C·B·H

a division of DBHIDS

CLINICAL PRACTICE GUIDELINES

Trauma and Stressor-Related Disorders (TSRD)

Updated December 26, 2025

Community Behavioral Health

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1. BACKGROUND

An individual may experience a traumatic event or stressor at any point during their lifespan. Trauma and stressor-related disorders (TSRD) are impairing conditions that develop in the aftermath of a traumatic event. Five psychiatric disorders are included in TSRD: reactive attachment disorder (RAD); disinhibited social engagement disorder (DSES); post-traumatic stress disorder (PTSD); acute stress disorder (ASD); and adjustment disorder (AD).[1] RAD and DSES primarily affect young children and can be observed in a child's attachment to caregivers or caregiver figures. PTSD, ASD, and AD can be found in both children and adults following a traumatic event. This clinical practice guideline will focus on PTSD, ASD, and AD. The appendix will contain resources and information on RAD and DSES.

Symptoms of TSRD include many shared characteristics such as avoidance, irritability, hyperarousal, dissociation, sleep disturbances, and comorbidity. Diagnosis requires exposure to a traumatic or stressful event, and the severity and duration of symptoms influence the category of diagnosis.[2]

- ASD typically develops immediately after the traumatic event and lasts from three days to one month.
- ADs tend to develop shortly after a stressful event and persist for less than six months. Reactions to stressful events may be triggered by common developmental milestones (e.g., moving, becoming a parent) or more disruptive events (e.g., losing a job, divorce).
- PTSD is diagnosable when symptoms are present for more than one month. It may develop as a continuation of ASD or develop separately up to six months after the event.

2. PURPOSE

CBH is committed to working with our provider partners to continuously improve the quality of behavioral health care for our shared population. Whenever possible, this is best accomplished by implementing evidence-based practices, as well as those informed by nationally recognized treatment guidelines, while respecting the need for individualized treatment and recovery planning.

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[1] *Brownlow, J. A., Miller, K. E., Gehrman, P. R., & Ross, R. J. (2020). Trauma- and stressor-related disorders. In A. Chopra, P. Das, & K. Doghramji (Eds.), Management of sleep disorders in psychiatry (pp. 337–350). Oxford University Press.*

[2] *American Psychiatric Association. (2013). **Diagnostic and Statistical Manual of Mental Disorders, 5th Edition**. American Psychiatric Association.*

These guidelines will be maintained and updated in collaboration with providers and system stakeholders to reflect evolving evidence-based practices and changes in national guidelines.

The aim of these clinical practice guidelines (CPG) is to articulate best practices and quality monitoring standards for providers who treat trauma and stressor-related disorders for children and adults. Appendices acknowledge that potential approaches to certain populations may require more specialized approaches to care. Specific guidelines for reactive attachment disorder and disinhibited social engagement disorder are not covered here, even though they are part of the five TSRD categorized in the DSM. CBH recognizes that there may be other potential sub-groups for which modifications to these guidelines can be clinically justified based on evidence.

CBH expects providers to follow these guidelines in addition to all other relevant CBH, state, and federal regulations and standards, including the **CBH Provider Manual** and the Department of Behavioral Health and Intellectual Disability Services (DBHIDS) **Practice Guidelines for Resiliency and Recovery-Oriented Treatment.**

CBH and DBHIDS encourage a biopsychosocial and recovery-based approach to treatment. In each case, these guidelines for treatment should be part of a multidisciplinary treatment approach that also involves collaboration between physical health and behavioral health providers, as well as the inclusion of families and other supports whenever appropriate and possible.

3. PRACTICE GUIDELINES [3]

3.1. Screening/Assessment and Referral

An event is deemed traumatic if it is extremely upsetting, overwhelms the person's internal resources, and produces lasting psychological symptoms. Examples include, but are not limited to: child sexual abuse, child physical abuse, rape and sexual assault, intimate partner violence, community violence, torture, war, sex trafficking, mass interpersonal violence, natural disasters, fire and burns, and motor vehicle accidents.[4]

The first priority of treatment is to assess safety and make appropriate referrals for any urgent or emergent medical or psychiatric problems. Suicidality and self-harm are concerning behaviors that may develop or increase in intensity following a potentially traumatic event, hereafter referred to as a traumatic event. A brief screener for suicidal thoughts and intentions should be incorporated in the screening and assessment protocols. The **Columbia Suicide Severity Rating Scale (C-**

[3] *Summarized and adapted from the **APA Practice Guidelines***

[4] *Briere, J. N., and Scott, C. (2015). Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment. Thousand Oaks, CA: Sage.*

SSRS) is a suicide screener with validity for children as young as six. Recommended screening and assessment tools vary depending on the member's age. Utilizing a tool with demonstrated validity is always important.

Trauma exposure is a necessary condition for PTSD. Thus, screening for trauma exposure is typically conducted first. The National Child Traumatic Stress Network (NCTSN) has information on recommended trauma screeners that are appropriate for children and/or their caregivers. The Trauma History Questionnaire (THQ) or the Child Trauma Screen (CTS) are two examples of valid trauma screeners appropriate for children under 18 or their caregivers to detect exposure to a traumatic event. Numerous trauma screeners have been validated for adults. A comprehensive list of trauma screening tools can be found on the Department of Veterans Affairs' (VA) PTSD Screening webpage, which also includes the PTSD Checklist for DSM-5 (PCL-5) and the Brief Trauma Questionnaire.

Once exposure to a traumatic event is established, it is important to measure the impact that the traumatic event is having on a person's well-being. The following factors play an important role in the mental health outcome: characteristics of the trauma; level of family and social support; family dysfunction; previous trauma exposure; greater stress at the time of trauma or immediately after, and the child's temperament and coping skills.[5]

It is strongly recommended that both empirically validated screeners and a structured diagnostic interview by a licensed mental health professional with expertise in trauma-related disorders be administered.

3.2. Safety/Risk Assessment

Following the disclosure of a traumatic event, members should be assessed for risk of continued danger or harm. It is important to support members to mitigate the risk of trauma reoccurring when possible. Following a traumatic event, individuals may blame themselves and express passive or active suicidal ideation. Providers should utilize an evidence-based structured tool (C-SSRS is recommended) to assess suicide risk when the member discloses suicidal ideation, thoughts of self-harm, or feelings of hopelessness or isolation. Providers should follow their internal policies to address any risk of harm to themselves and ensure that anyone at imminent risk of harm to themselves or others is referred to the appropriate level of care.

Co-occurring conditions are common for individuals with PTSD. About 80% of individuals with PTSD carry a second diagnosis, such as major depressive disorder (MDD) or substance use disorders. When an individual presents with substance use or MDD, a trauma screener may be an

[5] *Briere, J. N., and Scott, C. (2015). Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment. Thousand Oaks, CA: Sage.*

appropriate tool to identify if PTSD or another trauma stressor disorder is present. Identifying a traumatic event helps develop an accurate assessment and treatment plan.

3.3. Assessment

A complete evaluation of exposure to traumatic events should address the following:

- History of present illness and current symptoms, with particular consideration for intrusive, distressing memories/thoughts of the event; distressing dreams/nightmares; dissociative symptoms; flashbacks; avoidance; negative alterations in cognitions and mood associated with the event; changes in arousal or reactivity associated with the event; irritability; hypervigilance; and other PTSD symptoms
- Trauma history, including trauma type(s), age of exposure(s), frequency, and duration of the traumatic event
- Assessment of the degree to which the traumatic event is causing functional impairment
- Medical history focused on the medical causes of mood disorders
- Past psychiatric history, including onset, periodicity, and chronicity of symptoms of PTSD; prior treatment (e.g., medication trials, interventions, hospitalizations), side effects, and response
- Presence of symptoms relevant for differential diagnosis, including depression, mania, psychosis, panic disorder, generalized anxiety disorder, etc.
- Current medications, including prescribed and over-the-counter agents and supplements
- Current and past substance use and treatment for substance use disorders
- Personal, social, and occupational history (e.g., response to life transitions, major life events)
- Health-related social needs (HRSN) that may increase trauma exposure
- Family history of intergenerational trauma and psychiatric disorders
- Mental status examination
- Suicide risk assessment

Assessors should evaluate the severity of symptoms, identify any immediate safety concerns, assess protective factors, and determine treatment needs. The determination of the appropriate level of care intervention should follow the assessment, with preference given to the level of care most

likely to be effective in improving and stabilizing symptoms, while respecting the individual's rights and supporting their preferences. Most individuals with a trauma stressor disorder will be effectively treated with outpatient treatment. However, when impaired activities of daily living or safety risks are identified, providers may consider a higher level of care, including family-based mental health services, partial hospitalization, subacute inpatient psychiatric, or acute inpatient psychiatric level of care. For imminent safety concerns, providers should ensure transfer to a secure treatment location with appropriate monitoring.

Individuals exposed to traumatic events may develop a range of traumatic stress reactions, not just limited to PTSD. Depression, anxiety, and substance abuse, driven by the traumatic event, might require trauma-specific treatment, even in the absence of PTSD. Significant PTSD symptoms will typically include sleep disturbances, persistent horror, anger, or shame, avoidance of people, places, and situations that remind of the trauma, flashbacks, and unhelpful thoughts (e.g., "I am bad and crazy.", "No adult can be trusted.", "It was my fault that he raped me.").

3.4. Cultural and Health-Related Social Needs (HRSN)

The interaction between HRSN and trauma exposure is bidirectional in that stressors often increase the likelihood of trauma exposure. Many items on the Adverse Childhood Experiences Survey (ACES) intersect with HRSN (i.e., poverty, limited access to healthcare, unsafe living environments). This intersection can amplify health risks, leading to long-term mental and physical health challenges. The 2013 Philadelphia ACES study found that 70% of Philadelphians had experienced at least one ACE, and approximately 40% had experienced four or more, more than twice the national average, thereby providing support for the need to develop Philadelphia-specific trauma-focused interventions.[6]

Many symptoms of trauma stressor disorders are similar to other common behavioral disorders, such as ADHD and ODD. It is important for providers to understand these commonalities and to be able to use appropriate assessments to determine if behaviors are due to trauma stressors or a result of a neurological or psychiatric condition.

3.5. Diagnosis

Diagnosis of a trauma and other stressor-related disorder should be made in accordance with DSM-5-TR Criteria. Specifiers of severity and other features of illness (e.g., risk of suicidality, panic attacks, flashbacks) should inform evidence-based treatment decisions. Comorbid psychiatric conditions, like major depressive disorders, anxiety disorders, substance use disorders, and

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[6] *Public Health Management Corporation, Merritt, M., Cronholm, P., Davis, M., Dempsey, S., Fein, J.,…Wade, R. (2013). **Findings from the Philadelphia Urban ACE Survey**.*

personality disorders, should be appropriately treated concurrently. The selection of treatment should consider the complete diagnostic picture, including comorbidities.

To support accurate diagnosis, the following screening measures are recommended. The "gold standard" for PTSD diagnosis is the **Clinician-Administered PTSD Scale for DSM-5 Adult (CAPS-5)** and **Child/Adolescent (CAPS-CA-5)** versions. For providers in federally qualified health centers (FQHCs) or primary care facilities, the **Primary Care-PTSD Screen (PC-PTSD5)** and the **PTSD Checklist (PCL5)** are the recommended diagnostic screeners for those settings. Finding a measure that captures the impact of a traumatic event on a person's mental, emotional, and physical well-being across various domains (e.g., family, work, school, community) is important. When assessing the impact of a traumatic event, it is essential to recognize that a single measure may not accurately capture a person's acuity; however, it can provide a baseline of symptom severity that should be tracked throughout treatment. The CPSS-5 is a standard PTSD symptom measure that is validated for children ages 8 to 18. The Trauma Symptom Checklist for Young Children (TSCYC) is validated for children ages three to 12. For adults, the VA identifies various assessments, including the CAPS-5, PSS-I-5, and SI-PTSD.

3.6. Treatment

When developing a course for treatment, it is essential to employ an individualized or patient-centered approach and to practice shared decision-making. Shared decision-making enables providers, clients, and their support systems (family, friends, caregivers) to consider clinical evidence in conjunction with patient values and preferences to inform treatment decisions. Since individuals with PTSD are more likely also to experience co-occurring conditions, PTSD must be managed collaboratively with other care providers. When co-occurring conditions are present, an integrated approach that addresses both conditions simultaneously is recommended. Many evidence-based trauma treatments (TF-CBT and PE) teach skills for managing co-occurring symptoms (i.e., depression, anxiety) and can be integrated with substance use treatment.[7]

Therapeutic approaches that focus on building skills to manage stressors, such as Cognitive Behavioral Therapy (CBT), may be appropriate for individuals who develop an adjustment disorder after experiencing a stressful event (e.g., divorce, job loss, chronic illness).

Below is a list of recommended, manualized trauma treatments. Please see the CBH **Evidence-Based Practice and Innovation Center (EPIC) webpage** for more information.

[7] *Norman, S. Hicks, T., Klein, A., & Hamblen, J. **Treatment of Co-Occurring PTSD and Substance Use Disorder in VA**.*

3.6.1. Evidence-Based Trauma Treatments for Children and Youth

- Trauma-Focused Cognitive Behavioral Health (TF-CBT) for children and youth ages three to 18
- Child Parent Psychotherapy (CPP) for children ages 0 to six
- Cognitive Behavioral Interventions for Trauma in Schools (CBITS) ages 10 to 18

3.6.2. Evidence-Based Trauma Treatments for Adults (also adapted for adolescents)

- Cognitive Processing Therapy (CPT)
- Prolonged Exposure (PE)
- Eye Movement Desensitization Reprocessing (EMDR)

According to the **APA's CPG for the Treatment of PTSD**, the only FDA-approved medications for PTSD are sertraline (Zoloft®) and paroxetine (Paxil®), and any other medication used is considered "off-label." The **VA/DOD CPG on the Management of PTSD and ASD** indicate the selective serotonin reuptake inhibitors (SSRIs) sertraline and paroxetine, and the selective serotonin-norepinephrine reuptake inhibitor (SNRI) venlafaxine have the strongest evidence base for PTSD pharmacotherapy. A discussion around benefits, risks, side effects, and stigma can guide shared decision-making on the use of pharmacotherapy. Pharmacotherapy should be started at a low dose and gradually titrated based on efficacy and tolerability. Enough time should be given to trial a medication before considering changes in treatment. There is limited evidence to support the use of other medications for the treatment of PTSD.

However, sleep disturbances, such as nightmares, are common in PTSD. For adults, there is evidence to support the use of prazosin, an alpha-1-blocker, to treat sleep disturbance in PTSD.[8,9] Prazosin should be started at a low dose and gradually titrated based on efficacy and tolerability.

Benzodiazepines are not a recommended pharmacologic treatment for PTSD due to a lack of clear benefit, risk for functional impairments/side effects, and concerns about the high comorbidity of PTSD and substance use disorders. For any individuals who are prescribed benzodiazepines,

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[8] *Khachatryan D, Groll D, Booij L, Sepehry AA, Schütz CG. Prazosin for treating sleep disturbances in adults with post-traumatic stress disorder: a systematic review and meta-analysis of randomized controlled trials. Gen Hosp Psychiatry. 2016 Mar-Apr;39:46-52. doi: 10.1016/j.genhosppsych.2015.10.007. Epub 2015 Nov 1. PMID: 26644317.*

[9] *Raskind MA, Peterson K, Williams T, Hoff DJ, Hart K, Holmes H, Homas D, Hill J, Daniels C, Calohan J, Millard SP, Rohde K, O'Connell J, Pritzl D, Feiszli K, Petrie EC, Gross C, Mayer CL, Freed MC, Engel C, Peskind ER. A trial of prazosin for combat trauma PTSD with nightmares in active-duty soldiers returned from Iraq and Afghanistan. Am J Psychiatry. 2013 Sep;170(9):1003-10. doi: 10.1176/appi.ajp.2013.12081133. PMID: 23846759.*

providers should adhere to the **CBH CPG for the Prescribing and Monitoring of Benzodiazepines and Related Medications**.

3.7. Monitoring of Treatment

In all phases, careful and objective monitoring of treatment response is crucial for guiding adjustments to treatment and maximizing the likelihood of achieving a successful recovery. Monitoring should occur regularly to assess response to psychotherapy, pharmacotherapy, or both. Measurement-based care is helpful for efficient and consistent reassessment of the response to treatment. Examples of validated and standardized tools used for monitoring of treatment include, but are not limited to, the PCL-5 (adults) and CPSS-5 (children), which measure PTSD symptoms. Side effects of medications require monitoring. Safety concerns should receive regular attention.

Frequency of monitoring should be determined by:

- Severity of symptom(s) (e.g., level of psychological stability; suicidality, self-injurious behavior)
- Co-occurring (including pre-existing) mental and physical health conditions
- Adherence to treatment
- Social support
- Frequency and severity of side effects

If improvements are not seen within four to eight weeks of treatment initiation:

- Reappraise diagnosis
- Assess side effects
- Assess and address co-occurring conditions that may be complicating therapy
- Review psychosocial factors
- Assess adherence
- Adjust treatment plan

3.8. Coordination of Care/Linkages

One foundational goal in coordinating care for individuals who have experienced trauma is to minimize the impact of re-traumatization through increasing the understanding of trauma-informed

care (TIC) within our provider organizations. TIC includes aspects of patient empowerment, choice, collaboration, safety, and trustworthiness within organizational and clinical practices. Treatment planning should involve shared decision-making, where all treatment options are considered, and the benefits and risks are discussed with the member. The use of peer support or family navigators as part of the care team can be a successful strategy in engaging individuals who have experienced trauma in trauma treatment. In coordinating care, any information on a member's trauma screening and assessment, participation in trauma treatments, and completion of trauma treatments should be shared to improve warm handoffs and support a timely transition.[10] If the need for trauma treatment is identified, providers must recognize the depth of their training and that often specialized training in trauma-specific interventions is needed. When this occurs, providers should work to link members to appropriate, recommended trauma treatments. Members should be involved in discussions about seeking trauma treatment and selecting a new provider for the treatment.[11]

3.9. Aftercare Planning/Discharge

If a member completes a trauma-focused treatment (PE, TFCBT, EMDR), continued outpatient therapy and/or medication management may be recommended to monitor symptoms and provide continued support. For any transitions in care, providers should ensure consistent access to prescribed medications and have a plan in place for continued medication provision.

CBH requires all members to be discharged with a 30-day supply of medication (or a prescription) and a refill prescription until their next medication appointment, which should be scheduled no more than 30 days following discharge (see the **CBH Clinical Performance Standards for Acute Inpatient Psychiatric (AIP) Services**).

Please reference Discharge Medication Planning on the CBH website's **Pharmacy Resources for Providers page**. This resource outlines best practices for medications during discharge planning, key considerations for building relationships with outpatient pharmacies, and checklists to ensure all stakeholders are involved in the appropriate actions.

4. MONITORING

CBH encourages providers to maintain robust internal quality management programs to ensure treatment of CBH members adheres to these and other applicable guidelines. In addition to "as needed" reviews of records when quality issues arise, CBH will be tracking various performance

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[10] *Menschner, C. & Maul, A. Center for Health Care Strategies.* ***Key Ingredients for Successful Trauma-Informed Care Implementation****.*

[11] *American Psychological Association.* ***Clinical Practice Guideline for the Treatment of PTSD in Adults****.*

metrics, including the following **National Committee for Quality Assurance (NCQA)** HEDIS measures:

- The HEDIS FUH Measure for Follow-up After Hospitalization for Mental Illness will be adapted to capture follow-up after hospitalization due to suicidal ideation or attempted suicide. The FUH measure is two parts, including:
  - 7-day follow-up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner, within seven days of discharge.
  - 30-day follow-up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner, within thirty days of discharge
- The HEDIS FUM Measure for Follow-up After Emergency Department Visit for Mental Illness will be adapted to capture follow-up after ED presentation due to suicidal ideation or attempted suicide. The FUM measure is two parts, including:
  - 7-day follow-up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner, within seven days of discharge.
  - 30-day follow-up: An outpatient visit, intensive outpatient visit, or partial hospitalization with a mental health practitioner, within thirty days of discharge

All available HEDIS Tip Sheets can be found on the **CPG page** of the CBH website.

Additionally, providers must maintain documentation of all evaluations and interventions described in these guidelines, whether the provider or an outside practitioner delivers them. CBH will continue to monitor treatment provided to ensure that care is consistent.

5. APPENDICES

5.1. References

- American Psychiatric Association. (2013). **Diagnostic and Statistical Manual of Mental Disorders, 5th Edition**. American Psychiatric Association.
- American Psychological Association. (2025). **Medications for PTSD**. American Psychological Association.
- Briere, J. N., and Scott, C. (2015). Principles of Trauma Therapy: A Guide to Symptoms, Evaluation and Treatment. Thousand Oaks, CA: Sage.
- Brownlow, J. A., Miller, K. E., Gehrman, P. R., & Ross, R. J. (2020). Trauma- and stressor-related disorders. In A. Chopra, P. Das, & K. Doghramji (Eds.), Management of sleep disorders in psychiatry (pp. 337–350). Oxford University Press.
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- Raskind MA, Peterson K, Williams T, Hoff DJ, Hart K, Holmes H, Homas D, Hill J, Daniels C, Calohan J, Millard SP, Rohde K, O'Connell J, Pritzl D, Feiszli K, Petrie EC, Gross C, Mayer CL, Freed MC, Engel C, Peskind ER. A trial of prazosin for combat trauma PTSD with nightmares in active-duty soldiers returned from Iraq and Afghanistan. Am J Psychiatry. 2013 Sep;170(9):1003-10. doi: 10.1176/appi.ajp.2013.12081133. PMID: 23846759.
- VA/DOD Clinical Practice Guideline. (2023). **Management of Posttraumatic Stress Disorder and Acute Stress Disorder** Work Group. Washington, DC: U.S. Government Printing Office.

5.2. Provider Resources

- Substance Abuse Mental Health Services Administration (SAMHSA). **Trauma and Violence**.
- **Veterans Affairs (VA) PTSD CPG**

- **APA PTSD CPG**
- **Philadelphia Adverse Childhood Experiences (ACE) Project**
- **National Center for PTSD (VA) Resources for Providers**

5.3. Member Resources

- The **National Child Traumatic Stress Network (NCTSN)** offers numerous fact sheets and an overview of trauma for caregivers.
- National Alliance for Mental Health (NAMI). **Trauma and PTSD: Dispelling Myths, Inspiring Hope**.
- Mental Health America (MHA). **Understanding Trauma and PTSD**.
- 988 Lifeline: **988philly.org**

5.4. Information on Additional Trauma and Other Stressor-related Disorders

Information on Reactive Attachment Disorder:

- Ellis EE, Yilanli M, Saadabadi A. **Reactive Attachment Disorder**. [Updated 2023 May 1]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2025 Jan.
- Child Mind Institute. **Quick Guide to Reactive Attachment Disorder**.

Information on Disinhibited Social Engagement Disorder:

- Guyon-Harris, K. L., Humphreys, K. L., Miron, D., Gleason, M. M., Nelson, C. A., Fox, N. A., & Zeanah, C. H. (2019). **Disinhibited Social Engagement Disorder in Early Childhood Predicts Reduced Competence in Early Adolescence**. *Journal of Abnormal Child Psychology*, *47*(10), 1735–1745.

5.5. Community Resources

- **CBH Provider Directory**
- **EPIC Evidence-Based Practice (EBP) Program Designation**
- **Healthy Minds Philly Mental Health Screening Tools**
- **CBH Depression Screening Program**

- The City of Philadelphia, through DBHIDS, operates a 24-hour telephone hotline to assist people and their families dealing with behavioral health emergencies: 215-685-6440