

VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POST TRAUMATIC STRESS

Module A1 Summary

POST-TRAUMA ACUTE STRESS REACTION (ASR) CIVILIAN POPULATION

KEY ELEMENTS

1. Provide for basic survival needs and comfort (e.g., liquids, food, shelter, clothing, heat/cooling).
2. Help survivors achieve restful and restorative sleep.
3. Preserve an interpersonal safety zone protecting basic personal space (e.g., privacy, quiet, personal effects).
4. Provide nonintrusive, ordinary social contact (e.g., a "sounding board," judicious uses of humor, small talk about current events, silent companionship).
5. Address immediate physical health problems or exacerbations of prior illnesses.
6. Assist in locating and verifying the personal safety of separated loved ones/friends.
7. Reconnect survivors with loved ones, friends, trusted other persons (e.g., work mentors, health care, clergy).
8. Help survivors take practical steps to resume ordinary day-to-day life (e.g., daily routines or rituals).
9. Help survivors take practical steps to resolve pressing immediate problems caused by the disaster (e.g., loss of a functional vehicle, finance, housing).
10. Facilitate resumption of normal family, community, school, and work roles.
11. Provide opportunities for grieving for losses.
12. Help survivors reduce problematic tension or anxiety to manageable levels.
13. Support survivors' helpers through consultation and training about common stress reactions and stress management techniques.

BACKGROUND

Although acute stress reaction (ASR) is not defined in the DSM-IV, there has long been recognition among mental health professionals that individuals who experience a traumatic event react in certain predictable ways. A key point in the World Health Organization definition (WHO, 1992) of ASR is the assertion that “the symptoms usually appear within minutes of the impact of the stressful stimulus or event, and disappear within 2-3 days (often within hours)” (WHO, 1992). This view is echoed in a Guideline for Evidence-Based Early Psychological Intervention for Victims/Survivors of Mass Violence, released in 2002 by a collaborative group of Federal Departments and the American Red Cross: “a sensible working principle in the immediate post-incident phase is to expect normal recovery.” (NIMH, 2002).

In light of the transient nature of this reaction, health care professionals and other caregivers need to know how to provide optimal support to persons in the first days following a traumatic event. In developing the current guideline, the authors carefully reviewed the

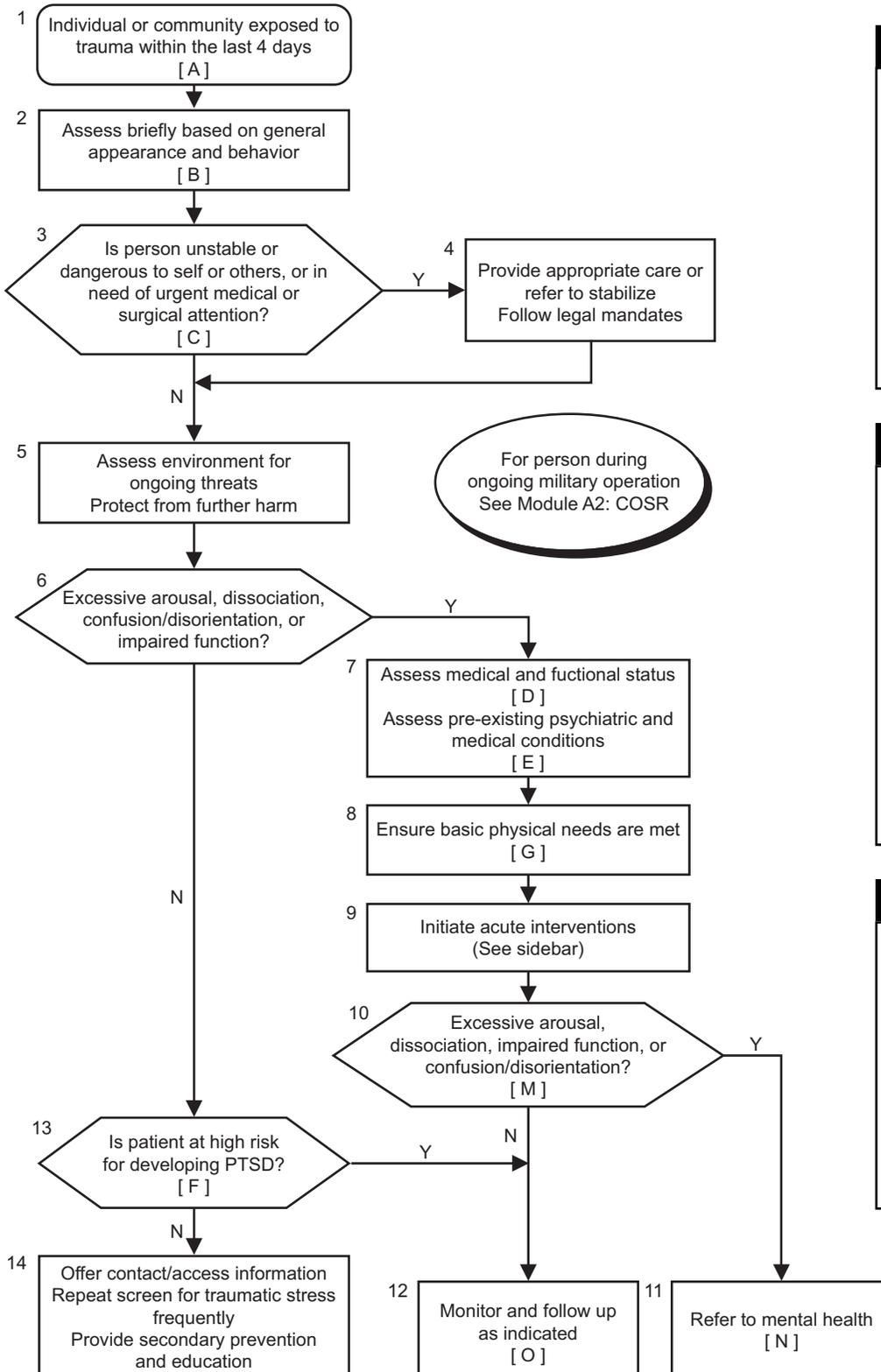
NIMH Guideline recommendations (NIMH, 2002) and the recommendations presented in a National Center for PTSD Fact Sheet (Litz et al., 2002):

- Early, brief, and focused psychotherapeutic intervention can reduce distress in bereaved spouses, parents, and children.
- Selected cognitive behavioral approaches may help reduce incidence, duration, and severity of acute stress disorder, post-traumatic stress disorder, and depression in survivors.
- When feasible, initial screening is required so that preventive interventions can be used for those individuals who may have difficulty recovering on their own.

The authors of this guideline used the statements above as a starting point for research and discussion, and have formulated the recommendations discussed below for the treatment of persons with ASR. Most of the recommendations in this module are based on group consensus. When available, the evidence and supporting research are presented in evidence tables.

**VA/DoD CLINICAL PRACTICE GUIDELINE
FOR THE MANAGEMENT OF TRAUMATIC STRESS
MODULE A1 - ACUTE STRESS REACTION**

A1



- ASSESSMENT**
- a) Symptoms
 - b) Trauma
 - c) Risk factors
 - d) Medical status
 - e) Mental status
 - f) Functional status
 - g) Psychosocial status
 - h) Dangerousness
 - i) Unit disruption

- IMMEDIATE NEEDS**
- Survival
 - Safety
 - Security
 - Food
 - Shelter
 - Sleep
 - Medical care (first aid)
 - Mental health triage
 - Orientation
 - Communication with family friends and community

- ACUTE INTERVENTIONS**
- Provide:
- Acute symptom management [H]
 - Education & normalization [J]
 - Social & spiritual support [K]
 - Consider medication [L] (avoid use of benzodiazepines)
- Avoid:
- Individual debriefing [I]
 - Compulsory group debriefing

ANNOTATIONS

ASSESSMENT

A. Trauma Exposure

DEFINITION

Traumatic events are events that cause a person to fear that he or she may die or be seriously injured or harmed. These events also can be traumatic when the person witnesses them happening to others. Such events often create feelings of intense fear, helplessness, or horror for those who experience them. Among the common kinds of traumatic events are:

- Combat in a war zone
- Rape or other sexual assault
- Natural disaster (e.g., hurricanes, floods or fires)
- Child physical and/or sexual abuse
- Domestic violence (battering)
- Motor vehicle accidents
- Exposure to the sudden or unexpected death of others
- Sudden life-threatening physical illness (e.g., heart attack or cancer).

B. Screen For ASR

Identify individuals who may be at risk for endangering themselves or others due to emotional distress or functional incapacity.

Screening and needs assessments for individuals, groups and populations are important for the provision of informed early intervention following a major incident or traumatic event. Initial reactions following trauma are varied, complex, and unstable (see Core Module Table 0-1 for a list of common signs after exposure to trauma or loss). There are a number of possible reactions to a traumatic situation that are considered within the "norm" for persons experiencing traumatic stress. These reactions are considered 'normal' in the sense of affecting most survivors, being socially acceptable, psychologically effective, and self-limited. At this stage (less than 4 days after the trauma exposure), it is important not to classify these reactions as "symptoms" in the sense of being indicative of a mental disorder.

RECOMMENDATIONS

1. Identification of a patient with ASR symptoms is based on observation of behavior and function.
2. There is no evidence to support any specific screening tool.
3. Individuals exhibiting the following responses to trauma should be screened for ASR:
 - Physical: exhaustion, hyperarousal, somatic complaints (GI, GU, MS, CV, Resp, NS), Conversion Disorder symptoms
 - Emotional: anxiety, depression, guilt/hopelessness
 - Behavioral: avoidance, problematic substance use
 - Cognitive/mental: amnesic or dissociative symptoms, hypervigilance, paranoia, intrusive re-experiencing.

An acute stress reaction may occur concurrent with other wounds or illnesses. As in any medical condition, providers should confirm that the symptoms are not due to identified medical/surgical conditions requiring other urgent treatment. ASR does not require a specific traumatic event and may result from cumulative exposure to multiple stressors.

In the aftermath of a disaster, most of those suffering from acute trauma will be easy to spot. Those who have been injured will be obvious. Among the uninjured there will also be many who look stunned, appear pale and faint, or be shaking. Some of those who appear to be suffering from trauma may not even be the actual victims of the disaster, but witnesses or rescuers who may be deeply affected by what they have or are seeing. Some may not be immediately identifiable as traumatized because they may be highly active - looking for others or after others, organizing help and rescue. A percentage of these may, in the next days or weeks, develop symptoms of trauma.

C. Dangerousness To Self Or Others

RECOMMENDATIONS

1. Acute medical issues should be addressed to preserve life and avoid further harm:
 - ABC's (Maintain: Airways, Breathing, Circulation)
 - Substance intoxication or withdrawal
 - Danger to self or others: suicidal, homicidal behavior
 - Self-injury or mutilation
 - Inability to care for oneself.
2. A safe, private and comfortable environment should be arranged for continuation of the evaluation.
 - Establish a working treatment alliance with the patient
 - Maintain a supportive, non-blaming, non-judgmental stance throughout the evaluation
 - Help with the **removal of any ongoing traumatic event**
 - Minimizing further traumas that may arise from the initial traumatic event.
 - Assess and optimize social supports.
3. Legal mandates should be followed:
 - Reporting of violence, assault
 - Confidentiality for the patient
 - Mandatory testing
 - Attend to chain of evidence in criminal cases (e.g. rape, evaluation)
 - Involuntary commitment procedures if needed.
4. Carefully consider the following potential interventions to secure safety:
 - Find safe accommodation and protect against further trauma
 - Voluntary admission
 - Restraint/seclusion only if less restrictive measures are ineffective
 - Forced medications.

First aid can be applied to stress reactions of the mind as well as to physical injuries of the body. Psychological first aid can be envisioned as the mental health correlate

of physical first aid, with the goal being to “stop the psychological bleeding”. The first, most important measure should be to eliminate (if possible) the source of the trauma or to remove the victim from the traumatic, stressful environment. Once the patient is in a safe situation, the provider should attempt to reassure the patient, encourage a professional, healing relationship, encourage a feeling of safety, and identify existing social supports.

Psychological first aid really means assisting people with emotional distress whether it results from physical injury, disease or excessive traumatic stress. Emotional distress is not always as visible as a wound, a broken leg or a reaction to pain from physical damage. However, overexcitement, severe fear, excessive worry, deep depression, misdirected aggression, or irritability and anger are signs that stress has reached the point of interfering with effective coping.

For extended discussion of dangerousness - See Module B – Annotation C

D. Obtain Assessment of Medical and Functional Status Based on General Appearance and Screening Instruments

RECOMMENDATIONS

1. Medical status should be obtained for all persons presenting with symptoms to include:
 - History, physical examination and a neurological examination
 - Use of prescribed medications, mood or mind-altering substances and possible biological or chemical agent exposure
 - A minimal mental status examination to assess cognitive function.
2. The history and physical examination findings should lead the provider to other assessments as clinically indicated. There is no test for acute stress reaction, so testing is directed towards detection of associated medical conditions. Assessment may include:
 - Screen for toxicology if the symptom presentation indicates
 - Radiological assessment of patients with focal neurological findings or possible head injury

- Appropriate laboratory studies to rule out medical disorders that may cause symptoms of acute stress reactions (e.g., complete blood count [CBC], chemistry profile, thyroid studies, HCG, EKG, EEG)
3. A focused psychosocial assessment should be performed including active stressors, losses, current social supports, basic needs (e.g. housing, food, financial resources)
 4. A brief assessment of function based on general appearance and behavior should be completed to evaluate: 1) objectively impaired function; 2) subjectively impaired function; 3) baseline level of function (LOF) vs. current LOF; and 4) family and relationship functioning.

The approach to triage in the immediate response to traumatic exposure for service members with symptoms during ongoing military operations may vary markedly from the management of civilians exposed to traumatic events. Combat and operational stress reactions (COSR) management is targeted to preserve the fighting force and return the service member (SM) to functional status.

SEE MODULE A2 - Management of Combat And Operational Stress Reaction (COSR)

E. Assess Pre-Existing Psychiatric And Medical Conditions

Circumstances brought about by a traumatic event may complicate any existing psychiatric conditions or may exacerbate pre-existing pathology. Establishing safety and assurance may enable people to get back on track, and maintain their pre-trauma stable condition.

RECOMMENDATIONS

1. Assessment of patients with pre-existing psychiatric conditions to identify the vulnerable, high risk individuals and groups.
2. Referral to mental health specialty when indicated or emergency hospitalization if needed.

F. Risk Factors For Developing ASD/PTSD

Not all trauma survivors develop permanent disorder. In fact, many recover. Thus, the search for risk factors that increase vulnerability to chronic PTSD occurred early in the history of the disorder. The study of risk factors has

become increasingly popular, emphasizing environmental and demographic factors, personality and psychiatric history, dissociation, cognitive and biological systems, and genetic or familial risk.

Early identification of those at-risk for negative outcomes following trauma can facilitate prevention, referral, and treatment. Screening for current psychopathology and risk factors for future impairment can be accomplished via brief semi-structured interviews and standardized assessment questionnaires. Screening should address past and current psychiatric and substance use problems and treatment, prior trauma exposure, pre-injury psychosocial stressors, and existing social support. Event-related risk factors should also be assessed, including exposure to death, perception of life-threat, and peri-traumatic dissociation.

RECOMMENDATIONS

1. Individuals exposed to trauma should be screened for one or more of the following risk factors for developing ASD/PTSD.

Pre-traumatic factors

- Ongoing life stress
- Lack of social support
- Pre-existing psychiatric disorder
- Other pre-traumatic factors including: female gender, low socioeconomic status, lower level of education, lower level of intelligence, race (Hispanic, Japanese, other ethnic minority), reported abuse in childhood, report of other previous traumatization, report of other adverse childhood factors, family history of psychiatric disorders, poor training or preparation for the traumatic event.

Peri-traumatic or trauma related factors

- Severe trauma
- Type of trauma (interpersonal traumas such as torture, rape or assault convey high risk of PTSD)
- High perceived threat to life
- Age at trauma (school age youth, 40-60 years of age)
- Community (mass) trauma
- Other peri-traumatic factors including: history of peri-traumatic dissociation and interpersonal trauma.

Post-traumatic factors

- Ongoing life stress
- Lack of social support
- Bereavement
- Major loss of resources
- Other post-traumatic factors including: children at home and female with distressed spouse.

Risk Factors for ASD?

When evaluating risk factors for ASD, the clinician should keep in mind that ASD is defined as occurring in the first four weeks after a traumatic event. Thus pre-traumatic and peri-traumatic factors will be more likely to be relevant in this period. While it is possible that post-traumatic factors such as loss of financial resources may play a role, in many cases not enough time will have passed following the trauma for these factors to have developed.

Risk Factors for PTSD?

When evaluating risk factors for developing PTSD, the clinician should keep in mind that PTSD is defined as occurring only after four weeks have elapsed following a traumatic event. PTSD symptoms, however, may not appear until a considerable time has passed, sometimes surfacing years later.

Patients who are totally incapacitated, physically injured, or suffered major losses, are also at higher risk for developing PTSD. Different types of trauma have different toxicity, e.g., interpersonal violence (rape torture physical assault), is more likely to produce PTSD than impersonal events (accidents, group trauma, etc.). A high perceived threat to life may predict PTSD after major traumatic injury

Another major risk factor for the development of PTSD is poor social support at the time of the trauma. The intrapersonal characteristic of hardiness as well as postwar social support may be protective against developing PTSD. In contrast, negative life events in the postwar or trauma period are linked to PTSD. Gender differences in PTSD risks have been reported in studies of veterans. War-zone stressors appear preeminent for PTSD in men. Posttrauma resilience-recovery variables

are more important for women. However, the effects of combat exposure on women and men in recent conflicts warrant further study.

For further discussion of risk factors for PTSD - See Module B Annotation F

TRIAGE AND TREATMENT

G. Ensure Basic Physical Needs Are Met

Ensure trauma-exposed persons with acute stress symptoms have their basic needs met.

Trauma victims often have significant disruption to their routines for sleep, nutrition, exercise, access to finances, and health care. Their normal shelter, clothing, etc., may be destroyed or inaccessible. These disruptions are additionally traumatizing.

RECOMMENDATIONS

1. Acute intervention should ensure that the following needs are met:

Basic Needs

- Safety/Security/Survival
- Food, hydration, clothing and shelter
- Sleep
- Medication (i.e., replace medications destroyed/lost)
- Orientation
- Communication with family, friends and community
- Protection from ongoing threats/toxins/harm.

Psychological First Aid

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

DISCUSSION

Psychological first aid should be envisioned as the mental health correlate of physical first aid, with the goal being to “stop the bleeding”. The patient should be removed from the traumatic situation. When the situation is safe, the clinician should attempt to reassure the patient and encourage a feeling of safety.

In the Disaster Mental Health Response Handbook (Raphael, 2000), a group of PTSD experts propose three stages of care:

Protect:

Find ways to protect survivors from further harm and from further exposure to traumatic stimuli. If possible, create a "shelter" or safe haven for them, even if it is symbolic. The fewer traumatic stimuli people see, hear, smell, taste, or feel, the better off they will be.

Direct:

Kind and firm direction is needed and appreciated. Survivors may be stunned, in shock, or experiencing some degree of dissociation. When possible, direct ambulatory survivors:

- Away from the site of destruction
- Away from severely injured survivors
- Away from continuing danger

Connect:

Survivors who are encountered will usually have lost connection to the world that was familiar to them. A supportive, compassionate and nonjudgmental verbal or nonverbal exchange between you and survivors may help to give the experience of connection to the shared societal values of altruism and goodness. Help survivors connect:

- To loved ones
- To accurate information and appropriate resources
- To locations where they will be able to receive additional support

Triage:

The majority of survivors experience normal stress reactions. However, some may require immediate crisis intervention to help manage intense feelings of panic or grief. Signs of panic are trembling, agitation, rambling speech, and erratic behavior. Signs of intense grief may be loud wailing, rage, or catatonia. In such cases, attempt to quickly establish therapeutic rapport, ensure the survivor's safety, acknowledge and validate the survivor's experience, and offer empathy. Medication may be appropriate and necessary, if available.

H. Acute Symptom Management

It is likely that not all patients will require intervention immediately following a traumatic occurrence. Depending on the intensity and duration of the trauma, there will be people who will make it through unharmed. Often, if a person appears to be coping well and denies symptoms of ASD or PTSD, they may not need specialized care.

For people who show signs of ASD or PTSD (including symptoms of intrusive recollections, avoidance, numbing, and physiological hyperarousal when confronted with reminders of the trauma) psychological intervention, either alone or in combination with medication, may be indicated.

RECOMMENDATIONS

1. Symptoms treatment should be provided after basic needs are met (sleep, normalization, and other non-pharmacological modalities).
2. Apply a series of specific psychological interventions (individually or in a group) to reduce acute stress symptoms and to address both general recovery and specific symptoms (e.g., breathing/relaxation treatment).

Individual psychological interventions may include:

- Assurance/reassurance
- Defusing (3-phased discussion provided within hours of the crisis for purpose of assessment triage and acute symptom mitigation)
- Mitigate fear and anxiety
- Sleep hygiene

- Re-establish routine
- Exercise and nutrition
- Bereavement
- Survivor success
- Advise about alcohol/substance use
- Modulate mood/irritability

Group psychological interventions

- Groups may be effective vehicles for providing trauma related education, training in coping skills, and increasing social support especially in the context of multiple group sessions.
 - Group participation should be voluntary.
3. Peoples' reaction to ASR varies. Some want and feel a need to discuss the event and some have no such need. Respect individual and cultural preferences in the attempt to meet their needs as much as possible. Allow normal recovery and monitor.
 4. Consider a short course of medication for some individuals targeted for specific symptoms (e.g., sleep disturbance). [See Annotation M]

I. Psychological Debriefing

Reduce risk for development of PTSD following traumatic event.

In recent years, providing psychological debriefings to subjects following exposure to a traumatic event has been touted as an effective means of reducing subsequent development of PTSD. It has been widely used with victims of natural and man-made disaster as well as public safety personnel, crime and accident victims.

The approach grew out of practices and experiences involving the military of the United States and other western nations. For soldiers exhibiting signs of acute stress reactions following combat-related traumatic events, the practice of conducting early debriefings as part of a larger restoration approach, appeared to have significant impact on reducing more permanent disability.

The use of debriefings soon after exposure to traumatic events became part of military doctrine in the United States and elsewhere, as well as part of standards for early response to catastrophe for organizations such as

the Red Cross. Unfortunately, the technique appears to be of little help, and potentially harmful, as prophylaxis for PTSD

DEFINITIONS

In considering the use of debriefings as part of early interventions following trauma exposure, a distinction between the general approaches of psychological versus operational debriefings is in order.

Psychological Debriefing is a one-time individual and/or group review of a traumatic event, by survivors or other impacted persons, for the purpose of actively encouraging the individuals to: (a) talk about their experiences during the event, (b) recognize and verbalize their thoughts, emotions and physical reactions during and since the event, and (c) thereby reduce later PTSD. Psychological debriefings are led by specially trained debriefers according to several protocols. Some protocols emphasize normalization of symptoms and group support. Some include psycho-education and information about resources for those who find they need it.

The term "Psychological Debriefing" should not be extended to purely informational briefings or to operational debriefings.

Operational Debriefing is a routine individual or team review of the details of an event from a factual perspective, for the purpose of: (a) learning what actually happened for the historical record or planning purposes; (b) improving results in similar future situations or missions; and (c) increasing the readiness of those being debriefed for further action. Operational debriefings are conducted by leaders or specialized debriefers according to the organization's standing operational procedure.

Although operational debriefings achieve important short-term objectives of the organization, there is insufficient evidence that they can also reduce subsequent PTSD or other long-term negative outcomes. Organizations that use operational debriefings should train their debriefers to avoid causing unintentional psychological harm and to identify individuals who need mental health follow-up.

Critical Incident Stress Debriefing (CISD) is a formalized structured method of group review of the stressful experience of a disaster. In fact, **CISD was developed to assist first responders such as fire and police personnel, not the survivors of a disaster or their relatives.** CISD was never intended as a substitute for therapy, was designed to be delivered in a group format, and is meant to be incorporated into a larger, multi-component crisis intervention system labeled "Critical Incident Stress Management (CISM)." CISM incorporates several components, including pre-crisis intervention, disaster or large-scale incident, demobilization, and informational briefings, "town meetings," and staff advisement, defusing, CISD, one-on-one crisis counseling or support, family crisis intervention and organizational consultation, and follow-up and referral mechanisms for assessment and treatment, if necessary.

RECOMMENDATION

Individual

1. Recommend against Psychological Debriefing as a viable means of reducing acute posttraumatic distress (ASR or ASD) or progression to post-traumatic stress disorder.

Group

2. There is insufficient evidence to recommend for or against conducting structured group debriefing.
3. Compulsory repetition of traumatic experiences in a group may be counterproductive.
4. Group debriefing with pre-existing groups (teams, units, EMTs, co-workers, family members) may assist with group cohesion, morale and other important variables that have not been demonstrated empirically.
5. Group participation should be voluntary.

J. Education And Normalization / Expectancy Of Recovery

Education for trauma survivors and their families may help normalize common reactions to trauma, improve coping, enhance self-care, facilitate recognition of significant problems, and increase knowledge of and access to services. Individuals should be reassured about common reactions to traumatic experiences and advised

regarding positive and problematic forms of coping with them. Information about social support and stress management is particularly important. Opportunities to discuss emotional concerns in individual, family or group meetings can enable survivors to reflect on what has happened. Education regarding indicators that initial acute reactions are failing to resolve will be important. Signs and symptoms of PTSD, anxiety, depression, substance use disorders, and other difficulties should be explained. Survivors will need information about financial, mental health, rehabilitation, legal, and other services available to them, as well as education about common obstacles to pursuing needed services.

RECOMMENDATION:

1. All survivors should be given educational information to help normalize common reactions to trauma, improve coping, enhance self-care, facilitate recognition of significant problems, and increase knowledge of and access to services. Such information can be delivered in many ways, including public media, community education activities, and written materials.

See also CORE Module – Annotation E

K. Facilitate Social and Spiritual Support

Social support will be critical for helping the individual cope after a trauma has occurred. It may be necessary to identify potential sources of support and facilitate support from others (e.g., partners, family, friends, work colleagues, and work supervisors).

Hunter (1996) notes the need for integrated care for PTSD: "given the complex range of PTSD symptomatology, a successful treatment program will address not only the emotional issues that characterize the disorder but also its psychophysiological, cognitive, and interpersonal processes and existential meanings."

The terms "religious" and "spiritual" are both used in the clinical literature to refer to beliefs and practices to which individuals may turn for support following a traumatic event. Some researchers have attempted to differentiate between organized practices such as "attendance at services and other activities" and non-organized practices, including "prayer and importance of religious and spiritual beliefs" (Strawbridge et al., 1998). Because the terms are so

closely related, and because researchers in this area have not consistently differentiated between the two concepts, the reader should assume that in the discussion below we refer to religion/spirituality in the general sense and not in any specific terms.

RECOMMENDATION

1. Preserve an interpersonal safety zone protecting basic personal space (e.g., privacy, quiet, personal effects).
2. Provide nonintrusive ordinary social contact (e.g., a "sounding board," judicious use of humor, small talk about current events, silent companionship).
3. Provide opportunities for grieving for losses. Provide access to religious/spiritual resources when sought. (Providing space and opportunities for prayers, mantras, rites and rituals, and end-of-life care as determined important by the patient).
4. Consider providing direct spiritual care or ensuring patient access to spiritual care when sought.

L. Pharmacotherapy

Stress reactions produce biologic, psychological and behavioral changes. Biologic alterations include disruptions in neurochemicals, sleep patterns, hyper-arousal, and somatic symptoms (e.g., pain, gastrointestinal symptoms, etc). Psychological changes include: mood disturbances (e.g., emotional lability, irritability, blunting, numbing), anxiety (e.g., increased worry, ruminations) and cognitive disturbances (e.g., memory impairment, confusion and impaired task completion).

To facilitate providing physical needs, normalization, and psycho-education, it may be prudent, when possible, to wait 24 to 48 hours before beginning medications. Pharmacotherapy may be aided by determining whether the patient suffers from excessive adrenergic arousal or symptoms of psychomotor withdrawal. If non-pharmacological treatments fail to improve symptomatology, and potential medical causes of neuropsychiatric impairment are ruled out, then medications may be considered.

The use of medications for short-term treatment of targeted symptoms may be beneficial (e.g., insomnia).

Table 2: Summary Table – Pharmacotherapy for ASR

| R | Significant Benefit | Some Benefit | Unknown | No Benefit/Harm |
|---|---------------------|-----------------|---|------------------------|
| A | | | | |
| B | | Propranolol | | |
| C | | | | |
| I | | Benzodiazepines | Other Sympatholytics Antidepressants Anticonvulsants Atypical Antipsychotics Antihistamines | |
| D | | | | Typical Antipsychotics |

R = level of recommendation

A A strong recommendation that the intervention is always indicated and acceptable

B A recommendation that the intervention may be useful/effective

C A recommendation that the intervention may be considered

I Insufficient evidence to recommend for or against – the clinician will use clinical judgment

D A recommendation that a procedure may be considered not useful/effective, or may be harmful.

RECOMMENDATIONS

1. Strongly recommend providing for physical needs, sleep, normalization, and other non-pharmacological modalities.
2. Recommend the use of medication only for individuals who do not respond to non-pharmacological treatment as a normal recovery is expected from ASR.
3. Consider a short course of medication targeted for specific symptoms.
4. Consider management of sleep disturbance/insomnia (e.g., benzodiazepines, antihistamines).
5. Consider management of hyperarousal/excessive arousal/panic attacks. (e.g. benzodiazepines, propranolol [up to 10 days]).
6. There is insufficient evidence to support a recommendation for preventative use of a pharmacological agent to prevent the development of ASD or PTSD.

REASSESSMENT

M. Reassessment

Identify patients with persistent traumatic stress symptoms, related dysfunction or additional treatment needs.

Clinical reassessment within 4 days of the acute intervention is indicated to determine if there are persistent symptoms and to develop a follow-up plan.

Especially important are acute levels of traumatic stress symptoms, which predict chronic problems; for example, more than three-quarters of motor vehicle accident patients diagnosed with ASD will have chronic PTSD at 6 months post-trauma (Bryant and Harvey 2000). In follow-up appointments, it will be important to screen for PTSD and other anxiety disorders, depression, alcohol and substance abuse, problems with return to work and other productive roles, adherence with medication regimens and other appointments, and potential for re-traumatization.

RECOMMENDATION

1. Treatment response to the acute intervention should be reassessed. This should include an evaluation for the following risk factors:
 - Persistent or worsening traumatic stress symptoms (e.g., dissociation, panic, autonomic arousal, cognitive impairment)
 - Significant functional impairments (e.g. role/work, relationships)
 - Dangerousness (suicidal or violent ideation, plan, and/or intent)
 - Severe psychiatric comorbidity (e.g., psychotic spectrum disorder, substance use disorder or abuse)
 - Maladaptive coping strategies (e.g., pattern of impulsivity, social withdrawal, etc., under stress)
 - New or evolving psychosocial stressors
 - Poor social supports
2. Follow-up after acute intervention to determine patient status.
 - Patient does not improve or status worsens – refer to mental health provider and/or PTSD specialty team. Recommend continued involvement of the primary care provider in the treatment. Patients with multiple problems may benefit from a multi-disciplinary approach to include occupational therapy, spiritual counseling, recreation therapy, social work, psychology and/or psychiatry.
 - Patient demonstrates partial improvement (e.g. less arousal, but no improvement in sleep) – consider augmentation or adjustment of the acute intervention within 2 weeks.
 - Patient recovers from acute symptoms – provide education about acute stress reaction and contact information with instructions for available follow-up if needed.

FOLLOW-UP

N. Referral And Consultation With Mental Health

A crucial goal of follow-up activities is referral, as necessary, for appropriate mental health services. In fact, referral and subsequent delivery of more intensive interventions, will depend upon adequate implementation of screening. Screening, whether conducted in formal or informal ways, that can best help determine who is in need of referral. But even if those who might benefit from mental health services are adequately identified, factors such as embarrassment, fear of stigmatization and cultural norms may all limit motivation to seek help or pursue a referral. Those making referrals can directly discuss these attitudes about seeking help and attempt to preempt avoidance of needed services. Motivational interviewing techniques may help increase rates of referral acceptance.

RECOMMENDATIONS

1. Individuals who exhibit any of the following conditions should be referred to mental health:
 - Failure to respond to acute supportive interventions
 - Worsening of stress related symptoms
 - High potential for dangerousness
 - Development of ASD/PTSD
 - New onset of dangerousness or maladaptive coping to stress
 - Exacerbation of pre-existing psychiatric conditions
 - Deterioration in function
 - New onset stressors, poor social supports or inadequate coping skills

O. Monitor And Follow-Up

1. Follow-up should be offered to those individuals who request it.
2. Follow-up should be offered to individuals and groups at high risk of developing adjustment difficulties following exposure to major incidents and disasters, including individuals who:
 - Have acute stress disorder or other clinically significant symptoms stemming from the trauma
 - Are bereaved
 - Have a pre-existing psychiatric disorder
 - Have required medical or surgical attention
 - Were exposed to a major incident or disaster that was particularly intense and of long duration

Many trauma survivors experience some symptoms in the immediate aftermath of a traumatic event. These are not necessarily cause for long-term follow-up since, in most instances, symptoms will eventually remit. Those exposed to traumatic events and who manifest no symptoms after a period of time (approximately two months) do not require routine follow-up, but follow-up should be provided if requested.