TREATING PATIENTS WITH
ACUTE STRESS DISORDER AND POSTTRAUMATIC STRESS DISORDER
A Quick Reference Guide

Based on *Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder*, originally published in November 2004. A guideline watch, summarizing significant developments in the scientific literature since publication of this guideline, may be available in the Psychiatric Practice section of the APA web site at www.psych.org.

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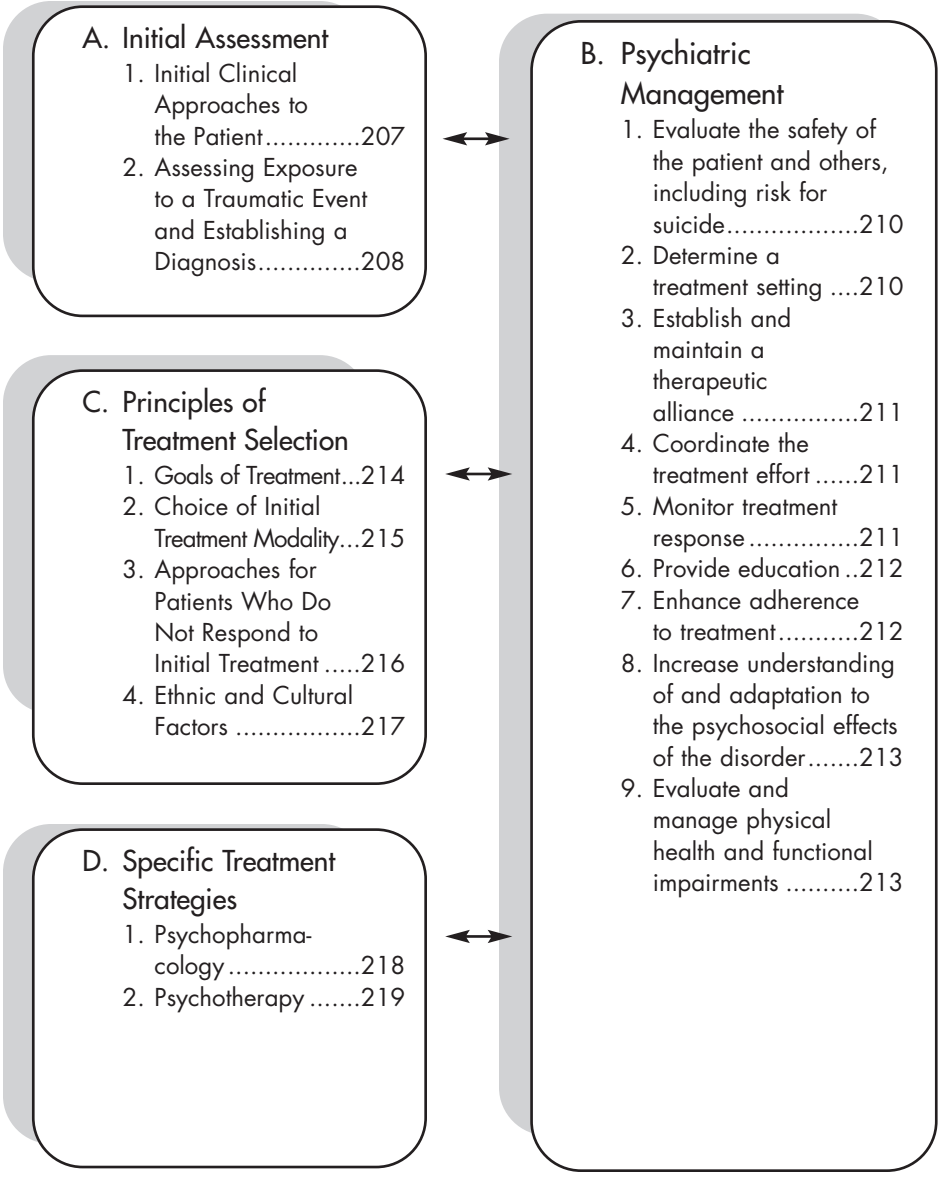
Statement of Intent

The Practice Guidelines and the Quick Reference Guides are not intended to be construed or to serve as a standard of medical care. Standards of medical care are determined on the basis of all clinical data available for an individual patient and are subject to change as scientific knowledge and technology advance and practice patterns evolve. These parameters of practice should be considered guidelines only. Adherence to them will not ensure a successful outcome for every individual, nor should they be interpreted as including all proper methods of care or excluding other acceptable methods of care aimed at the same results. The ultimate judgment regarding a particular clinical procedure or treatment plan must be made by the psychiatrist in light of the clinical data presented by the patient and the diagnostic and treatment options available.

The development of the APA Practice Guidelines and Quick Reference Guides has not been financially supported by any commercial organization. For more detail, see APA's "Practice Guideline Development Process," available as an appendix to the compendium of APA practice guidelines, published by APPI, and online at http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm.

OUTLINE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A. Initial Assessment

1. Initial Clinical Approaches to the Patient

Consider type of event and available resources.

- The timing and nature of initial assessments depends on the type of traumatic event (e.g., sexual assault vs. natural disaster) and the scope of any destruction caused by the event.
- In large-scale catastrophes, the initial assessment may be the triage of individuals at greatest risk for psychiatric sequelae, including acute stress disorder (ASD) or posttraumatic stress disorder (PTSD).
- If local resources are overwhelmed by a catastrophe, psychiatric assessment will need to be prioritized so that the most severely affected individuals are seen first.

Address the individual's requirements for medical care, rest, nutrition, and control of injury-related pain and establish a safe environment.

Be aware that in triage or emergency department settings, in-depth exploration of the traumatic event and the patient's experiences may increase distress but may be required for medical or safety reasons.

Respond to individual needs and capabilities (e.g., premature exploration of recent life-threatening events may lead some persons to avoid medical care, whereas others find in-depth exploration helpful).

2. Assessing Exposure to a Traumatic Event and Establishing a Diagnosis

- Screen for recent or remote exposure to a traumatic event (necessary for a diagnosis of ASD or PTSD).
- Consider the individual's response to the event as well as the nature of the event itself.
- Consider limitations in making a diagnosis.
  - Dissociative symptoms may prevent patients from recalling feelings of fear, helplessness, or horror.
  - Initial assessment may occur in a triage setting immediately after the trauma and before all symptoms are manifest.
- After determining that the traumatically exposed individual can tolerate more extensive evaluation, obtain a detailed history of the exposure and the patient's early responses.
- Collect a history of all salient traumas (including the patient's age at the time of the trauma and the duration of the trauma) and factors or interventions that may have intensified or mitigated the traumatic response.
- Consider validating the clinical interview with a self-rated measure (e.g., the PTSD Checklist).

Conduct a complete psychiatric evaluation.

- Assess for symptoms of ASD and PTSD, including dissociative, reexperiencing, avoidance/numbing, and hyperarousal symptom clusters and their time of onset relative to the trauma. PTSD is diagnosed if symptoms persist for at least 30 days after the traumatic event; if the symptoms have been present for less than 30 days, and if dissociative symptoms are present, ASD may be diagnosed.
- Evaluate safety, including risk for suicide and potential to harm others.
- Determine level of functioning (social, occupational, interpersonal, self-care).
- Determine availability of basic care resources (e.g., safe housing, social support network, companion care, food, clothing).
- Diagnose comorbid physical or psychiatric disorders, including depression, substance use disorders, and sexually transmitted diseases.
- Assess personal characteristics such as coping skills, resilience, and interpersonal relatedness/attachment.
- Assess behavioral risks such as treatment nonadherence and impulsivity.
- Assess military experiences.
- For individuals with legal system involvement, assess meaning of symptoms and ascertain if compensation is based on disability determination or degree of distress.
- Assess stressors such as poverty, loss, and bereavement.
- Assess psychosocial situation, including employment status, exposure to ongoing violence, and parenting or caregiver responsibilities.

Refer also to APA's *Practice Guideline for Psychiatric Evaluation of Adults.*

Establish a differential diagnosis and determine whether symptoms are the result of physical or psychological effects of the traumatic event (e.g., anxiety resulting from hemodynamic compromise, hyperventilation, somatic expressions of psychological distress).

B. Psychiatric Management

1. Evaluate the safety of the patient and others, including risk for suicide.

2. Determine a treatment setting.

Deliver treatment in a setting that is least restrictive, yet most likely to prove safe and effective. Consider

- symptom severity;
- comorbid physical or psychiatric diagnoses;
- suicidal and homicidal ideation, plans, or intention;
- level of functioning and available support system;
- the patient's personal safety;
- ability to adequately care for self;
- ability to provide reliable feedback to the psychiatrist; and
- willingness to participate in treatment and ability to trust clinicians and the treatment process.

Outpatient treatment is appropriate for the majority of individuals, but consider inpatient treatment for patients who

- have comorbid psychiatric and other medical diagnoses;
- have suicidal or homicidal ideation, plans, or intention; or
- are severely ill and lack adequate social support outside of a hospital setting.

3. Establish and maintain a therapeutic alliance.

- Conduct evaluation and treatment with sensitivity in a safe environment that facilitates the development of trust.
- Acknowledge the patient's worst fears about reexposure to intolerable traumatic memories.
- Recognize that treatment itself may be perceived as threatening or overly intrusive.
- Address the patient's concerns and treatment preferences.

4. Coordinate the treatment effort.

One team member (sometimes the psychiatrist) must assume primary overall responsibility for the patient's treatment.

Establish clear role definitions, plans for the management of crises, and regular communication among clinicians involved in the treatment.

5. Monitor treatment response.

- Monitor for the emergence of changes in destructive impulses toward self or others.
- If risk of harmful behaviors increases, consider hospitalization or more intensive treatment.
- Reevaluate diagnostically if new symptoms emerge, there is significant deterioration in functional status, or significant periods elapse without response to treatment.

6. Provide education.

- Provide education about the natural course of and interventions for ASD and PTSD as well as the broad range of normal stress-related reactions.
- Clarify that symptoms may be exacerbated by reexposure to traumatic stimuli, perceptions of being in unsafe situations, or remaining in abusive relationships.
- Consider providing ongoing educational efforts for individuals or groups whose occupation entails likely exposure to traumatic events (e.g., military personnel, police, firefighters, emergency medical personnel, journalists).
- Refer to APA's Disaster Psychiatry web site (http://www.psych.org/disasterpsych/) for additional information and educational materials.

7. Enhance adherence to treatment.

Improve medication adherence by emphasizing to the patient

- when and how often to take the medicine;
- the expected time interval before beneficial effects of treatment may be noticed;
- the necessity to take medication even after feeling better;
- the need to consult with the physician before tapering or discontinuing medication, to avoid the possibility of symptom rebound or relapse; and
- steps to take if problems or questions arise.

8. Increase understanding of and adaptation to the psychosocial effects of the disorder.

- Assist the patient in addressing issues that may arise in various life domains, including family and social relationships, living conditions, general health, and academic and occupational performance.

9. Evaluate and manage physical health and functional impairments.

- Monitor presence, type(s), and severity of medical symptoms continuously.
- Assess level of functioning on an ongoing basis.

C. Principles of Treatment Selection

1. Goals of Treatment

Reduce the severity of ASD or PTSD symptoms.
- Assist the patient to better tolerate and manage the immediate distress of the memories of the traumatic experience(s) and to decrease distress over time.
- Help reduce intrusive reexperiencing and psychological and physiological reactivity to reminders.
- Reduce trauma-related avoidant behaviors, nightmares, and sleep disturbance.
- Diminish anxieties related to fears of recurrence.
- Reduce behaviors that unduly restrict daily life, impair functioning, interfere with decision making, and contribute to engagement in high-risk behavior.

Prevent or treat trauma-related comorbid conditions that may be present or that may emerge.

Improve adaptive functioning and restore a psychological sense of safety and trust.
- Foster resilience and assist the patient in adaptively coping with trauma-related stresses and adversities.
- Help identify and develop strategies to restore and promote normal developmental progression.
- Limit the generalization of the danger experienced as a result of the traumatic situation(s).

Protect against relapse.
- Help the patient anticipate symptomatic exacerbation resulting from exposure to reminders of trauma or loss, additional life stresses or adversities, subsequent encounters with situations of danger or trauma, or discontinuation of psychotropic medication.
- Assist the patient in developing skills such as problem solving, emotional regulation, and the appropriate use of interpersonal support and professional help.

Integrate the danger experienced as a result of the traumatic situation(s) into a constructive schema of risk, safety, prevention, and protection.
- Assist the patient in addressing the meaning of the trauma in terms of his or her life experience.

2. Choice of Initial Treatment Modality

Treatment for the symptoms of ASD or PTSD involves three approaches either alone or in combination: psychopharmacology, psychotherapy, and education and supportive measures.

Consider pharmacological intervention to relieve overwhelming physical or psychological pain, impairing insomnia, or extremes of agitation, rage, or dissociation, especially for patients whose degree of distress precludes new verbal learning or nonpharmacologic treatment strategies.

Once the patient's safety and medical stabilization have been addressed, supportive psychotherapy, psychoeducation, and assistance in obtaining resources such as food and shelter and in locating family and friends are useful.

2. Choice of Initial Treatment Modality *(continued)*

Consider
- the patient's age and gender;
- presence of comorbid medical and psychiatric illnesses;
- propensity for aggression or self-injurious behavior;
- recency of the precipitating traumatic event;
- severity and pattern of symptoms;
- presence of particularly distressing target symptoms or symptom clusters;
- development of interpersonal or family issues or occupational or work-related problems;
- preexisting developmental or psychological vulnerabilities, including prior traumatic exposure; and
- the patient's preferences.

Attempt to minimize the risk for additional trauma and development or prolongation of PTSD through direct and vigorous treatment of underlying depression with psychotherapy, antidepressant pharmacotherapy, or both.

3. Approaches for Patients Who Do Not Respond to Initial Treatment

Systematically review factors that may contribute to treatment nonresponse, including
- the specifics of the initial treatment plan, including its goals and rationale;
- the patient's perceptions of the effects of treatment;
- the patient's understanding of and adherence to the treatment plan;
- the patient's reasons for nonadherence if nonadherence is a factor; and
- the potential for other psychological disorders or underlying personality traits to interfere with treatment.

- One strategy for nonresponse is to augment the initial treatment with another, for example, by adding pharmacotherapy to psychotherapy, psychotherapy to pharmacologic intervention, or couples therapy to individual psychotherapy.
- Exhaust first the treatments for which there is the best evidence of efficacy before trying more novel treatments.
- In some cases, the original treatment may need to be discontinued and a different modality selected, as in the case of a patient who is too overwhelmed by anxiety to tolerate exposure therapy.

4. Ethnic and Cultural Factors

- Understand the importance of social and cultural dynamics, to avoid alienating the patient from his or her family and community.
- Consider the cultural meaning of symptoms or illness and the cultural values of the patient and the patient's family.
- Recognize that cultural context and societal views may affect development of symptoms and treatment response.
- Consider cultural values in the patient's decision making about taking medication and adhering to medication regimens and other treatment.
- When determining a pharmacologic treatment plan, understand that genetic polymorphisms in hepatic cytochrome P450 enzymes occur at varying frequencies across ethnic groups.

D. Specific Treatment Strategies

1. Psychopharmacology

No specific pharmacologic interventions can be recommended as efficacious in preventing the development of ASD or PTSD in at-risk individuals.

For ASD, **selective serotonin reuptake inhibitors (SSRIs)** and other antidepressants represent reasonable clinical interventions.

SSRIs are recommended as first-line medication treatment for PTSD because they

- ameliorate all three PTSD symptom clusters (i.e., reexperiencing, avoidance/numbing, and hyperarousal).
- are effective treatments for psychiatric disorders that are frequently comorbid with PTSD (e.g., depression, panic disorder, social phobia, and obsessive-compulsive disorder).
- may reduce clinical symptoms (such as suicidal, impulsive, and aggressive behaviors) that often complicate management of PTSD.
- have relatively few side effects.

Tricyclic antidepressants and **monoamine oxidase inhibitors** may also be beneficial. Mimimal evidence is available to recommend the use of other antidepressants (e.g., venlafaxine, mirtazapine, bupropion).

Benzodiazepines may be useful in reducing anxiety and improving sleep.
- Efficacy in preventing PTSD or treating the core symptoms of PTSD has been neither established nor adequately evaluated.
- Concerns about addictive potential in individuals with comorbid substance use disorders may prompt additional caution regarding the use of benzodiazepines.
- Worsening of symptoms with benzodiazepine discontinuation has also been reported.

Anticonvulsant medications (e.g., divalproex, carbamazepine, topiramate, lamotrigine) may have benefit for treating symptoms related to reexperiencing the trauma.

Second-generation antipsychotic medications (e.g., olanzapine, quetiapine, risperidone) may be helpful in individual patients as well as for patients with comorbid psychotic disorders or when first-line approaches have been ineffective in controlling symptoms.

α_2-Adrenergic agonists and β-adrenergic blockers may also be helpful in treating specific symptom clusters in individual patients.

2. Psychotherapy

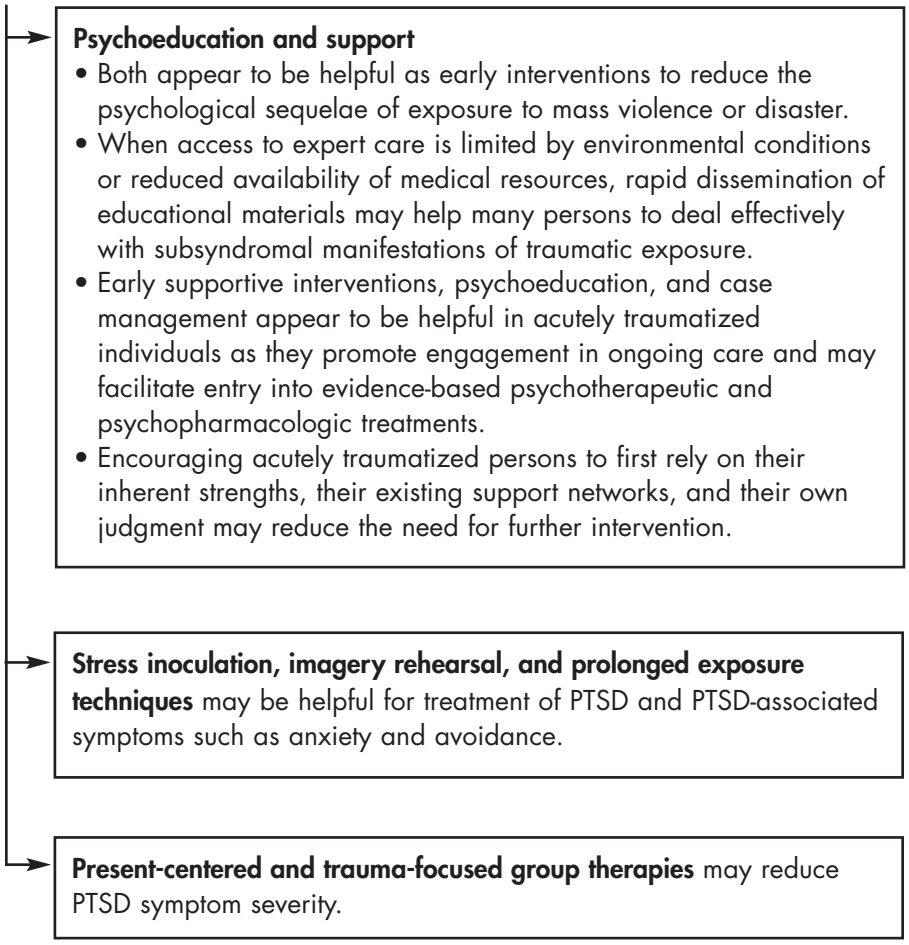
Cognitive and behavior therapies
- Target the distorted threat appraisal process (e.g., through repeated exposure or through techniques focusing on information processing without repeated exposure) in an effort to desensitize the patient to trauma-related triggers.
- May speed recovery and prevent PTSD when therapy is given over a few sessions beginning 2 to 3 weeks after trauma exposure.

2. Psychotherapy *(continued)*

Eye movement desensitization and reprocessing (EMDR)
- Includes an exposure-based therapy (with multiple brief, interrupted exposures to traumatic material), eye movement, and recall and verbalization of traumatic memories of an event or events.
- Has demonstrated efficacy similar to other forms of cognitive and behavior therapy.

Psychodynamic psychotherapy
- Focuses on the meaning of the trauma for the individual in terms of prior psychological conflicts and developmental experience and relationships.
- Focuses on the effect of the traumatic experience on the individual's prior self-object experiences, self-esteem, altered experience of safety, and loss of self-cohesiveness and self-observing functions.

Psychological debriefing
- Provides education about trauma experiences, the usual chronology of development of PTSD, and emotions associated with a recently experienced traumatic event.
- There is no evidence that psychological debriefing is effective in preventing PTSD or improving social and occupational functioning.
- May increase symptoms, especially when used with groups of unknown individuals with widely varying trauma exposures or when administered early after trauma exposure and before safety and decreased arousal are established.


Psychoeducation and support
• Both appear to be helpful as early interventions to reduce the psychological sequelae of exposure to mass violence or disaster.
• When access to expert care is limited by environmental conditions or reduced availability of medical resources, rapid dissemination of educational materials may help many persons to deal effectively with subsyndromal manifestations of traumatic exposure.
• Early supportive interventions, psychoeducation, and case management appear to be helpful in acutely traumatized individuals as they promote engagement in ongoing care and may facilitate entry into evidence-based psychotherapeutic and psychopharmacologic treatments.
• Encouraging acutely traumatized persons to first rely on their inherent strengths, their existing support networks, and their own judgment may reduce the need for further intervention.
Stress inoculation, imagery rehearsal, and prolonged exposure techniques may be helpful for treatment of PTSD and PTSD-associated symptoms such as anxiety and avoidance.
Present-centered and trauma-focused group therapies may reduce PTSD symptom severity.