counselling where the trauma arose from a violent crime in BC, and the province's **low- and no-cost community counselling** initiative funds sessions through community organizations, with trauma among the most common presenting needs — availability is community-dependent and tied to periodically renewed funding. **Interior Health MHSU** accepts both self-referral and physician referral via 310-6478.
- **BounceBack** (CMHA BC, 1-866-639-0522) is available with no waitlist and can help comorbid low mood or anxiety, but it is scoped to mild-to-moderate presentations and is not a PTSD treatment. Adult coaching eligibility currently requires PHQ-9 ≤23; note BounceBack's own pages are internally inconsistent on this figure, so confirm before quoting it to a patient.
- **Do not defer** on the basis of comorbidity, complexity, or "insufficient stability" unless there is an active safety reason.

REFERRAL TO THIS PRACTICE

Virtual adult psychiatric consultation for British Columbia patients. A referral is most useful when it includes: the index trauma in one line, duration of symptoms, PCL-5 and PHQ-9 scores, prior medication trials with doses and duration, prior psychotherapy including modality and whether it was completed, current substance use, and the specific question being asked.

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Referral instructions: www.dr-mcb.com/psychiatry/refer. Do not send patient information by ordinary email.

SECTION 09

Divergences worth holding

- **Fluoxetine** — APA 2017 first-line; VA/DoD 2023 insufficient evidence.
- **Psychotherapy over pharmacotherapy** — Strong in VA/DoD 2023; not stated as such in APA 2017. NICE prioritizes psychological therapy and restricts medication largely to patient preference.
- **EMDR** — Strong across ISTSS and NICE, and the largest effect in network meta-analysis, but with a thin military-specific evidence base.
- **Prazosin** — positive early RCTs against the negative PACT trial; the guidelines split the difference by indication.
- **Medication overall** — ISTSS 2019 placed all first-line agents in its "Interventions with Low Effect(s)" category, a notably more conservative framing than the North American guidelines. Across all its recommendations: eight Strong, eight Standard, five Low Effect, 26 Emerging Evidence, 78 Insufficient Evidence.
- **Social interventions** — clinically essential, ungraded everywhere. Absence of high-grade evidence here reflects a research gap, not demonstrated ineffectiveness.
- **Canadian guidance** — there is no updated standalone Canadian PTSD guideline as of August 2026. Katzman et al. 2014 (BMC Psychiatry) predates the current evidence base. Recent CANMAT output — the 2023 MDD update and the 2024 Perinatal Mood, Anxiety and Related Disorders guideline — does not include a dedicated PTSD guideline, and no current CPA position paper exists.

Guidelines referenced. VA/DoD Clinical Practice Guideline for PTSD and ASD (2023; synopsis Annals of Internal Medicine 2024) · American Psychological Association Clinical Practice Guideline for the Treatment of PTSD in Adults (2017) · ISTSS Prevention and Treatment Guidelines (2019) · NICE NG116 (2018, still current) · WHO Guidelines for Management of Conditions Specifically Related to Stress (2013), mhGAP (2023) · Katzman et al., Canadian anxiety/PTSD/OCD guidelines (2014) · DSM-5-TR (2022).

Trials cited. Mavranezouli et al., Psychological Medicine 2020 · Sloan et al., JAMA Psychiatry 2018 · Raskind et al., NEJM 2018 (PACT) · Shear et al., JAMA Psychiatry 2016 · Feder et al., American Journal of Psychiatry 2021.

Prepared for clinician use. Verify all dosing against the current product monograph. Clinical judgment for the individual patient supersedes any summary document. Reviewed August 2026.