Q/What is the most effective way to relieve symptoms of acute stress disorder?

James M. Scott III, MD; Neil Nipper, MD
Eglin Air Force Base Family Medicine Residency, Eglin AFB, Fla

Rita Smith, MS, MEd
Lackland Air Force Base Medical Library, Lackland AFB, Tex

EVIDENCE-BASED ANSWER

A/ **COGNITIVE BEHAVIORAL THERAPY (CBT) THAT EMPHASIZES EXPOSURE-BASED TREATMENT** is the most effective intervention for adults with acute stress disorder (ASD) (strength of recommendation [SOR]: **B,** meta-analysis of limited-quality randomized controlled trials [RCTs]).

Exposure-based therapy reduces symptoms in adults with ASD more than CBT that focuses on cognitive restructuring; both therapies are better than no treatment at all (SOR: **B,** a limited-quality RCT).

Avoid drug treatment within 4 weeks of appearance of symptoms, unless distress is too severe to be managed with psychological treatment alone (SOR: **C,** consensus guideline).

Exposure-based therapy reduces subsequent symptoms of post-traumatic stress disorder in adults with acute stress disorder more than cognitive restructuring.

Evidence summary

ASD refers to a constellation of psychological symptoms that can occur within 4 weeks after a traumatic event.[1] (For more on ASD, see http://www.psychologynet.org/dsm/stress.html.) Patients with symptoms that persist beyond 4 weeks or develop after 4 weeks are diagnosed with post-traumatic stress disorder (PTSD). Approximately 12.5% of people who experience a traumatic event develop ASD, and 10% develop PTSD, although not all patients who develop PTSD have preceding ASD.[2] Early identification and treatment of ASD can decrease the percentage of patients who go on to develop PTSD.[2]

Exposure-based therapy works better than cognitive restructuring

A 2009 meta-analysis of small, limited-quality RCTs noted that CBT based on re-exposure to memories of the traumatic event, when started within 3 months of the event, is more effective than supportive counseling for adults with ASD; supportive counseling is more effective than no treatment at all.[3]

Exposure-based therapy reduces subsequent PTSD symptoms in adults with ASD more than cognitive restructuring.[2] Exposure-based CBT attempts to decrease unrealistic anxiety by challenging anxiety-provoking thoughts, situations, activities, and people that are not fundamentally dangerous.[4] Both exposure-based therapy and cognitive restructuring are better than no treatment at all.[3]

A small 2008 RCT evaluated the effect of weekly 90-minute CBT sessions with daily homework activities that were started within 1 month after a motor vehicle accident or nonsexual assault for patients with ASD.[2] Only 33% of patients who received exposure-based therapy had PTSD symptoms 6 weeks after starting treatment, whereas 63% of the cognitive restructuring group and 77% of untreated patients had PTSD at the 6-week follow-up.[2]

Medication shows no clear benefit over CBT

A 2007 meta-analysis of mixed-method trials concluded that medication should not be substituted for CBT, which is more effective.[5] The evidence showed no clear benefit for pharmacologic treatment; medication was as effective as placebo, but with higher drop-out rates.[5]

CONTINUED

TABLE

The Primary Care Post-Traumatic Stress Disorder Screen (PC-PTSD)

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:*

1. Have had nightmares about it or thought about it when you did not want to?
   YES NO
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
   YES NO
3. Were constantly on guard, watchful, or easily startled?
   YES NO
4. Felt numb or detached from others, activities, or your surroundings?
   YES NO

*Score 1 point for each "yes" answer. A score of 3 or higher has a sensitivity of 78% and specificity of 87% for PTSD.

Source: Prins A et al. *Prim Care Psychiatry*. 2003.[8]

Medication should not be substituted for cognitive behavioral therapy, which is more effective.

Recommendations

The US Veterans Affairs/Department of Defense Clinical Practice Guideline for the Management of PTSD and the 2007 Australian Guidelines for the Treatment of Adults with ASD and PTSD recommend 3 early interventions for patients exposed to traumatic events:[5,6]

- early assessment
- watchful waiting if ASD is not present
- psychological first aid (includes things like reducing physiologic arousal, ensuring patient's safety and security, and encouraging active use of social support and self-care strategies).

The US and Australian guidelines also recommend educating patients about typical responses to traumatic events (normalizing early responses), referring patients with ASD/PTSD symptoms to mental health providers for exposure-based psychotherapy, and adding selective serotonin reuptake inhibitors to CBT for patients severely impaired by ASD and patients diagnosed with PTSD.[5,6]

A recent comparative analysis[7] recommends using the Primary Care Post-Traumatic Stress Disorder (PC-PTSD) Screen[8] as a simple, effective way to identify patients with PTSD (**TABLE**). This tool hasn't yet been validated in patients with only ASD, however. **JFP**

ACKNOWLEDGMENT

The opinions and assertions contained herein are the private views of the authors and are not to be construed as official, or as reflecting the views of the US Air Force Medical Service or the US Air Force at large.

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