

Acute Stress Disorder

A National Center for PTSD Fact Sheet

By Laura E. Gibson, Ph.D., University of Vermont

What is Acute Stress Disorder?

Acute Stress Disorder, or ASD, is a psychiatric diagnosis that was introduced into the DSM-IV in 1994. The current diagnostic criteria for ASD are similar to the criteria for PTSD, although the criteria for ASD contain a greater emphasis on dissociative symptoms and the diagnosis can only be given within the first month after a traumatic event. The inclusion of ASD in the DSM-IV was not accompanied by extensive research, and some debate exists regarding whether the diagnostic criteria accurately reflect pathological reactions to trauma that occur within the first month after a trauma¹. However, even though debate exists about the empirical basis of the diagnosis, it has been found to be highly predictive of subsequent PTSD.

How Common Is ASD?

Because ASD is a relatively new diagnosis, research on the disorder is in the early stages. Studies of ASD have utilized a variety of measurement tools with varying degrees of reliability and validity. The following rates should be interpreted with some caution, and it is possible that rates will change as measures for ASD become more uniform among researchers.

Studies of motor vehicle accident (MVA) survivors have found rates of ASD ranging from approximately 13%^{2,3} to 21%⁴. A study of survivors of a typhoon revealed an ASD rate of 7%⁵ while a study of survivors of an industrial accident revealed a rate of 6%.⁶ A rate of 19% was found in survivors of violent assault⁷ while a rate of 13% was found in a mixed group consisting of survivors of assaults, burns, and industrial accidents.⁸ A recent study of victims of robbery and assault found that 25% met criteria for ASD⁹ while a study of victims of a mass shooting found that 33% met criteria.¹⁰

A study that used PTSD criteria and evaluated rape survivors within the first month of a trauma revealed a rate of 94%.¹¹ This last study evaluated PTSD diagnostic criteria related to the first month of a trauma. Therefore, it did not assess for the presence of dissociative symptoms that are specific to the diagnosis of ASD (but not PTSD). However, the Rothbaum et al.¹¹ study is included here to give the reader a sense of the level of posttraumatic sequelae that may be expected after sexual assault.

Who is at risk for ASD resulting from trauma?

While many studies have examined factors that place individuals at risk for developing PTSD, only a handful of studies have examined risk factors for the development of ASD. One retrospective study¹² found that individuals with exposure to prior trauma, individuals with prior PTSD, and individuals with more psychiatric dysfunction were all more likely to develop ASD when confronted with a new traumatic stressor. Bryant and Harvey¹ report that in their sample of MVA survivors without head injuries, depression score, history of psychiatric treatment, history of PTSD, and prior motor vehicle accidents were strong predictors of ASD severity (accounting for 61% of the variance). There is also some evidence that individuals prone to experiencing dissociation in the face of traumatic stressors may be more likely to develop ASD.¹³

How do PTSD and ASD differ?

ASD and PTSD differ in two fundamental ways. The first difference is that the diagnosis of ASD can be given only within the first month following a traumatic event. If posttraumatic symptoms were to persist beyond a month, the clinician would assess for the presence of PTSD. The ASD diagnosis would no longer apply. ASD also differs from PTSD in that it includes a greater emphasis on dissociative symptoms. An ASD diagnosis requires that a person experience three symptoms of dissociation (e.g., numbing, reduced awareness, depersonalization, derealization, or amnesia) while the PTSD diagnosis does not include a dissociative symptom cluster. (Please see Bryant and Harvey's comprehensive text on ASD¹ for a thorough discussion of the differences between ASD and PTSD.)

How predictive of PTSD is ASD?

A diagnosis of ASD, in the absence of treatment, appears to be an accurate predictor of subsequent PTSD. Harvey and Bryant³ found that 78% of MVA survivors who initially met criteria for ASD met criteria for PTSD 6 months posttrauma. In a similar study of MVA survivors with mild traumatic brain injury, 82% of those initially diagnosed with ASD met criteria for PTSD 6 months posttrauma¹⁴. Brewin et al.⁷ found that 83% of assault victims who initially met criteria for ASD met criteria for PTSD at a 6-month follow-up.

Bryant and Harvey¹ note that while ASD is highly predictive of subsequent PTSD, subthreshold ASD (which is typically ASD without the dissociative symptoms) is also a good predictor of PTSD. This suggests that the ASD criteria do not adequately capture all individuals who are at risk for developing full-blown PTSD. The reason for this appears to be that some individuals at risk for PTSD do not develop acute dissociative symptoms and therefore do not ever meet criteria for ASD. Research is currently underway regarding the different trajectories that individuals follow in the development of PTSD.

How is ASD diagnosed?

Because ASD is a relatively new diagnosis, there are few well-established and empirically validated measures to assess it. Although a comprehensive review of assessment measures is beyond the scope of this fact sheet, the tools with the strongest psychometric properties are described below:

* The *Acute Stress Disorder Interview (ASDI)*¹⁵ is the only structured clinical interview that has been validated against DSM-IV criteria for ASD. It appears to meet standard criteria for internal consistency, test-retest reliability, and construct validity. The interview was validated by comparing it with independent diagnostic decisions made by clinicians with experience in diagnosing both ASD and PTSD.

* The *Acute Stress Disorder Scale (ASDS)*¹⁶ is a self-report measure of ASD symptoms that correlates highly with symptom clusters on the ASDI. It has good internal consistency, test-retest reliability, and construct validity. Both scales may be found in Bryant and Harvey's text on ASD.¹

Are there effective treatments for ASD?

Cognitive-behavioral interventions

At present, cognitive-behavioral interventions during the acute aftermath of trauma exposure have yielded the most consistently positive results in terms of preventing subsequent posttraumatic psychopathology. Four out of five randomized clinical trials (RCTs) related to early cognitive-behavioral interventions during the acute aftermath of trauma^{17,18,19,20} found that the Cognitive-Behavioral Therapy (CBT) group experienced a greater reduction of PTSD symptoms than comparison groups. One of the RCTs²¹ did not find this to be true. The study by Brom et al.²¹ found that all three active conditions (desensitization, hypnotherapy, and psychodynamic therapy) yielded equal improvement relative to the waitlist control group. However, the Brom et al.²¹ study lacked a treatment adherence measure so it is unclear whether the CBT intervention was implemented in a standardized manner relative to other studies of CBT.

A different controlled (but not randomized) comparison of a CBT versus an assessment-only course of action in the acute phase posttrauma found fewer PTSD symptoms in the CBT group at a 5 1/2 -month follow-up.²²

Bryant and colleagues^{15,19} have conducted the only studies that specifically assessed and treated ASD. They have shown that a brief cognitive-behavioral treatment may not only ameliorate ASD, but it may also prevent the subsequent development of PTSD. Approximately 10 days after exposure to an MVA, industrial accident, or nonsexual assault, Bryant and colleagues randomly assigned those with ASD to five individual, 11/2-hour sessions of either a cognitive-behavioral treatment or a supportive counseling control condition. They found that fewer CBT subjects met criteria for PTSD posttreatment and 6 months later. In the 1999 study, Bryant and colleagues compared two different individual CBT approaches (prolonged exposure plus anxiety management and prolonged exposure alone) to a supportive counseling intervention. They found that both CBT groups showed significantly greater reductions in PTSD symptom severity compared to the supportive counseling group. (Please see Bryant and Harvey's text¹ for a detailed description of their cognitive-behavioral intervention for ASD.)

Psychological debriefing

Psychological debriefing is an early intervention that was originally developed for rescue workers that has been more widely applied in the acute aftermath of

potentially traumatic events. RCTs of debriefing have yielded inconsistent findings in terms of its efficacy. A review of the literature on debriefing RCTs²³ concluded that there is little evidence to support the continued use of debriefing with acutely traumatized individuals. Mitchell and Everly²⁴, the originators of the debriefing model, have made the cogent argument that most of the debriefing RCTs to date have studied only one component (debriefing) of the longer-term and more comprehensive Critical Incident Stress Management model. It is possible that this more comprehensive intervention would prove efficacious, but to date no RCTs have been conducted using the full intervention.

ADDITIONAL INFORMATION

Please see Bryant and Harvey's comprehensive text, *Acute Stress Disorder: A Handbook of Theory, Assessment, and Treatment*¹, published by the American Psychological Association. This contains an overview of relevant research as well as theoretical and treatment considerations.

Related Fact Sheets

Assessment of PTSD

Provides brief information about how PTSD is assessed

Risk factors

A fact sheet about the risk factors for adverse outcomes in natural and human-caused disasters

What is PTSD?

Answers basic questions about the signs and symptoms of PTSD, who gets it, how common it is, and what treatments are available

References

1. Bryant, R.A., & Harvey, A.G. (2000). *Acute Stress Disorder: A handbook of theory, assessment, and treatment*. Washington, D.C.: American Psychological Association.
2. Harvey, A.G., & Bryant, R.A. (1998a) Acute Stress Disorder following mild traumatic brain injury. *Journal of Nervous and Mental Disease*, 186, 333-337.
3. Harvey, A.G., & Bryant, R.A. (1998b). The relationship between Acute Stress Disorder and Posttraumatic Stress Disorder: A prospective evaluation of motor vehicle accident survivors. *Journal of Consulting and Clinical Psychology*, 66, 507-512.
4. Holeva, V., TARRIER, N., & Wells, A. (2001). Prevalence and predictors of Acute Stress Disorder and PTSD following road traffic accidents: Thought control strategies and social support. *Behavior Therapy*, 32, 65-83.

5. Stabb, J.P., Grieger, T.A., Fullerton, C.S., & Ursano, R.J. (1996). Acute Stress Disorder, subsequent Posttraumatic Stress Disorder and depression after a series of typhoons. *Anxiety, 2*, 219-225.
6. Creamer, M., & Manning, C. (1998). Acute Stress Disorder following an industrial accident. *Australian Psychologist, 33*, 125-129.
7. Brewin, C.R., Andrews, B., Rose, S., & Kirk, M. (1999). Acute Stress Disorder and Posttraumatic Stress Disorder in victims of violent crime. *American Journal of Psychiatry, 156*, 360-366.
8. Harvey, A.G., & Bryant, R.A. (1999). Acute Stress Disorder across trauma populations. *Journal of Nervous and Mental Disease, 187*, 443-446.
9. Elklit, A. (2002). Acute Stress Disorder in victims of robbery and victims of assault. *Journal of Interpersonal Violence, 17*, 872-887.
10. Classen, C., Koopman, C., Hales, R., & Spiegel, D. (1998). Acute Stress Disorder as a predictor of posttraumatic stress symptoms. *American Journal of Psychiatry, 155*, 620-624.
11. Rothbaum, B.O., Foa, E.B., Riggs, D.S., Murdock, T., & Walsh, W. (1992). A prospective examination of Post-traumatic Stress Disorder in rape victims. *Journal of Traumatic Stress, 5*, 455-475.
12. Barton, K.A., Blanchard, E.B., & Hickling, E.J. (1996). Antecedents and consequences of Acute Stress Disorder among motor vehicle accident victims. *Behaviour Research and Therapy, 34*, 805-813.
13. Bryant, R.A., Guthrie, R.M., & Moulds, M.L. (2001). Hypnotizability in Acute Stress Disorder. *American Journal of Psychiatry, 158*, 600-604.
14. Bryant, R.A., & Harvey, A.G. (1998). The relationship between Acute Stress Disorder and Posttraumatic Stress Disorder following mild traumatic brain injury. *American Journal of Psychiatry, 155*, 625-629.
15. Bryant, R.A., Harvey, A.G., Dang, S., & Sackville, T. (1998). Assessing Acute Stress Disorder: Psychometric properties of a structured clinical interview. *Psychological Assessment, 10*, 215-220.
16. Bryant, R.A., Moulds, M., Guthrie, R. (2000). Acute Stress Disorder scale: A self-report measure of Acute Stress Disorder. *Psychological Assessment, 12*, 61-68.
17. Gidron, Y., Gal, R., Freedman, S.A., Twiser, I., Laudén, A., Snir, Y., & Benjamin, J. (2001). Translating research findings to PTSD prevention: Results of a randomized-controlled pilot study. *Journal of Traumatic Stress, 14*(4), 773-780.
18. Bryant, R. A., Harvey, A. G., Dang, S. T., Sackville, T., & Basten, C. (1998). Treatment of Acute Stress Disorder: A comparison of cognitive-behavioral therapy and supportive counseling. *Journal of Consulting and Clinical Psychology, 66*, 862-866.

19. Bryant, R.A., Sackville, T., Dang, S.T., Moulds, M., & Guthrie, R. (1999). Treating Acute Stress Disorder: An evaluation of cognitive behavior therapy and counseling techniques. *American Journal of Psychiatry*, 156, 1780-1786.
20. Echeburua, E., deCorral, P., Sarasua, B., & Zubizarreta, I. (1996). Treatment of acute Posttraumatic Stress Disorder in rape victims: An experimental study. *Journal of Anxiety Disorders*, 10, 185-199.
21. Brom, D., Kleber, R.J., & Hofman, M.C. (1993). Victims of traffic accidents: Incidence and prevention of Post-traumatic Stress Disorder. *Journal of Clinical Psychology*, 49, 131-140.
22. Foa, E. B., Hearst-Ikeda, D., & Perry, K. J. (1995). Evaluation of a brief cognitive-behavioral program for the prevention of chronic PTSD in recent assault victims. *Journal of Consulting and Clinical Psychology*, 63, 948-955.
23. Litz, B.T., Gray, M.J., Bryant, R.A., Adler, A.B. (2002). Early intervention for trauma: Current status and future directions. *Clinical Psychology-Science & Practice*, 9, 112-134.
24. Mitchell, J.T., & Everly, G.S. (2000). Critical Incident Stress Management and Critical Incident Stress Debriefings: Evolutions, effects and outcomes. In B. Raphael & J.P. Wilson (Eds.), *Psychological debriefing: Theory, practice and evidence* (pp.71-90). New York, New York: Cambridge University Press.

[Top](#) | [Format for browsing](#)

[VA Home Page](#) / [VA Search](#) / [VA Site Map](#) / [VA Facilities Locator](#) / [Disclaimer](#) / [Patient Care Services](#)
[Privacy & Security Statement](#) / [Freedom of Information Act](#) / [Contact the VA](#) / [Accessibility Notice](#)
[Feedback Survey](#) / [FirstGov](#)

The information on this Web site is presented for educational purposes only. It is not a substitute for informed medical advice or training. Do not use this information to diagnose or treat a mental health problem without consulting a qualified health or mental health care provider.

All information contained on these pages is in the public domain unless explicit notice is given to the contrary, and may be copied and distributed without restriction.

For more information call the PTSD Information Line at (802) 296-6300 or send email to ncptsd@ncptsd.org. This page was last updated on Mon Jul 4 17:40:58 2005.