CIGNA ADOPTED PRACTICE GUIDELINE FOR THE TREATMENT OF PATIENTS WITH ACUTE STRESS DISORDER OR POSTTRAUMATIC STRESS DISORDER

Ad Hoc Behavioral Health Guideline Committee

Cigna Clinical Guidelines and Steering Committee

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Overview

This document is an overview of the Cigna adopted clinical practice guideline for the treatment of patients with Acute Stress Disorder or Post Traumatic Stress Disorder. It is an adoption of the American Psychiatric Association Clinical Practice Guideline for the Treatment of Acute Stress Disorder or Post Traumatic Stress Disorder

Cigna has adopted this guideline as an evidenced base practice, not intended to supersede the clinical expertise and judgment of the practitioner, but to provide options for evidentiary support, diagnostic and treatment standardization and best practice decision making in managing Major Depression. Cigna recognizes that clinical exceptions to these best practices may arise and recommends that these be documented in the member's medical chart, including all pertinent rationales for treatment choices.

The adoption of this guideline does not indicate that Cigna endorses any or all of the findings, determinations or offerings with regards to specific medications that may be referenced in this or the American Psychiatric Association guideline. All Food and Drug Administration (FDA) warnings and guides and relevant formularies should be considered in determining medication treatment protocols. The treating clinician has the obligation to remain current on medication and equipment alerts or warnings that may be announced by the FDA and other regulatory sources.

Obtaining the APA Clinical Practice Guideline

The American Psychiatric Association *Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder, Second Edition* (2004) and *Guideline Watch for the Practice Guideline for the Treatment of Patients With Acute Stress Disorder and Posttraumatic Stress Disorder 2009)* is made freely available by the APA with all applicable copyright rules enforced. The complete text can be found at www.psych.org/psych_pract/treatg/pg/prac_guide.cfm.

Cigna Adopted Guideline for the Treatment of patients with Acute Stress Disorder and Posttraumatic Stress Disorder

There are many interventions and activities available to the practitioner and member for the treatment of patients with Acute Stress Disorder (ASD) and Posttraumatic Stress Disorder (PYSD). The following is a summary of the treatment guidelines adopted from the APA Practice Guideline and does not represent all of the options, paths and information available in the complete text referenced above.

Summary Highlight of Adopted Guideline

Assessment and Diagnosis

Acute Stress Disorder	Posttraumatic Stress Disorder
A. Exposure to a traumatic event with both of the following:	Same as ASD
- Experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury or a threat to physical integrity of self or others - the person's response was intense fear, helplessness or horror	Same as ASD
B. Either while or after experiencing the event, the individual had at least 3 out of the 5 following:	**B. The traumatic event is persistently reexperienced in one or more of the following ways:**
- Numbing, detachment, absence of emotional responsiveness - Decreased awareness of their surroundings - derealization - depersonalization - dissociative amnesia	- recurrent, intrusive, distressing recollections of the event - recurrent distressing dreams - reliving the experiences, illusions, hallucinations, dissociative flashbacks - intensive psychological distress at exposure to internal or external cures that are similar to an aspect of the traumatic event. - physiological reactivity on exposure to internal or external cues that are similar to an aspect of the traumatic event.

C. The traumatic event is re-experienced through at least one of the following	**C. Persistent Avoidance of Stimuli associated with the trauma; numbing of responsiveness indicated by 1 or more of the following:**
- Dreams/nightmares	- efforts to avoid thoughts, feelings,
- Recurrent images/thoughts - flashbacks/reliving - distress at reminders/triggers	conversation associated with the trauma - efforts to avoid, activities, places or people associated with the trauma - inability to recall an important aspect of the trauma - Markedly Diminished interest participation in significant activities - Feelings of detachment or estrangement from others - Restricted range of affect - Sense of doom or foreshortened future
D. Marked Avoidance of associated stimuli	**D. Persistent Symptoms of increased arousal, not present before the trauma as indicated by two or more of the following:**
	- difficulty falling or staying asleep - irritability or outbursts of anger - difficulty concentrating - Hyper-vigilance - exaggerate startle response
E. Marked Anxiety or Arousal	**E. Duration of the disturbance (above symptoms greater than 1 month)**
- Difficulty sleeping, irritability, hypervigilaince - Exaggerated startle response, motor restlessness	
F. The disturbance causes clinically significant impairment in functioning	**F. The disturbance causes clinically significant functional impairment**
G. Occurs within 4 weeks of the traumatic event, lasts at least 2 days-4 weeks	

H. The disturbance is not due to a general medical condition or effect of a substance or is the result of an exacerbation of a preexisting mental, developmental or personality disorder.	

Sub-Typing

ASD Sub-Types	PTSD Sub-Types	Characteristics
None	1. ACUTE	Symptom duration < 3months
	2. Chronic	Symptom duration > 3months
	□ Delayed Onset	Symptoms appear at least 6 months after the trauma

Psychiatric Management

Heading 1	Heading 2	Heading 3
Therapeutic Alliance	- Establish trust, and boundaries	
Identify Treatment Goals	- Reduce the severity of ASD or PTSD symptoms - Reduce trauma related to co-morbid conditions - Improve Adaptive functioning or promote normal developmental progression - Protect against relapse - Reconstruct personal schema of risk, safety and protection	
Establish treatment plan	- In coordination with other treating professionals as combination therapies are most often utilized	
1. Physical/psychological safety	- Ensuring environmental safety; ensuring absence of suicidal ,homicidal ideation and/or plan to address	
2. Adaptive coping/ Psychoeducation	- Providing education regarding the disorder; expectations and how to deal with these on a go-forward basis.	

3. Psychopharmacology	- Selective Serotonin Reuptake Inhibitors are recommended as first line - antidepressants. Tricyclic and other Antidepressants are - recommended as second line pharmacological treatment Benzodiazepines are useful in calming acute anxiety, but dependency issues and lack of demonstrated effect on the core symptoms of avoidance and dissociation must be considered, and make it a relatively - contraindicated group. Additionally noted was the presence of rebound anxiety. Second generation/Atypical antipsychotics are useful, where there is co-morbid psychosis or the presence of psychotic symptoms. But does not have	<u>First Line SSRIs</u> Sertraline 50-200mg/d10 Paroxetine 20-60mg/d10 Fluoxetine 20-60mg/d10 Fluvoxamine 50-150mg/d10 Citalopram 2060mg/d10 Escitalopram 10-29 mg/d.10 <u>Second Line Antidepressants</u> Nortriptyline 50-150mg/d10
	- specific effect on the core symptoms. Sympatholytics/ Alpha-adrenergic antagonists/beta blockers , have a role in aiding with sleep, decreasing levels of recall of - distressing memories, reduce stress Anticonvulsants/Mood Stabilizers may have a role in treating hyperarousal, reexperiencing and avoidance/numbing	Amitriptyline 150-300mg/d10 Imipramine 150-300mg/d10 Desipramine 100-300mg/d10 Protriptyline 30-60mg/d10 Clomipramine 150-250mg/d.10
4. Psychotherapy	- Cognitive Behavior Therapy has been shown to be helpful in preventing PTSD and promoting recovery. - Supportive Therapy and case Management have evidence base for success in acutely traumatized persons - Exposure Therapy/Eye Movement Desensitization reprocessing	
5. Co-Morbidities	- All co-morbidities such as pre-existing mental disorder, substance misuse and abuse should be	

	addressed as early in the treatment process as possible	
Treatment Resistance	- All patients should have on-going monitoring of medication (adherence, dosage, efficacy, side effect). Those with adequate treatment with a first line medication	Step approach: Psychotherapeutic intervention combined with pharmacological, followed by the assessment of adequacy and compliance. If treatment is adequate and no progress noted, consider the addition of or switch to complementary strategy; reassessment of psychosocial stressors

Provider Comments

Cigna values our clinical partners and requests your feedback, questions and or concerns regarding these guidelines. These may all be directed to:

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References

American Psychiatric Association Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Post Traumatic Stress Disorder (2004) *Am J Psychiatry* 161 (11 Supple): 3:31

American Psychiatric Association Guideline Watch: Practice Guidelines for the Treatment of Patients with Acute Stress Disorder and Post Traumatic Stress Disorder (March 2009)

American Psychiatric Association *Diagnostic and Statistical Manual of Mental disorder, 4th Ed Test Revision*