Phoenix AUSTRALIA

Treatment recommendations

The purpose of this chapter is to present the Guideline treatment recommendations alongside issues for consideration in implementation. A list of the interventions recommended for further research are also presented. Full details of the research studies included in the systematic review, summaries of the evidence for each research question, and the rationale behind recommendations, are provided in the online platform of the Guidelines.

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. Practitioners should be enabled to interpret and implement treatment recommendations in the context of good clinical judgement, not as rigid rules.

Recommendations are made for or against a treatment option, with the strength of the recommendation designated **strong** (there is moderate to strong certainty in the evidence and clinicians should provide the intervention to all or almost all people in all or almost all circumstances) or **conditional** (there is lower certainty in the evidence and clinicians should provide the intervention to most people, but not all). **Research recommendations** are made for interventions that are considered promising on the basis of preliminary evidence and warrant further research. The research recommendations are listed after the treatment recommendations.

The interventions for children and adolescents, and for adults are presented separately. The three main categories of interventions are presented in the below sequence, based on the recommended timing of the appropriate treatment. A **universal** intervention is applicable for all who are exposed to trauma, while an **indicated** intervention is applicable for those people with PTSD symptoms.

- Pre-incident preparedness (universal interventions for those likely to experience trauma)
- Interventions within the first three months of trauma (universal and indicated interventions)
- Interventions for those with clinically significant PTSD symptoms

In the December 2021 update of these Guidelines, two new categories of interventions were added: *Interventions for adults with comorbid PTSD* and *Alternative* (to face-to-face) *treatment delivery modalities* (for adults, and for children and adolescents).

Treatment Recommendations for Children and Adolescents

Grade Methodology - Key	
Strong Recommendation FOR	Strong Recommendation AGAINST
Conditional Recommendation FOR	Conditional Recommendation AGAINST

Interventions within the first three months of trauma

Universal interventions (for all children and adolescents who experience trauma)	**Conditional recommendation AGAINST individual psychological debriefing** For children and adolescents within the first three months of trauma, we suggest providing information, emotional support and practical assistance in preference to individual psychological debriefing.
Indicated interventions (for children and adolescents 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 of trauma where symptoms of PTSD are present, we suggest offering child and family traumatic stress intervention (CFTSI) in preference to supportive counselling.

Interventions for children and adolescents with symptoms of PTSD

Psychological interventions	**Strong recommendation FOR trauma-focused cognitive behavioural therapy (trauma-focused CBT) for child** For children and adolescents with symptoms of PTSD, we recommend trauma-focused CBT. **Strong recommendation FOR trauma-focused CBT for caregiver and child** For children and adolescents with symptoms of PTSD, we recommend trauma-focused CBT for caregiver and child. **Conditional recommendation FOR eye movement desensitisation and reprocessing (EMDR)** For children and adolescents with symptoms of PTSD, we suggest offering EMDR where trauma-focused CBT is unavailable or unacceptable.
Pharmacological interventions	Insufficient evidence to make a recommendation. Where medication is indicated, practitioners are advised to follow depression treatment guidelines.

Treatment Recommendations for Adults

Grade Methodology - Key	
Strong Recommendation FOR	Strong Recommendation AGAINST
Conditional Recommendation FOR	Conditional Recommendation AGAINST

Interventions within the first three months of trauma

Universal interventions

(for all adults who experience trauma)

Conditional recommendation AGAINST individual psychological debriefing

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

Indicated interventions

(for adults with PTSD symptoms within the first three months of trauma)

Strong recommendation FOR a stepped/collaborative care model

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

Conditional recommendation FOR trauma-focused CBT

For adults with PTSD symptoms within the first three months of trauma, we suggest offering trauma-focused cognitive behavioural therapies (includes prolonged exposure, cognitive processing therapy, cognitive therapy) in preference to doing nothing.

Conditional recommendation FOR brief eye movement desensitisation and reprocessing (EMDR)

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

Interventions for adults with PTSD

Psychological interventions	**Strong recommendation FOR cognitive processing therapy (CPT)** For adults with PTSD, we recommend cognitive processing therapy (CPT). **Strong recommendation FOR cognitive therapy (trauma-focused) (CT)** For adults with PTSD, we recommend cognitive therapy (trauma-focused) (CT). **Strong recommendation FOR EMDR** For adults with PTSD, we recommend EMDR. **Strong recommendation FOR prolonged exposure (PE)** For adults with PTSD, we recommend prolonged exposure (PE). **Strong recommendation FOR trauma-focused CBT** For adults with PTSD, we recommend trauma-focused CBT. **Conditional recommendation FOR guided internet-based trauma-focused CBT** For adults with PTSD where trauma-focused cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest guided internet-based trauma-focused CBT. **Conditional recommendation FOR guided trauma-focused CBT via telehealth (video conferencing)** For adults with PTSD where face-to-face trauma-focused cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest offering guided trauma-focused CBT delivered via telehealth. **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-focused 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-focused cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest stress inoculation training (SIT). **Conditional recommendation FOR trauma-focused CBT (group)** For adults with PTSD where individual trauma-focused cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest group trauma-focused CBT.

Pharmacological interventions	**Conditional recommendation FOR SSRIs (sertraline, paroxetine or fluoxetine) or venlafaxine (an SNRI)** For adults with PTSD, we suggest SSRIs (sertraline, paroxetine or fluoxetine) or venlafaxine (an SNRI) 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 (trauma-focused CBT, PE, CT, CPT, 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 (for example as a result 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.

Interventions for adults with comorbid PTSD

Psychological interventions (for comorbid PTSD and Substance Use Disorder)	**Conditional recommendation FOR trauma-focused CBT** For adults with comorbid PTSD and Substance Use Disorder, we suggest trauma-focused CBT in preference to treatment as usual. **Conditional recommendation FOR non-trauma-focused CBT** For adults with comorbid PTSD and Substance Use Disorder, where trauma-focused CBT is unavailable or unacceptable, we suggest non-trauma-focused CBT (Seeking Safety or Integrated CBT).

Alternative treatment delivery modalities

Psychological interventions (for adults with PTSD)	**Conditional recommendation FOR guided internet-based trauma-focused CBT** For adults with PTSD where trauma-focused cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest guided internet-based trauma-focused CBT. **Conditional recommendation FOR trauma-focused CBT via telehealth (video conferencing)** For adults with PTSD where face-to-face trauma-focused cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest offering trauma-focused CBT delivered via telehealth.

Implementation considerations

A range of psychological and pharmacological interventions is currently used in the treatment of people with PTSD. In routine clinical practice, of course, these interventions do not occur in isolation, but in the context of a trusting therapeutic relationship and, in many cases, broader mental health care for a range of associated posttraumatic mental health issues. They are also not mutually exclusive and the overall treatment may involve several of these interventions at various stages of the treatment process.

This section summarises some of the broad clinical considerations in the implementation of Guideline recommendations.

Availability of evidence-based psychological treatments

Trauma-focused CBT and its variants of cognitive processing therapy (CPT), cognitive therapy (trauma-focused) (CT), and prolonged exposure (PE), along with EMDR, are recommended as first line treatments for PTSD in adults; for PTSD in children and adolescents, trauma-focused CBT for the child alone or for child and caregiver are recommended as first line treatment.

These treatments require specialised training and, unfortunately, the availability of suitably qualified practitioners is limited, particularly in rural and remote regions of Australia. The risk is that in the absence of this expertise, practitioners fall back on supportive counselling, which has been found to be ineffective for people with PTSD. There are conditional recommendations for treatment that should be considered if trauma-focused therapy is not available. The emergence of guided internet-based trauma-focused CBT and trauma-focused CBT delivered via telehealth as evidence-based treatments is a particularly important development in this context. Internet-based and telehealth therapy provide an effective means of increasing access to evidence-based treatment for people living in rural and remote regions, or who are otherwise unable to access an appropriately qualified practitioner.

This does not of course negate the need to increase the expertise of mental health practitioners in providing evidence-based care for PTSD.

Role of medication

Currently the recommended first line treatments for PTSD are trauma-focused psychological therapies, with pharmacological treatment considered a second line option. This is based on the relatively stronger clinical effects found for trauma-focused psychological therapies (generally large effect size changes) compared to pharmacological therapies (generally small effect size changes). The one head-to-head trial found equivalence of these psychological therapies with enhanced medication management with sertraline.[1] Hence we do not underestimate the important role of pharmacological therapies, particularly antidepressant medications, in the treatment of PTSD in clinical practice. This includes when PTSD presents as a standalone disorder, as well as when it is comorbid with depression.

Four antidepressants have the strongest evidence base for treating PTSD in adults. These are three selective serotonin reuptake inhibitors (SSRIs; paroxetine, fluoxetine and sertraline) and one serotonin noradrenaline reuptake inhibitor (SNRI; venlafaxine). In clinical practice, both in the treatment of PTSD and depression, there is an equivalence observed within and between these classes of antidepressants in their effectiveness and tolerability.

In clinical practice, medication is often the first if not the only treatment offered for PTSD in adults. This arises where trauma-focused CBT is not available, not readily accessible, or not acceptable to the individual. Further, for those who receive trauma-focused therapy, it is often delivered in conjunction with pharmacological therapy. Indeed, combined medication and psychotherapy is the most common treatment practice for veterans with PTSD.[2] Despite this common practice, there is a lack of research evidence for the additive benefit of combined psychotherapy and medication in the treatment of PTSD. Given the strong evidence of the additive benefit of combined psychotherapy and medication in the treatment of anxiety and depression,[3] it is reasonable to suppose that the same would be true of PTSD. However, a recent randomised clinical trial found that combining sertraline with PE did not increase efficacy in a sample of combat veterans.[1] Of interest, this head-to-head study comparing three treatment conditions, PE + sertraline, PE + placebo, and sertraline + enhanced medication management (to balance clinical attention), found all conditions to be equally effective in the treatment of PTSD.

When PTSD is comorbid with depression, research into the effective treatment of depression is also important to consider. Further to the evidence of the additive benefit of psychotherapy and medication in the treatment of depression noted above,[3] a recent randomised clinical trial[4] found a reduced incidence of recurrence in depression that had been successfully treated with CBT with maintenance antidepressant treatment.

Medication use is also important to consider in relation to reducing suicide risk. A large US study of all deaths by suicide between 1996 and 1998 found that prescribing rates of SSRIs and other new generation antidepressants (including venlafaxine) in different regions of the country were associated with lower suicide rates within the population.[5] Similar results have been found in Japan, where increased utilisation of SSRIs and other newer antidepressants was associated with decrease in suicide rates.[6] Further, a systematic review of suicide prevention interventions[7] has found that effective pharmacological and psychological treatments of depression are important.

Importantly, a Canadian meta-analysis[8] has found that, contrary to research indicating an increase in suicidal ideation and behaviour in children and adolescents treated with antidepressant medication,[9] there was no increased risk in adults taking antidepressant medication.

Anecdotally, suboptimal prescribing is common in treating PTSD, with the dose and choice of medication inconsistent with the evidence base. Further, the limits of the evidence base that guides pharmacological treatment can be reached quickly. Clinical strategies that can mitigate problems arising from idiosyncratic prescribing and assist clinicians in making appropriate decisions about pharmacological treatment include:

- providing the patient with sufficient information about the likely risks and benefits of a specific medication to allow them to make a fully informed decision,
- commencing pharmacological treatment using the existing evidence base, including recommended dose,
- using a prescribing protocol or algorithm.

Prescribing according to an algorithm to treat depression has been shown to result in significantly better outcomes than prescribing based purely on clinician choice[10] and it seems likely a similar outcome would be applicable to the treatment of PTSD. One such algorithm has been proposed by Cardiff University Traumatic Stress Research Group[11] and provides an example of how PTSD pharmacological treatment recommendations can be implemented into practice. The algorithm is appended to this chapter.

Pharmacotherapy for children and adolescents

In the systematic reviews underpinning these Guidelines, there was insufficient evidence to recommend any pharmacological treatment for children with PTSD. In this circumstance, where medication is indicated, practitioners are advised to follow depression guidelines which currently favour fluoxetine as the antidepressant of first choice for people aged 12–18 years.[12]

Non-psychological and non-pharmacological therapies

In recent years there has been increasing interest in a range of non-psychological and non-pharmacological interventions for people with PTSD. These include interventions such as yoga, meditation, and exercise. While none of these therapies have a sufficient evidence base to recommend them as a treatment for PTSD, we would support their use as adjunctive or supplementary interventions to promote general wellbeing.

Populations underrepresented in the research

The guideline recommendations are based on the international published research and include a broad range of people from high- and low-income countries as well as culturally and linguistically diverse backgrounds. Of particular note, however, none of the studies in the systematic review has a specific focus on the treatment of trauma in Australian Aboriginal or Torres Strait Islander peoples. This represents a significant gap in the evidence base for an Australian guideline for the treatment of PTSD, and there is an urgent and compelling case for research to address the gap.

Research recommendations

The guideline development group considered that the preliminary evidence for the following interventions was promising and warranted further research. However, it is important to note that interventions that have been recommended for further research are NOT currently recommended for the treatment of PTSD. Nor should it be inferred that evaluating these interventions should take priority over strengthening the evidence for some more routinely used interventions or among important populations who are under-represented in current research.

Research Recommendations for Children and Adolescents

Interventions within the first three months of trauma

Universal interventions (for all children and adolescents who experience trauma)	**Self-directed online psychoeducation for caregivers and children** There is emerging evidence for self-directed online psychoeducation for caregivers and children following traumatic physical injury and it could be used in a research context. However, in routine practice for children and adolescents within the first three months of trauma, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for caregivers and children.
	Self-directed online psychoeducation for children There is emerging evidence for self-directed online psychoeducation for children following an acute medical event and it could be used in a research context. However, in routine practice for children and adolescents within the first three months of trauma, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for children.

Interventions for children and adolescents with symptoms of PTSD

Psychological interventions	**Group trauma-focused cognitive behavioural therapy (CBT) for child** There is emerging evidence for group trauma-focused CBT for child following exposure to traumatic events and it could be used in a research context. However, in routine practice for children and adolescents with symptoms of PTSD, we suggest doing trauma-focused CBT in preference to group trauma-focused CBT for child.
	Individual and group trauma-focused CBT for caregiver and child There is emerging evidence for individual and group trauma-focused CBT for caregiver and child following exposure to traumatic events and it could be used in a research context. However, in routine practice for children and adolescents with symptoms of PTSD, we suggest doing trauma-focused CBT in preference to individual and group trauma-focused CBT for caregiver and child.
	Narrative Exposure Therapy for children (KidNET) There is emerging evidence for narrative exposure therapy for children (KidNET) following exposure to traumatic events and it could be used in a research context. However, in routine practice for children and adolescents with symptoms of PTSD, we suggest continuation of treatment as usual in preference to KidNET.

Psychological interventions (continued)	**Parent–child relationship enhancement (play therapy)** There is emerging evidence for parent–child relationship enhancement (play therapy) for children with symptoms of PTSD and it could be used in a research context. However, in routine practice for children and adolescents with symptoms of PTSD, we suggest continuation of treatment as usual in preference to parent–child relationship enhancement (play therapy).
Non-psychological and non-pharmacological interventions	**Mind–body skills group** There is emerging evidence for mind–body skills group in refugee populations exposed to war-related traumatic events and it could be used in a research context. However, in routine practice for children and adolescents with symptoms of PTSD, we suggest continuation of treatment as usual in preference to mind–body skills group.

Alternative treatment delivery modalities

Early psychosocial prevention interventions (for all children and adolescents who experience trauma)	**Self-directed online psychoeducation for caregivers and children** There is emerging evidence for self-directed online psychoeducation for caregivers and children following traumatic physical injury and it could be used in a research context. However, in routine practice for children and adolescents within the first three months of trauma, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for caregivers and children.
	Self-directed online psychoeducation for children There is emerging evidence for self-directed online psychoeducation for children following an acute medical event, and it could be used in a research context. However, in routine practice for children and adolescents within the first three months of trauma, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for children.

Research Recommendations for Adults

Abbreviations for common psychological treatments	
TF-CBT (trauma-focused CBT)	EMDR (eye movement desensitisation and reprocessing)
CT (cognitive therapy with a trauma focus)	CPT (cognitive processing therapy)
PE (prolonged exposure)	

Pre-incident preparedness

Universal interventions

(for all adults likely to experience trauma)

Attention bias modification training (ABMT)

There is emerging evidence for pre-incident attention bias modification training (ABMT) in military populations and it could be used in a research context. However, in routine practice for adults who are likely to be exposed to trauma, we suggest usual practice in preference to pre-incident ABMT.

Attention control training

There is emerging evidence for pre-incident attention control training and it could be used in a research context. However, in routine practice for adults who are likely to be exposed to trauma, we suggest usual practice in preference to pre-incident attention control training.

Heart rate variability biofeedback (HRVB)

There is emerging evidence for heart rate variability biofeedback (HRVB) and it could be used in a research context. However, in routine practice for adults who are likely to be exposed to trauma, we suggest usual practice in preference to HRVB.

Interventions within the first three months of trauma

Universal interventions

(for all adults who experience trauma)

Brief dyadic therapies

There is emerging evidence for brief dyadic therapies, and these could be used in a research context. However, in routine practice for adults within the first three months of trauma, we suggest usual practice in preference to brief dyadic therapies.

Brief individual trauma processing therapy

There is emerging evidence for brief individual trauma processing therapy for adults within the first three months following exposure to a potentially traumatic event and this could be used in a research context. However, in routine practice for adults within the first three months of trauma, we suggest usual practice in preference to brief individual trauma processing therapy.

Group 512 PIM (Psychological Intervention Model)

There is emerging evidence for Group 512 PIM in Chinese military populations exposed to natural disasters and it could be used in a research context. However, in routine practice for adults within the first three months of trauma, we suggest usual practice in preference to Group 512 PIM.

Universal interventions (continued)	**Internet-based CBT** There is emerging evidence for internet-based CBT and it could be used in a research context. However, in routine practice for adults within the first three months of trauma, we suggest usual practice in preference to internet-based CBT.
Indicated interventions (for adults with PTSD symptoms within the first three months of trauma)	**Helping to overcome PTSD through empowerment (HOPE)** There is emerging evidence for Helping to Overcome PTSD through Empowerment (HOPE) and it could be used in a research context. However, in routine practice for adults with PTSD symptoms within the first three months of trauma, we recommend offering TF-CBT, PE, CT, or brief EMDR in preference to HOPE.
Psychosocial interventions	**Internet-based guided self-help** There is emerging evidence for internet-based guided self-help and it could be used in a research context. However, in routine practice for adults with PTSD symptoms within the first three months of trauma, we recommend offering TF-CBT, PE, CT, or brief EMDR in preference to internet-based guided self-help.
	Structured writing therapy There is emerging evidence for structured writing therapy and it could be used in a research context. However, in routine practice for adults with PTSD symptoms within the first three months of trauma, we recommend offering TF-CBT, PE, CT, or brief EMDR in preference to structured writing therapy.
Pharmacological interventions	**Hydrocortisone** There is emerging evidence for hydrocortisone and it could be used in a research context. However, in routine practice for adults with PTSD symptoms within the first three months of trauma, we recommend offering TF-CBT, PE, CT, or brief EMDR in preference to hydrocortisone.

Interventions for adults with PTSD

Psychological interventions	**Couples TF-CBT** There is emerging evidence for couples TF-CBT and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to couples TF-CBT.
	Group and individual (combined) TF-CBT There is emerging evidence for group and individual (combined) TF-CBT and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to group and individual (combined) TF-CBT.
	Meta-cognitive therapy There is emerging evidence for meta-cognitive therapy and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to meta-cognitive therapy.

Psychological interventions (continued)	**Non-trauma focused CBT (affect regulation)** There is emerging evidence for non-trauma focused CBT (affect regulation) and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to non-trauma focused CBT (affect regulation).
	Reconsolidation of traumatic memories (RTM) There is emerging evidence for the reconsolidation of traumatic memories (RTM) and it could be used in a research setting. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to RTM.
	Single-session TF-CBT There is emerging evidence for single-session TF-CBT and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to single-session TF-CBT.
	Virtual reality therapy There is emerging evidence for Virtual Reality Therapy and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, CPT, PE, CT or EMDR in preference to Virtual Reality Therapy.
	Written exposure therapy (WET) There is emerging evidence for Written Exposure Therapy (WET) and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to WET.
	3MDR (Military motion-assisted memory desensitisation and reprocessing treatment) There is emerging evidence for 3MDR and this could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to 3MDR.

Interventions for adults with PTSD

Non-psychological and non-pharmacological interventions	**Acupuncture** There is emerging evidence for acupuncture and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to acupuncture.
	Mindfulness-based stress reduction (MBSR) There is emerging evidence for mindfulness-based stress reduction (MBSR) and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to MBSR.
	Neurofeedback There is emerging evidence for neurofeedback and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to neurofeedback.
	Repetitive transcranial magnetic stimulation (rTMS) There is emerging evidence for repetitive transcranial magnetic stimulation (rTMS) and this could be used in a research context. For adults with PTSD we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to rTMS.
	Transcendental meditation (TM) There is emerging evidence for Transcendental Meditation and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to Transcendental Meditation (TM).
	Yoga There is emerging evidence for yoga and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to yoga.
Pharmacological interventions	**Ketamine** There is emerging evidence for the use of ketamine in the treatment of PTSD and it could be used in a research context. However, where medication is indicated for the treatment of PTSD, we suggest an SSRI or SNRI antidepressant in preference to ketamine.
	Quetiapine There is emerging evidence for the use of quetiapine in the treatment of PTSD and it could be used in a research context. However, where medication is indicated for the treatment of PTSD, we suggest an SSRI or SNRI antidepressant in preference to quetiapine.

Interventions for adults with comorbid PTSD

Psychological interventions	**Trauma-focused CBT for adults with comorbid PTSD and severe mental illness** There is emerging evidence for TF-CBT for adults with comorbid PTSD and severe mental illness and this could be used in a research context.

Alternative treatment delivery modalities

Universal interventions (for all adults who experience trauma)	**Internet-based CBT** There is emerging evidence for internet-based CBT and it could be used in a research context. However, in routine practice for adults within the first three months of trauma, we suggest usual practice in preference to internet-based CBT.
Indicated interventions (for adults with PTSD symptoms in the first three months after trauma)	**Internet-based guided self-help** There is emerging evidence for Internet-based guided self-help and it could be used in a research context. However, in routine practice for adults with PTSD symptoms within the first three months of trauma, we recommend offering TF-CBT, PE, CT, or brief EMDR in preference to internet-based guided self-help.
Interventions for adults with PTSD **Psychological interventions**	**Trauma-focused CBT (TF-CBT) via telehealth (videoconferencing)** Further research is needed to better understand the factors affecting patient preferences for delivery of face-to-face TF-CBT versus telehealth. However, for adults with PTSD where face-to-face TF-CBT or EMDR are unavailable or unacceptable, TF-CBT delivered via telehealth is conditionally recommended.
	Virtual Reality Therapy There is emerging evidence for Virtual Reality Therapy and it could be used in a research context. However, in routine practice for adults with PTSD, we recommend offering TF-CBT, CPT, or EMDR in preference to Virtual Reality Therapy.

Comparison with recommendations in previous Guidelines

This section provides a summary of changes to the recommendations when compared with the 2013 Guidelines.

For **children and adolescents** exposed to trauma there is a conditional recommendation against individual psychological debriefing, similar to the Grade B recommendation made against this intervention in 2013. For those with symptoms within the first three months there is a new conditional recommendation for the Child and Family Traumatic Stress Intervention (CFTSI). For children and adolescents with PTSD, the recommendation in support of trauma-focused CBT has strengthened from Grade C in 2013 to a strong recommendation in the current Guidelines. In addition, there is a strong recommendation for the use of trauma-focused CBT for caregiver and child combined, and a conditional recommendation for the use of EMDR for children and adolescents.

In relation to **adults**, in the current Guidelines there is a conditional recommendation against individual or group psychological debriefing, similar to the Grade B recommendation against this intervention in 2013. For adults with symptoms of PTSD within the first few months, the current Guidelines contain a new strong recommendation for the use of a stepped/ collaborative care model. In addition there are conditional recommendations for TF-CBT and EMDR for adults with symptoms of PTSD within the first few months, compared to a Grade C recommendation for TF-CBT only in the 2013 Guidelines. An important development in recommendations for the treatment of adults with PTSD is that the broad category of trauma-focused-CBT has been divided into the variants of trauma-focused-CBT with separate recommendations for each, reflecting growth in the size of the evidence base. In 2013 there was a Grade A recommendation for the use of trauma-focused-CBT or EMDR for adults with PTSD. The current Guidelines contain strong recommendations for trauma-focused CBT, CPT, CT, PE, and EMDR. In addition, a number of interventions have been given a conditional recommendation for a specific population (Narrative Exposure Therapy for refugees) or when trauma-focused-CBT or EMDR is unavailable or unacceptable (group trauma-focused-CBT, present-centred therapy, guided internet-based TF-CBT, TF-CBT delivered via telehealth, and stress inoculation training). Of these interventions, internet delivered and group-based TF-CBT were given a Grade C recommendation in the 2013 Guidelines.

Additionally, there are three new recommendations for adults with comorbid PTSD. Trauma-focused CBT is now conditionally recommended for adults with comorbid PTSD and Substance Use Disorder, as is non-trauma focused CBT for the same population. Trauma-focused CBT has also been included as a research recommendation for adults with comorbid PTSD and severe mental illness.

With respect to medication, the 2013 Guidelines included a Grade C recommendation for the use of SSRIs in adults when medication was indicated. This is similar to the current conditional recommendation for SSRIs (sertraline, paroxetine or fluoxetine), but the current Guidelines contain an additional conditional recommendation for the use of venlafaxine (an SNRI).

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