

Brief Summary

GUIDELINE TITLE

Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder.

BIBLIOGRAPHIC SOURCE(S)

- American Psychiatric Association. Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Arlington (VA): American Psychiatric Association; 2004 Nov. 57 p. [463 references]

GUIDELINE STATUS

This is the current release of the guideline.

According to the guideline developer, this guideline is still considered to be current as of November 2004, based on a review of literature published since the original guideline publication.

In addition, a Guideline Watch, which summarizes significant developments in practice since the publication of the original guideline, was published in March 2009 and is available from the [American Psychiatric Association Web site](#) (see also the "Availability of Companion Documents" field below).

** REGULATORY ALERT **

FDA WARNING/REGULATORY ALERT

Note from the National Guideline Clearinghouse: This guideline references a drug(s) for which important revised regulatory and/or warning information has been released.

- [September 29, 2006, Lamictal \(lamotrigine\)](#): New preliminary information available regarding the effects of Lamictal on the baby if taken during the first three months of pregnancy.
- [May 12, 2006, Paxil \(paroxetine\) and Paxil CR](#): Changes to the Clinical Worsening and Suicide Risk subsection of the WARNINGS section in the prescribing Information related to adult patients, particularly those who are younger adults.
- [December 8, 2005, Paxil \(paroxetine\)](#): Pregnancy category changed from C to D and new data and recommendations added to the WARNINGS section of prescribing information.
- [September 27, 2005, Paxil \(paroxetine\) and Paxil CR](#): Changes to the Pregnancy/PRECAUTIONS section of the Prescribing Information to describe the results of a retrospective epidemiologic study of major congenital malformations in infants born to women taking antidepressants during the first trimester of pregnancy.
- [July 1, 2005, Antidepressants](#): Public Health Advisory issued to update patients and healthcare providers in response to recent scientific publications that report the possibility of increased risk of suicidal behavior in adults treated with antidepressants.

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RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. Definitions of the categories of endorsement are provided at the end of the "Major Recommendations" field.

1. **Initial Assessment**

The initial step in identifying individuals with acute stress disorder (ASD) or post traumatic stress disorder (PTSD) involves screening for recent or remote trauma exposure, although the clinical approach may vary depending on the recency of the traumatic event [I]. If eliciting vivid and detailed recollections of the traumatic event immediately after exposure enhances the patient's distress, the interview may be limited to gathering information that is essential to provide needed medical care [I]. The first interventions in the aftermath of an acute trauma consist of stabilizing and supportive medical care and supportive psychiatric care and assessment [I]. After large-scale catastrophes, initial psychiatric assessment includes differential diagnosis of physical and psychological effects of the traumatic event (e.g., anxiety resulting from hemodynamic compromise, hyperventilation, somatic expressions of psychological distress, fatigue) and identification of persons or groups who are at greatest risk for subsequent psychiatric disorders, including ASD or PTSD [I]. This identification may be accomplished through individual evaluation, group interviews, consultation, and use of surveillance instruments [I].

Diagnostic evaluation may be continued after the initial period has passed and a physically and psychologically safe environment has been established, the individual's medical condition has been stabilized, psychological reassurance has been provided, and, in disaster settings, necessary triage has been accomplished. It is important for this diagnostic assessment to include a complete psychiatric evaluation that specifically assesses for the symptoms of ASD and PTSD, including dissociative, reexperiencing, avoidance/numbing, and hyperarousal symptom clusters and their temporal sequence relative to the trauma (i.e., before versus after 1 month from the traumatic event) [I]. Other important components of the assessment process include functional assessment, determining the availability of basic care resources (e.g., safe housing, social support network, companion care, food, clothing), and identifying previous traumatic experiences

and comorbid physical or psychiatric disorders, including depression and substance use disorders [I].

2. **Psychiatric Management**

Psychiatric management for all patients with ASD or PTSD includes instituting interventions and activities to ensure physical and psychological safety, required medical care, and availability of needed resources for self-care and recovery [I]. The patient's level of functioning and safety, including his or her risk for suicide and potential to harm others, is always important to evaluate during initial assessment and may determine the treatment setting [I]. The goals of psychiatric management for patients with ASD and PTSD also include establishing a therapeutic alliance with the patient; providing ongoing assessment of safety and psychiatric status, including possible comorbid disorders and response to treatment; and increasing the patients understanding of and active adaptive coping with psychosocial effects of exposure to the traumatic event, such as injury, job loss, or loss of loved ones [I]. Additional goals of psychiatric management include providing education regarding ASD and PTSD, enhancing treatment adherence, evaluating and managing physical health and functional impairments, and coordinating care to include collaborating with other clinicians [I].

3. **General Principles of Treatment Selection**

The goals of treatment for individuals with a diagnosis of ASD or PTSD include reducing the severity of ASD or PTSD symptoms, preventing or treating trauma-related comorbid conditions that may be present or emerge, improving adaptive functioning and restoring a psychological sense of safety and trust, limiting the generalization of the danger experienced as a result of the traumatic situation(s), and protecting against relapse [I].

Patients assessed within hours or days after an acute trauma may present with overwhelming physiological and emotional symptoms (e.g., insomnia, agitation, emotional pain, dissociation). Limited clinical trial evidence is available in this area, as randomized designs are difficult to implement; however, clinical experience suggests that these acutely traumatized individuals may benefit from supportive psychotherapeutic and psychoeducational interventions [II]. Pharmacotherapy may be the first-line intervention for acutely traumatized patients whose degree of distress precludes new verbal learning or nonpharmacological treatment strategies [III]. Research has not consistently identified patient- or trauma-specific factors that predict the development of ASD or interventions that will alter the evolution of ASD into PTSD. However, early after a trauma, 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 locating family and friends are useful [II].

Effective treatments for the symptoms of ASD or PTSD encompass psychopharmacology, psychotherapy, and psychoeducation and other supportive

measures [I]. Although studies using a combination of these approaches for ASD and PTSD are not presently available, combination treatment is widely used and may offer advantages for some patients [II]. The psychotropic medications used in clinical practice and research for the treatment of ASD and PTSD were not specifically developed for these disorders but have been used in doses similar to those recommended or approved for other psychiatric illnesses.

For patients with ASD or PTSD, choice of treatment includes consideration of age and gender, presence of comorbid medical and psychiatric illnesses, and propensity for aggression or self-injurious behavior [I]. Other factors that may influence treatment choice include the recency of the precipitating traumatic event; the severity and pattern of symptoms; the presence of particularly distressing target symptoms or symptom clusters; the development of interpersonal or family issues or occupational or work-related problems; preexisting developmental or psychological vulnerabilities, including prior trauma exposure; and the patient's preferences [I].

When the patient's symptoms do not respond to a plan of treatment, selection of subsequent interventions will depend on clinical judgment, as there are limited data to guide the clinician. It is important to systematically review factors that may contribute to treatment nonresponse, including the specifics of the initial treatment plan and its goals and rationale, the patient's perceptions of the effects of treatment, the patient's understanding of and adherence to the treatment plan, and the patient's reasons for nonadherence if nonadherence is a factor [I]. Other factors that may need to be addressed in patients who are not responding to treatment include problems in the therapeutic alliance; the presence of psychosocial or environmental difficulties; the effect of earlier life experiences such as childhood abuse or previous trauma exposures; and comorbid psychiatric disorders, including substance-related disorders and personality disorders [I].

4. **Specific Treatment Strategies**

- **Psychopharmacology**

Although it has been hypothesized that pharmacological treatment soon after trauma exposure may prevent the development of ASD and PTSD, existing evidence is limited and preliminary. Thus, no specific pharmacological interventions can be recommended as efficacious in preventing the development of ASD or PTSD in at-risk individuals.

For patients with ASD, there are few studies of pharmacological interventions. However, selective serotonin reuptake inhibitors (SSRIs) [II] and other antidepressants [III] represent reasonable clinical interventions that are supported by limited findings in ASD as well as by findings of therapeutic benefits in patients with PTSD.

SSRIs are recommended as first-line medication treatment for PTSD [I]. In both male and female patients, treatment with SSRIs has been associated with relief of core PTSD symptoms in all three symptom

clusters (reexperiencing, avoidance/numbing, hyperarousal). Other antidepressants, including tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs), may also be beneficial in the treatment of PTSD [III].

Benzodiazepines may be useful in reducing anxiety and improving sleep [III]. Although their efficacy in treating the core symptoms of PTSD has not been established, benzodiazepines are often used in trauma-exposed individuals and patients with PTSD. However, clinical observations include the possibility of dependence, increased incidence of PTSD after early treatment with these medications, or worsening of PTSD symptoms after withdrawal of these medications. Thus, benzodiazepines cannot be recommended as monotherapy in PTSD.

In addition to being indicated in patients with comorbid psychotic disorders, second generation antipsychotic medications (e.g., olanzapine, quetiapine, risperidone) may be helpful in individual patients with PTSD [III]. Anticonvulsant medications (e.g., divalproex, carbamazepine, topiramate, lamotrigine), alpha-2-adrenergic agonists, and beta-adrenergic blockers may also be helpful in treating specific symptom clusters in individual patients [III].

- **Psychotherapeutic Interventions**

Some evidence is available about the effectiveness of psychotherapeutic intervention immediately after trauma in preventing development of ASD or PTSD. Studies of cognitive behavior therapy in motor vehicle and industrial accident survivors as well as in victims of rape and interpersonal violence suggest that cognitive behavior therapies may speed recovery and prevent PTSD when therapy is given over a few sessions beginning 2-3 weeks after trauma exposure [II].

Early supportive interventions, psychoeducation, and case management appear to be helpful in acutely traumatized individuals, because these approaches promote engagement in ongoing care and may facilitate entry into evidence-based psychotherapeutic and psychopharmacological treatments [III]. Encouraging acutely traumatized persons to first rely on their inherent strengths, their existing support networks, and their own judgment may also reduce the need for further intervention [II]. In populations of patients who have experienced multiple recurrent traumas, there is little evidence to suggest that early supportive care delivered as a stand-alone treatment will result in lasting reductions in PTSD symptoms. However, no evidence suggests that early supportive care is harmful. In contrast, psychological debriefings or single-session techniques are not recommended, as they may increase symptoms in some settings and appear to be ineffective in treating individuals with ASD and in preventing PTSD.

No controlled studies of psychodynamic psychotherapy, eye movement desensitization and reprocessing (EMDR), or hypnosis have been conducted that would establish data-based evidence of their efficacy as an early or preventive intervention for ASD or PTSD.

For patients with a diagnosis of ASD or PTSD, available evidence and clinical experience suggest that a number of psychotherapeutic interventions may be useful. Patients with ASD may be helped by cognitive behavior therapy and other exposure-based therapies [II]. In addition, cognitive behavior therapy is an effective treatment for core symptoms of acute and chronic PTSD [I]. EMDR also appears to be effective [II]; however, therapeutic benefit for the rapid eye movement component of this therapy has not been consistently demonstrated. Stress inoculation, imagery rehearsal, and prolonged exposure techniques may also be indicated for treatment of PTSD and PTSD-associated symptoms such as anxiety and avoidance [II]. The shared element of controlled exposure of some kind may be the critical intervention.

Psychodynamic psychotherapy may be useful in addressing developmental, interpersonal, or intrapersonal issues that relate to the nature, severity, symptoms, or treatment of ASD and PTSD and that may be of particular importance to social, occupational, and interpersonal functioning [II].

Case management, psychoeducation, and other supportive interventions may be useful in facilitating entry into ongoing treatment, appear not to exacerbate PTSD symptoms, and in some pilot investigations have been associated with PTSD symptom reduction [II]. Present-centered and trauma-focused group therapies may also reduce PTSD symptom severity [III].

Definitions

Each recommendation is identified as falling into one of three categories of endorsement, indicated by a bracketed Roman numeral following the statement. The three categories represent varying levels of clinical confidence regarding the efficacy of the treatment for the disorder and conditions described.

[I] Recommended with substantial clinical confidence

[II] Recommended with moderate clinical confidence

[III] May be recommended on the basis of individual circumstances

CLINICAL ALGORITHM(S)

None provided

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EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The evidence base for practice guidelines is derived from two sources: research studies and clinical consensus. Where gaps exist in the research data, evidence is derived from clinical consensus, obtained through extensive review of multiple drafts of each guideline. In addition, each reference at the end of the original guideline document is followed by a letter code in brackets that indicates the nature of the supporting evidence, as follows:

[A] *Randomized, double-blind clinical trial.* A study of an intervention in which subjects are prospectively followed over time; there are treatment and control groups; subjects are randomly assigned to the two groups; and both the subjects and the investigators are "blind" to the assignments.

[A] *Randomized clinical trial.* Same as above but not double blind.

[B] *Clinical trial.* A prospective study in which an intervention is made and the results of that intervention are tracked longitudinally. Does not meet standards for a randomized clinical trial.

[C] *Cohort or longitudinal study.* A study in which subjects are prospectively followed over time without any specific intervention.

[D] *Case-control study.* A study in which a group of patients is identified in the present and information about them is pursued retrospectively or backward in time.

[E] *Review with secondary data analysis.* A structured analytic review of existing data, (e.g., a meta-analysis or a decision analysis).

[F] *Review.* A qualitative review and discussion of previously published literature without a quantitative synthesis of the data.

[G] *Other.* Opinion-like essays, case reports, and other reports not categorized above.

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IDENTIFYING INFORMATION AND AVAILABILITY

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- American Psychiatric Association. Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Arlington (VA): American Psychiatric Association; 2004 Nov. 57 p. [463 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Nov

GUIDELINE DEVELOPER(S)

American Psychiatric Association - Medical Specialty Society

SOURCE(S) OF FUNDING

American Psychiatric Association (APA)

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

This practice guideline has been developed by psychiatrists who are in active clinical practice. In addition, some contributors are primarily involved in research or other academic endeavors. It is possible that through such activities some contributors have received income related to treatments discussed in this guideline. A number of mechanisms are in place to minimize the potential for producing biased recommendations due to conflicts of interest. The guideline has been extensively reviewed by members of the American Psychiatric Association (APA) as well as by representatives from related fields. Contributors and reviewers have all been asked to base their recommendations on an objective evaluation of available evidence. Any contributor or reviewer who has a potential conflict of interest that may bias (or appear to bias) his or her work has been asked to notify the APA Department of Quality Improvement and Psychiatric Services. This potential bias is then discussed with the work group chair and the chair of the Steering Committee on Practice Guidelines. Further action depends on the assessment of the potential bias.

GUIDELINE STATUS

This is the current release of the guideline.

In addition, a Guideline Watch, which summarizes significant developments in practice since the publication of the original guideline, was published in March 2009 and is available from the [American Psychiatric Association Web site](#)

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the [American Psychiatric Association's Web site](#).

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1400 K Street NW, Washington, DC 20005; (202) 682-6262; (800) 368-5777; fax (202) 789-2648.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Treating patients with acute stress disorder and posttraumatic stress disorder. A Quick Reference Guide. Washington, DC: APA, 2004. Electronic copies: Available in Portable Document Format (PDF) from the [American Psychiatric Association \(APA\) Web site](#).
- American Psychiatric Association practice guideline development process. Washington, DC: APA, 2004. Electronic copies: Available in Portable Document Format (PDF) from the [APA Web site](#).
- Benedek, D., Friedman, M., Ursano, R., & Zatzick, D., Guideline Watch: practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Arlington (VA): American Psychiatric Association; March 2009. 12 p. Electronic copies available in Portable Document Format (PDF) from the [American Psychiatric Association Web site](#)

Print copies: Available from the American Psychiatric Press, Inc (APPI), 1400 K Street NW, Washington, DC 20005; (202) 682-6262; (800) 368-5777; fax (202) 789-2648.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on December 1, 2004. The information was verified by the guideline developer on January 4, 2005. This summary was updated by ECRI on February 23, 2005, following the release of a public health advisory from the U.S. Food and Drug Administration regarding the use of Gabitril. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on October 3, 2005, following the U.S. Food and Drug Administration advisory on Paxil (paroxetine). This summary was updated by ECRI on December 12, 2005, following the U.S. Food and Drug Administration advisory on Paroxetine HCL - Paxil and generic paroxetine. This summary was updated by ECRI on May 31, 2006 following the U.S.

Food and Drug Administration advisory on Paxil (paroxetine hydrochloride). This summary was updated by ECRI on November 16, 2006, following the FDA advisory on Lamictal (lamotrigine).

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