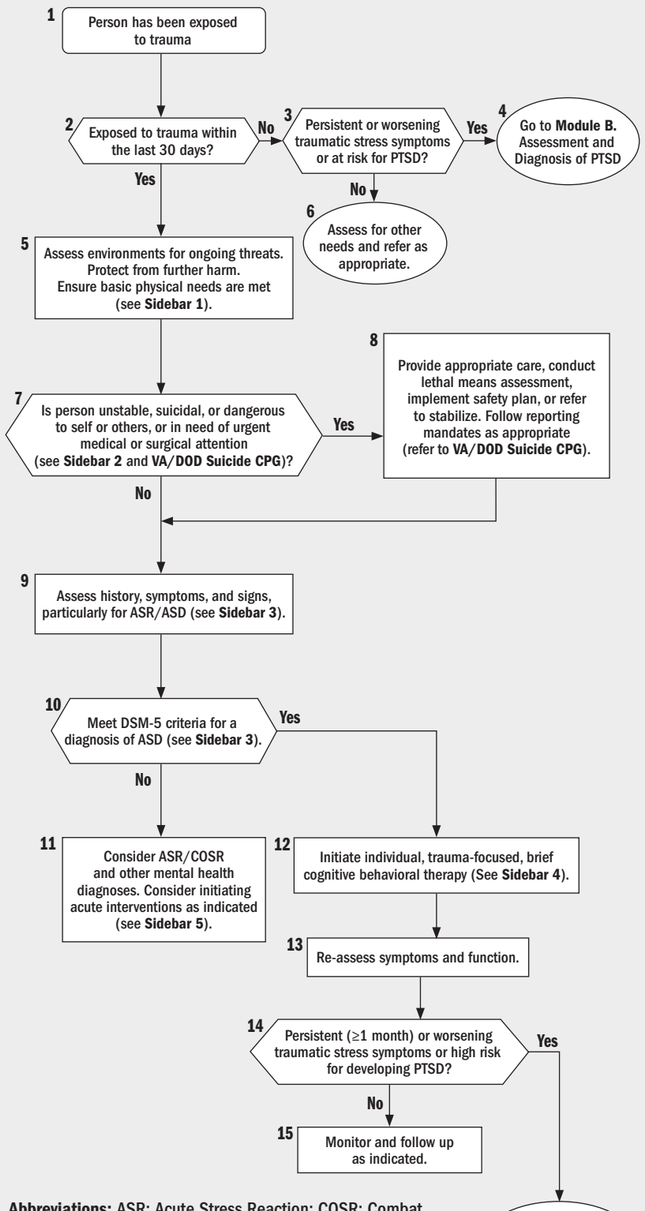
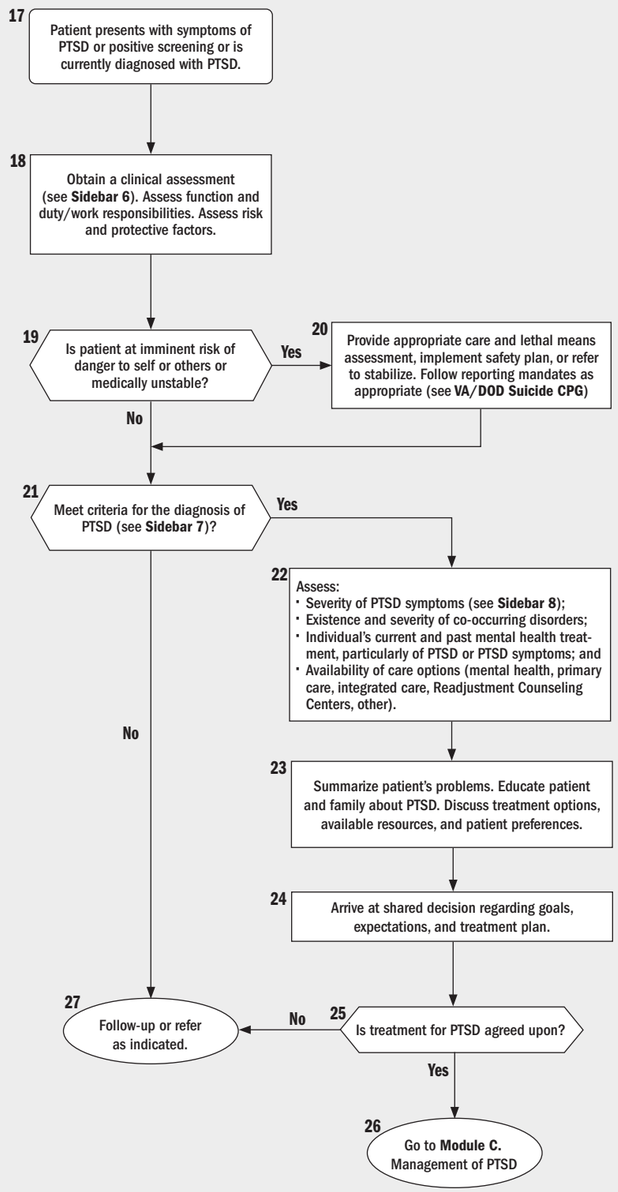
Management of Posttraumatic Stress Disorder and Acute Stress Disorder

Module A: Acute Stress Reaction/Disorder



Abbreviations: ASR: Acute Stress Reaction; COSR: Combat and Operational Stress Reaction; CPG: clinical practice guideline; DSM: Diagnostic and Statistical Manual of Mental Disorders; PTSD: posttraumatic stress disorder; VA: Veterans Affairs; DOD: Department of Defense

Module B: Assessment and Diagnosis of Posttraumatic Stress Disorder



Abbreviations: CPG: clinical practice guideline; PTSD: posttraumatic stress disorder; VA: Veterans Affairs; DOD: Department of Defense

Sidebar 1: Immediate Needs

- Survival (including first aid and stabilizing physical condition), safety, and security.
- Food, hydration, shelter, and clothing.
- Sleep.
- Orientation.
- Communication with unit, family, friends, and community.
- Education and normalization of reactions to trauma.

Sidebar 2: Assessment

- History of trauma and mental health concerns.
- Symptoms.
- Consider screening for PTSD symptoms using thle PC-PTSD-5 (Recommendation 1).
- Medical status.
- Mental status, including suicidality (consult VA/DOD CPG for Assessment and Management of Patients at Risk for Suicide,[a] as needed).
- Functional status.
- Psychosocial status, including intimate and family relationships; financial problems; legal issues.
- Occupational performance.
- Substance use.
- Strengths, coping skills, and protective factors.

[a] See the VA/DOD CPG for the Assessment and Management of Patients at Risk for Suicide, available at https://www.healthquality.va.gov/.

Abbreviations: PC-PTSD-5: Primary Care PTSD Screen for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; PTSD: posttraumatic stress disorder; VA: Veterans Affairs; DOD: Department of Defense.

Sidebar 3: DSM-5-TR Diagnostic Criteria for Acute Stress Disorder(6)

Criterion A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the event(s) as it occurred to others.
3. Learning that the event(s) occurred to a close family member or close friend.
   Note: In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedly exposed to details of child abuse).

Note: This does not apply to exposure through electronic media, television, movies, or pictures unless this exposure is work-related.

Criterion B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion Symptoms

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings.)
4. Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative Mood

5. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Sidebar 3: DSM-5-TR Diagnostic Criteria for Acute Stress Disorder(6) (conti.)

Dissociative Symptoms

6. An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
7. Inability to remember an important aspect of the event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Avoidance Symptoms

8. Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
9. Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal Symptoms

10. Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
11. Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
12. Hypervigilance.
13. Problems with concentration.
14. Exaggerated startle response.

Criterion C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.

Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to 1 month is needed to meet disorder criteria.

Criterion D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Criterion E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury) and is not better explained by a brief psychotic disorder.

Sidebar 4: Acute Interventions for Acute Stress Disorder

- Individual, manualized trauma-focused cognitive behavioral psychotherapy.
- Consider: Collaborative care or wellness-oriented activities.

Sidebar 5: Acute Interventions for Acute Stress Response/Combat and Operational Stress Reaction

- Education and normalization, acute symptom management, social support.
- Suggest: Brief cognitive behavioral psychotherapy.

Sidebar 6: General Assessment

- Complete comprehensive clinical assessment of presenting complaints and comorbid conditions.
- Perform safety, lethal means, and environmental assessment.
- Consider history and presenting complaints: mental health, medical, military, marital, family, substance use, social and spiritual life, functional status.
- Identify lifetime trauma history and duration of exposure.
- Record current and past medications (including over-the-counter drugs and herbals) and psychosocial treatment.
- Consider, with patient consent, obtaining an additional history from family, significant other, or both.
- Perform mental status exam.
- Consider, in cases of diagnostic uncertainty, use of validated structured clinical interviews for PTSD (i.e., CAPS-5, PSSI) (see Recommendation 2).

Abbreviations: CAPS-5: Clinician-Administered Posttraumatic Stress Disorder Scale for Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision; PSSI: PTSD Symptom Scale - Interview Version

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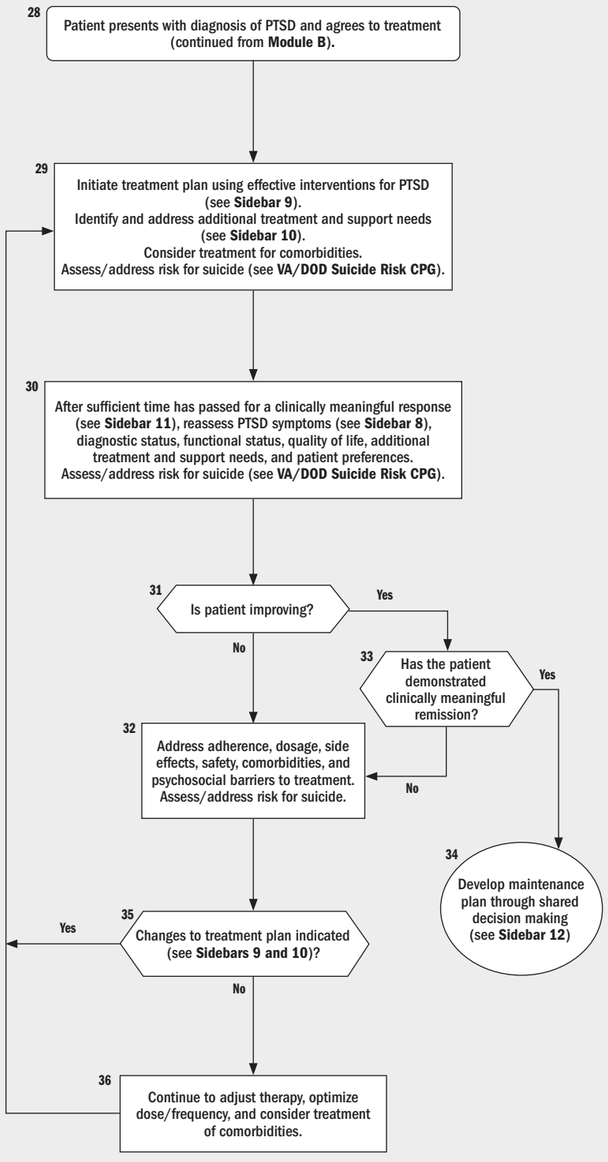
Module C: Management of Posttraumatic Stress Disorder



Abbreviations: CPG: clinical practice guideline; PTSD: posttraumatic stress disorder; VA: Veterans Affairs; DOD: Department of Defense

Sidebar 7: DSM-5-TR Diagnostic Criteria for PTSD(6)

Criterion A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

15. Directly experiencing the traumatic event(s).
16. Witnessing, in person, the event(s) as it occurred to others.
17. Learning that the traumatic event(s) occurred to a close family member or close friend. In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
18. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g., first responders collecting human remains, police officers repeatedfy exposed to details of child abuse).

Note: Criterion A4 does not apply to exposure through electronic media, television, movies, or pictures unless this exposure is work related.

Criterion B. Presence of one (or more) of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:

1. Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s).
2. Recurrent distressing dreams in which the content and/or affect of the dream are related to the traumatic event(s).
3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings)
4. Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
5. Marked physiological reactions to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Criterion C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by one or both of the following:

1. Avoidance of or efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
2. Avoidance or efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Criterion D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Inability to recall an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
2. Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous," "My whole nervous system is permanently ruined").
3. Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame themself or others.
4. Persistent negative emotional state (e.g., fear, horror, anger, guilt, shame).
5. Markedly diminished interest or participation in significant activities.
6. Feeling of detachment or estrangement from others.
7. Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Criterion E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:

1. Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
2. Reckless or self-destructive behavior.
3. Hypervigilance.
4. Exaggerated startle response.
5. Problems with concentration.
6. Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).

Sidebar 7: DSM-5-TR Diagnostic Criteria for PTSD(6) (cont.)

Criterion F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.

Criterion G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Criterion H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

***Specify* whether:**

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream; feeling a sense of unreality of self or body or of time moving slowly).
2. **Derealization:** Persistent or recurrent experiences of unreality of surroundings (e.g., the world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, behavior during alcohol intoxication) or another medical condition (e.g., complex partial seizures).

***Specify* if:**

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Sidebar 8: Assessment of PTSD Symptoms

- Assess PTSD symptoms using validated instruments, such as the PTSD Checklist for DSM-5 (PCL-5), or a structured clinician-administered interview (e.g., CAPS-5) (see Recommendation 3).

Abbreviations: CAPS-5: Clinician-Administered PTSD Scale for DSM-5; DSM-5: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition; PCL-5: PTSD Checklist for DSM-5; PTSD: posttraumatic stress disorder

Sidebar 9: Treatment Selection

1. Initiate recommended individual, manualized psychotherapy (see Recommendation 8) according to patient preference.
2. If individual psychotherapy is unavailable or not preferred, initiate recommended pharmacotherapy (see Recommendation 15).
3. If options 1 and 2 are infeasible or are not preferred, offer suggested psychotherapy (see Recommendation 9) or suggested CIH (see Recommendation 26).
4. If options 1, 2, and 3 are infeasible or are not preferred, consider other psychotherapies (see Recommendation 10, Recommendation 12, and Recommendation 14), other pharmacotherapy (see Recommendation 16), complementary, integrative, or alternative approaches (see Recommendation 27 and Recommendation 28) based on availability, patient preference, and review of current evidence.
5. If none of the options above are acceptable to the patient, consider treating other disorders, issues, or both and reevaluating for PTSD treatment later.

Abbreviations: CIH: complementary and integrative health; PTSD: posttraumatic stress disorder

Sidebar 10: Additional Treatment and Support Needs

- Consider treatment for comorbidities and other identified problems (see Recommendation 34 as well as other relevant VA/DOD CPGs*).
- Consider symptom-specific management (e.g., sleep, pain).
- Facilitate social support.
- Address Whole Health by offering CIH, alternative approaches, health and wellbeing coaching, recreation therapy, etc.

*VA/DOD CPGs can be found at the following link: https://www.healthquality.va.gov/index.asp. Relevant VA/DOD CPGs to consult might include CPGs for the Management of Major Depressive Disorder, Substance Use Disorder, Bipolar Disorder, Suicide, Chronic Multisymptomatic Illness, Concussion-Mild Traumatic Brain Injury, and others.

Abbreviations: CIH: complementary and integrative health

Sidebar 11: Clinically Meaningful Response Time

- Psychotherapies require an adequate dosage to be fully effective in reducing PTSD symptoms; some effects might also not become apparent until some period has elapsed after treatment is initiated. For the indicated psychotherapies for PTSD (see Recommendation 8), it is generally accepted that initial treatment effects will be noticeable after 4–8 sessions typically delivered over 8–12 weeks. Psychotherapies might have an attenuated effect if delivered less than weekly.
- The pharmacological management of PTSD requires the SSRI (e.g., sertraline) or SNRI (e.g., venlafaxine) be given at an appropriate dosage for an adequate time to allow for the full therapeutic effects before moving to alternative or augmentative treatment options. These medications should be initiated at the recommended starting dose and titrated based on clinical response and tolerability (see Appendix B). The duration of the trial should be 8–12 weeks.

Abbreviations: PTSD: posttraumatic stress disorder; SNRI: serotonin-norepinephrine reuptake inhibitor; SSRI: selective serotonin reuptake inhibitor

Sidebar 12: Maintenance Plan

- Terminate PTSD treatment or taper based on clinician judgment and patient preference, normalize fluctuations in symptoms, discuss self-monitoring for symptoms that warrant future attention, and provide resources for seeking care in the future.
- Before termination of psychopharmacology, discuss the risks and benefits of discontinuing medication, including possible side effects and return of symptoms. Make a schedule to taper based on patient preference with a discussion of the length of time required and consideration of anticipated life events and stressors. Discuss the plan for monitoring during and post taper, including steps needed to reinitiate pharmacology.
- Should the patient wish to continue pharmacotherapy, investigate, and discuss continuing medications with behavioral health or primary care.
- Refer the patient for treatment of other disorders or functional issues (e.g., relationship distress).
- If desired, facilitate referral to health and wellbeing programs as a part of a Whole Health approach to care.

Abbreviations: PTSD: posttraumatic stress disorder

Access to the full guideline and additional resources is available at: https://www.healthquality.va.gov/