

# Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD



## Introduction

The first Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder (the Guidelines) were approved by the National Health and Medical Research Council (NHMRC) in 2007. The scope of the second version of the Guidelines, the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder, was expanded to include children and adolescents, and was approved by NHMRC in 2013. The scope of the third and current version of the Guidelines, has been expanded again to include consideration of the new diagnosis of complex posttraumatic stress disorder (ICD-11<sup>1</sup>). In addition, the format of the Guidelines has been changed to become a 'living guideline'. As such, the current Guidelines will be published in an online format, with potential to update individual recommendations when there is sufficient new evidence to do so. This ensures that guideline recommendations are always current and valid, and a source of timely and trustworthy advice to clinicians and other service decision-makers. It also improves the efficiency of guideline development as effort is not wasted in undertaking formal systematic reviews on topics for which there is insufficient additional evidence to change guideline recommendations.

The purpose of this chapter is to describe the aims, scope, development process, and implementation strategy for this living guideline, the Australian Guidelines for the Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder.

## Comparison with the previous Guidelines

Like the 2007 and 2013 Guidelines, these current Guidelines were informed by a systematic review of the peer reviewed literature. At the time that we were commencing the Guidelines development process, the International Society for Traumatic Stress Studies (ISTSS) had just completed a systematic review of the literature to inform the development of the ISTSS PTSD Treatment Guidelines. The ISTSS review, conducted by Professor Jonathon Bisson, Dr Neale Roberts and Dr Catrin Lewis, Cardiff University, included literature published between January 2008 and October 2018. Phoenix Australia was granted permission to use the ISTSS systematic review as the foundation for these Guidelines, meaning that it was only necessary to undertake an update of the systematic review with literature published between November 2018 and June 2019. A small number of additional studies were identified and appraised, and the findings integrated into the meta-analyses and GRADE assessment of the body of evidence.

A key difference between the current and the 2013 Guidelines was the approach to assessing the body of evidence underpinning guideline recommendations, with a shift in line with NHMRC guidance. The 2013 Guidelines were based on the NHMRC publication *How to review the evidence: systematic identification*

*and review of the scientific literature* (NHMRC 2000), with the quality of evidence assessed on the basis of volume, consistency, clinical impact, generalisability, and applicability to the Australian healthcare context and the grade of recommendation (from A being the strongest through to D being the weakest) based on the body of evidence. In addition, Consensus Points based on the consensus opinion of the working party were used when the search yielded insufficient research to make a recommendation, and Good Practice Points were used to provide clinical guidance in areas for which there is no research. Research Recommendations were made for interventions in need of further research. In the current Guidelines, the certainty of the body of evidence was assessed using Grading of Recommendations, Assessment, Development and Evaluations (GRADE) and recommendations have been developed using the GRADE evidence-to-decision (EtD) framework as outlined in Chapter 5 Methodology. Under the GRADE system, recommendations are limited to four types - strong or conditional, for or against an intervention. Recommendations for further research are also made.

The new approach makes direct comparison between the recommendations contained in the current Guidelines and those contained in the 2013 Guidelines less straightforward, but still possible. A summary of changes to the recommendations from the 2013 Guidelines is presented at the end of Chapter 6 Treatment Recommendations.

Membership of the Guideline Development Group was another key point of difference in the current Guidelines. Membership was expanded from academic subject matter experts to include a broader range of people with lived experience of trauma and end users (GP, psychology and social work practitioners) with experience working with particular trauma populations including Aboriginal and Torres Strait Islander peoples, refugees and asylum seekers, and survivors of sexual assault and disasters.

## **Guidelines aims**

These Guidelines aim to support high quality treatment for children, adolescents, and adults with acute stress disorder (ASD), posttraumatic stress disorder (PTSD) and complex PTSD (CPTSD) by providing a framework of best practice around which to structure treatment. The Guidelines have been designed to be used by: a) general and mental health practitioners planning and providing treatment across clinical settings; b) people affected by trauma, to make decisions about their treatment; and c) funding bodies making service purchasing decisions. The intended outcome of the Guidelines is increased recognition of ASD, PTSD and CPTSD, increased uptake of evidence-based care, and ultimately, better treatment outcomes for people affected by trauma.

These Guidelines should not be regarded as an inflexible prescription for the content or delivery of treatment. They are guidelines, to be interpreted and implemented in the context of good clinical judgement, not rigid rules. They should not limit treatment innovation and development that is based upon scientific evidence, expert consensus, practitioner judgment of the needs of the person, and the person's preferences. Equally, these Guidelines should be used to drive the delivery of first and second line evidence-based treatment approaches unless there is a strong justification for not doing so in a particular case.

## **Scope of the Guidelines**

These Guidelines provide information and recommendations about evidence-based methods of treating people who, following exposure to potentially traumatic events, have developed (or are at risk of

developing) problems consistent with the criteria for ASD and PTSD. They focus on the conditions of ASD and PTSD rather than the type of trauma that may have precipitated these disorders (although the final chapter discusses the application of the Guidelines recommendations to various traumatised populations). Of course, PTSD may exist in the context of a complex life history, other disorders, and ongoing life issues and stressors.

The diagnostic criteria for ASD and PTSD are defined in internationally accepted diagnostic manuals. In research settings, the most widely used is the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. The fifth version of this manual (DSM-5<sup>2</sup>) was published in 2013. The other major diagnostic classificatory system, used more often in clinical settings within Australia, is the International Classification of Diseases (ICD), the current version being ICD-11 which was released in 2018. Unlike the DSM-5, the ICD-11 includes the diagnosis of complex PTSD.

The Guidelines are intended to influence the care of all people living in Australia, across the full range of populations, who develop, or are at risk of developing, these forms of distress following traumatic events and receive care in hospital and community based healthcare settings. While those who have PTSD in combination with broader posttraumatic mental health problems or other mental or physical health problems may require additional treatment and care, the recommendations in these Guidelines are still relevant and applicable. The Guidelines are intended to include the care of older adults who do not have significant age-related comorbidity relevant to their treatment for PTSD. A brief section in the 'Specific Populations' chapter discusses issues relevant to that age group. Like the 2013 version of the Guidelines, this version covers the treatment of children and adolescents with PTSD.

The Guidelines developers recognise that there are a number of interventions that are widely used in clinical practice that have not been adequately tested, and it is important to acknowledge that the absence of evidence does not necessarily mean that these interventions are ineffective. However, interventions that have a proven evidence base should be considered as first line. The gap between evidence-based interventions and clinical practice should help define the research agenda into the future. Equally, evidence-based interventions should be used in preference to non-evidence-based interventions, unless there is a strong reason not to do so.

The Guidelines have been formulated with the assumption that treatment will be provided by qualified professionals who are skilled in the relevant psychosocial and medical interventions, as assessed against the prevailing professional standards. The Guidelines do not substitute for the knowledge and skill of competent individual practitioners and are designed to guide appropriate interventions in the context of each person's unique circumstances and their overall mental health care needs. In the application of these Guidelines to the Australian health care setting, consideration needs to be given to the availability and accessibility of appropriate and relevant services – especially in rural and remote settings – and of appropriate education and training to support practitioners in the delivery of the recommended evidence-based interventions.

## **Limitations of the Guidelines**

As noted above, these Guidelines seek to address the treatment response to ASD and PTSD (including complex PTSD). The Guidelines are not intended to be used prescriptively; rather, practitioners should use their experience and expertise in applying the Guidelines. Practitioners should always provide treatment within the limits of their expertise and seek further training and/or supervision as required.

These Guidelines are based on the highest quality research currently available. As new and emerging treatments develop a sufficiently strong evidence base to be included as recommended interventions it is anticipated they will be incorporated into this living guideline.

## **Development of the Guidelines**

A brief overview of the roles and responsibilities of people involved in the development of the Guidelines is provided here.

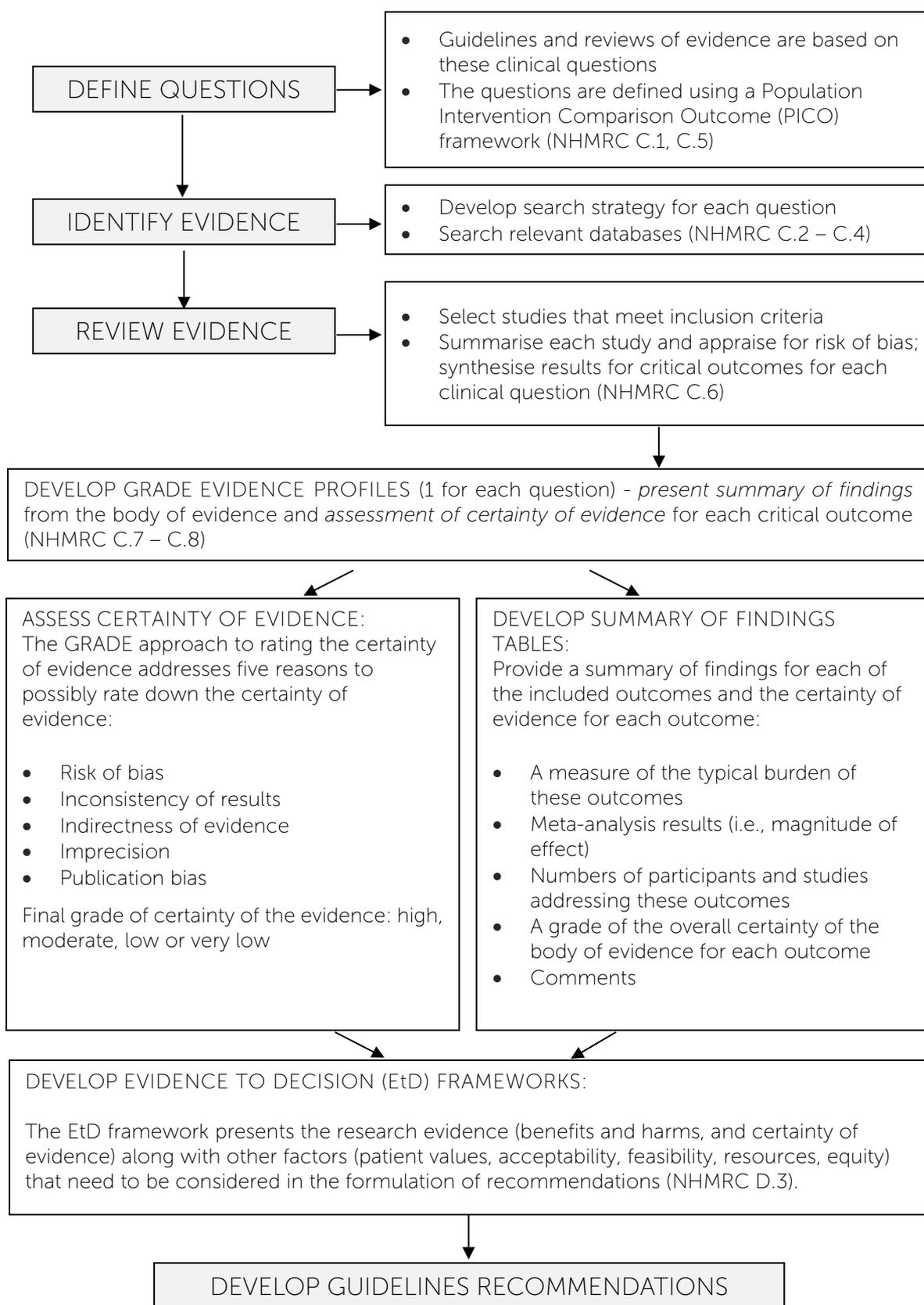
The overall guidelines development process was led by Associate Professor Andrea Phelps. The Guideline Development Group was chaired by Professor Derrick Silove and comprised research experts, a methodologist, end users, and consumers. The composition of the Guideline Development Group is listed in the Acknowledgments.

The Guideline Development Group was supported by the Phoenix Australia project team, comprising Associate Professor Andrea Phelps, Dr Ros Lethbridge, Dr Kim Jones, Dr Tracey Varker, and Dr John Cooper, who were responsible for the evidence synthesis and preparation of evidence summaries, writing, and coordinating the development and writing of the Guidelines.

The Guidelines used GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology to assess certainty of the evidence, interpret and summarise findings, and determine the strength and direction of recommendations. Dr Sue Brennan, the methodologist, advised the Guideline Development Group on the GRADE approach, mapping the GRADE process to NHMRC requirements, and the process for determining recommendations.

## **Process**

The Australian Guidelines were based on the systematic review undertaken for the ISTSS Guidelines, and updated by the Phoenix Australia team to include research published between November 2018 and June 2019. In addition to the questions addressed in the ISTSS systematic review, the Australian Guideline Development Group selected two additional questions for systematic review; the first on treatment for complex PTSD and the second on pre-incident preparedness interventions. The Guideline Development Group, under the guidance of our expert methodologist, used GRADE methodology to inform the development of recommendations based on the systematic reviews. The final recommendations are set out in Chapter 6. The Australian Guidelines online platform also sets out the recommendations and includes the research evidence underpinning those recommendations and further guidance on them. A pictorial summary of the process used for developing the recommendations is set out in Figure 1 on the following page.



**Figure 1: Evidence Review Methodology**

The Draft Guidelines for the Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder were made available for public consultation between 21 February 2020 and 23 March 2020.

## **Implementation and dissemination of the Guidelines**

The NHMRC outlines six principles of implementation that should underpin guideline development and extend from the planning phase through to dissemination. To that end the developers of these Guidelines have:

1. considered the expected users of the Guidelines (see 'Guidelines aims')
2. considered the scope of the Guidelines, with the overarching objective of these Guidelines to improve outcomes for people affected by trauma (see 'Scope of the Guidelines')
3. ensured the underpinning of a transparent development process to ensure the recommendations are 'trustworthy' (see 'Development of the Guidelines')
4. formed actionable recommendations which are clearly written
5. consulted the public prior to publishing the Guidelines
6. considered the presentation and format of the Guidelines, including the use of an online platform to enhance access to the evidence that underpins the Guidelines recommendations and enable a process of regular update when new evidence becomes available.

In addition, a practical implementation plan is provided as a separate document, based on considerations of the Australian health care context and identification of appropriate organisation/s where the key recommendations may be directed. The key Guidelines recommendations need to be effectively disseminated to health practitioners, service planners, purchasers and people directly affected by trauma. The communication objectives of the dissemination strategy include the following.

1. Generate awareness of the Guidelines and recommended interventions amongst health practitioners.
2. Generate awareness of the Guidelines amongst education and child mental health professionals.
3. Engage professional bodies and peak organisations in the dissemination process.
4. Engage organisations that promote best practice in the dissemination process.
5. Ensure mental health consumers have access to the Guidelines' key recommendations.
6. Demonstrate practical policy implications of the Guidelines to decision makers in key government departments and industry organisations.

These objectives will be met through a range of activities including the provision of accessible Guidelines companion documents for practitioners and community members, peer reviewed publications, media releases (including the use of social media), targeted consultation with key stakeholders and decision makers in government and mental health services, and the integration of recommendations into relevant policy and training initiatives.

In regard to the implementation in Australia of pharmacological recommendations outlined in these Guidelines, doctors should be mindful of regulations that may apply where the cost of the medicine is subsidised by the Government (Pharmaceutical Benefits Schedule) or another third party.

## **Maintaining currency of the living Guidelines**

To ensure that Guidelines recommendations are always current, the Guideline Development Group will establish a schedule for reviewing the literature, based upon the certainty of the body of evidence in relation to each question addressed in the systematic reviews. The prioritisation criteria proposed by Akl and colleagues (2017)<sup>3</sup> will be considered in determining the frequency of updating individual recommendations:

1. The priority of the recommendation for decision-making (includes, but is not limited to areas of known variation in practice, emerging interventions, and high prevalence).
2. The chance that a recommendation will change with emergence of new evidence (i.e. recommendations for which underpinning evidence is of low or very low certainty).
3. The likelihood of finding new research evidence.

The first review and update is scheduled to occur before the end of 2021.

## **Disclaimer**

These Guidelines must be used in conjunction with clinical judgement and patient preference. The attending clinician has ultimate responsibility for the appropriate choice of therapy.

## References

1. World Health Organisation. International Classification of Diseases, 11th Revision (ICD-11). Geneva, Switzerland: World Health Organisation; 2018.
2. American Psychiatric Association. *Diagnostic and statistical manual of mental disorders (DSM-5)*. Washington DC: American Psychiatric Association; 2013.
3. Akl EA, Meerpohl JJ, Elliott J, et al. Living systematic reviews: 4. Living guideline recommendations. *Journal of clinical epidemiology*. 2017;91:47-53.