Complete Summary

GUIDELINE TITLE

Trauma and post-traumatic stress disorder in patients with HIV/AIDS.

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Trauma and post-traumatic stress disorder in patients with HIV/AIDS. New York (NY): New York State Department of Health; 2007 Dec. 8 p. [3 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Trauma and post-traumatic stress disorder in patients with HIV/AIDS (updated online 2004 Sep). In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 69-75.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

- Human immunodeficiency virus infection/acquired immune deficiency syndrome (HIV/AIDS)
- Acute stress disorder (ASD)
- Post-traumatic stress disorder (PTSD)

GUIDELINE CATEGORY

Diagnosis
Management
Screening

CLINICAL SPECIALTY

Allergy and Immunology
Family Practice
Infectious Diseases
Internal Medicine
Psychiatry
Psychology

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Physician Assistants
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

To provide guidelines for the diagnosis and management of post-traumatic stress disorder (PTSD) and acute stress disorder (ASD) in patients with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in primary care settings

TARGET POPULATION

Patients with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS)

INTERVENTIONS AND PRACTICES CONSIDERED

1. Screening for post-traumatic stress disorder (PTSD) annually or as clinically indicated
2. Use of *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV)* criteria
3. Screening for other mental disorders
4. Referral to a mental health professional
5. Medications (sertraline, paroxetine)

   Note: Long-term benzodiazepines are not a preferred treatment

6. Psychotherapy including exposure therapy, anxiety management programs, and cognitive therapy

MAJOR OUTCOMES CONSIDERED

- Prevalence of post-traumatic stress disorder (PTSD) in human immunodeficiency virus (HIV)-infected patients
- Effectiveness of treatment on relieving symptoms of PTSD

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus (Committee)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

AIDS Institute clinical guidelines are developed by distinguished committees of clinicians and others with extensive experience providing care to people with HIV infection. Committees* meet regularly to assess current recommendations and to write and update guidelines in accordance with newly emerging clinical and research developments.

The Committees* rely on evidence to the extent possible in formulating recommendations. When data from randomized clinical trials are not available, Committees rely on developing guidelines based on consensus, balancing the use of new information with sound clinical judgment that results in recommendations that are in the best interest of patients.

*Current committees include:

- Medical Care Criteria Committee
- Committee for the Care of Children and Adolescents with HIV Infection
- Dental Standards of Care Committee
- Mental Health Committee
- Women's Health Committee
- Substance Use Committee
- Physician's Prevention Advisory Committee
- Pharmacy Committee

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

All guidelines developed by the Committee are externally peer reviewed by at least two experts in that particular area of patient care, which ensures depth and quality of the guidelines.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Key Point

Exposure to traumatic events can lead to increased risk-taking behavior, including substance use, unsafe sexual practices, and difficulty forming therapeutic relationships with medical personnel.

Post-Traumatic Stress Disorder (PTSD)

Key Point

The likelihood of a patient developing PTSD varies according to the vulnerability of the affected person and the severity of the stressor.

Diagnosis

The primary care clinician should screen for PTSD annually or more often as clinically indicated.

Clinicians should use the criteria listed in the *Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV)* for a diagnosis of PTSD in patients with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) (see table below).

Clinicians should screen patients with PTSD or significant trauma histories for clinical depression, anxiety disorders, or alcohol or other substance use disorders.

Diagnostic Criteria for Post-Traumatic Stress Disorder

A. **The person has been exposed to a traumatic event in which both of the following were present**:
   1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death, serious injury, or a threat to the physical integrity of self or others.
   2. The person's response involved intense fear, helplessness, or horror.

B. **The traumatic event is persistently re-experienced in one (or more) of the following ways**:
   1. Recurrent and intrusive distressing recollections of the event including images, thoughts, or perceptions
   2. Recurrent distressing dreams of the event
   3. Acting or feeling as if the traumatic event were recurring (e.g., a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur upon awakening or when intoxicated)
   4. Intense psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event
   5. Physiological reactivity upon exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event

C. **Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma) as indicated by three (or more) of the following**:
   1. Efforts to avoid thoughts, feelings, or conversations associated with the trauma
   2. Efforts to avoid activities, places, or people that arouse recollections of the trauma
   3. Inability to recall an important aspect of the trauma
   4. Markedly diminished interest or participation in significant activities
   5. Feeling of detachment or estrangement from others
   6. Restricted range of affect (e.g., unable to have loving feelings)
   7. Sense of a foreshortened future (e.g., does not expect to have a

Diagnostic Criteria for Post-Traumatic Stress Disorder

career, marriage, children, or a normal life span)

D. **Persistent symptoms of increased arousal (not present before the trauma) as indicated by two (or more) of the following**:
    1. Difficulty falling or staying asleep
    2. Irritability or outbursts of anger
    3. Difficulty concentrating
    4. Hypervigilance
    5. Exaggerated startle response

E. **Duration of the disturbance (symptoms in criteria B, C, and D) is more than 1 month**.

F. **The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning**.

Key Point

Patients with PTSD may have dissociative symptoms, which may be mistaken for HIV-related dementia or other HIV-related neuropsychiatric disorders.

Management of Survivors of Trauma

Clinicians should refer patients with symptoms of PTSD to a mental health professional as soon as possible for evaluation for psychotherapy or other forms of psychiatric treatment. The goal of treatment should be to reduce symptoms and fully reintegrate a safe sense of self.

If specialized services are unavailable, the primary care clinician should prescribe medications (refer to Appendix XII [see the "Availability of Companion Documents" field]) and monitor the degree of improvement achieved with this strategy alone.

During the acute phase of treatment, clinicians should assess the patient's risk for harm to him/herself or others.

Key Point

Although patients with PTSD may seek help for associated somatic symptoms, they may perceive medical intervention as intrusive and thus re-traumatizing.

Acute Stress Disorder (ASD)

For patients who meet the criteria for ASD, clinicians should follow the same guidelines as those recommended for management of PTSD (see "Management of Survivors of Trauma" section above).

Diagnostic Criteria for Acute Stress Disorder

A. **The person has been exposed to a traumatic event in which both of the following were present**:
   1. The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death, serious injury, or a threat to the physical integrity of self or others
   2. The person's response involved intense fear, helplessness, or horror

B. **Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms**:
   1. A subjective sense of numbing, detachment, or absence of emotional responsiveness
   2. A reduction in awareness of his/her surroundings (e.g., "being in a daze")
   3. Derealization
   4. Depersonalization
   5. Dissociative amnesia (i.e., inability to recall an important aspect of the trauma)

C. **The traumatic event is persistently re-experienced in at least one of the following ways**:

   Recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event

D. **Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people)**
E. **Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness)**
F. **The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience**
G. **The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event**
H. **The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by brief psychotic disorder, and is not merely an exacerbation of a preexisting Axis I or Axis II disorder**

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate diagnosis and management of post-traumatic stress disorder and acute stress disorder in patients with human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) in primary care settings

POTENTIAL HARMS

If benzodiazepines are prescribed, careful monitoring is required due to the potential for abuse and concerns about disinhibition in those with significant dissociative symptoms.

Refer to Appendix XII (see the "Availability of Companion Documents" field) for side effect profile and drug-drug interactions.

CONTRAINDICATIONS

CONTRAINDICATIONS

Paroxetine should be avoided in patients less than 18 years old because of its possible association with increased suicide risk.

Refer to Appendix XII (see the "Availability of Companion Documents" field) for contraindications between human immunodeficiency virus (HIV)-related medications and psychotropic medications.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

The AIDS Institute's Office of the Medical Director directly oversees the development, publication, dissemination and implementation of clinical practice guidelines, in collaboration with The Johns Hopkins University, Division of Infectious Diseases. These guidelines address the medical management of adults, adolescents and children with HIV infection; primary and secondary prevention in medical settings; and include informational brochures for care providers and the public.

Guidelines Dissemination

Guidelines are disseminated to clinicians, support service providers and consumers through mass mailings and numerous AIDS Institute-sponsored educational programs. Distribution methods include the HIV Clinical Resource website, the Clinical Education Initiative, the AIDS Educational Training Centers (AETC) and the HIV/AIDS Materials Initiative. Printed copies of clinical guidelines are available for order from the New York State Department of Health (NYSDOH) Distribution Center for providers who lack internet access.

Guidelines Implementation

The HIV Clinical Guidelines Program works with other programs in the AIDS Institute to promote adoption of guidelines. Clinicians, for example, are targeted through the Clinical Education Initiative (CEI) and the AETC. The CEI provides tailored educational programming on site for health care providers on important topics in HIV care, including those addressed by the HIV Clinical Guidelines Program. The AETC provides conferences, grand rounds and other programs that cover topics contained in AIDS Institute guidelines.

Support service providers are targeted through the HIV Education and Training initiative which provides training on important HIV topics to non-physician health and human services providers. Education is carried out across the State as well as through video conferencing and audio conferencing.

The HIV Clinical Guidelines Program also works in a coordinated manner with the HIV Quality of Care Program to promote implementation of HIV guidelines in New York State. By developing quality indicators based on the guidelines, the AIDS Institute has created a mechanism for measurement of performance that allows providers and consumers to know to what extent specific guidelines have been implemented.

Finally, best practices booklets are developed through the HIV Clinical Guidelines Program. These contain practical solutions to common problems related to access, delivery or coordination of care, in an effort to ensure that HIV guidelines are implemented and that patients receive the highest level of HIV care possible.

IMPLEMENTATION TOOLS

Personal Digital Assistant (PDA) Downloads
Pocket Guide/Reference Cards

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

New York State Department of Health. Trauma and post-traumatic stress disorder in patients with HIV/AIDS. New York (NY): New York State Department of Health; 2007 Dec. 8 p. [3 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Sep (revised 2007 Dec)

GUIDELINE DEVELOPER(S)

New York State Department of Health - State/Local Government Agency [U.S.]

SOURCE(S) OF FUNDING

New York State Department of Health

GUIDELINE COMMITTEE

Mental Health Committee

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Trauma and post-traumatic stress disorder in patients with HIV/AIDS (updated online 2004 Sep). In: Mental health care for people with HIV infection: HIV clinical guidelines for the primary care practitioner. New York (NY): New York State Department of Health; 2001 Mar. p. 69-75.

GUIDELINE AVAILABILITY

Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Mental health screening: a quick reference guide for HIV primary care clinicians. New York (NY): New York State Department of Health; 2006 Feb. 2 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.
- Appendix XII: Interactions between HIV-related medications and psychotropic medications. . New York (NY): New York State Department of Health; 2007 Dec. 3 p. Electronic copies: Available from the New York State Department of Health AIDS Institute Web site.

This guideline is also available as a Personal Digital Assistant (PDA) download from the New York State Department of Health AIDS Institute Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on May 5, 2005. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on August 15, 2005, following the U.S. Food and Drug Administration advisory on antidepressant medications. This summary was updated by ECRI on October 3, 2005, following the U.S. Food and Drug Administration advisory on Paxil (paroxetine). This summary was updated by ECRI on December 12, 2005, following the U.S. Food and Drug Administration advisory on Paroxetine HCL - Paxil and generic paroxetine. This summary was updated by ECRI on May 31, 2006 following the U.S. Food and Drug Administration advisory on Paxil (paroxetine hydrochloride). This NGC summary was updated by ECRI Institute on June 6, 2008.

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