Module A– Acute Stress

1. Individual or community exposed to trauma within the last 30 days [A]

2. Assess briefly based on general appearance and behavior [B]

3. Unstable, suicidal, or dangerous to self or others, or in need of urgent medical or surgical attention? [C]
   - Y: Provide appropriate care or refer to stabilize. Follow legal mandates
   - N: Assess environment for ongoing threats. Protect from further harm

4. Ensure basic physical needs are met [D]

5. Excessive arousal, dissociation, or impaired function? or Meet DSM-IV criteria for diagnosis of ASD? [E]
   - N: Offer contact/access information. Repeat screen for traumatic stress frequently. Provide secondary prevention and education
   - Y: Continue Treatment for ASD
Treatment for ACUTE Stress Disorder

Assess:
- medical and functional status [F]
- pre-existing psychiatric and medical conditions [G]
- risk factors for developing PTSD [H]

Initiate acute interventions
Provide:
- Education & normalization [I]
- Brief sessions psychotherapy with exposure and cognitive restructuring components [J]
- Acute symptom management: [K]
  -- Sleep disturbance
  -- Hyperarousal
  -- Pain
- Social & spiritual support [L]
Avoid:
- Individual and group debriefing [J]

Reassess symptoms and function [N]

- Persistent (≥1 month) or worsening traumatic stress symptoms, or
- Significant functional impairment, or
- High risk for developing PTSD? [N]

Monitor and follow up as indicated [O]

Continue to Module B PTSD
Patient presents with symptoms of PTSD, positive screening or previously diagnosed PTSD

2. Assess trauma exposure and the environment for ongoing threats and protect from further harm

3. Assess dangerousness to self/others based on observation

4. Is patient suicidal, medically unstable or dangerous to self or others?

5. Provide appropriate care or refer to stabilize. Follow legal mandates

6. Obtain medical history, physical examination, mental status and psychosocial assessment and appropriate lab tests

7. Meet DSM-IV criteria for diagnosis of PTSD or significant clinical symptoms suggestive of PTSD or functional impairment?

8. 11. Follow-up as indicated. Repeat screen for PTSD within 3-8 months and annually thereafter

Continue Treatment PTSD
Treatment for PTSD

Assess for co-occurring conditions and severity of PTSD.

- Summarize patient's problems
- Educate patient and family about PTSD
- Discuss treatment options and resources
- Arrive at shared decision regarding goals, expectations and treatment.

Develop collaborative interdisciplinary treatment plan
Determine optimal setting for care

Patient with diagnosis of PTSD (Continue from page B1)

- Initiate treatment using effective interventions for PTSD
- Address other issues using adjunctive treatment
- Manage co-occurring conditions

Continue
Reassessment and Follow-up
Reassessment/Follow-up PTSD

13
Reassess PTSD symptoms; diagnostic status, functional status; quality of life; additional treatment needs; patient preferences [N]

14
Is patient improving?

15
Patient demonstrates full remission? [O]

16
Discontinue treatment as appropriate for psychotherapy or medication. Educate patient about indications for, and route of access to future treatment [O]

17
No

18
Improved symptoms and functioning but requires maintenance treatment? [O]

19
Allow sufficient time for full response
- Continue/adjust therapy
- Optimize dose / frequency
- Change treatment modality
- Apply adjunctive therapies
- Increase level of care / refer to specialty [O]

20
No

21
Continue current course of treatment
- Consider stepping down frequency or dose
- Transition from intensive psychotherapy to care management.
- Transition from individual to group treatment modalities [O]
Table 1: Common Symptoms After Exposure to Trauma or Loss

<table>
<thead>
<tr>
<th>Physical</th>
<th>Cognitive/Mental</th>
<th>Emotional</th>
<th>Behavioral</th>
<th>Symptoms Presentation</th>
</tr>
</thead>
</table>
| * Chest pain * Chills * Difficulty breathing * Dizziness * Elevated blood pressure * Fainting * Nausea * Fatigue * Grinding teeth * Headaches * Muscle tremors * Profuse sweating * Rapid heart rate * Shock symptoms * Thirst * Twitches * Visual difficulties * Vomiting * Weakness | * Blaming someone * Change in alertness * Confusion * Difficulty identifying familiar objects or people * Hyper-vigilance * Increased or decreased awareness of surroundings * Intrusive images * Loss of orientation to time, place, person * Memory problems * Nightmares * Poor abstract thinking * Poor attention * Poor concentration * Poor decisions * Poor problem solving | * Agitation * Anxiety * Apprehension * Denial * Depression * Emotional shock * Fear * Feeling overwhelmed * Grief * Guilt * Inappropriate emotional response * Irritability * Loss of emotional control * Severe pain * Uncertainty | * Alcohol consumption * Antisocial acts * Change in activity * Change in communication * Change in sexual functioning * Change in speech pattern * Emotional outbursts * Erratic movements * Hyper-alert to environment * Inability to rest * Loss or increased appetite * Pacing * Somatic complaints * Startle reflex intensified * Suspiciousness * Withdrawal | **Physical** - chronic pain, migraines, or vague somatic complaints  
**Mental** - substance abuse, MDD, anxiety, or depression  
**Behavior** - irritability, avoidance, anger or non-compliance, self risk behavior (HIV), evokes aversion or fear in provider  
**Change** in function |
### Key Elements of Psychological First Aid (PFA)

- **Contact and Engagement** - Respond to contacts initiated by affected persons, or initiate contacts in a non-intrusive, compassionate, and helpful manner.
- **Safety and Comfort** - Enhance immediate and ongoing safety, and provide physical and emotional comfort.
- **Stabilization** (if needed) - Calm and orient emotionally overwhelmed or distraught survivors.
- **Information Gathering** - Current Needs and Concerns - Identify immediate needs and concerns, gather additional information, and tailor PFA interventions.
- **Practical Assistance** - Offer practical help to the survivor in addressing immediate needs and concerns.
- **Connection with Social Supports** - Help establish opportunities for brief or ongoing contacts with primary support persons or other sources of support, including family members, friends, and community helping resources.
- **Information on Coping** - Provide information (about stress reactions and coping) to reduce distress and promote adaptive functioning.
- **Linkage to Collaborative Services** - Link survivors with needed services and inform them about available services that may be needed in the future.

### Risk Factors for Developing ASD/PTSD

#### Pre-traumatic factors
1. Ongoing life stress
2. Lack of social support
3. Young age at time of trauma
4. Pre-existing psychiatric disorders, or substance misuse
5. History of traumatic events (e.g., MVA)
6. History of post-traumatic stress disorder (PTSD)
7. Other pre-traumatic factors, including: female gender, low socioeconomic status, lower level of education, lower level of intelligence, race (e.g., Hispanic, African-American, American Indian, and Pacific Islander), reported abuse in childhood, report of other previous traumatization, report of other adverse childhood factors, family history of psychiatric disorders, and poor training or preparation for the traumatic event.

#### Peri-traumatic or trauma related factors
1. Severe trauma
2. Physical injury to self or other
3. Type of trauma (combat, interpersonal traumas, such as killing another person, torture, rape, or assault, convey high risk of PTSD)
4. High perceived threat to life of self or others
5. Community (mass) trauma
6. Other peri-traumatic factors, including: history of peri-traumatic dissociation and interpersonal trauma.

#### Post-traumatic factors
1. Ongoing life stress
2. Lack of positive social support
3. Bereavement or traumatic grief
4. Major loss of resources
5. Negative social support (shaming or blaming environment)
6. Poor coping skills
7. Other post-traumatic factors, including: children at home and/or a distressed spouse.
### Early Interventions after Exposure to Trauma (<4 days after exposure)

<table>
<thead>
<tr>
<th>SR</th>
<th>Significant Benefit</th>
<th>Some Benefit</th>
<th>Unknown Benefit</th>
<th>No Benefit Potential Harm</th>
</tr>
</thead>
</table>
| I  | --                  | - Psychological First Aid  
- Psychoeducation and normalization  
- Social support | Spiritual support | -- |
| D  | --                  | --           | --             | Psychological debriefing |

### Early Interventions after Exposure to Trauma (4 to 30 days after exposure)

<table>
<thead>
<tr>
<th>SR</th>
<th>Significant Benefit</th>
<th>Some Benefit</th>
<th>Unknown Benefit</th>
<th>No Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>- Brief Cognitive Behavioral Therapy (4-5 sessions)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>- Social support</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| D  |                     |               | - Individual psychological debriefing  
- Formal psychotherapy for asymptomatic survivors  
- Benzodiazepines  
- Typical Antipsychotics |            |
| I  | - Psychoeducation and normalization  
- Imipramine  
- Propranolol  
- Prazosin  
- Other Antidepressants  
Anticonvulsants  
- Atypical Antipsychotics  
- Spiritual support  
- Psychological First Aid | - Group psychological debriefing |
### Psychotherapy Intervention for Treatment of PTSD

<table>
<thead>
<tr>
<th>Balance Benefit and Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significant Benefit</td>
</tr>
<tr>
<td>S</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>C</td>
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<td>I</td>
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</tbody>
</table>

Strongly recommend that patients who are diagnosed with PTSD should be offered one of the evidence-based **trauma-focused psychotherapeutic interventions** that include components of exposure and/or cognitive restructuring; or stress inoculation training. [A]

The choice of a specific approach should be based on the severity of the symptoms, clinician expertise in one or more of these treatment methods and patient preference, and may include:

- Exposure-based therapy (e.g., Prolonged Exposure),
- Cognitive-based therapy (e.g., Cognitive Processing Therapy),
- Stress management therapy (e.g., SIT) or
- Eye Movement Desensitization and Reprocessing (EMDR).
### Balance of Benefit and Harm

<table>
<thead>
<tr>
<th>S</th>
<th>R</th>
<th>Significant</th>
<th>Some Benefit</th>
<th>Unknown</th>
<th>No Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>SSRIs</td>
<td>Mirtazapine</td>
<td>Atypical antipsychotics (as adjunct)</td>
<td>Prazosin (for sleep/nightmares)</td>
<td>TCAs</td>
</tr>
<tr>
<td>B</td>
<td>SNRIs</td>
<td>- Mirtazapine</td>
<td>- Atypical antipsychotics (as adjunct)</td>
<td>- Prazosin (for sleep/nightmares)</td>
<td>- TCAs</td>
</tr>
<tr>
<td>C</td>
<td></td>
<td>- Prazosin</td>
<td>(for global PTSD)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td></td>
<td>- Benzodiazepines</td>
<td>[Harm]</td>
<td>Tiagabine</td>
<td>Guanfacine</td>
</tr>
<tr>
<td>I</td>
<td></td>
<td>- Atypical antipsychotic (monotherapy)</td>
<td>Conventional antipsychotics</td>
<td>Buspirone</td>
<td>Non-benzodiazepine hypnotics</td>
</tr>
</tbody>
</table>

### General Recommendations:
Risks and benefits of long-term pharmacotherapy should be discussed prior to starting medication and should be a continued discussion item during treatment.

Monotherapy therapeutic trial should be optimized before proceeding to subsequent strategies by monitoring outcomes, maximizing dosage (medication or psychotherapy), and allowing sufficient response time (for at least 8 weeks).

If there is some response and patient is tolerating the drug, continue for at least another 4 weeks.

If the drug is not tolerated, discontinue the current agent and switch to another effective medication.

If no improvement is observed at 8 weeks consider:
- Increasing the dose of the initial drug to maximum tolerated
- Discontinuing the current agent and switching to another effective medication
- Augmenting with additional agents.

Recommend assessment of adherence, side effects and management to minimize or alleviate adverse effects.

Assess for treatment burden (e.g., medication adverse effects, attending appointments) after initiating or changing treatment when the patient is non-adherent to treatment or when the patient is not responding to treatment.
**PHARMACOTHERAPY FOR PTSD**

**Monotherapy:**

- Strongly recommend that patients diagnosed with PTSD should be offered selective serotonin reuptake inhibitors (SSRIs), for which fluoxetine, paroxetine, or sertraline have the strongest support, or serotonin norepinephrine reuptake inhibitors (SNRIs), for which venlafaxine has the strongest support, for the treatment of PTSD. [A]
- Recommend mirtazapine, nefazodone, tricyclic antidepressants (TCAs), amitriptyline and imipramine, or monoamine oxidase inhibitors (phenelzine) for the treatments for PTSD. [B]
- Recommend against the use of guanfacine, anticonvulsants (tiagabine, topiramate, or valproate) as monotherapy in the management of PTSD. [D]
- The existing evidence does not support the use of bupropion, buspirone, and trazodone, anticonvulsants (lamotrigine or gabapentin) or atypical antipsychotics as monotherapy in the management of PTSD. [I]
- There is evidence against the use of benzodiazepines in the management of PTSD. [D]
- There is insufficient evidence to support the use of prazosin as monotherapy in the management of PTSD. [I]

**Augmented Therapy for PTSD:**

- Recommend atypical antipsychotics as adjunctive therapy: risperidone or olanzapine [B] or, quetiapine [C].
- Recommend adjunctive treatment with prazosin for sleep/nightmares. [B]
- There is insufficient evidence to recommend a sympatholytic or an anticonvulsant as an adjunctive therapy for the treatment of PTSD. [I]

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**Adjunctive Problem-Focused Method/Services for PTSD**

<table>
<thead>
<tr>
<th>If the client and clinician together conclude that the patient with PTSD:</th>
<th>Service/Training</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Is not fully informed about aspects of health needs and does not avoid high-risk behaviors (e.g., PTSD, substance use)</td>
<td>Provide patient education</td>
</tr>
<tr>
<td>2 Does not have sufficient self-care and independent living skills</td>
<td>Refer to self-care/independent living skills training services</td>
</tr>
<tr>
<td>3 Does not have safe, decent, affordable, stable housing that is consistent with treatment goals</td>
<td>Use and/or refer to supported housing services</td>
</tr>
<tr>
<td>4 Does not have a family that is actively supportive and/or knowledgeable about treatment for PTSD</td>
<td>Implement family skills training</td>
</tr>
<tr>
<td>5 Is not socially active</td>
<td>Implement social skills training</td>
</tr>
<tr>
<td>6 Does not have a job that provides adequate income and/or fully uses his or her training and skills</td>
<td>Implement vocational rehabilitation training</td>
</tr>
<tr>
<td>7 Is unable to locate and coordinate access to services such as those listed above</td>
<td>Use case management services</td>
</tr>
<tr>
<td>8 Does request spiritual support</td>
<td>Provide access to religious/spiritual advisors and/or other resources</td>
</tr>
</tbody>
</table>

**OTHER CONDITIONS**

| 9 Does have a borderline personality disorder typified by parasuicidal behaviors | Consider Dialectical Behavioral Therapy |
| 10 Does have concurrent substance abuse problem | Integrated PTSD substance abuse treatment (e.g., Seeking Safety) |