AUSTRALIAN GUIDELINES FOR THE PREVENTION AND TREATMENT OF

Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD

Phoenix AUSTRALIA

Executive summary

In 2007 and 2013, the National Health and Medical Research Council (NHMRC) approved the first and second Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder (the Guidelines). The 2007 Guidelines were limited to adults, while the 2013 Guidelines were extended to include children and adolescents. The scope of this third and current version of the Guidelines has been expanded again to include consideration of the new diagnosis in the ICD-11 of complex PTSD. In addition, the format has been changed to a 'living guideline'. The recommendations have been published in an online format (the Australian PTSD Guidelines), with potential to update individual recommendations when there is sufficient new evidence to do so.

Chapter 1 Introduction provides an overview of the Guidelines development process and details their objectives and scope. The Guideline Development Group consisted of Australia's leading trauma experts, specialist practitioners working with people affected by trauma, individuals with lived experience of trauma, and a guidelines methodologist. The Guideline Development Group was supported by a project team from Phoenix Australia.

The Guidelines were developed using GRADE (grading of recommendations, assessment, development, and evaluation) methodology to assess the certainty of the evidence, interpret and summarise findings, and determine the strength and direction of recommendations. The certainty of the evidence was assessed as high, moderate, low, or very low, based on the scientific rigour of the studies. In addition to using GRADE to assess the quality of the evidence, the Guideline Development Group considered other factors when formulating recommendations, such as benefits and harms, patient values and preferences, acceptability to key stakeholders, and feasibility of implementation.

Recommendations are made for or against a treatment option, with the strength of the recommendation as strong (clinicians should provide the intervention to all or almost all patients in all or almost all circumstances), conditional (clinicians should provide the intervention to most patients, but not all), or as insufficient evidence to make a recommendation. These areas that require further research are noted as research recommendations.

Importantly, the Guideline recommendations are not intended to be prescriptive. Practitioners should use their experience and expertise in applying these Guidelines in routine clinical practice and all clinical interventions should be provided with compassion and sensitivity.

Chapter 2 Trauma and trauma reactions provides background information on trauma and trauma reactions. While the focus of the Guidelines is acute stress disorder (ASD), posttraumatic stress disorder (PTSD), and complex posttraumatic stress disorder (CPTSD - discussed in Chapter 7), the range of possible reactions is noted, including resilience as the usual outcome following traumatic exposure.

The key distinguishing feature between PTSD and ASD is the duration of symptoms required for the diagnosis to be made. ASD is diagnosed between two days and one month following the traumatic event, while PTSD requires that the symptoms be present for at least one month following the traumatic event.

In terms of symptom constellation, PTSD diagnosis requires meeting a certain number of symptoms within established clusters. In the DSM-5, ASD symptoms are not classified within clusters, therefore an individual meets diagnosis based upon expression of symptoms in total. PTSD includes non-fear based symptoms (risky or destructive behaviour, overly negative thoughts and assumptions about oneself or the world, exaggerated blame of self or others for causing the trauma, negative affect, decreased interest in activities, feeling isolated), while ASD does not. And finally, PTSD includes a dissociative subtype, whereas in ASD, depersonalisation and derealisation are included as symptoms under the dissociative heading.

In ICD-11, PTSD and CPTSD fall under a general parent category of 'Disorders Specifically Related to Stress'. PTSD is comprised of three symptom clusters:

1. re-experiencing of the trauma
2. avoidance of traumatic reminders
3. a persistent sense of current threat that is manifested by exaggerated startle and hypervigilance

CPTSD includes the three PTSD clusters and three additional clusters that reflect 'disturbances in self-organisation' (DSO): problems with self-concept, and disturbances in relationships.

Estimates of lifetime prevalence of PTSD range from 5% to 10%. The likelihood of developing PTSD varies according to the nature of the event. In general terms, the highest incidence of PTSD is associated with interpersonal trauma such as rape and other sexual assault; the lowest rate is associated with natural disasters and witnessing harm to others. Naturally, this varies depending on the nature of the particular incident that the individual is exposed to.

Information about screening, assessment (including individual strengths), diagnosis and treatment planning is presented in Chapter 2 with a number of guidance points for clinical practice, including:

- For people presenting to primary care services with repeated non-specific physical health problems, it is recommended that the primary care practitioner consider screening for psychological causes, including asking whether the person has experienced a traumatic event and describing some examples of such events.
- The importance of a thorough clinical assessment, covering relevant history (including trauma history), PTSD and related diagnoses, general psychiatric status (noting extent of comorbidity), physical health, substance use, marital and family situation, social and occupational functional capacity, and quality of life.
- The development of a robust therapeutic alliance should be regarded as the necessary basis for undertaking specific psychological interventions and may require extra time for people who have experienced prolonged and/or repeated traumatic exposure.
- Appropriate goals of treatment should be tailored to the unique circumstances and overall mental health care needs of the individual and established in collaboration with the person.

Chapter 3 General considerations when working with children and adolescents outlines key issues for younger people with PTSD, including:

- Children and adolescents are typically dependent upon an adult to bring them for treatment, so engagement with the relevant adult is important.
- Children are part of a system (typically a family) so assessment and treatment needs to take the whole system into consideration.
- There is a need to be constantly mindful of psychosocial development, and the impact of trauma and appropriateness of treatment in that context

Typical clinical presentations in children and adolescents, as well as issues of screening, assessment, and treatment in this group are described in Chapter 3. Among the key guidance points for clinicians:

- Questions about exposure to commonly experienced potentially traumatic events should be included as standard during any psychiatric assessment of children and adolescents. If such exposure is reported, the child should be screened for the presence of PTSD symptoms.
- For children and adolescents, a structured clinical interview is regarded as a better assessment measure when making a diagnosis than a questionnaire.
- Parent/caregiver involvement in assessment and treatment is desirable for children and adolescents with ASD or PTSD.
- For children and adolescents, treatment needs to be tailored to meet the developmental needs of the individual. Protocols that have been designed specifically for children and adolescents should be used in preference to attempting to modify an adult treatment protocol.

Chapter 4 Interventions presents descriptions of all of the interventions in the Guidelines on which strong, conditional, or research recommendations were made. Descriptions of all the interventions that are referenced in the systematic review of the literature (including those that are not supported by the evidence) are set out in the online Australian PTSD Guidelines. For an intervention or treatment to be listed in the Guidelines there must have been at least one randomised controlled trial that was included in at least one of the meta-analyses undertaken to answer the relevant scoping questions (the latter included in Chapter 5 Methodology).

Chapter 5 Methodology provides an overview of the systematic review of evidence that underpins the Guideline treatment recommendations. The chapter sets out the approach taken to the systematic review including literature sources, the search strategy employed, data extraction and analysis, quality assessment and assessment of certainty of the evidence base (using the GRADE system: Grading of Recommendations, Assessment, Development and Evaluations). This chapter also considers the limitations of the systematic review.

Chapter 6 Treatment recommendations presents the Guideline treatment recommendations alongside issues for consideration in implementation. A list of the interventions recommended for further research are also presented.

Continued on next page

The treatment recommendations are as follows:

Recommendations for children and adolescents

Interventions within the first three months of trauma

Universal interventions (for all children and adolescents exposed to trauma)

Conditional recommendation AGAINST individual psychological debriefing

For children and adolescents within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to individual psychological debriefing.

Indicated interventions (for those with PTSD symptoms within the first three months)

Conditional recommendation FOR child and family traumatic stress intervention (CFTSI)

For children and adolescents within the first three months after trauma exposure where symptoms of PTSD are present, we suggest offering child and family traumatic stress intervention (CFTSI) in preference to supportive counselling.

Psychological interventions for children and adolescents with PTSD

Strong recommendation FOR trauma-focussed CBT (TF-CBT)

For children and adolescents with symptoms of PTSD, we recommend trauma-focussed CBT.

Strong recommendation FOR trauma-focussed CBT for caregiver and child

For children and adolescents with symptoms of PTSD, we recommend trauma-focussed CBT for caregiver and child.

Conditional recommendation FOR EMDR

For children and adolescents with symptoms of PTSD, we suggest offering eye movement desensitisation and reprocessing (EMDR) where trauma-focussed CBT is unavailable or unacceptable.

Pharmacological interventions for children and adolescents with PTSD

No recommendations made.

Recommendations for adults

Interventions within the first three months of trauma

Universal interventions (for all adults exposed to trauma)

Conditional recommendation AGAINST individual psychological debriefing

For adults within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to individual psychological debriefing.

Conditional recommendation AGAINST group psychological debriefing

For adults within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to group psychological debriefing.

Indicated interventions (for those with PTSD symptoms)

Strong recommendation FOR a stepped/collaborative care model

For adults with PTSD symptoms in the first three months following trauma, we recommend a stepped/collaborative care model, in which individuals receive evidence-based care commensurate with the severity and complexity of their need.

Conditional recommendation FOR trauma-focussed CBT

For adults with PTSD symptoms in the first three months following trauma, we suggest offering trauma-focussed CBT (includes prolonged exposure, cognitive processing therapy, cognitive therapy) in preference to doing nothing.

Conditional recommendation FOR brief EMDR

For adults with PTSD symptoms in the first three months following trauma, we suggest offering brief EMDR in preference to doing nothing.

Psychological interventions for adults with PTSD

Strong recommendation FOR cognitive processing therapy (CPT)

For adults with PTSD, we recommend cognitive processing therapy (CPT).

Strong recommendation FOR cognitive therapy (CT)

For adults with PTSD, we recommend cognitive Therapy (CT).

Strong recommendation FOR EMDR

For adults with PTSD, we recommend eye movement desensitisation and reprocessing (EMDR).

Strong recommendation FOR prolonged exposure (PE)

For adults with PTSD, we recommend prolonged exposure (PE).

Strong recommendation FOR trauma-focussed CBT (TF-CBT)

For adults with PTSD, we recommend trauma-focussed CBT.

Conditional recommendation FOR guided internet-based trauma-focussed CBT

For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest guided internet-based trauma-focussed CBT.

Conditional recommendation FOR narrative exposure therapy (NET)

For adults with PTSD where trauma is linked to genocide, civil conflict, torture, political detention, or displacement, we suggest narrative exposure therapy (NET).

Conditional recommendation FOR present-centred therapy (PCT)

For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest present-centred therapy (PCT).

Conditional recommendation FOR stress inoculation training (SIT)

For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest stress inoculation training (SIT).

Conditional recommendation FOR trauma-focussed CBT (group)

For adults with PTSD where individual trauma-focussed cognitive behavioural therapies or EMDR is unavailable or unacceptable, we suggest group trauma-focussed CBT.

Pharmacological interventions for adults with PTSD

Conditional recommendation FOR SSRIs (sertraline, paroxetine, or fluoxetine)

For adults with PTSD, we suggest SSRIs (sertraline, paroxetine, or fluoxetine) in circumstances where any of the following applies:

- The person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR).
- The person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SSRIs are indicated.
- The person's circumstances are not sufficiently stable to commence recommended psychological therapy (as a result, for example, of significant ongoing life stress such as domestic violence).
- The person has not gained significant benefit from recommended psychological therapy.
- There is a significant wait time before psychological treatment is available.

Conditional recommendation FOR venlafaxine

For adults with PTSD, we suggest venlafaxine in circumstances where any of the following applies:

- The person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR).
- The person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SNRIs are indicated.
- The person's circumstances are not sufficiently stable to commence recommended psychological therapy (as a result, for example, of significant ongoing life stress such as domestic violence).
- The person has not gained significant benefit from recommended psychological therapy.
- There is a significant wait time before psychological treatment is available.