TRAUMA- AND STRESSOR-RELATED DISORDERS

Acute Stress Disorder

ASD

DSM-5-TR 308.3 | ICD-10-CM F43.0

Marked stress symptoms lasting 3 days to 1 month after trauma, spanning intrusion, dissociation, avoidance, negative mood, and arousal.

PREVALENCE AFTER TRAUMA	DIAGNOSTIC WINDOW	SEX RATIO	PROGRESSION
~6-33% by event type	3 days to 1 month post-event	Higher in females	~50% go on to develop PTSD

CLINICAL PICTURE

- The presentation blends intrusion, negative mood, dissociation, avoidance, and arousal without requiring symptoms from every category.
- Dissociative features are prominent early: emotional numbing, reduced awareness of surroundings, derealization, and dissociative amnesia.
- Sleep disturbance, hypervigilance, exaggerated startle, and irritable or aggressive behavior appear within days of the index event.
- Patients most often surface in emergency departments, trauma centers, and primary care rather than in mental health settings.
- Functional collapse can be abrupt, with inability to work, drive, sleep alone, or return to the location where the trauma occurred.
- Many people recover spontaneously, so the diagnosis flags acute distress needing support rather than an inevitable path to PTSD.

DIAGNOSTIC CRITERIA AT A GLANCE

- Exposure to actual or threatened death, serious injury, or sexual violence, directly, as a witness, by learning of it, or through repeated occupational exposure.
- Requires at least nine symptoms drawn from five categories: intrusion, negative mood, dissociation, avoidance, and arousal.
- Duration is 3 days to 1 month after the trauma; beyond one month the presentation must be reassessed for posttraumatic stress disorder.
- Symptoms cause clinically significant distress or impairment and are not attributable to substances, medication, or traumatic brain injury.
- Unlike PTSD, no minimum count is required within any single cluster, which permits dissociation-heavy or arousal-heavy symptom profiles.

NEUROBIOLOGY & PHYSIOLOGY

- An acute noradrenergic and catecholamine surge at the time of trauma over-consolidates emotional memory and predicts later PTSD severity.
- Elevated heart rate in the first 24-48 hours after trauma is among the more replicated biological predictors of subsequent PTSD.
- A blunted cortisol response at the time of trauma is associated with failure to contain the sympathetic stress response afterward.
- Amygdala hyperreactivity with weak ventromedial prefrontal regulation is already measurable acutely, mirroring the chronic PTSD pattern.
- Peritraumatic dissociation appears to reflect prefrontal overmodulation of limbic arousal rather than the more typical underregulation.
- Prior trauma, female sex, low cortisol reactivity, and comorbid traumatic brain injury all raise the probability of progression to PTSD.

PSYCHOLOGICAL MECHANISMS

- Acute fear conditioning to trauma cues is established within days, and avoidance that begins early blocks the natural course of extinction.
- Catastrophic appraisals of early symptoms as evidence of permanent damage strongly predict symptom persistence beyond one month.
- Peritraumatic dissociation impairs encoding and integration of the trauma memory, producing the fragmented recall seen later in PTSD.
- Perceived social support and validation during the first weeks are among the strongest modifiable protective factors against chronicity.
- Rumination about the event and about one's own conduct during it converts a time-limited stress reaction into a chronic disorder.

DIFFERENTIAL & COMORBIDITY

- Beyond one month the diagnosis becomes PTSD, while adjustment disorder applies when the stressor or the response falls short of criteria.
- Rule out concussion and traumatic brain injury, substance intoxication or withdrawal, and delirium in medically injured patients.
- Brief psychotic disorder with marked stressors, and normal acute stress reactions without impairment, are the key boundary conditions.
- Comorbid depression, panic attacks, and escalating alcohol use develop quickly after trauma and warrant direct, repeated screening.
- Assess suicide risk, means access, and ongoing interpersonal safety, especially after assault or intimate partner violence.

Treatment EVIDENCE-BASED MANAGEMENT

PHARMACOLOGIC

- No medication is FDA-approved for acute stress disorder; pharmacotherapy targets specific symptoms rather than the syndrome itself.
- Avoid **benzodiazepines** in the acute period, since early use is associated with higher rather than lower rates of later PTSD.
- Short-term sleep support with **trazodone 25-100 mg** or **prazosin 1-5 mg at bedtime** for nightmares is a reasonable bridge.
- Do not use routine **propranolol** or hydrocortisone prophylaxis; trial evidence is inconsistent and neither is standard of care.
- Start an **SSRI** only when depression or panic is prominent, or when symptoms persist past one month and meet PTSD criteria.

PSYCHOTHERAPY

- **Trauma-focused CBT** delivered over 5-6 sessions beginning about two weeks post-trauma reduces progression to PTSD.
- Do not use single-session psychological debriefing; **critical incident stress debriefing** shows no benefit and may increase symptoms.
- **Psychological First Aid** is the appropriate immediate intervention: safety, calming, connectedness, self-efficacy, and hope.
- Watchful waiting with structured follow-up at two and four weeks is appropriate for mild presentations that are already improving.
- Brief **prolonged exposure** started in the emergency department within hours of trauma reduced later PTSD in controlled trials.

ADJUNCT & SUPPORTIVE

- Screen with the **Acute Stress Disorder Scale** or **PCL-5** and repeat at one month to determine whether PTSD has emerged.
- Restore sleep, nutrition, and daily routine early, since sleep disruption in the first week predicts chronic symptom trajectories.
- Mobilize practical support including housing, finances, legal advocacy, and reconnection with family and community networks.
- Limit repeated media exposure to the event, which sustains physiologic arousal and reinforces intrusive imagery.
- Arrange definite scheduled follow-up rather than as-needed return, because most patients will not self-refer despite ongoing distress.

CLINICAL PEARLS

- Three days to one month is the window; past that, reassess for PTSD.
- Skip debriefing and skip benzodiazepines; both can worsen outcomes.
- Nine of fourteen symptoms, with no per-cluster minimum, unlike PTSD.

References

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NOTE

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