Acute Stress Disorder

Acute stress disorder (ASD) is a trauma- and stressor-related disorder characterized by intrusive memories, negative mood, dissociation, avoidance, and/or hyperarousal experienced during the first month after a potentially traumatic event. ASD was added to the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-IV*) in 1994 to describe and classify symptoms occurring in the early post-trauma period and to identify people at risk for developing posttraumatic stress disorder (PTSD). The rate of ASD following a potentially traumatic event varies from as low as 1% in victims of mixed trauma to as high as 59% in sexual assault victims. Victims of violent crime are at the highest risk for ASD; other risk factors include female gender, younger age, lower socioeconomic status, and traumatic experiences of longer duration. ASD often co-occurs with depression, anxiety disorders, and substance use disorders. The introduction of ASD into *DSM-IV* sparked considerable debate about the value of the diagnosis, and concerns have been raised about whether it reliably predicts PTSD and whether it pathologizes normal reactions to trauma. In response to criticism, the ASD diagnostic criteria were changed substantially in 2013 with the publication of *DSM-5*.

Acute Stress Disorder Diagnostic Criteria
A. Exposure to actual or threatened death, serious injury, or sexual violation.
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 event(s). 3. Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring. 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. • **Dissociative Symptoms** 6. An altered sense of the reality of one's surroundings or oneself. 7. Inability to remember an important aspect of the traumatic event(s). • **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 that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s). • **Arousal Symptoms** 10. Sleep disturbance. 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.
C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure.
D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
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 brief psychotic disorder.

Table 1. *DSM-5* Diagnostic Criteria for Acute Stress Disorder

Source: American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders: DSM-5*. Washington, D.C: American Psychiatric Association.

Rationale for the ASD Diagnosis

PTSD symptoms are frequently experienced in the days and weeks following a potentially traumatic event, but these symptoms usually remit naturally. The ASD diagnosis attempts to distinguish between these transient stress reactions and responses that may represent a precursor to PTSD. Early identification of individuals at risk for developing PTSD enables, in turn, early intervention aimed at preventing long-term dysfunction. Additionally, the ASD diagnosis facilitates access to mental health care (and insurance coverage) for individuals who

suffer clinically significant distress or impairment during the first month after a potentially traumatic event—a period during which they cannot meet the symptom-duration criterion for a PTSD diagnosis.

Assessing and Treating ASD

For several years after its inclusion in *DSM-IV,* ASD was assessed using various PTSD symptom inventories and the Peritraumatic Dissociative Experiences Questionnaire, due to a strong emphasis on dissociation in the *DSM-IV* ASD diagnostic criteria. The assessment of ASD became more standardized with the introduction of the Acute Stress Disorder Interview (ASDI) in 1998. The ASDI is a clinical interview that remains the primary assessment tool for ASD. Several self-report measures have also been developed, including the Stanford Acute Stress Reaction Questionnaire and a self-report version of the ASDI called the Acute Stress Disorder Scale. Assessing ASD is complicated by the considerable instability of psychological states and symptoms in the early post-trauma period. Moreover, when a potentially traumatic event includes head injury, disentangling ASD symptoms from those of traumatic brain injury can be challenging.

The primary goal of treatment for ASD is reducing long-term PTSD symptom burden. A limited number of studies have demonstrated that focused early interventions for ASD may reduce the risk of developing PTSD. For example, in a study in which individuals with ASD were randomly assigned to receive either brief cognitive behavioral therapy (CBT) or supportive counseling, those receiving CBT were less likely to develop PTSD and continued to show lower symptom levels up to four years later.

Does ASD Predict PTSD?

Most research has indicated that the ASD diagnosis has reasonably good positive predictive power, with 50-75% of individuals who meet ASD diagnostic criteria eventually developing PTSD, but poor sensitivity, with fewer than 50% of individuals who meet PTSD diagnostic criteria having previously met criteria for ASD. Thus, the ASD diagnosis fails to identify the majority of people who will go on to develop PTSD after a potentially traumatic event. Moreover, ASD's predictive power is worse in children than in adults. These results have raised questions about the predictive utility of the diagnosis. However, the ASD diagnosis predicts PTSD as well as any other identified risk factor does; no single predictor, including PTSD symptoms, can accurately distinguish individuals who will recover naturally after trauma from those whose symptoms will persist or intensify. Further investigation of the conjoint impact of multiple risk factors operating in conjunction—including ASD—will be needed to improve prediction of who goes on to develop PTSD following a potentially traumatic event.

Criticism of the ASD Diagnosis

Aside from questions about its ability to predict PTSD, the ASD diagnosis has been subject to a variety of other criticisms. Many mental health professionals have argued that a diagnosis (ASD) should not exist primarily to predict another diagnosis (PTSD), and that distinguishing between two diagnoses largely on the basis of duration of symptoms is not justified. In other words, ASD and PTSD may be more parsimoniously conceptualized as a single disorder that persists beyond one month in only some individuals. Other experts have argued that because most trauma survivors gradually adapt within the first month and never develop PTSD, the ASD diagnosis, which can be made as early as three days after trauma exposure, inappropriately pathologizes short-term reactions that are likely to resolve naturally without intervention. Another major criticism stems from the requirement in the initial *DSM-IV*

ASD criteria that an individual endorse at least three dissociative symptoms. This requirement was based on the hypothesis that dissociation during or soon after a traumatic event plays an essential role in impeding emotional processing and hindering adaptation. Because little empirical evidence supports this hypothesis, the dissociative symptoms requirement has engendered substantial controversy, with researchers noting that this criterion rules out an ASD diagnosis in many individuals who go on to develop PTSD. *DSM-5* consequently dropped the dissociative symptoms requirement, and the *DSM-5* ASD diagnostic criteria may have stronger predictive power as a result. Finally, ASD assessment is focused primarily on fear-based reactions, and there has been increasing recognition that not all traumatic events entail peri-event fear (e.g., some traumas do not entail direct exposure to threats). Consequently, critics have noted that the ASD construct overlooks various non-fear-based emotional, behavioral, cognitive, and spiritual consequences of trauma.

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See Also

Trauma

Posttraumatic Stress Disorder

Trauma- and Stressor-Related Disorders

Psychotherapy

Resilience

Further Readings

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