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Medical

TRAUMATIC STRESS RESPONSE

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This instruction implements AFD 44-1, *Medical Operations*. It establishes the requirement for Traumatic Stress Response (TSR) teams at all active duty Air Force installations, encouraging an integration of resources and efforts of the Air Force Reserve Command (AFRC) and Air National Guard (ANG). It provides guidance to these teams, whose primary function is to consult with unit leaders and provide initial response when groups or individuals expect to be, or have been, exposed to potentially traumatic stress. The primary goal of TSR teams is to foster resiliency in those exposed to potentially traumatic stress. This is accomplished through preparatory education for those likely to experience potentially traumatic stress, and through education, screening, psychological first aid, and referral for those exposed to potentially traumatic stress.

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SUMMARY OF CHANGES

This document is substantially revised and must be completely reviewed. This revision establishes TSR teams at all active duty Air Force installations. TSR teams (1) serve as trauma response consultants to unit leaders; (2) prepare personnel likely to be exposed to potentially traumatic events; and (3) provide screening, education, psychological first aid, and referral for those exposed to potentially traumatic events. This document also provides revised training guidance.

1. General Information. Many types of events have the potential to produce traumatic stress responses. **Most individuals exposed to such events will not experience long-term adverse effects.** However,

exposure to potentially traumatic events often results in short-term symptoms (i.e., normal responses to an abnormal event), which may worsen if unaddressed. Therefore it is Air Force policy to provide TSR services to enhance resilience to potentially traumatic events. Designated TSR teams, in close coordination with unit leaders, provide TSR services. Pre-Exposure Preparation (PEP) services are provided to unit and community members whenever potentially traumatic events are anticipated. Assistance will be available after potentially traumatic civil and military events.

2. Organizational Responsibilities.

2.1. Establishment of TSR teams

2.1.1. The senior wing commander or installation commander at each active duty Air Force installation with a medical treatment facility will ensure the establishment of at least one TSR, with a privileged Life Skills provider designated as the TSR team chief. At geographically separated units and bases without medical treatment facilities, the need to provide TSR services can be met by ensuring there is a TSR team available to respond as needed. TSR teams will assist individuals and units in preparing for and dealing with potentially traumatic events. When forming these teams, commands should consider TSR resources available through nearby active and/or AFRC/ANG military installations. Installations with more than one resident wing are not required to have more than one TSR team.

2.1.1.1. AFRC and ANG units are encouraged to develop and utilize their own resources, when possible. Partnership with the regular component or with other military resources is encouraged when necessary.

2.1.1.2. AFRC unit commanders will request the AFRC TSR team through HQ AFRC. AFRC/SG will coordinate and fund TSR response for AFRC events at collocated and non-collocated AFRC Wings. AFRC/SG will coordinate with AD TSR teams as necessary.

2.1.2. Local TSR teams will be contacted in the event of a potentially traumatic event. When the local command post becomes aware of a potentially traumatic event, it will notify the TSR team chief as part of required notification protocol. The wing commander is responsible for ensuring an effective notification and activation process.

2.1.3. TSR services will be made available in response to all air or ground mishaps that involve loss of life or major injury. TSR services may also be provided in response to other events at the request of the unit commander. The affected wing commander will support or arrange for consultation between the TSR team chief and the affected unit commander to determine what level of service, if any, is needed. The services provided will vary depending on the nature of the mishap and the needs of the squadrons involved in the mishap. In general, the commander of any unit that incurs loss of personnel or significant injury to personnel as a result of a mishap should consult with a TSR team leader to determine whether there is a need for TSR support. Then, if the commander subsequently requests service, the nature of those services should be developed by the commander in collaboration with the TSR team leader.

2.1.3.1. All individuals participating in search and rescue activities, as well as professional personnel such as forensic pathologists and mortuary personnel should have the opportunity to receive TSR services.

2.2. Team membership and formation. TSR teams will be composed of individuals fulfilling the following roles:

2.2.1. **Life Skills** – typically a psychiatrist, psychologist, social worker, mental health nurse, 7-level mental health technician, or fully-trained 5-level if assigned with one of the above. A privileged Life Skills provider serves as the TSR team chief.

2.2.2. **Spiritual support** – a chaplain and chaplain assistant;

2.2.3. **Family Support Center-** a community readiness consultant (NOTE: Personnel from the above areas who may be deployed are highly encouraged to be selected as team members, or if not, to participate in TSR training in order that they can apply TSR training in deployed situations.)

2.2.4. These multidisciplinary teams will include, as a minimum, individuals in each of the three roles noted, with at least one officer. Identification and training of primary and alternate members for each role is required to ensure continuous availability.

2.2.5. When forming TSR teams on active duty installations, qualified AFRC/ANG personnel should be considered as candidates for membership when available.

2.2.6. The TSR team chief may request additional volunteer personnel, such as non-caregiver workforce representatives, to serve as TSR members on either a long-term or short-term basis. Long-term team members will participate in all team training, while volunteers used for single incidents will receive just-in-time training. The TSR team chief must ensure all team augmentees have sufficient training to assist with education, screening and referral activities.

2.2.7. The wing commander will appoint a privileged Life Skills provider as the TSR team chief, who has overall responsibility for TSR training and service implementation. The TSR team chief will be identified to the command post by the wing commander to ensure required notification in the event of a potentially traumatic event.

2.2.8. The TSR team chief will coordinate with the Family Support Center and other agencies as appropriate to arrange TSR services to family and community members at installations impacted by a potentially traumatic event.

2.2.9. All TSR teams will establish standard operating procedures that will include, as a minimum, an assessment of local conditions and high-risk groups, a survey of locally trained resources, and a plan addressing various response scenarios.

2.2.10. TSR teams will support the Medical Group in developing and executing Medical Risk Communication plans for Chemical, Biological, Radiological and High-Yield Explosive (CBRNE) events.

2.3. TSR Team Training Requirements.

2.3.1. TSR teams will meet at least quarterly to train. Training will focus on preparation to respond to real world circumstances which have the potential to produce traumatic stress responses, such as pre and post deployment activities, mass violence incidents and natural disasters.

2.3.2. TSR teams will coordinate with other base agencies, such as security forces, to participate in exercises involving potentially traumatic scenarios.

2.3.3. Formal course attendance that provides certification is not required for TSR team members. Rather, team members must be able to apply the principles outlined in [Attachment 2](#). The TSR

team chief is responsible for ensuring all team members and augmentees are knowledgeable with the training material contained in [Attachment 2](#), and are able to provide education, screening and referral services as required.

2.3.4. A complete list of reference material for training is provided in [Attachment 1](#).

2.3.5. When possible, it is preferable for teams to train and exercise as a unit. TSR team chiefs will establish ongoing training and exercise requirements to assure the primary and backup team members maintain proficiency and can function effectively as a team.

2.4. Requesting Deployable Units for TSR

2.4.1. In the event an installation does not have the necessary local TSR resources to manage a traumatic event, the installation commander will request deployable mental health and chaplain assets as needed through the responsible MAJCOM, which makes necessary arrangements to ensure sufficient TSR resources are available.

3. Pre-Exposure Preparation (PEP).

3.1. PEP training is a preventive approach that helps individuals and units prepare for potentially traumatic events. TSR teams are available to provide pre-exposure consultation to units and communities who expect to face trauma.

3.2. PEP focuses on effective approaches to trauma stress management and emphasizes resiliency and the normalcy of feeling stress under abnormal circumstances. Material for conducting pre-exposure preparation training is contained in [Attachment 2](#).

3.3. PEP training should be coordinated between unit leaders and the TSR team chief, and should only occur when both unit leader and TSR team chief agree such training is necessary. PEP training should be tailored to specific unit requirements and should not duplicate existing training.

4. Enhancing Resilience

4.1. Airmen are recruited and trained to excel under a variety of stressful conditions. The purpose of TSR services is to enhance resilience in individuals and groups who are or may be exposed to potentially traumatic events. This objective is accomplished through the utilization of TSR teams who (1) Consult with leaders regarding potentially traumatic events; (2) Prepare personnel who are likely to be exposed to potentially traumatic events; (3) Provide education, screening, psychological first aid, and referral to those exposed to potentially traumatic events.

4.2. To the extent possible with existing resources, all individuals directly involved in a potentially traumatic event should be provided the opportunity to access TSR services.

4.3. Participation in TSR services is voluntary, though unit leaders may require affected personnel receive TSR education, at a minimum, in some instances.

4.4. TSR team services, to include PEP, education, screening and referral, are not medical services, and therefore do not involve medical or mental health record documentation.

4.5. Members on Personnel Reliability Program (PRP) status exposed to trauma will be referred to competent medical authority (CMA) for evaluation and follow-up as needed and will be advised to report any decrement in functioning to their Certifying Official. When providing TSR services, TSR team members do not evaluate or report potentially disqualifying information for PRP purposes.

4.6. Following a potentially traumatic event, individuals can seek up to four one-on-one meetings with any member of the TSR team. One-on-one meetings are for the purpose of education and consultation and not for medical assessment and treatment.

5. Combat Stress Control (CSC)

5.1. IAW DoD Directive 6490.5, TSR teams in deployed environments shall be responsible for implementing CSC programs, which seek to prevent or minimize adverse effects of Combat and Ongoing Operational Stress Reactions (COSR) through primary, secondary and tertiary prevention efforts.

5.1.1. TSR teams shall coordinate with Public Health programs to ensure deployed members receive appropriate screening and education after arriving and prior to departing from the deployed environment.

5.1.2. TSR teams shall consult with line commanders about surveillance and prevention, identification, and management of COSR in units and individuals before and after deployments.

5.1.3. Deployed chaplains and Life Skills personnel shall be responsible for CSC programs in deployed locations.

5.1.4. TSR teams in deployed environments will use Module A2 from the VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress to manage COSR.

Attachment 1

GLOSSARY OF REFERENCES AND SUPPORTING INFORMATION

References

DoD Directive 6490.5, Combat Stress Control (CSC) Programs

DoD Instruction 5210.42-R, Nuclear Weapon Personnel Reliability Program

AFI 10-802, Military Support to Civil Authorities

AFI 41-106, Medical Readiness Planning and Training

AFI 44-109, Mental Health and Military Law

AFI 34-1101, *Assistance to Survivors of Persons Killed in Air Force Aviation Mishaps and Other Incidents*

AFI 91-204, *Safety Investigations and Reports*

AFMAN 37-123, *Management of Records*

National Institute of Mental Health (2002). *Mental Health and Mass Violence: Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence: A Workshop to Reach Consensus on Best Practices* NIH Publication No. 02-5138, Washington, D.C.: U.S. Government Printing Office <http://www.nimh.nih.gov/research/massviolence.pdf>

Iraq War Clinician Guide 2nd Edition. National Center for PTSD, Executive and Resource Center Division, www.ncptsd.org Phone: (802) 296-5132; Fax: (802) 296-5135

DoD/VA Clinical Practice Guideline for Management of Traumatic Stress: Module A: Acute Stress Reaction, http://www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm

Mental Health Response to Mass Violence and Terrorism: A Training Manual (2004). U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), Washington DC 20015. <http://www.mentalhealth.samhsa.gov/publications/allpubs/SMA-3959/default.asp>

Psychological First Aid, Field Operations Guide, National Center for PTSD http://www.nctsn.org/nccts/nav.do?pid=ctr_terr_resources_pfa

Abbreviations and Acronyms

AFSC—Air Force Safety Center

AFRC—Air Force Reserve Command

ANG—Air National Guard

ARC—Air Reserve Component and Air National Guard

CONUS—Continental United States

CPG—clinical practice guideline

CSC—combat stress control

COSR—combat and operational stress reaction

MAJCOM—major command

NIMH—National Mental Health Institute

OCONUS—Outside Continental United States

PACAF—Pacific Air Forces

PRP—Personal Reliability Program

SIB—safety investigation board

SG—Surgeon General

TSR—traumatic stress response

Terms

Class A Mishap—A mishap resulting in one or more of the following:

Direct mishap cost totaling \$1,000,000 or more.

A fatality or permanent total disability.

Destruction of a DoD aircraft.

Traumatic Stress Response—A coordinated response initiated by unit leaders in which TSR teams engage in the provision of services to individuals and groups who may have or who have had direct exposure to a potentially traumatic event.

Traumatic Stress Response teams—Designated teams that provide pre-exposure preparation training, consultation to unit commanders and leaders, screening, psychological first aid, education and referral in order to foster reliance to potentially traumatic events.

Potentially Traumatic Event—Direct exposure or personal experience of an event that involves actual or threatened death or serious injury, or other threat to one's physical integrity; or learning about unexpected or violent death, serious harm, or threat of death or injury experienced by a family member or other close associate.

Traumatic events that are experienced directly include, but are not limited to, military combat, violent personal assault (sexual assault, physical attack, robbery, mugging), being kidnapped, being taken hostage, terrorist attack, torture, incarceration as a prisoner of war or in a concentration camp, natural or manmade disaster, severe automobile accidents, or being diagnosed with life-threatening illness. Witnessed events include, but are not limited to, observing the serious injury or unnatural death of another person due to violent assault, accident, war, or disaster or unexpectedly witnessing a dead body or body parts. Events experienced by others that are learned about include, but are not limited to, violent personal assault, serious accident, or serious injury experienced by a family member or close friend; learning about the sudden, unexpected death of a family member or a close friend; or learning that one's child has a life-threatening disease.

Pre-Exposure Preparation—A preventive approach prior to exposure to a potentially traumatic event that uses an educational approach to emphasize the typical and normal stress responses and basic techniques in stress management.

Attachment 2

TRAINING OUTLINE FOR TRAUMATIC STRESS RESPONSE (TSR) TEAM MEMBERS

TSR team chiefs are responsible for ensuring TSR team members have reviewed all information contained in this attachment. TSR training, which must be accomplished at least quarterly and documented, will ensure all TSR team members are familiar with the key principles of: PEP, early interventions after mass violence, and clinical practice guidelines for traumatic stress management. All team members should be able to provide consultation, education, screening, psychological first aid and referral in response to potentially traumatic events.

I. PRE-EXPOSURE PREPARATION (PEP)

PEP education is the primary preventive function of TSR teams.

Community education regarding the functions of the TSR teams and PEP should be accomplished on a regular basis through briefings and articles in base publications. Education regarding the services of the TSR teams should not wait until a potentially traumatic event is anticipated or has occurred. Pre-exposure guidance should be offered to all individuals for whom exposure to a potentially traumatic event is anticipated.

The following information can be shared with units or individuals who may be exposed to potentially traumatic events, to enhance resilience.

TRAUMA-RELATED STRESS

What to expect when exposed to a potentially traumatic event

Responses to a potentially traumatic event vary from person to person, depending on a number of factors, including previous life experiences and personal experience of the actual event. Research has shown most stress-related symptoms, when present, are short-term in duration. However, sometimes symptoms persist, and should be addressed to prevent long-term problems.

Typical and Normal Stress Responses include:

Feeling keyed up, on edge, and restless; hyper-vigilance; exaggerated startle response; irritability or outbursts of anger; sadness and crying; fatigue; difficulty concentrating, preoccupation with the traumatic event; muscle tension; sleep disturbances (difficulty falling or staying asleep, or restless unsatisfying sleep); appetite disturbances (forgetting to eat or drink)

Keys Concepts to know when dealing with Traumatic Stress:

Trauma-related stress reactions are normal reactions to abnormal situations

Airmen are specially selected and trained to perform under highly stressful circumstances

Coping with and surviving a traumatic event enhances resilience and self-confidence

Effective Coping Strategies for Stress Include:

Talking about feelings of stress with others

Attention to basic needs: sleep, diet, exercise, social, spiritual needs

Helping others who are in need

When and Where to Seek Assistance from Professionals:

Seek immediate referral when the following symptoms are present:

Suicidal or homicidal ideation, intention, or plans; hallucinations or delusions; severe depression; alcohol or drug abuse

Seek assistance when the following symptoms last for over a month, and/or impact work or social functioning:

Persistent avoidance of reminders of the trauma and emotional numbing; persistent loss of interest in friends, family and activities; feelings of detachment from others; restricted range of affect (e.g., unable to have loving feelings); flashbacks; feeling as if the traumatic event were recurring; feelings of worthlessness or excessive guilt; depressed mood most of the day, nearly every day, with persistent crying, feelings of emptiness and sadness.

II. KEY OPERATING PRINCIPLES OF EARLY INTERVENTION FOLLOWING MASS VIOLENCE

The following information in paragraphs II and III are adapted from National Institute for Mental Health (NIMH) Recommendations. These recommendations apply to intervention efforts following episodes of mass violence.

Training for early interventions should address preparation, planning, education, training, service provision, and evaluation of efforts to assist those affected by mass violence and disasters. Early intervention policies should be based on empirically defensible and evidence-based practices. An ethical duty exists to discourage the use of ineffective or unsafe techniques.

Key Components of Early Intervention

Through exercises and training, TSR members will know how to implement the following key components in the event of mass exposure to trauma:

Basic Needs

- Provide survival, safety, and security
- Provide food and shelter
- Orient survivors to the availability of service/support
- Communicate with family, friends, and community
- Assess the environment for ongoing threats

Psychological First Aid

- Protect survivors from further harm
- Reduce physiological arousal
- Mobilize support for those who are most distressed
- Keep families together and facilitate reunions with loved ones
- Provide information and foster communication and education
- Use effective risk communication techniques

- Assess the current status of individuals, groups, and/or populations and institutions/systems. Ask how well needs are being addressed, what the recovery environment offers, and what additional interventions are needed.
- No requirement for a formal mental health evaluation unless there is a red flag in the initial screening, i.e., a red flag in a post-deployment screening

Rescue and Recovery Environmental Observation

- Observe and listen to those most affected
- Monitor the environment for toxins and stressors
- Monitor past and ongoing threats
- Monitor services that are being provided
- Monitor media coverage and rumors

Outreach and Information Dissemination

- Offer information/education and “therapy by walking around”
- Inviting community members to bring in other people that may be affected, but were not able to be involved in early interventions
- Use established community structures
- Distribute flyers; encourage those not initially identified to seek services
- Host web sites
- Conduct media interviews and programs and distribute media releases

Technical Assistance, Consultation, and Training

- Improve capacity of organizations and caregivers to provide what is needed
- Reestablish community structure
- Foster family recovery and resilience
- Safeguard the community
- Provide assistance, consultation, and training to relevant organizations, other caregivers and responders, and leaders

Fostering Resilience and Recovery

- Foster but do not force social interactions
- Provide coping skills training
- Provide risk assessment skills training
- Provide education on stress responses, traumatic reminders, coping, and normal versus abnormal functioning, risk factors, and services
- Offer group and family interventions
- Foster natural social supports

- Look after the bereaved
- Repair the organizational fabric

Triage

- Conduct clinical assessments, using valid and reliable methods
- Refer when indicated
- Identify vulnerable, high-risk individuals and groups
- Provide for emergency hospitalization

Treatment

- Know when to refer individuals for specialty assistance

III. GUIDANCE FOR TIMING OF EARLY INTERVENTIONS

PHASE:	Pre-incident	Impact (0-48 Hours)	Rescue (0-1 Week)	Recovery (1-4 weeks)	Return to Life (2Weeks-2 years)
GOALS:	Preparation; Improve coping	Survival, Communication	Adjustment	Appraisal/ Planning	Reintegration
BEHAVIOR:	Preparation vs. Denial	Fight/flight, freeze, Surrender, etc.	Resistance vs. Exhaustion	Grief, reappraisal, Intrusive memories, Narrative formation	Adjustment vs. Phobias, PTSD, Avoidance, depression
ROLE OF ALL HELPERS:	Prepare, train Gain knowledge	Rescue, protect	Orient; provide For needs	Respond with sensitivity	Continue Assistance
ROLE OF MENTAL HEALTH PROFESSIONALS:	<u>Prepare</u> Train Gain knowledge Collaborate Inform and influence policy Set Structures for rapid assistance	<u>Basic Needs</u> Establish safety/ security/survival Ensure food and shelter Facilitate communication with family, friends, and community Assess the	<u>Needs Assessment</u> Assess current status, how well needs are being addressed What additional interventions are needed for * Group * Population * Individual	<u>Monitor the Recovery Environment</u> Observe and listen for those most affected Monitor the environment for toxins Monitor past and ongoing threats	<u>Treatment</u> Reduce or ameliorate symptoms or improve functioning via: * Individual, family, and group psychotherapy * Pharmacotherapy * Short-term or long-term

PHASE:	Pre-incident	Impact (0-48 Hours)	Rescue (0-1 Week)	Recovery (1-4 weeks)	Return to Life (2Weeks-2 years)
	Provide Pre-Exposure training	environment for ongoing threat/ toxin <u>Psychological First Aid</u> Support and "presence" for those who are most distressed Keep families together and Assess caregivers	<u>Triage</u> Clinical Assessment Refer when indicated Identify vulnerable, high-risk individuals and groups	Monitor services that are being provided Spiritual Support	hospitalization

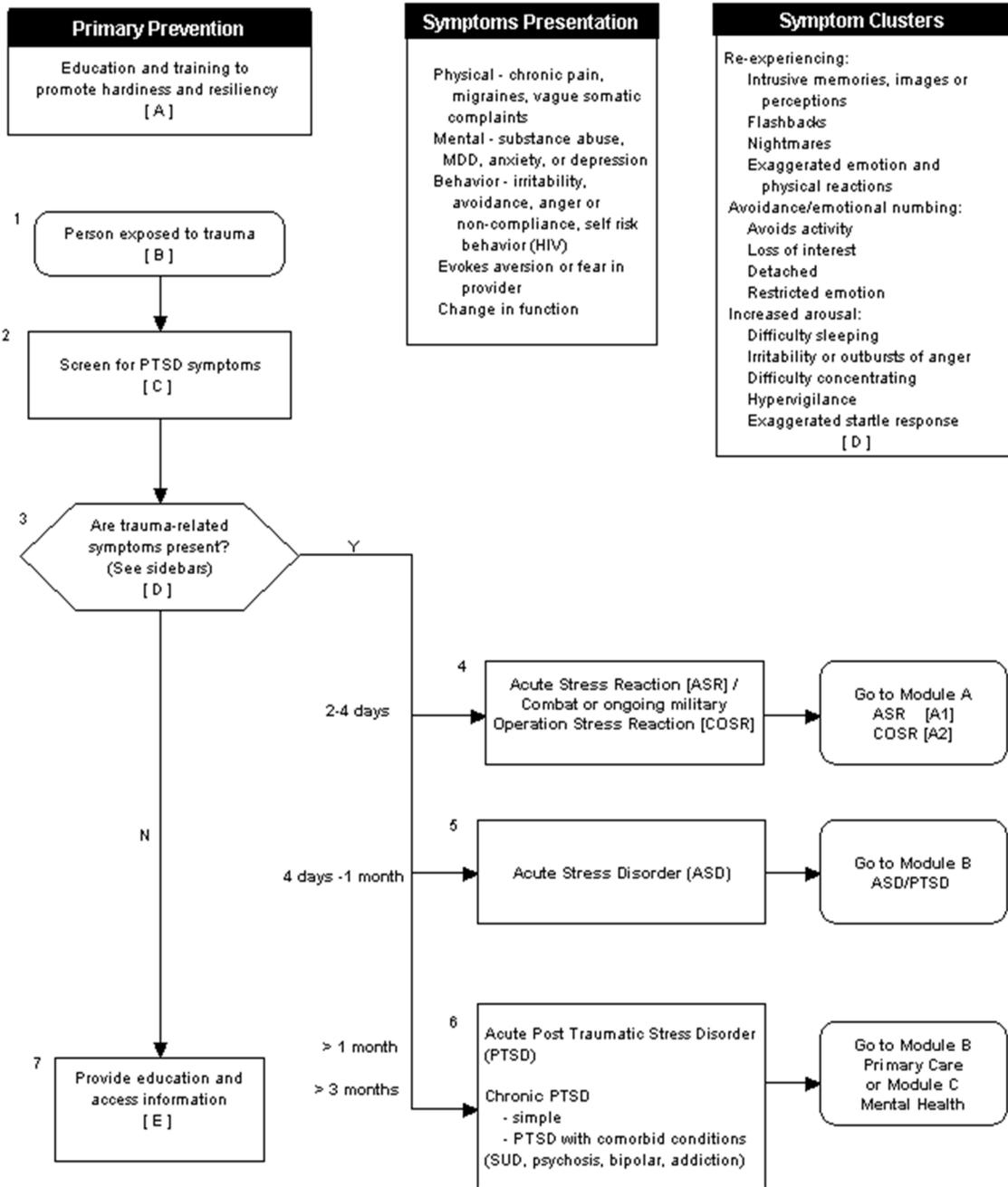
IV. CLINICAL PRACTICE GUIDELINES FOR TRAUMATIC STRESS MANAGEMENT

The following flow charts provide an overview of the Department of Veterans Affairs/ Department of Defense/ (VA/DoD) Clinical Practice Guideline (CPG) on Management of Traumatic Stress. TSR team members can use this CPG to screen and refer individuals who have been exposed to potentially traumatic events. The first flow chart depicts a core module that can be used to screen any individual who has been exposed to a potentially traumatic event. The remaining charts provide guidance on management of individuals with acute stress reactions, combat and operational stress reactions, and those who are referred to primary care or Life Skills for further assessment.

Medical and Life Skills providers are encouraged to review the entire VA/DoD CPG for the Management of Post-Traumatic Stress (see References section.)

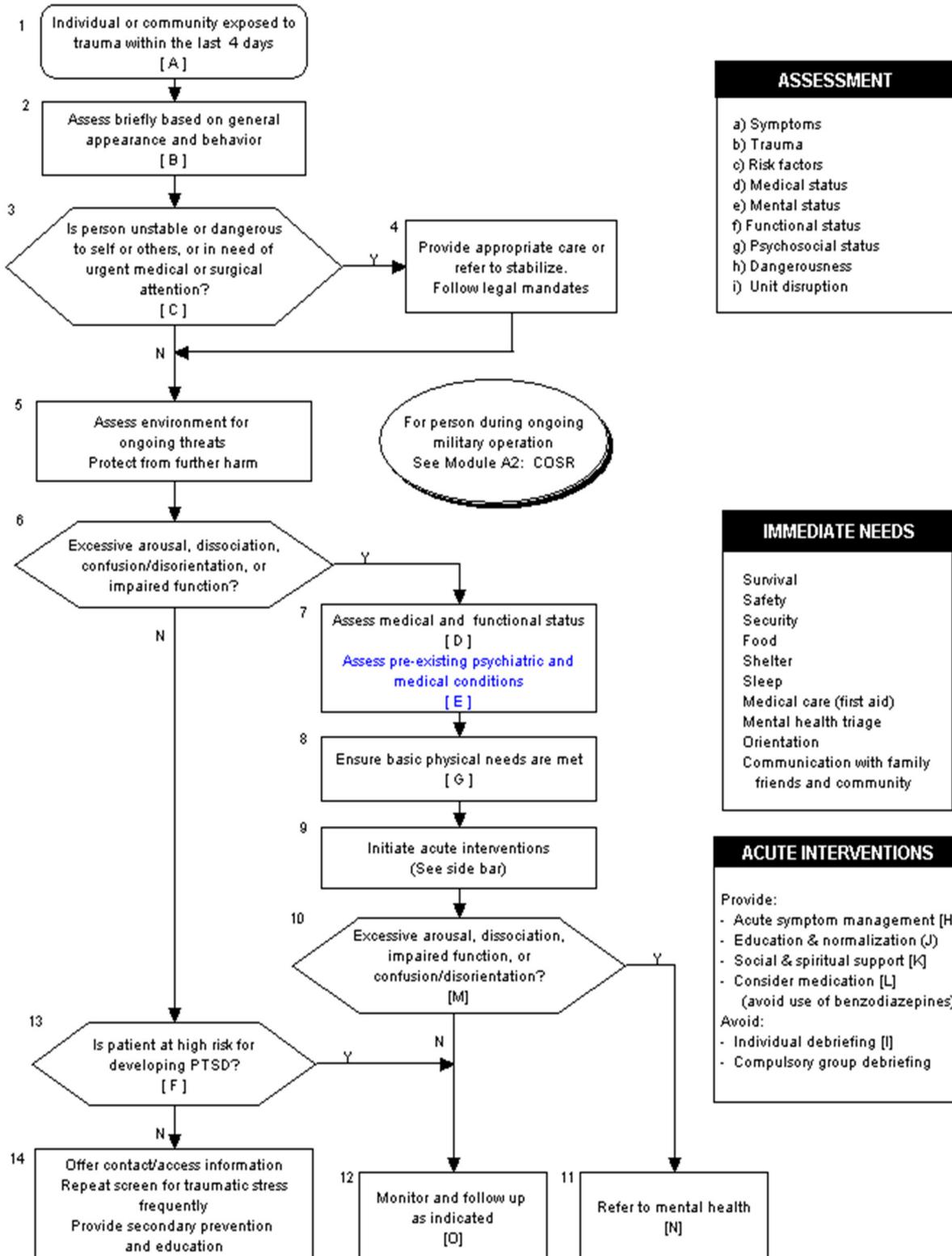
DoDVA Clinical Practice Guideline for Management of Traumatic Stress

**Core Module
Initial Evaluation and Triage**



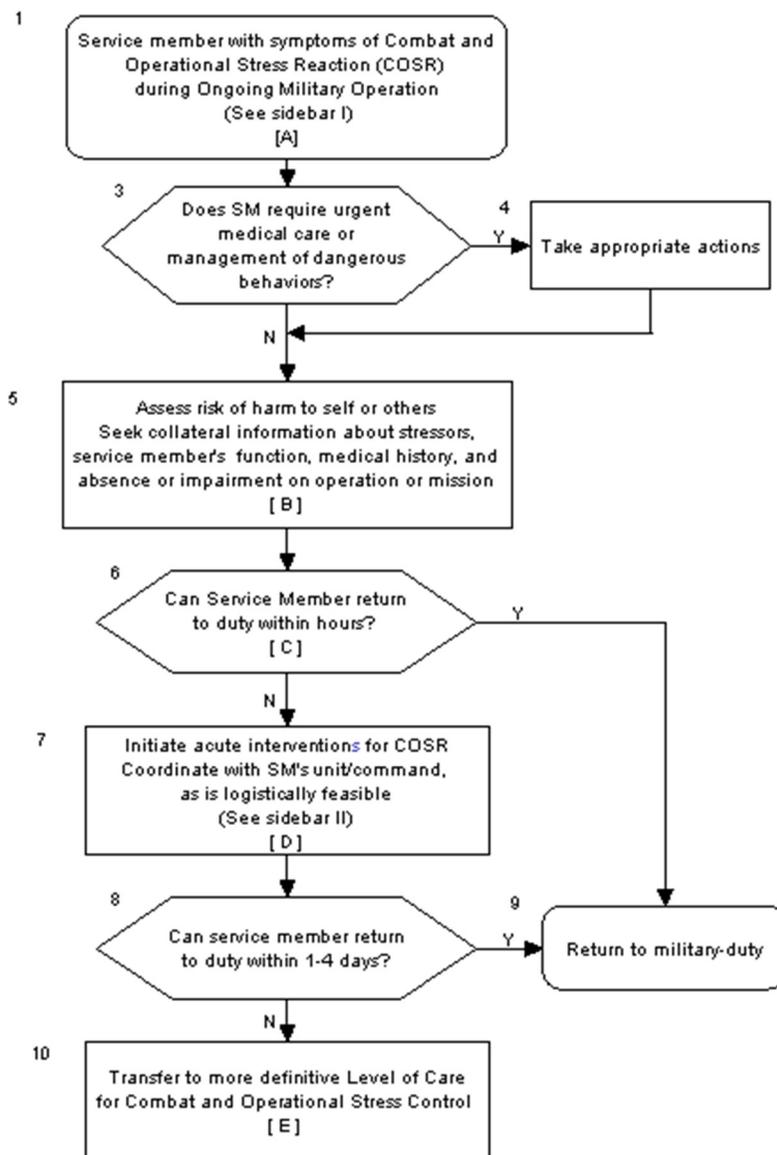
**VA/DoD Clinical Practice Guideline
for the Management of Traumatic Stress
Module A1 - Acute Stress Reaction**

A1



**Management of Stress Reactions
 Combat and Operational Stress Reaction(COSR)
 During Ongoing Military Operations**

A2



COSR SYMPTOMS

Possible Syndrome:

- exhaustion/burnout
- hyperarousal and anxiety
- somatic complaints (GI, GU, MS, CV, respiratory, NS)
- depression/guilt/hopelessness
- conversion disorder symptoms
- amnesic and/or dissociative symptoms
- behavioral changes
- emotional dysregulation
- anger/irritability
- brief, manageable "psychotic symptoms" (e.g., hallucinations due to sleep deprivation, mild "paranoia")

COSR does not require a specific traumatic event and can be a result of accumulating stress

COSR ACUTE INTERVENTIONS

Treat according to service member's prior role and not as a "patient": avoid a hospital setting

Assure or provide the following, as needed:

- o Reunion or contact with primary group
- o Respite from intense stress
- o Thermal comfort
- o Oral hydration
- o Oral food
- o Hygiene (toileting, shower, shave, and female needs)
- o Sleep (to facilitate rest and restoration)
- o Encourage talk about the event with supportive others

Reserve group debriefing for members of pre-existing and continuing groups (Voluntary attendance)

Assign appropriate duty tasks and recreational activities that will restore focus and confidence and reinforce teamwork

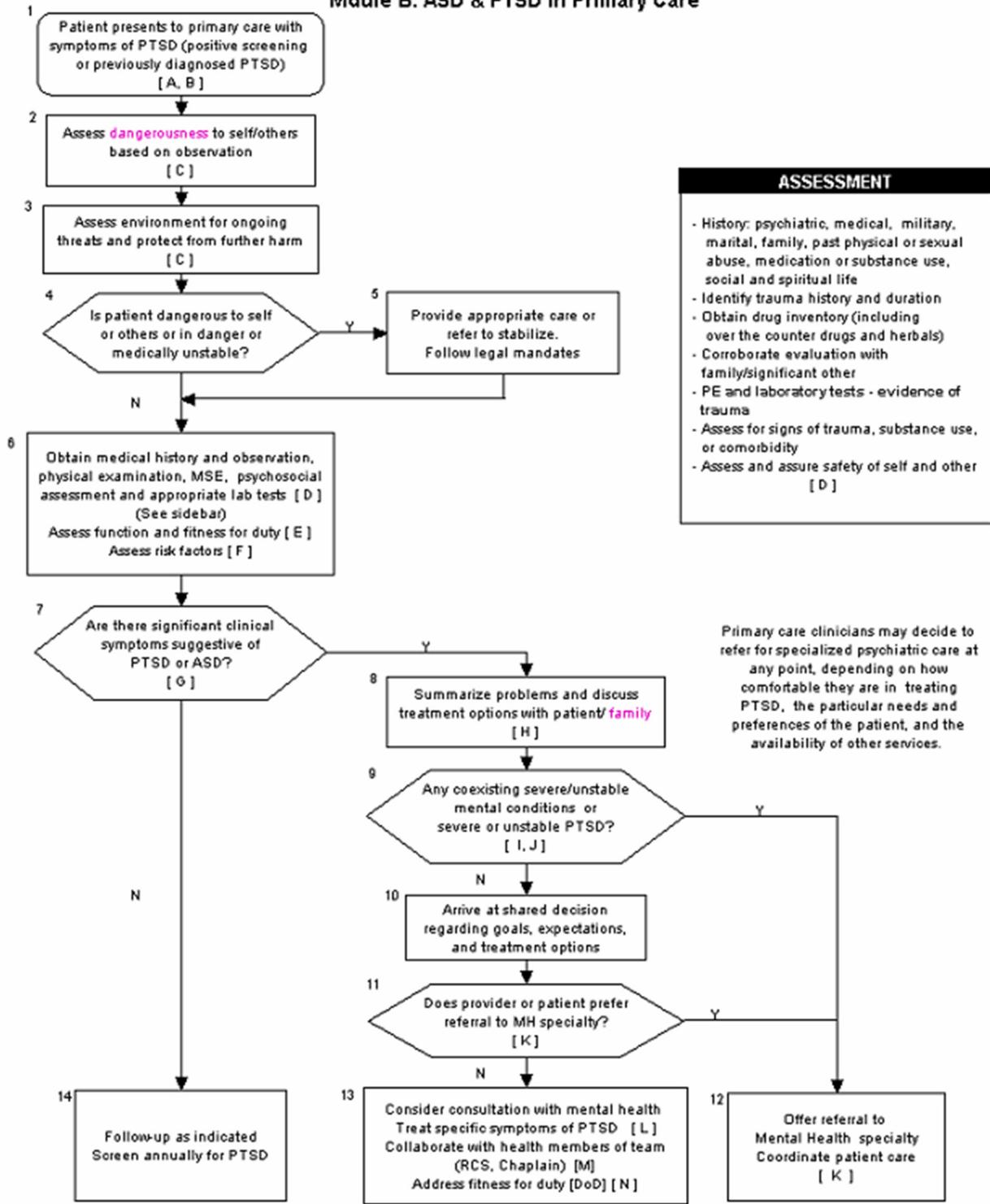
Avoid further traumatic events until recovered for full duty

Evaluate periodically

Consider using a short course of medication targeted for specific symptoms

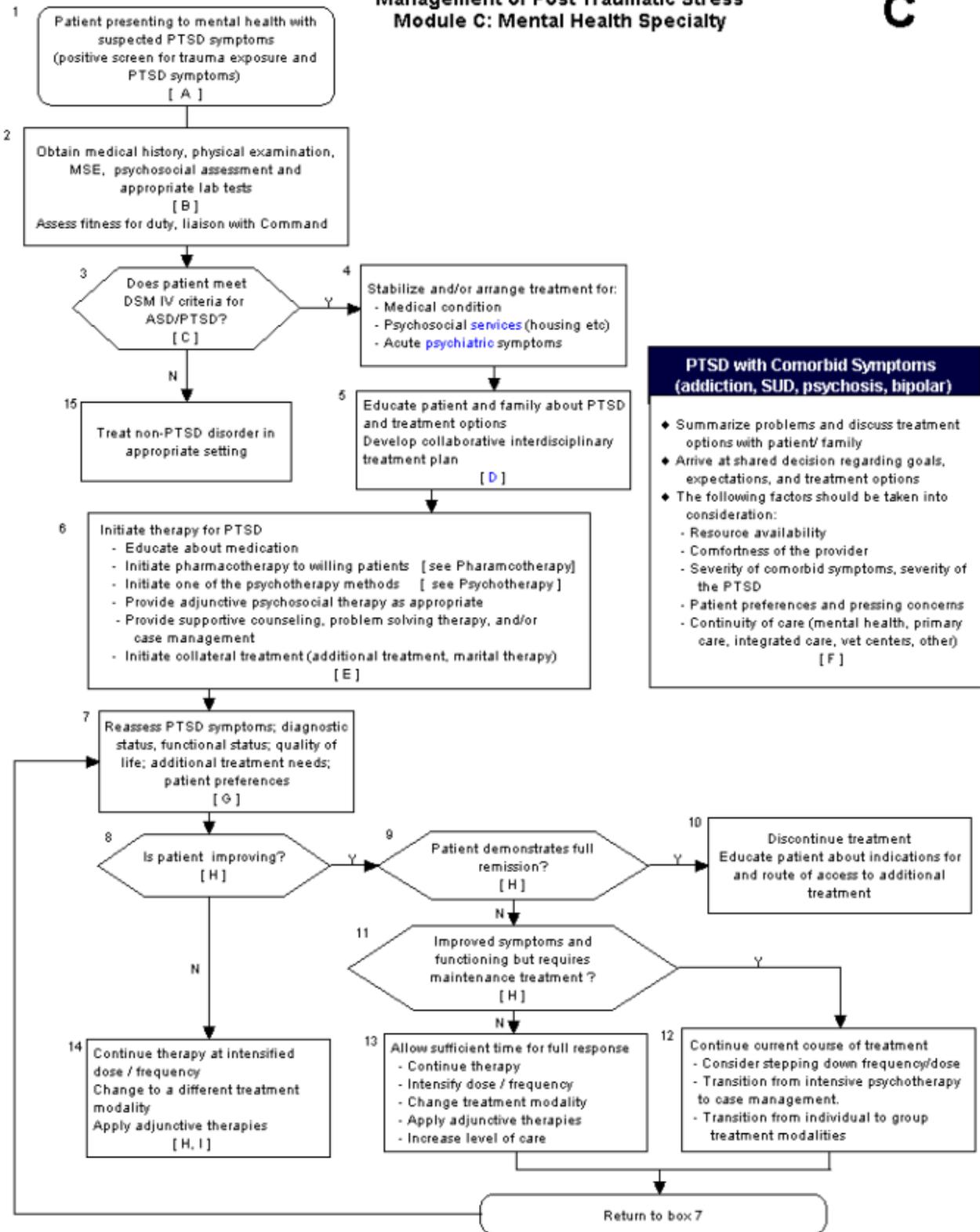
**VA/DoD Clinical Practice Guideline for the Management of Post Traumatic Stress
Module B: ASD & PTSD in Primary Care**

B



**VA/DoD Clinical Practice Guideline for the Management of Post Traumatic Stress
Module C: Mental Health Speciality**

C



PTSD with Comorbid Symptoms (addiction, SUD, psychosis, bipolar)

- Summarize problems and discuss treatment options with patient/ family
- Arrive at shared decision regarding goals, expectations, and treatment options
- The following factors should be taken into consideration:
 - Resource availability
 - Comfortness of the provider
 - Severity of comorbid symptoms, severity of the PTSD
 - Patient preferences and pressing concerns
 - Continuity of care (mental health, primary care, integrated care, vet centers, other)

[F]