

Exclusive Cochrane summary

Acute traumatic stress treatment

4 November, 2011

This Cochrane review looked at early psychological interventions to manage and treat acute traumatic stress symptoms

Figures and tables can be seen in the attached print-friendly PDF file of the complete article

Review question

What is the effectiveness of psychological treatments and interventions for acute traumatic stress reactions beginning within three months of a traumatic event? And how do these compare with controlled interventions and other forms of support or psychological interventions?

Nursing implications

The psychological impact of a traumatic event, such as physical or sexual assault, military combat, violent crime, severe accidents, and natural and man-made disasters affects people differently.

Some are resilient and experience short-term or subclinical reactions for a time then recover. Most of these people recover without medical or psychological intervention and go on with their lives.

For others, the trauma is overwhelming and they may begin to display symptoms such as depression, phobic reactions or acute stress disorder (ASD). Those who have ASD and are untreated often develop post-traumatic stress disorder (PTSD).

Several studies have focused on evaluating interventions that lessen the effects of acute traumatic stress and aim to prevent chronic PTSD. A review compared the effectiveness of different interventions.

Study characteristics

This summary is based on a Cochrane review of 15 randomised controlled trials.

Any individual who experienced a traumatic event and began psychological intervention within three months for "acute traumatic stress symptoms" was eligible. Trauma was defined as any condition recognised as such by criterion A1 of *DSM-IV*. For this review, the term "acute traumatic stress symptoms" referred to people with symptoms of ASD, acute PTSD, sub-threshold ASD and sub-threshold acute PTSD.

A diagnosis of ASD required symptoms to occur within four weeks of the trauma and to last for at least two days. Diagnosis of acute PTSD required the symptoms to be present for more than a month. For a chronic PTSD diagnosis, symptoms had to be present for at three months or more.

The diagnoses of ASD and PTSD featured four sets of symptoms: dissociative symptoms such as numbing; frequently re-experiencing the traumatic event; avoidance of any stimuli or place that would remind the person of the traumatic event; and heightened arousal such as becoming easily startled.

Interventions considered included any psychological intervention designed to reduce or treat traumatic stress symptoms in people identified as being symptomatic when they entered the study. Interventions could be offered by one or more health professionals or lay persons, provided that contact between therapists and participants occurred at least twice.

Interventions included: trauma-focused cognitive behavioural therapy (TF-CBT), including exposure therapy; trauma-focused cognitive group therapy; and eye movement desensitisation and reprocessing (EMDR). Other interventions were non-trauma focused cognitive behavioural therapy; psychological therapies such as hypnosis or counselling; educational interventions; stepped care interventions; and any intervention aimed at enhancing positive coping skills.

Interventions were compared with a waiting list, usual care or other interventions. The frequency or number of sessions varied from two to six, or seven sessions and more. Eight studies had follow-up beyond six months, but the number of participants was small.

The primary outcome was clinician-rated severity of traumatic stress symptoms. Clinicians used various standard measures to report this. Self-reported stress symptoms related to standard measures were used as secondary outcomes.

Summary of key evidence

Of the 15 studies, 12 provided the main evidence to support the finding that TF-CBT was effective in treating acute traumatic stress (early traumatic stress symptoms) in people with symptoms. This was more beneficial for people with ASD or acute PTSD.

A total of 471 participants found TF-CBT more effective than a waiting list intervention, while 198 felt TF-CBT was more effective than supportive counselling. Four studies showed people were still experiencing the positive effects of TF-CBT over supportive counselling at six months follow-up.

This review looked at other psychological interventions such as cognitive restructuring, relaxation training and structured writing, but the evidence showed that TF-CBT had the greatest effect.

Most symptomatic individuals were likely to benefit from TF-CBT given within one to three months after the trauma, although improvements may not be large.

Best practice recommendations

These results of this review suggest nurses should enable patients with ASD and acute PTSD to gain access to TF-CBT within one to three months of the trauma.

Nurses should take part in trauma-focused psychological therapy training to deliver this effectively to prevent acute traumatic stress and PTSD.

The full review report, including references, can be accessed [here](#).

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References: Roberts NP et al (2010) Early psychological interventions to treat acute traumatic stress symptoms. Cochrane Database of Systematic Reviews; Issue 3, Art No: CD007944. DOI: 10.1002/14651858.CD007944.pub2

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