Recommendations for Pharmacological Treatment of Acute Stress Reactions

A National Center for PTSD Fact Sheet

Who should receive pharmacological treatment?

Pharmacological treatment for acute traumatic stress reactions (within one month of the trauma) is generally reserved for individuals who already have received individual or group debriefing and/or brief crisis-oriented psychotherapy. If these approaches are ineffective, clinicians should consider pharmacotherapy. To date there have been no controlled pharmacological treatment trials for acute stress reactions. Consequently, the present recommendations are based on controlled studies of insomnia, anxiety, and depression, as well as anecdotal evidence. Furthermore, there are no FDA approved medications for acute stress reactions and the only FDA approved medication for PTSD is sertraline.

Prior to receiving medication, the trauma survivor should have a thorough psychiatric and medical examination. Ongoing medical conditions, psychiatric diagnoses, current medications, and possible drug allergies should be assessed. In addition, clinicians should ask questions regarding alcohol, marijuana, and other drugs since these substances may interact with prescribed medications and may complicate an individual's psychological and physiological response to the trauma. For individuals with medical and/or surgical concerns, a clinician may need to take special precautions when prescribing psychotropic medications. It is also extremely important to consider possible drug interactions for individuals who are taking other prescribed or over-the-counter medications.

When should pharmacological treatment begin?

In some cases, a clinician may need to prescribe psychotropic medications even before he or she has completed the medical and psychiatric evaluation. The acute use of medications may be necessary when the survivor is dangerous, extremely agitated, or psychotic. In such circumstances, the individual should be taken to an emergency room. In the emergency room, short-acting benzodiazepines (e.g. lorazepam) or high potency neuroleptics (e.g. haldol) with minimal sedative, anticholinergic, and orthostatic side effects may prove effective. Atypical neuroleptics (e.g. risperidone), at relatively low doses, may also be useful in treating impulsive aggression.

After a disaster, some survivors experience extreme and persistent arousal in the form of anxiety, panic, hyper-vigilance, irritability, and insomnia. Empirical research has shown that hyper-arousal during the first few weeks following trauma is a risk factor for the development of PTSD. Techniques to reduce arousal include relaxation and breathing exercises, utilizing social supports, psychotherapy, and pharmacotherapy. Pharmacological agents for the treatment of trauma-related arousal include benzodiazepines and antiadrenergic agents such as clonidine, guanfacine and propranolol.

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Veterans
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Documents
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What pharmacological agents should clinicians prescribe?

Benzodiazepines are useful because they are effective and fast acting. In recent-trauma survivors, benzodiazepines can reduce anxiety and arousal and improve sleep. However, prolonged use may not be effective. In a study of trauma survivors with acute stress disorders (i.e., occurring 1-3 months after the trauma), the short-term use of benzodiazepines for sleep was associated with an acute reduction in posttraumatic stress symptoms (Mellman et al., 1998). However, another study found that the early and more prolonged use of benzodiazepines was actually associated with a higher rate of subsequent PTSD (Gelpin et al., 1996). It is recommended that benzodiazepines be used to treat extreme arousal, insomnia, and anxiety, but their use should be time limited. Other pharmacological agents may also be helpful in treating insomnia in persons suffering from acute traumatic stress. Low doses of trazadone, nefazadone, and amitriptyline are possible choices.

Antiadrenergic agents have not been studied for the treatment of acute stress reactions. However, several open trials have been conducted relating to chronic PTSD. These agents have been useful for some patients in controlling hyper-arousal, irritable aggression, intrusive memories, and insomnia. Low doses of propranolol have also been successfully used to combat stage fright and performance anxiety because it modulates physical and cognitive manifestations of stress. However, clinicians should prescribe clonidine, guanfacine and propranolol judiciously for survivors with cardiovascular disease. This is because these medications may reduce blood pressure. In addition, clonidine may induce rebound hypertension if the client's blood levels fall due to infrequent dosing or a sudden discontinuation. Furthermore, these agents should not be prescribed to persons with diabetes as they may interfere with counterregulatory hormone responses to hypoglycemia.

What other factors need to be considered?

Recent trauma survivors may also suffer from debilitating symptoms of depression. Since all three symptom clusters of PTSD respond to selective serotonin reuptake inhibitors (SSRIs), and because depressive symptoms originating soon after trauma may predict PTSD, it is recommended that SSRIs be considered for persistent posttraumatic depression. In addition, SSRIs may be useful for controlling anxiety and irritability. It is important to note that traumatized women, compared to men, may be particularly responsive to the beneficial effects of SSRIs. SSRIs as well as other antidepressants should be administered in a "start low and go slow" dosing regimen because some individuals may develop increased anxiety or agitation in response to them. In addition, individuals occasionally develop psychotic or manic symptoms in response to SSRIs.

Some individuals have preexisting psychiatric disorders, including preexisting PTSD, at the time that they experience trauma. The most recent trauma may exacerbate these preexisting conditions, making it essential to carefully assess the individual's psychotherapeutic and pharmacological needs. It is imperative that a clinician contact any other current treaters and maintain

continuity of care.

It is also possible that trauma will precipitate disorders other than depression, traumatic grief, Acute Stress Disorder, or PTSD. In such cases, careful assessment and diagnosis should inform appropriate treatment.

Finally, it is essential that treaters educate patients about their medication's interactions with alcohol, other medications, or substances of abuse. Treaters also need to (1) inform their patients of the medication's potential side effects, and (2) remain in close touch with their patients after initiating the use of these and other psychotropic agents. This will allow treaters to gauge the severity of any side effects, encourage compliance, and forestall complications that might arise as a result of extreme or otherwise idiosyncratic reactions to these medications. In addition, the added therapeutic support can help relieve the psychological burden from which people with posttraumatic distress suffer.

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