Washington State Department of Labor & Industries Clinical Guideline for Posttraumatic Stress Disorder (PTSD)

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Psychotherapies Covered	
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II. Coverage Decisions Affecting this Guideline

Coverage Decisions Affecting this Guideline HTCC indicates the coverage is based on a decision of the WA State Health Technology Clinical Committee.[a] Please check the HTCC webpage for the most recent information. L&I indicates the coverage is based on an L&I coverage decision.[b]	
Transcranial Magnetic Stimulation (TMS) HTCC	TMS is not covered for the treatment of PTSD[c]

III. Introduction

A. Purpose of This Guideline

This guideline synthesizes the best available published medical evidence, along with a consensus of subcommittee expertise to clarify Washington State L&I's criteria for the treatment of Posttraumatic Stress Disorder (PTSD). PTSD is a treatable condition, and should be approached as such. Where appropriate, specific guidance and recommendations should be taken and applied alongside best clinical judgement and the worker's needs, as well as within the context of the workers' compensation system rules and laws. The included recommendations may be updated with additional research and clinical developments over time.

B. Background and Prevalence of PTSD

Posttraumatic stress disorder (PTSD) is a mental health condition that may arise after experiencing or witnessing a traumatic, life-threatening event. Specific diagnostic criteria for PTSD (Criteria A-F) are laid out in the Diagnostic and Statistical Manual of Mental Disorders, 5th edition (DSM-5).[1] These criteria are the basis for any accepted diagnosis of PTSD in the Washington workers' compensation system.

A majority of individuals are exposed to traumas in their lifetime, including childhood, interpersonal, occupational, military, or disaster exposures.[2] In most cases, individuals will resume their lives, will demonstrate resilience, and will not develop any mental health condition. Sometimes, individuals will continue to have persistent and impairing symptoms, a condition defined as PTSD. Numerous studies have reported a range of prevalence for PTSD. Schein et. al, in a 2021 systematic review of articles on PTSD prevalence, reported a lifetime prevalence of PTSD of 6.1%.[3] A 2016 analysis of a representative

[a] https://www.hca.wa.gov/about-hca/health-technology-assessment/health-technology-reviews
[b] https://lni.wa.gov/patient-care/treating-patients/conditions-and-treatments/
[c] https://www.lni.wa.gov/patient-care/treating-patients/conditions-and-treatments/transcranial-magnetic-stimulation-tms

sample of US citizens included in this review found that 68.8% reported exposure to at least one traumatic event. Lifetime prevalence of DSM-5 classified PTSD was estimated at about 6.1%, and past-year prevalence at 4.7%.[4]

Based on the DSM-5 criteria, a PTSD diagnosis must include *all* of the following[1]:

- Exposure, directly or indirectly[d] to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence,
- Persistent re-experiencing of the traumatic event,
- Avoidance of trauma-related stimuli,
- Negative thoughts or feelings that began or were worsened following the trauma,
- Trauma-related arousal and reactivity that began or were worsened following the trauma,
- Symptoms persisting for at least one month,
- Symptoms create distress or functional impairment, and
- Symptoms are not due to medication, substances, or other illness

While specific characteristics may not directly predict the incidence of PTSD, trauma severity, demographic, lifestyle, and workplace factors have all been shown to be associated with lifetime PTSD prevalence. This can include[5-7]:

- Type of traumatic event exposure (e.g., childhood trauma, interpersonal violence, or sexual assault),
- Lack of social support,
- Negative workplace factors (e.g., injury, accidents, workplace violence, disasters)[8, 9]
- Lower socioeconomic status,
- Female gender,
- Comorbid or prior mental health disorder(s)

Occupation has also been linked with PTSD, with certain occupations (e.g., first responders) and job duties demonstrating a higher prevalence of PTSD than the general population.[5, 8, 10] Studies have reported prevalence of PTSD ranges of 7-19% in law enforcement, 17-22% in firefighters, 13-15% in dispatchers, and up to 20% in paramedics/EMTs.[11, 12] In nurses, a systematic review reported 8.5% to 20.8% of nurses meeting criteria for PTSD, though included studies reported using various select report scales, such as Impact of Event or Posttraumatic Diagnostic Scale, potentially overestimating actual prevalence.[13]

C. Natural Course of PTSD

One of the best tools a worker can be provided is accurate information and education regarding their PTSD diagnosis—PTSD does not mean that a worker cannot love, live, and work. A PTSD diagnosis is not

[d] "Indirectly" can refer to witnessing or confronting an exposure in the workplace

a life sentence, and does not indicate someone will be permanently distressed or disabled. When utilizing effective, evidence-based care, PTSD is a treatable condition, and the expectation for workers and providers is that workers should expect to get better. Providers should be careful to avoid stigmatization of PTSD. Effective clinical care should focus on the highly treatable aspects of the condition, and should maintain positive messaging and reframing.

A variety of outcomes can ensue following trauma exposure. It is expected, and normal, for individuals to experience symptoms of posttraumatic stress such as fear, nightmares, and avoidance as well as depressive symptoms, poor sleep, guilt, and shame in the initial time after an injury or exposure to a traumatic event. The majority of individuals who experience a traumatic event do not develop PTSD and instead experience a resilience trajectory.[14] A minority of individuals exposed to trauma go on to develop diagnosable PTSD. Sequelae from exposure to trauma can be wide-ranging and include various mental health conditions or diagnoses (not only PTSD), substance misuse, and impaired physical health. Many individuals may instead experience symptom resolution (without any treatment), resilience, and posttraumatic growth.

One systematic review of 42 prospective, observational PTSD studies of the natural course of PTSD without specific treatment found that over a mean 40-month period, an average of 44% (range 8%-89% across studies) of individuals who had a PTSD diagnosis at baseline did not retain the diagnosis at follow-up.[15] Additionally, the remission rate was found to be higher when PTSD was assessed within the first 5 months following trauma, indicating the utility of early identification.

Another meta-analysis of PTSD prevalence over time among individuals with a single index trauma found that PTSD prevalence following trauma exposure decreased from 27% at 1 month to 17.6% at 3 months, and 16.9% at 12 months.[16] Longer term results have also been reported, with the World Health Organization (WHO) World Mental Health survey reporting recovery from PTSD as 20% at 3 months, 27% at 6 months, 50% at 24 months, and 77% at 10 years.[17]

D. PTSD in the Workers' Compensation System

1. General Information

Occupational trauma, whether acute (e.g., a single event) or chronic (e.g., repetitive or cumulative), can increase the risk for development of PTSD.[5, 8, 9, 18] Research has found the re-experiencing symptoms of PTSD are associated with impairments in occupational functioning and physical health functioning.[19, 20] PTSD has also been shown to lead to increased time-loss from work following injury or surgery, and failure to return to work.[21-24]

2. Comorbid Conditions

Studies have reported various comorbid diagnoses with PTSD. Hefner et al. 2019 found that among veterans (N=638,451) diagnosed with PTSD, 29.8% had only a PTSD diagnosis, 36.7% had one comorbid psychiatric diagnosis, 21.3% had two, and 12.2% had three or more.[25] In a work-related population, Hensel et al. found that among a sample of workers injured on the job (N=531), 44% had a primary

diagnosis of PTSD on the Structured Clinical Interview for DSM-IV (SCID-IV), but 58% of the study population had one or more secondary diagnosis, such as depression.[26]

3. Treatment of PTSD

Much like other work-related conditions, the focus in treating PTSD must be on functional restoration and return to work (RTW). First-line treatment options have demonstrated long-term results, including sustained remission of PTSD diagnoses.[27-29] Although some individuals may experience residual symptoms, even long-term, this does not mean they are not ready to be discharged from trauma-focused psychotherapy, nor does it mean they should not return to work.[30, 31] Typically, individuals will be ready to gradually return to work after a few sessions of treatment. Often, subclinical and/or manageable PTSD symptoms may still be present even when successful treatment has been administered or PTSD diagnostic criteria are no longer met.

4. Presumptive Coverage

In the Washington workers' compensation system, certain job classes (firefighters, law enforcement officers, public safety telecommunicators, emergency medical technicians, and direct care registered nurses) have an established presumption of PTSD as on occupational disease (different from an industrial injury) after serving a certain period of time within an applicable occupation (RCW 51.08.142). This statute does not alter the diagnostic criteria used for PTSD. Presumption does not indicate a PTSD diagnosis will be made, only that if a diagnosis is made, there is a presumption that the diagnosis is related to the occupation, and thus work-related.

For the PTSD presumption to apply:

- First-responders (firefighters, law enforcement officers, public safety telecommunicators, emergency medical technicians) must have had a pre-employment mental health examination administered by a psychiatrist or a psychologist that ruled out the presence of PTSD from pre-employment exposures. Alternately, they did not receive an examination because none was required or was not administered.
- PTSD must have manifested after the individual has served at least 10 years as a first-responder, or 90 days as a Direct Care Registered Nurse.
- The PTSD diagnosis must meet the diagnostic criteria specified by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders, fifth addition (DSM-5), or in a later edition as adopted by the department (RCW 51.08.165).

PTSD is not considered an occupational disease if the diagnosis is directly attributed to disciplinary action, work evaluation, job transfer, layoff, demotion, termination or similar action taken in good faith by an employer (RCW 51.08.142, WAC 296-14-300).

Single, traumatic events that lead to a PTSD diagnosis would not be included under the presumption, and would follow L&I's normal mental health pathways and coverage.

IV. Diagnosis, Assessment, and Evaluation of PTSD

In this section, information is provided on the necessary components of a PTSD assessment in Washington workers' compensation. The exact sequence of screening, diagnostic evaluation, establishment of causation, and history taking may differ depending on the individual worker's needs and clinical presentation. Significant care and attention should be taken to conduct a thorough and detailed trauma-informed assessment of the worker without inadvertently or incorrectly rendering a PTSD diagnosis.

A PTSD diagnosis requires that all necessary DSM-5 criteria for PTSD are met.[1] The assessments and scales listed within this section are all based on and validated using DSM-5 criteria.

For more information on diagnosis of mental health conditions in the Washington workers' compensation system, including who can diagnose, please refer to lni.wa.gov/mentalhealth.

A. History and Clinical Exam

A thorough and detailed clinical exam is integral to the proper diagnosis of PTSD, as it allows for confirmation of the presence of PTSD or differential diagnosis of other mental health conditions that may be present. An appropriate clinical exam should include ***all of the following***:

a. Relevant background information (e.g., past mental health history, past medical history)
b. Current mental health symptoms
c. Current cognitive symptoms
d. Current substance use/misuse
e. Current job duties and functioning day-to-day
f. Current suicidal ideation, intent, plan, means. Historical suicidal attempt(s) or self-harm.
    a. If suicidal ideation is present, there must be a description of prevention and/or intervention measures taken.
g. Previous coping skills, current coping skills
h. Previous impairments in function (physical, cognitive, emotional)
i. Legal history
j. History of abuse (physical, sexual, emotional)
k. Work & educational history, education attainment
l. Hobbies/leisure activities
m. Social support system, perception of social support

Other mental health conditions may be present other than PTSD, and it is important to screen for and diagnose them appropriately to avoid an inadvertent or incorrect diagnosis of PTSD. For more information on diagnosis of mental health conditions in the Washington workers' compensation system, including who can diagnose, please refer to lni.wa.gov/mentalhealth.

Additionally, if no mental health conditions are present but a physical condition diagnosis is present on the claim, a worker may benefit from Health Behavior Assessment and Intervention (HBAI). Please refer to L&I payment policy for further information.[e]

B. Establishing the Diagnosis

1. Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)

To properly establish a diagnosis of PTSD, the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) is considered the gold standard assessment tool.[32] Developed by the Department of Veterans Affairs (VA), the CAPS-5 is a freely available, highly validated, structured diagnostic interview consisting of 30 items that can be utilized to make a current (past month) diagnosis of PTSD, and a lifetime diagnosis of PTSD. It is also used to assess PTSD symptoms over the previous week.

In administering the CAPS-5, a symptom severity rating is produced for each of the 30 items based on the frequency and intensity of PTSD symptoms. These severity ratings are utilized to identify both the presence and the attribution of symptoms, and determine a PTSD diagnostic status based on the presence of symptoms corresponding to the DSM-5 PTSD diagnostic requirements.

L&I requires a diagnosis of PTSD to be confirmed via CAPS-5. For the most consistent and accurate results, the CAPS-5 should be administered by a clinician trained on the tool, with experience in PTSD assessment and diagnosis. To assist in training clinicians, the VA provides free, online courses in CAPS-5 administration and assessment.[f]

C. Screening and Tracking

Screening tools can be utilized to establish a possible presence of PTSD, but do not replace the need for further assessment in making an appropriate diagnosis. Acceptable screening tools for PTSD include the PTSD Checklist for DSM-5 (PCL-5) and the Primary Care PTSD Screen for DSM-5 (PC-PTSD-5). In addition to screening, The PCL-5 can also be used for monitoring treatment response.

For tracking and measuring improvement over the course of treatment, L&I requires the PCL-5 and the Brief Inventory of Psychosocial Functioning (B-IPF) to be administered at every psychotherapy session, though every other week administration may also be considered based on structure of the treatment protocol. Note that the PCL-5 should not be administered at every session if the worker is participating in psychotherapy twice weekly.

At the end of a manualized protocol (e.g., 90 days), a worker's PCL score should demonstrate improvement. A 5-10 point change represents reliable change (i.e., change not due to chance) and a 10-

[e] https://lni.wa.gov/patient-care/billing-payments/marfsdocs/2024/2024MarfsChapter22.pdf
[f] https://www.ptsd.va.gov/professional/continuing_ed/caps5_clinician_training.asp

20 point change represents clinically significant change. If this degree of change has not occurred, additional treatment might not be authorized.

Additional generic scales required by L&I must also be utilized at baseline and at least every 30 days. Please see "Additional Labor & Industries Required Scales" below for further details and applicable measures.

1. PTSD Checklist for DSM-5 (PCL-5)

The PTSD Checklist for DSM-5 (PCL-5) is a self-report scale that assesses DSM-5 symptoms of PTSD.[33, 34] Comprised of 20 items, the PCL-5 is utilized in the provisional diagnosis of PTSD, screening for PTSD, and monitoring symptom change during the course of PTSD treatment. The PCL-5 has been highly validated, and studied across numerous populations including veterans, active duty military, university students, treatment-seeking individuals, and community participants.[35]

Each item of the PCL-5 is scored from 0 to 4, with a total score ranging from 0-80. A higher score is indicative of increased symptom severity, and a general cutoff score of 31-33 has been found to indicate possible PTSD presence.[35-37] ***Presence of possible PTSD on the PCL-5 does not establish a diagnosis of PTSD, but would indicate need for a more detailed assessment using the CAPS-5.***

For monitoring symptom change, a 5-10 point change is considered to represent reliable change (i.e., change not due to chance) and a 10-20 point change represents clinically significant change.[35, 38] Currently, these change scores are based on DSM-IV testing, and newly published studies may necessitate further updates to scoring and monitoring of change.

The PCL-5 is freely available online through the VA's National Center for PTSD.[g]

2. Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5) can be utilized to identify possible PTSD in primary care settings, or in settings where a brief screen is required.[39] It consists of 5 yes/no questions about how a previous trauma exposure has affected the individual over the last month. The PC-PTSD-5 is not recommended for routine use or tracking, and should only be utilized to identify the possible presence of PTSD.

When utilizing the PC-PTSD-5, a score of 4 has been associated with positive screening for PTSD confirmed by the CAPS-5.[39-41] ***Presence of possible PTSD on the PC-PTSD-5 does not establish a diagnosis of PTSD, but would indicate need for a more detailed assessment using the CAPS-5.***

The PC-PTSD-5 is freely available online through the VA's National Center for PTSD.[h]

[g] https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
[h] https://www.ptsd.va.gov/professional/assessment/screens/pc-ptsd.asp

3. Screening and Assessment Tools for Other Conditions

It is critical to identify and monitor other comorbid conditions that may be present. Studies have consistently reported a variety of comorbid diagnoses, including depression.

Condition specific scales (e.g., PHQ-9, GAD-7) may be appropriate based on the details of the clinical interview, and should be noted in the worker's documentation to allow for appropriate treatment and communication.

For information on general mental health treatment and authorization in Washington workers' compensation, please refer to lni.wa.gov/mentalhealth.

D. Care Pathway for Screening and Diagnosis of PTSD in Workers' Compensation

To properly establish and monitor a diagnosis of PTSD in the workers' compensation system, the following must be undertaken:

1. Utilize the PCL-5 or PC-PTSD-5 to determine possible PTSD presence, and to establish a baseline score/measure for ongoing care:
    a. For PCL-5, a score of 31-33 or higher has been identified as an optimal cutoff score to indicate possible PTSD Presence
    b. For PC-PTSD-5, a score 4 has been identified as an optimal cutoff score to indicate possible PTSD Presence

If item 1 is positive OR significant concern exists regarding symptom presentation/reporting and the numerical score is insufficient:

2. Utilize CAPS-5 (or subsequent official versions as approved by the Department) to confirm a diagnosis of PTSD

AND

3. Conduct a thorough, detailed trauma-informed clinical interview (see "History and Clinical Exam" above for necessary details)

AND

4. Establish work-relatedness/causation

E. Measuring Symptom and Functional Improvement

Symptom and functional improvement over the course of PTSD treatment must be measured utilizing the PCL-5, and the Brief Inventory of Psychosocial Functioning (B-IPF). The PCL-5 and B-IPF can be administered weekly, every other week, or monthly based on the structure of the treatment protocol (e.g., the PCL-5 should not be administered at every session if the worker is participating in psychotherapy twice weekly). Quality clinical care requires administration of the PCL-5 and B-IPF every 2-3 sessions minimum, with no longer than one month between administration.

When administering symptom and functional measures, collaborative review (e.g., discussion with the patient) of any scores, changes, or thresholds can be highly beneficial. Involving the patient in the discussion of improvement, and explanation of changes and benefits, can positively impact the patient relationship with their recovery process.

For the PCL-5, a 5-10 point change is considered to represent reliable change (i.e., change not due to chance) and a 10-20 point change represents clinically significant change in PTSD symptoms.[35, 38]

The Brief IPF is a condensed version of the IPF, an 80-item self-report measure of PTSD-related functional impairment over the previous 30 days.[42] The Brief IPF contains 7 items related to psychosocial functional impairment caused by PTSD, and is designed for situations where the full IPF would be burdensome or time consuming to administer. The respondent is asked to answer questions related to functional domains that were applicable in the previous 30 days, with each domain score contributing to an overall score ranging from 0-100, and a higher number indicating higher impairment.[42]

Additional general functional difficulties attributable to PTSD are also important to monitor over the course of treatment. In studies comparing healthy participants to those with PTSD, those diagnosed with PTSD experience significant impairments in many functional domains.[43]

F. Additional Labor & Industries Required Scales

L**&I requires administration of at least one of the following scales at baseline and at least every 30 days**:

- World Health Organization Disability Assessment Schedule 2.0 (WHODAS 2.0),
- Patient Reported Outcomes Measurement Information System (PROMIS),
- Short-form 36 or Short-form 12 (SF-36 or SF-12)

The WHODAS is a generic assessment instrument, developed by the World Health Organization, to measure health and disability across cultures.[44] It has been validated and utilized in the assessment of health and disability levels, and in measuring clinical effectiveness of interventions across domains including health conditions. In addition to being required by L&I, the WHODAS has been demonstrated to successfully assess functional impairment and disability in veterans with PTSD.[45, 46]

The PROMIS is an instrument that has been widely validated in numerous populations and in different health measures.[47] It contains standardized item banks to measure outcomes across physical, mental, and social domains and can score responses based on overall population level results.[47]

The SF-36 and SF-12 are health surveys for the measurement of general functional health and well-being from the worker's perspective, using 8 domains of health: physical functioning, role limitations due to physical health, role limitations due to emotional problems, energy/fatigue, general mental health, social functioning, pain, and general health.[48, 49]

V. Psychotherapy and Non-pharmacological Care

A. Treatment Selection

L&I covers several evidence-based, first-line trauma focused therapies for the treatment of PTSD. In selecting an appropriate first-line treatment, it is important to respect patient preference, after ensuring that patients understand the options and can make an informed decision. Choice in evidence-based first-line treatment should be based on patient preference, clinical judgement, and the response of treatments to date. Treatment type is not based on the type of trauma exposure, because all the first-line treatments recommended in this and other guidelines are appropriate and effective for all types of trauma exposure.[50-55] For providers less familiar with available treatment options, or for those who want to provide workers with additional information about effective treatments they can view on their own, the Veterans Administration (VA) provides a treatment decision aid based on the 2023 VA/DoD PTSD guideline.[i]

Treatment duration should be based on the first-line treatment chosen, and according to the manual for that treatment, but typically should not exceed six months.

Providers can potentially increase patient engagement or buy-in for these therapies by how they present them. Providers can use strategies such as sharing prior success stories, relating the treatment to the patient's experiences, and detailed and practical description of the processes in treatment.[56] Offering preferred treatment has been shown to improve dropout rates in psychotherapy.[57, 58] If, for any reason, the provider is unable to provide first-line manualized treatment with fidelity, or the worker indicates a preference for an approach in which the provider is not an expert, providers are encouraged to offer transition in care. L&I staff and claim managers will support transitions in care and help to facilitate referral to another provider in alignment with WAC 296-20-065.[j]

A primary goal in working with clients who have experienced a work-related injury or condition is to improve function and assist workers with returning to work. It is expected that providers will engage in consistent assessment of functioning, including return to work. The treatment approach must focus on both of these. This can be incorporated via exposure and/or exploration of cognitions and behaviors relating to work.

B. Trauma-focused Therapies

Trauma-focused therapies provide the best opportunity for rehabilitation and return to work, in addition to superior outcomes relative to non-trauma therapies. Trauma-focused Cognitive Behavioral Therapies result in increased return to work over time compared to standard PTSD treatment (e.g., non-trauma

[i] https://www.ptsd.va.gov/apps/Decisionaid/index.aspx
[j] https://app.leg.wa.gov/wac/default.aspx?cite=296-20-065

focused therapies).[59] Patient characteristics (e.g., single incident or cumulative trauma exposure, job of injury) do not preclude them from any type of treatment listed. On this basis, L&I recommends the following individual manualized[k] treatments:

- Cognitive Processing Therapy (CPT),
- Prolonged Exposure (PE),
- Cognitive Therapy (CT or CT-PTSD),
- Eye-movement Desensitization and Reprocessing (EMDR),
- Written Exposure Therapy (WET)

Currently, there is not an existing evidence base for different modalities of treatment performing better for specific types of trauma.[60] Efficacy and effectiveness appear to be similar among the recommended first-line treatments.[60-62] L&I will continue to monitor and update the list of recommended and approved treatments as new, high-quality evidence and recommendations arise.

Proper engagement of the patient in selection of treatment can help to decrease the dropout rates.[57, 58] Trauma-focused therapies tend to have elevated dropout rates, and while this is something to attend to and be aware of, rates are not higher than dropout in CBT for other disorders (e.g., anxiety, depression).[63] One recent meta-analysis of guideline-recommended psychotherapy reported a mean 20.9% dropout from recommended treatments across studies, compared to 7.8% dropout in control arms.[64]

Studies have demonstrated that non-completion or dropout from treatment does not indicate a lack of success or improvement. Szafranski et al. found that 37.74% of women who dropped out (did not fully complete 100% of treatment sessions) of two randomized controlled trials for PTSD treatment still demonstrated significant improvement in PTSD symptoms.[65] Galovski et al., in a randomized, controlled study of modified CPT, found that 58% of the study population no longer met pre-established PTSD criteria before completing 12 sessions.[66]

1. Cognitive Processing Therapy (CPT)

Cognitive Processing Therapy (CPT) is a highly studied, gold-standard approach for the treatment of PTSD, with all major PTSD guidelines recommending utilization of CPT as a first-line treatment.[67] Generally delivered over 12 sessions, CPT focuses on addressing thoughts, behaviors, and emotions that interfere with trauma recovery.[68] In CPT, the patient begins treatment with an impact statement describing beliefs and consequences of the trauma linked to their PTSD symptoms. Over the course of treatment, CPT focuses on changing and modifying the thoughts and experiences related to trauma exposures, developing better ways to reframe beliefs and meaning which leads to a decrease in unhelpful or maladaptive emotional and behavioral responses.

[k] Manualized refers to specific/established guidelines for conducting the individual psychotherapy approaches

As of 2024, at least 44 Randomized Controlled Trials (RCTs) have examined the effectiveness of CPT, demonstrating significant results for the treatment of PTSD across populations including community samples, veterans, and active duty service members.[68] Additionally, CPT has been shown to be effective in treating PTSD in the presence of comorbid disorders including depression, suicidal ideation, and substance use disorder.[68] While CPT previously contained a written account, evidence has demonstrated that this version does not improve treatment outcomes, and CPT without written accounts is now considered the standard.

Completion of the initial 12 sessions of CPT has been shown to produce significant positive outcomes in patients.[66, 69] Modified CPT protocols have also shown success, with shorter (as low as 4) and longer (up to 18) sessions demonstrating reduction in PTSD symptoms.[66, 70] One study of VA electronic medical records found that patients completing at least 8 sessions of CPT had 6.4 points greater improvement on PCL and 8.7 times greater odds of recovery than those completing non-evidence based psychotherapy.[71]

2. Prolonged Exposure Therapy (PE)

Prolonged Exposure therapy (PE) is another first-line treatment for PTSD, with early versions of the therapy dating back to the 1980s.[72, 73] The general protocol for PE consists of 8 to 15 individual 90 minute sessions (10 sessions being common), with overall session number/duration depending on the progress of the patient.[74, 75] PE is composed of three main components: psychoeducation, in vivo (directly facing/in real life) exposure, and imaginal exposure with processing. This reliving of the trauma experienced, followed by discussion of the patient's experience over sessions, has the goal of reducing the impact of the experienced trauma and distress through exposure and repetition.

PE has demonstrated effectiveness for treating PTSD across numerous studies and populations, as well as in non-standard formats.[74] It has also demonstrated a dose-response relationship between number of sessions completed and the likelihood of achieving clinically significant improvement.[76] One study of VA electronic medical records found that patients completing at least 8 sessions of PE had 9.7 points greater improvement on PCL and 1.9 times greater odds of recovery than those completing non-evidence based psychotherapy.[71]

When delivering PE, the imaginal exposure component, which starts at session 3, has been shown to be a point of highest risk for dropout.[76] Extra care may be warranted when beginning this portion of treatment.

3. Cognitive Therapy (CT)

Cognitive Therapy (CT), also referred to as Cognitive Therapy for PTSD (CT-PTSD), is another trauma-focused Cognitive Behavioral Therapy based on the idea that PTSD symptoms are maintained when an individual's trauma processing leads to an ongoing sense of a serious, current threat derived from negative appraisal of their trauma and involuntary re-experiencing aspects or memories of their trauma. The goal of treatment is to identify and modify relevant behaviors and cognitive strategies that are

maintaining the individual's PTSD through techniques such as questioning, probing, exposure (real or imaginal), or writing.

CT has demonstrated effectiveness in several RCTs, and is recommended in multiple guidelines for the treatment of PTSD.[50, 51, 60, 77-79]

4. Eye-movement Desensitization and Reprocessing (EMDR)

Eye-movement Desensitization and Reprocessing (EMDR) is an evidence based protocol for treating PTSD. EMDR sessions are generally 60-90 minutes, and encompass eight steps/phases utilizing dual attention tasks (e.g., visualization of trauma alongside rapid eye movement) to identify negative beliefs and memories and enhance alternate, desired beliefs.[80, 81] Numerous RCTs have demonstrated the efficacy of EMDR, with systematic reviews and meta-analyses further supporting these findings.[60, 80, 82, 83]

5. Written Exposure Therapy (WET)

Written Exposure Therapy (WET) is a brief form of PTSD therapy involving expressive writing about the traumatic event and emotions felt at the time of the traumatic event. The protocol consists of five sessions, and in each session the patient writes about their traumatic experience followed by a check-in with the therapist regarding their feelings and emotions about what they have written.[84] WET requires no between session homework and is more brief in duration, which may provide a beneficial option for a patient who may be likely to dropout or not participate in their treatment outside of the in-person sessions.

WET is a newer treatment than CPT and PE but has a growing evidence-base. A recent systematic review highlighted the effectiveness of WET in reducing PTSD symptoms across 17 studies (7 of which were randomized controlled trials).[85] It has also been related to reductions in comorbid mental health conditions such as depression and anxiety.[84]

C. Non-Trauma Focused Therapies

Providers are encouraged to first engage workers in one of the aforementioned trauma-focused approaches, as they have the strongest evidence for improving PTSD outcomes. When trauma focused therapy is not possible (e.g., treatment non-response to trauma-focused therapies, patient preference) or effective, Present Centered Therapy (PCT) may be recommended. PCT is a non-trauma focused, manualized psychotherapy that has been utilized as a comparator for trauma-focused therapies in studies. Consisting of nonspecific elements of individual psychotherapy and without a focus on traumatic events, PCT has shown some success in reducing PTSD symptom severity, but is less effective than trauma-focused therapies in its effects.[76, 86] PCT has demonstrated lower dropout compared to trauma-focused therapies.[76]

D. Other Therapies

Therapies or treatment options not listed are not recommended or covered, as they lack sufficient evidence of efficacy and/or effectiveness in the treatment of PTSD.[50, 60, 67, 77, 87, 88]

E. Treatment Fidelity

Fidelity of manualized treatments, or adherence to the established protocols, is incredibly important in the treatment of PTSD. Higher treatment fidelity has been associated with greater reductions in PTSD symptoms.[89, 90]

Modifications happen, and may be necessary in certain circumstances, but should be consistent with the treatment's approach, with several recent studies demonstrating higher adherence to manualized protocols leading to better results. Marques et al. 2019 found that fidelity-consistent modifications to CPT, and higher competence of the provider, were associated with greater reductions in PTSD symptoms.[91] Farmer et al. found that higher therapist competence in delivery of certain CPT components were related to increased improvement in PTSD severity.[92]

F. Telehealth/Telemedicine

Telehealth or telemedicine involve the provision or utilization of healthcare services virtually and synchronously. Significant evidence has demonstrated the efficacy and safety of telehealth delivery of evidence-based psychotherapies (e.g., PE, CPT) for the treatment of PTSD.[93, 94] Telehealth use can increase access to appropriate providers and treatments for PTSD, and is a covered benefit.

G. General Guidance on Treatment Duration and Intensity

In general, most manualized treatment approaches for recommended psychotherapies include approximately 12 sessions, consisting of at least one session per week (roughly equating to about a 90 day time period). During the course of treatment, the PCL-5 and B-IPF should be administered at every session, though every other week administration may also be considered based on structure of the treatment protocol (e.g., the scales do not need to be administered at every session if the worker is participating twice weekly). Additionally, one of the L&I required functional scales must be administered at baseline and at least every 30 days.

At the end of the manualized protocol (e.g., 90 days), a worker's PCL score should be showing improvement—a 5-10 point change represents reliable change (i.e., change not due to chance) and a 10-20 point change represents clinically significant change.

In some cases, transition to different treatment (e.g., a new first-line treatment protocol) or a different provider (e.g., one trained in a different first-line treatment) may be necessary. There is some evidence to suggest that a different treatment approach (e.g., switching from CPT to PE) can lead to increased improvement after a first course of treatment, but the results are not always significant (the same study found switching from PE to CPT did not significantly improve PCL score changes).[95]

Some things to consider when determining approaches to treatment include:

- Evidence has demonstrated that response to treatment can occur early in the process, with symptom reduction seen within the first 6-8 sessions in some patients.
    - Sripada et al. found that symptom reduction by session 8 is associated with meaningful change (at least 50% reduction in PTSD symptoms) over the course of treatment.[96]
    - Galovski et al. 2012 found that in a sample (N=50) completing a modified CPT protocol, 58% achieved resolution of PTSD diagnosis prior to 12 sessions.[66]
    - Hoyt et al. 2018 found that PTSD symptoms tended to decrease over the course of the first 8 interventions, and leveled out at 8-14 sessions.[97]
- If the worker is not improving (as defined by decreases on PCL-5 and improvements in function) by around 6-8 sessions of a manualized, first-line treatment approach, a conversation about non-response should be undertaken and a different first-line treatment may need to be considered, as meaningful change may be less likely without an update to the treatment protocol.
- If the end of a manualized protocol is reached (e.g., around 10-12 sessions) and incremental change can be seen as demonstrated by validated functional questionnaires or improvements in behavioral indices such as return to work, engagement in social interactions, recreational activities, exercise, etc., then additional sessions may be warranted depending on the specific needs and situation of a worker.
    - Galovski et al. 2012 found that in a population (N=50) completing a modified CPT protocol, 34% experienced resolution of PTSD diagnosis after 18 sessions.[66]
- When discussing or considering transitioning to a different treatment with a patient, it is important to remind the patient that another treatment may benefit them and that a lack of improvement in one treatment does not mean they will not get better with a different treatment.
- If a worker participates in 18-20 sessions and does not respond to treatment, a change in treatment approach or provider must be made. While longer courses of treatment may be warranted for some individuals who demonstrate improvement, continuation of treatment past 20 visits may produce negative results.
    - Hoyt et al. 2018 found that after 20 sessions, PTSD symptoms in a large population of active duty service members worsened.[97]

L&I considers up to two full treatment cycles (e.g., two 90-day authorizations) as a potentially appropriate course of treatment that allows for completion of 1-2 manualized protocols and with the option for additional sessions if needed. If at the end of these treatment cycles the worker is not responding, other considerations must be made in regards to continuation of treatment, as ongoing treatment beyond manualized protocols has a limited evidence-base and is unlikely to result in improvement of symptoms or gain in functioning.

While limited or lack of improvement may be viewed as a failure of treatment for PTSD, before determining that treatment has "failed," the provider should consider:

- Was it the appropriate treatment for this worker (is there another first-line treatment that may result in better response)?

- Was there treatment fidelity (e.g., have they been provided the treatment, with adherence to the manualized protocol)?
- Was the treatment dose appropriate (e.g., appropriate number of sessions)?
- Was the worker properly engaged in treatment (e.g., in-session engagement, completing homework)?
- Was the provider appropriate for the worker (e.g., treatment expertise, general provider fit)

H. Other Treatment Approaches—Group or Massed Therapy

Other approaches to delivering trauma-focused therapy, such as massed treatment, have shown success in reduction of PTSD symptom severity similar to standard protocols, or in increasing acceptability of treatment (e.g., less dropout).[98-104] In massed treatment, individual psychotherapy sessions are delivered in a shorter timeframe than in standard treatment protocols (e.g., 10 visits over 2 weeks), and may provide benefit for those who require or desire a shorter timeframe for treatment, or to attempt a quicker return to work. Currently, evidence exists for massed treatment protocols for CPT, PE, CT-PTSD, and EMDR.[103, 104]

Group therapy, in which multiple people with the same diagnosis (PTSD) are treated in a group session typically 1-2 hours in length using the guideline recommended treatment options, has shown some efficacy in PTSD symptom reduction and in increasing treatment acceptability, though reported results are not as effective as individual psychotherapy.[105, 106] One study demonstrated that VA patients who initiated psychotherapy treatment in a group setting participated in more psychotherapy visits and were twice as likely to attend eight or more visits than those in individual therapy.[107] Group therapy is not synonymous with residential therapy.

Both group and massed therapy for PTSD are covered benefits in the workers' compensation system.

VI. Pharmacotherapy for PTSD

Psychotherapy is the first-line recommendation for treatment of PTSD, even in situations where comorbid conditions such as depression are present, as these conditions tend to respond well to psychotherapy.[108, 109] There is no demonstrated evidence that pharmacotherapy produces better outcomes for PTSD compared to psychotherapy.[110, 111] Adding medication to psychotherapy does not significantly improve outcomes for most patients, but combined treatments may be better than medication alone.[110, 112]

Pharmacotherapy should only be considered as an initial option when a worker refuses psychotherapy as a first-line treatment, cannot obtain it, or a separate compelling reason exists (e.g., a strong preference for pharmacotherapy).

Pharmacotherapy treats mainly the symptoms of PTSD, and does not provide the curative aspect of psychotherapy.[111, 113] The available medications may produce modest reductions in some symptoms, but the effects are not likely to persist without continued medication.[111] In a situation where a worker

has responded to medication prior to receiving psychotherapy, psychotherapy should be recommended as there is likely to be a more robust response.[111]

The current evidence for pharmacotherapy for PTSD includes only the following selective serotonin reuptake inhibitor (SSRI) and serotonin-norepinephrine reuptake inhibitor (SNRI) antidepressants[113-115]:

- Paroxetine
- Sertraline
- Venlafaxine

Some guidelines also recommend fluoxetine (SSRI), though current evidence suggests a lack of efficacy in the treatment of PTSD.[115]

The only other medication that has an evidence-base is prazosin for nightmares associated with PTSD.

- Prazosin has demonstrated effectiveness in treating nightmares related to PTSD, but has no demonstrated effectiveness for other PTSD symptoms. While psychotherapy is still the best option for treatment of nightmares, prazosin may be recommended if nightmares are particularly distressing, impairing, or intransigent.[2, 111] This is an off-label use.

In complex prescribing cases, such as multiple comorbidities and/or complicated drug regimens, a psychiatrist (MD/DO) or psychiatric advanced practice registered nurse (APRN, PMHNP) should be consulted. In the situation where multiple providers are involved in treatment, there should be coordination of care and monitoring of symptom and functional improvement using guideline required scales.

Currently, there is insufficient evidence to support other pharmacotherapies for PTSD. As such, L&I does not recommend pharmacotherapy for PTSD beyond those listed above. This does not preclude pharmacotherapy for the treatment of comorbid conditions.

If treating comorbid conditions, care must be taken to identify all other treatments/medications being provided. Antidepressants or psychoactive medications being used to treat other conditions should generally be maintained, but it is important to identify all other medications, and to watch for interactions.

Benzodiazepines and antipsychotics have demonstrated evidence of harm and lack of efficacy for PTSD treatment, are not covered by L&I, and are not recommended throughout other published guidelines.[50-52, 111, 115, 116]

VII. Residential or Inpatient Treatment Facilities

Currently, there is no reliable evidence to suggest that residential treatment facilities provide a significant benefit for the treatment of PTSD over standard outpatient care, or that treatment delivered in a residential setting has improved efficacy compared to an outpatient setting.[117, 118] Given this lack of

evidence, residential treatment facilities are not a covered benefit for the treatment of PTSD.[119] Residential treatment will be evaluated on a case-by-case basis and requires prior authorization for allowance.

Inpatient treatment, beyond emergent use for acute safety issues, similarly does not have a reliable evidence-base of increased benefit over standard (e.g., outpatient) treatment approaches.[120] Given this lack of evidence, inpatient treatment is not a covered benefit for the treatment of PTSD without the presence of safety issues.

VIII. Investigational Treatments

Investigational treatments, as defined in WAC 296-20-02850[l], are not recommended or covered at this time. L&I does allow for approval of payment for treatments when a worker participates in IRB-approved studies after a PTSD diagnosis has been made and the diagnosis has been accepted on the claim.

Psychedelics have also been studied as primary or adjunct pharmacotherapies for the treatment of PTSD. Preliminary results are mixed, and they are not considered evidence-based. Significant research is still needed to identify proper dosage, timing, and concurrent psychotherapy. At this time psychedelics are not recommended or covered in WA workers' compensation.[2] Other options, such as cannabis, have known evidence of harm in the treatment of PTSD and are not recommended.[2, 121] If a worker utilizes such products, it is crucial to provide education on the dangers of these substances and the potential for unidentified compounds at unknown doses in the drugs.

IX. Improvement in PTSD

A. How is PTSD-related Improvement Defined?

PTSD is a treatable condition, and the expectation for workers and providers is that with effective treatment they should expect to get better and return to work, sometimes quickly. Providers should be careful to avoid stigmatization of PTSD, and to focus on the highly treatable aspects, maintaining positive messaging and reframing.

One of the best tools a worker can be armed with is accurate information and education regarding their PTSD diagnosis, the natural history of PTSD, and in particular that PTSD does not mean that a worker cannot love, live, and work. It does not indicate someone will be permanently disabled. Improvement following treatment can take the form of reduced PTSD symptoms, improved quality of life, and/or removal of a PTSD diagnosis.[122]

B. Return to Work

Return to work (RTW) may be one of the most therapeutic options available for a worker diagnosed with PTSD.[59] RTW can be an important part of the treatment plan to facilitate healing through exposure or meaningful engagement with activities and routine. Exploring the cognitions and behaviors related to

[l] https://app.leg.wa.gov/WAC/default.aspx?cite=296-20-02850

work, as well as gradual RTW, may be considered therapeutic at the beginning of treatment in order to promote healing.

Unless PTSD symptoms would create safety issues that might place the worker or their coworkers at risk, RTW should be encouraged.

Recovery is worker-dependent, and accommodations for PTSD must be worker-centric and specific to the individual's needs, taking into consideration the job and employment environment. Individual needs should be considered on a case-by-case basis. Some workers may return to work immediately, and some may require a short time away. Potential RTW considerations assisting workers with a work-related PTSD diagnosis may include:

- Is the worker successfully self-managing their symptoms outside of work settings?
- Are symptoms present that put the worker or others at risk?
- Is the worker experiencing dissociative experiences triggered easily, without necessary self-management skills?
- Is there evidence of major depression? Suicidal ideation or action plans?
    - Please note, it may still be beneficial for someone with major depression or even suicidal thoughts to return to work, especially if the work environment provides a sense of meaning and contributing.
- Do the provider and/or vocational rehabilitation counselor endorse RTW readiness?
- Can RTW trials be implemented, depending on the workers' needs?
- Are there temporary accommodations that could ease the worker back into work so they can be successful (e.g., flexible start/end times to accommodate sleep disturbances or therapy appointments, graduated RTW, breaks to engage in symptom self-management)?
- Can a safeguard commitment from the employer be obtained?

If a worker does not, or cannot return to work in their occupation of injury, then the goal of treatment should be a return to function and another job. This could include:

- Changing employers
- Changing location within the same employer, depending on the type of trauma experienced (e.g., a nurse transferring to a different unit or shift following trauma exposure)
- Pursuing another career

L&I provides many avenues to encourage and support RTW, which can be found on the L&I webpage:

- For Workers[m]
- For Employers[n]

C. Quality of Care

Quality care for PTSD depends primarily on applying interventions that have been shown to produce measurable improvements in symptoms and functioning. While variances may occur or be warranted in certain cases, low-quality care for PTSD can be harmful, prolonging treatment and delaying return to work and recovery.

[m] https://www.lni.wa.gov/claims/for-workers/getting-back-to-work/
[n] https://www.lni.wa.gov/claims/for-employers/help-your-employee-return-to-work/

When determining if the quality of care being provided is appropriate, consider if any of the following are occurring:

- Are validated instruments for diagnosis and monitoring symptoms and function utilized on a consistent basis?
  - Are target measures identified and tracked?
- Is there a pattern of not applying first-line therapies?
- Is there prolonged treatment with no focus or documentation toward return to work?
  - Is the treatment that is being delivered considered curative and/or rehabilitative?
  - Is there a pattern of ineffective, extended treatment?
- Have co-morbidities been identified and appropriate treatments recommended/attempted?
- Are harmful medications and/or investigational treatments for PTSD being prescribed or attempted, such as but not limited to:
  - Benzodiazepines
  - Cannabis
  - Electroconvulsive Therapy (ECT)
  - Vagus nerve stimulation
  - Ketamine
  - Transcranial Magnetic Stimulation (TMS)

X. Prevention

Evidence for the efficacy and effectiveness of primary prevention of PTSD symptoms (e.g., resilience training or prevention programs) is limited and not yet compelling, as results are generally not-significant in any sustained benefit compared to no intervention.[123] In light of this lack of evidence, it is important to reinforce some of the "soft" areas of support prior to and immediately after traumatic experiences. This can include steps like:

- Proactive planning for what to do in the event of an employee's trauma exposure(s)
- Reaching out to employees who have experienced traumatic events, showing kindness and support
- Creating positive connections between workers and the workplace
- Supporting positive social interactions and social support within the workplace
- Fostering an environment of safety in which employees are encouraged to openly discuss issues
- Normalizing difficulties in the immediate aftermath of trauma exposure and offering reassurance that symptoms are expected to naturally decrease, and that if they don't, there are resources available.

Some evidence exists for trauma-focused psychotherapy in the secondary prevention of PTSD (after exposure to trauma, but prior to a diagnosis).[124, 125] Care should be taken in the approach to secondary prevention, because some apparently plausible approaches, such as psychological debriefing, may be harmful.[126]

The only true way to prevent PTSD is to prevent exposure to traumatic events. Reactions to stress and trauma are normal, and improvement and recovery of symptoms can happen naturally. While prevention may not be a realistic option in many cases, providing proper support through evidence-based treatments, proactive planning, and positive social support are the best options to help a worker with PTSD heal and return to work.

XI. Acknowledgements

Acknowledgement and gratitude go to all committee members, clinical experts, consultants, and L&I staff who contributed to this important guideline:

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XIII. Appendix

DSM-5 Checklist

☐ **Criterion A**: The person was exposed to: death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence, in one or more of the following way(s):

- ☐ Direct exposure
- ☐ Witnessing the trauma
- ☐ Learning that a relative or close friend was exposed to a trauma
- ☐ Indirect exposure to aversive details of the trauma, usually in the course of professional duties (e.g., first responders, medics)

Please supply specific examples from IW complaints or provider observation that meets each criteria, and comment on causal relationship

☐ **Criterion B**: The traumatic event is intrusive/persistently re-experienced in one or more of the following way(s):

- ☐ Unwanted upsetting memories
- ☐ Nightmares
- ☐ Flashbacks
- ☐ Emotional distress after exposure to traumatic reminders
- ☐ Physical reactivity after exposure to traumatic reminders

Please supply specific examples from IW complaints or provider observation that meets each criteria, and comment on causal relationship

☐ **Criterion C**: Avoidance of trauma-related stimuli after the trauma, in one or more of the following way(s):

- ☐ Trauma-related thoughts or feelings
- ☐ Trauma-related external reminders

Please supply specific examples from IW complaints or provider observation that meets each criteria, and comment on causal relationship

☐ **Criterion D**: Negative thoughts or feelings that began or worsened after the trauma, in two or more of the following way(s):

- ☐ Inability to recall key features of the trauma
- ☐ Overly negative thoughts and assumptions about oneself or the world
- ☐ Exaggerated blame of self or others for causing the trauma
- ☐ Negative affect
- ☐ Decreased interest in activities
- ☐ Feeling isolated
- ☐ Difficulty experiencing positive affect

Please supply specific examples from IW complaints or provider observation that meets each criteria, and comment on causal relationship

☐ **Criterion E**: Trauma-related arousal and reactivity that began or worsened after the trauma, in two or more of the following way(s):

- ☐ Irritability or aggression
- ☐ Risky or destructive behavior
- ☐ Hypervigilance
- ☐ Heightened startle reaction
- ☐ Difficulty concentrating
- ☐ Difficulty sleeping

Please supply specific examples from IW complaints or provider observation that meets each criteria, and comment on causal relationship

☐ **Criterion F**: duration of symptoms of more than 1 month.

Please supply specific examples from IW complaints or provider observation that meets each criteria, and comment on causal relationship

☐ **Criterion G**: Symptoms create distress or functional impairment (e.g., social, occupational).

Please supply specific examples from IW complaints or provider observation that meets each criteria, and comment on causal relationship

☐ **Criterion H**: Symptoms are not due to medication, substance use, or other illness.

Please supply specific examples from IW complaints or provider observation that meets each criteria, and comment on causal relationship