Copies of the full set of the Guidelines, this guide and a booklet for people with ASD and PTSD, their families and carers are available online:
www.acpmh.unimelb.edu.au

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Acknowledgements
This guide is a companion document to the *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder,* developed by acpmh in collaboration with key trauma experts from throughout Australia and in consultation with a panel representing the public, regulatory bodies, trauma specialists and generalists from a range of health professions.

A number of generalist medical and allied health practitioners were involved in focus testing this brief guide. Their feedback has helped to make the guide relevant and accessible to the range of practitioners in the trauma field and is gratefully acknowledged.

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The Guidelines have been endorsed by the Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society.

AUSTRALIAN GUIDELINES FOR THE TREATMENT OF ADULTS WITH

Acute Stress Disorder and Posttraumatic Stress Disorder

Practitioner Guide

Australian Centre for Posttraumatic Mental Health

February 2007

Australian Government
National Health and Medical Research Council

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This practitioner guide is a synopsis of the *Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder* developed by the Australian Centre for Posttraumatic Mental Health (acpmh) at the University of Melbourne. For more comprehensive information about interventions or the review of the evidence literature, a full-text version of the guidelines is available at www.nhmrc.gov.au. You can also order additional copies of this guide from www.acpmh.unimelb.edu.au. Organisations and health practitioners can contact acpmh on (03) 9496 2922 to discuss briefings and training about the Guidelines.

The practitioner guide was written with a wide range of health practitioners in mind, from primary health care providers through to mental health specialists. We hope that the information contained will be relevant to all but expect that its application will vary across settings and in line with the practitioners' training in particular interventions.

The guide has two sections. The first section gives a brief overview of Acute Stress Disorder (asd) and Posttraumatic Stress Disorder (ptsd) and outlines key guideline recommendations. The second section provides a full summary of the recommendations.

About the ASD and PTSD Treatment Guidelines

The Guidelines were developed to help health practitioners, policy makers and the public make appropriate decisions about screening, assessment, referral and treatment for asd and ptsd.

There has been a great deal of information published about the assessment and treatment of posttraumatic responses. While understanding of traumatic stress has grown in recent years, approaches to its treatment have varied widely. For example, there has been a lot of debate in the traumatic stress field about issues such as the usefulness of structured debriefing interventions, the use of exposure-based procedures and the timing of interventions when working with someone with comorbid conditions. These guidelines seek to provide recommendations so that consumers and providers can make informed decisions about some of these issues.

It is important to acknowledge that posttraumatic mental health problems manifest in many different ways and that asd and ptsd are only some of the issues encountered by health professionals when helping individuals affected by traumatic events. The guidelines take into account some of these complex issues by including people's psychosocial needs and comorbid conditions when making recommendations about assessment and treatment planning.

The Guidelines were developed in collaboration with Australian trauma experts and in consultation with a multidisciplinary panel of health practitioners and mental health service users. They are based on a systematic literature review of outcome research and have been endorsed by the National Health and Medical Research Council (nhmrc).

While there has been growing consensus about the treatment of asd and ptsd in recent years, approaches are varied and there is still a gap between evidence based practice and routine clinical care.

How to use the Guidelines

The guidelines aim to provide guidance and support to qualified professionals who are skilled in the relevant psychosocial and medical interventions. They do not substitute for the knowledge and skill of individual practitioners. The guidelines need to be used in conjunction with clinical judgment in the context of the client-practitioner relationship. Whenever possible, decisions about treatment should be made collaboratively with the individual, their family, carers and other professionals involved in their care.

A free information booklet designed for people diagnosed with asd or ptsd, their carers and families can be downloaded or ordered via www.acpmh.unimelb.edu.au or by calling the Centre on (03) 9496 2922.

PTSD and ASD: Definition & Prevalence

Individuals may develop a range of psychological problems following exposure to trauma, including depression, anxiety, and substance misuse. ptsd and asd, however, are trauma-specific psychological reactions that develop in some people following the experience of events such as a major disaster, war, sexual or physical assault, motor vehicle accidents and torture. Traumatic events include any threat, actual or perceived, to the life or physical safety of a person, their loved ones or those around them and lead to feelings of intense fear, helplessness or horror.

Exposure to a traumatic event is a common experience. Large community surveys in Australia and overseas reveal that 50–65% of people report at least one traumatic event in their lives. Most people will have some kind of psychological reaction to trauma—feelings of fear, sadness, guilt and anger are common. However, the majority recover over time with only a small proportion developing asd or ptsd. It is estimated that more than a quarter of a million Australians experience ptsd in any one year, and that around 5% of people have had ptsd at some point in their lives.

Many people are exposed to a traumatic event in their lifetime. Most will recover with the support of their family and friends but those who develop posttraumatic mental health problems may need professional assistance to recover.

Posttraumatic Stress Disorder

ptsd is characterised by three main groups of symptoms. Before a diagnosis can be made, a number of symptoms in each of the three categories must be present for at least a month and lead to significant distress or impairment in important areas of functioning:

- Re-experiencing—intrusive distressing recollections of the traumatic event; flashbacks; nightmares; intense psychological distress or physical reactions, such as sweating, heart palpitations or panic when faced with reminders of the event.
- Avoidance and emotional numbing—avoidance of activities, places, thoughts, feelings, or conversations related to the event; restricted emotions; loss of interest in normal activities; feeling detached from others
- Hyperarousal—difficulty sleeping; irritability; difficulty concentrating; hypervigilance; exaggerated startle response

While symptoms often develop in the days and weeks following exposure to trauma, the onset of ptsd can be delayed for a significant number of people.

Acute Stress Disorder

While ptsd requires that the symptoms be present for at least one month, asd is diagnosed between two days and one month following a traumatic event. There is significant overlap in the diagnostic criteria for each condition. The diagnoses differ in that asd requires the experience of several dissociative symptoms not included in ptsd (such as detachment, reduced awareness of surroundings, depersonalisation, and dissociative amnesia), while ptsd places greater emphasis on avoidance symptoms.

The key distinguishing feature between ptsd and asd is the duration of symptoms required for the diagnosis to be made.

Key Recommendations

The following recommendations outline core aspects of treatment. A full list of the recommendations is at the back of this guide.

Screening

People with asd and ptsd will not necessarily mention the fact that they have had a traumatic experience when they first go to see a doctor or another health professional. They may present with any of a range of problems including anger, relationship problems, poor sleep or physical health complaints such as fatigue, headaches or gastrointestinal problems. The distress and stigma associated with mental health problems or traumatic events may prevent some people from talking about their experience.

If people presenting to primary care services such as GP surgeries or community health centres report repeated non-specific physical health problems, practitioners may need to ask whether the person has experienced a traumatic event. If posttraumatic mental health problems are suspected, it is recommended that a brief screening measure such as the one provided overleaf be used to screen for ptsd.

Screening Measures

There is a range of ptsd screening measures currently in use. A list of screening measures is available in the Guidelines located at www.acpmh.unimelb.edu.au. The following is an example of a screening measure that has been empirically validated[1].

1. Do you avoid being reminded of the experience by staying away from certain places, people or activities?
2. Have you lost interest in activities that were once important or enjoyable?
3. Have you begun to feel more distant or isolated from other people?
4. Do you find it hard to feel love or affection for other people?
5. Have you begun to feel that there is no point in planning for the future?
6. Have you had more trouble than usual falling or staying asleep?
7. Do you become jumpy or easily startled by ordinary noise or movements?

If a person says "yes" to four or more of these questions, a ptsd diagnosis is likely. Research into this scale has established that, among individuals exposed to trauma, 71% of people who say yes to 4 or more items have a diagnosis of ptsd and 98% of people who say yes to less than 4 do not have the diagnosis.

1 Breslau , N., Peterson, E., Kessler, R., & Schultz, L. (1999). Short Screening Scale for DSM-IV Posttraumatic Stress Disorder. *American Journal of Psychiatry,* 156, 908-911

Assessment and diagnosis

Given that most people experience some level of distress after a traumatic event and recover using their own resources, professional help is only necessary when a person's distress is persistent or severe enough to cause significant impairment. In these circumstances, a thorough clinical assessment should be conducted including physical, psychological and social functioning. This would include enquiring about the traumatic event itself, any prior traumatic experience/s, the presence and course of posttraumatic symptoms, prior mental health problems, as well as broader quality of life indicators such as marital or family situation and occupational, legal and financial status. Particular attention should be paid to physical health including issues related to injury and health behaviour change arising from the traumatic incident.

The comprehensive assessment should include an assessment of risk of self-harm, suicide and harm to others. It is also worth noting that, because of the sustained nature of some traumatic experiences, people presenting for treatment may still be facing ongoing threat and be at risk of further exposure to trauma. For example, emergency personnel and victims of domestic violence may have to return to unsafe environments.

It is also important to include an assessment of the person's strengths and the positive coping strategies that he or she uses.

Comorbidity is common in ptsd: 85% of men and 80% of women with ptsd are likely to have another disorder such as depression, substance misuse or generalised anxiety. Thus, assessment should go beyond ptsd, covering the broad range of potential mental health problems and their implications for treatment. Consideration should also be given to the diagnosis of complicated grief (formerly known as traumatic grief), following bereavement and when grief-specific symptoms are reported.

Individuals who have experienced prolonged or repeated traumatic events such as childhood sexual abuse are more likely to experience a number of problems often associated with ptsd, including substance use or impaired emotional regulation. There is substantial symptom overlap between this more complex ptsd presentation and borderline personality disorder, and so careful assessment is required to differentiate between these two diagnoses.

Ideally, assessment should include validated self-report and structured clinical interview measures. Those are listed in the table below. However if the use of these or other measures is not feasible a thorough clinical assessment is the core requirement.

Wherever possible, family members should be included in the assessment process, education and treatment planning, and their own needs for care considered alongside the needs of the person presenting for treatment. This should be done with the person's consent.

Validated PTSD measures

There are several ptsd measures that you can use. They are listed in the assessment section of the guidelines located at www.acpmh.unimelb.edu.au.

Structured interviews

- The Clinician Administered ptsd Scale (caps) is a psychometrically robust instrument. It consists of 30 items that correspond to the dsm-iv criteria for ptsd.

Self-report questionnaires

- ptsd Checklist (pcl) assesses the 17 dsm-iv ptsd symptoms, with each rated on a five-point scale from "not at all" to "extremely". The scale takes only five minutes to complete and possesses excellent psychometric qualities. A score of 50 is recommended as the diagnostic cutoff.

The pcl and caps can be obtained at www.ncptsd.va.gov

Early interventions following traumatic exposure

Practitioners are often called upon to provide assistance in the first few days following a traumatic event. The available research evidence suggests that this should normally be limited to practical and emotional support. This means that:

- Practitioners should provide psychological first aid which involves ensuring people's safety and security, ongoing monitoring, providing practical assistance and information, and encouraging people to actively use their social supports. This should be a step-by-step process tailored to individual needs.
- Structured interventions such as psychological debriefing offered shortly after trauma exposure and focused on recounting the traumatic event and ventilation of feelings, should not be offered on a routine basis.
- Drug treatments should not be used as a preventive intervention following traumatic exposure.

If, in the first month following exposure, symptoms of asd appear:

- Practitioners should offer individual trauma-focussed cognitive behaviour therapy, including exposure and/or cognitive therapy. This treatment should not start until at least two weeks after the traumatic event.
- Drug treatments should not be used within four weeks of symptoms appearing unless the severity of the person's distress cannot be managed by psychological means alone.

Treating PTSD

Effective treatments for ptsd include psychological and medical interventions but the cornerstone of treatment involves confronting the traumatic memory and addressing thoughts and beliefs associated with the experience. Trauma-focussed interventions can reduce ptsd symptoms, lessen anxiety and depression, and improve quality of life. They are also effective with people who have experienced prolonged or repeated traumatic events.

As with all treatments, it is important to develop trust and a good therapeutic relationship to obtain a positive outcome.

Some interventions that may involve elements of trauma-focussed work are not included in this guide, either because they have not yet been properly tested (for example, brief psychodynamic therapy), or because they have been tested and found to be less effective than recommended interventions (for example hypnotherapy and supportive counselling). Non trauma-focussed interventions such as stress inoculation training or anxiety management, although not as effective when used on their own, may well have a role as part of a broader trauma-focussed treatment and are often included in trauma interventions.

- Adults with ptsd should be offered trauma-focussed psychological interventions (trauma-focussed cognitive behavioural therapy (cbt) or Eye Movement Desensitization and Reprocessing (emdr) that includes *in vivo* exposure)
- Where adults have developed ptsd and associated features following exposure to prolonged and/or severe traumatic events, more time to establish a trusting therapeutic alliance, more attention to teaching emotional regulation skills, and a gradual approach to exposure therapy may be required.
- Medication should not be used as a routine first-line treatment in preference to trauma-focussed psychological therapy.
- Medication can be useful if the person receiving treatment is not getting sufficient benefit from the psychological intervention alone. It can also be used as an alternative when psychological treatment is refused or unavailable.
- Where medication is considered for the treatment of ptsd in adults, selective serotonin reuptake inhibitors (ssri) antidepressants should be the first choice for practitioners

Trauma-focussed treatments

Recommended treatments (trauma-focussed cbt and emdr that includes *in vivo* exposure) share two key elements. They involve helping ptsd sufferers:

- confront the memory of their traumatic experience/s in a controlled and safe environment (imaginal exposure).
- confront situations, people or places they have avoided since the traumatic event (*in vivo* exposure).
- identify, challenge and modify any biased and distorted thoughts and memories of their traumatic experience as well as any subsequent beliefs about themselves and the world that are getting in the way of their recovery.

With these methods, people accessing treatment are encouraged to gradually recall and think about traumatic memories until they no longer create high levels of distress. They are encouraged to do so at their own pace and are given skills to manage feelings as they emerge during sessions.

A detailed description of emdr and cbt is included in the Guidelines located at www.acpmh.unimelb.edu.au

Treating comorbid conditions

For people with comorbid problems, the sequencing of treatment for each condition needs to be considered:

- ptsd and depression—in most cases, ptsd should be treated first as depression will often improve as ptsd symptoms reduce. However, depressive symptoms need to be managed first when they prevent effective engagement in therapy or are associated with a high risk of suicide.
- ptsd and substance misuse—treatment should be started on both conditions simultaneously as the two interact to maintain each other and treatment is likely to be less effective if one of them remains untreated. However substance misuse should be controlled before the trauma-focussed component of ptsd treatment begins.

Psychosocial rehabilitation

Effective intervention for individuals with ptsd should not be limited to reducing symptoms; attention to social and psychological functioning is crucial.

There should be a focus on psychosocial rehabilitation from the outset. The practitioner should assess immediate needs for practical, social and vocational support and provide education, advocacy and referrals accordingly.

Information about specific trauma populations

The Guidelines include advice to practitioners on applying the recommendations to particular populations who develop ptsd following trauma, and to particular types of trauma. Not all groups likely to be affected by trauma are included, but many of the issues discussed may have relevance to other groups.

The section provides expert advice on applying the guideline recommendations with Aboriginal and Torres Strait Islander peoples, refugees and asylum seekers, and military and emergency personnel, as well as survivors of motor vehicle accidents, crime, sexual assault, natural disasters and terrorism. More information about these populations can be accessed at www.acpmh.unimelb.edu.au.

Full List of Recommendations

The following section gives a list of all the recommendations made in the Guidelines. Recommendations are graded according to the strength of the evidence upon which they are based. The grading ranges from **A** for the strongest evidence through to **D** for the weakest evidence. The designation good practice point (gpp) is given to recommendations based on expert consensus opinion in the absence of an evidence base.

Screening, assessment and treatment planning

Screening, assessment and diagnosis

For people presenting to primary care services with repeated non-specific physical health problems it is recommended that the primary care practitioner consider asking whether the person has experienced a traumatic event and describe some examples of such events. gpp

Service planning should consider the application of screening of individuals at high risk for ptsd after major disasters or incidents. gpp

Programs responsible for the management of refugees should consider the application of culturally appropriate screening for refugees and asylum seekers at high risk for developing ptsd. gpp

Screening should be undertaken in the context of a service system that includes adequate provision of services for those who require care. gpp

Comprehensive assessment of PTSD

A thorough assessment is required, covering ptsd and related diagnoses, quality of life and psychosocial functioning, trauma history, general psychiatric status (noting extent of comorbidity), physical health, substance use, marital and family situation and vocational and social status. gpp

Assessment should include assessment of strengths and resilience. gpp

Assessment and intervention must be considered in the context of the time that has elapsed since the traumatic event occurred. Assessment needs to recognise that whereas the majority of people will display distress in the initial weeks after trauma exposure, most of these reactions will remit within the following three months. gpp

Assessment and monitoring should be undertaken throughout treatment. When adequate progress in treatment is not being made, the practitioner should re-visit the case formulation, re-assess potential treatment obstacles and implement appropriate strategies. gpp

Differential diagnosis

Assessment should cover the broad range of potential posttraumatic mental health problems beyond ptsd. gpp

Assessment instruments

It is recommended that practitioners be guided in their assessment of ptsd, comorbidity and quality of life by the available validated self-report and structured clinical interview measures. gpp

It is recommended that practitioners also use self-report measures to support their assessments of treatment outcomes over time. gpp

Intervention planning

Mental health practitioners are advised to note the presence and severity of comorbidities in their assessments, with a view to considering their implications for treatment planning. gpp

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. gpp

Mental health practitioners should provide a clear rationale for treatment and promote realistic and hopeful outcome expectancy. gpp

Treatment goals

The practitioner should assess immediate needs for practical and social support and provide education and referrals accordingly. gpp

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. gpp

From the outset, there should be a collaborative focus on recovery and rehabilitation between the person and practitioners and, where appropriate, family members. gpp

Cultural and linguistic diversity

Recommended treatments for ptsd should be available to all Australians regardless of cultural and linguistic background. gpp

The impact of PTSD on family

Wherever possible family members should be included in assessment processes, education and treatment planning, and their own needs for care considered alongside the needs of the person with ptsd. gpp

General professional issues

Primary care practitioners, especially in rural and remote areas, who assume responsibility for the care of people with asd and ptsd in the absence of specialist providers should be supported with accessible education and training. gpp

In their self-care, practitioners should pay particular attention to skill and competency development and maintenance including regular supervision, establishing and maintaining appropriate emotional boundaries with ptsd sufferers, and effective self-care including maintaining a balanced and healthy lifestyle and responding early to signs of stress. gpp

For those practitioners who work in an organisational context, broader policies and practices should support individual practitioners in these self-care measures. gpp

Interventions for adults with PTSD

Psychological interventions for adults with PTSD

Adults with ptsd should be provided with trauma-focussed interventions (trauma focussed cbt or eye movement desensitization and reprocessing in addition to in vivo exposure). a

As available evidence does not support the importance of eye movements per se in emdr , it is recommended that practitioners who use emdr be aware that treatment gains are more likely to be due to the engagement with the traumatic memory, cognitive processing and rehearsal of coping and mastery responses. gpp

Where symptoms have not responded to one form of first line trauma-focussed interventions (trauma focussed cbt or emdr in addition to in vivo exposure), health practitioners may consider the alternative form of trauma-focussed interventions. gpp

Non-trauma focused interventions such as supportive counselling and relaxation should not be provided to adults with ptsd in preference to trauma-focussed interventions. b

Where symptoms have not responded to a range of trauma focussed interventions, evidence based non trauma focussed interventions (such as stress management) and/or pharmacotherapy (see section 3.1.3.6) should be considered. c

Sessions that involve imaginal exposure require 90 minutes to ensure that therapy is adequate in those sessions. c

Following diagnosis, assessment and treatment planning, eight to 12 sessions of trauma-focussed treatment is usually sufficient. d

For ptsd sufferers with several problems arising from multiple traumatic events, traumatic bereavement or where ptsd is chronic and associated with significant disability and comorbidity, further sessions using specific treatments to address those problems may be required. gpp

Where adults have developed ptsd and associated features following exposure to prolonged and/or repeated traumatic events, more time to establish a trusting therapeutic alliance, more attention to teaching emotional regulation skills and a more gradual approach to exposure therapy may be required. gpp

Individual and group psychological interventions

Group cbt (trauma-focussed or non trauma focussed) may be provided as adjunctive to, but should not be considered an alternative to, individual therapy. c

Self-delivered interventions

For adults with ptsd, self-delivered interventions should not be prescribed in place of evidence-based practitioner delivered interventions. b

Facilitated although non face-to-face interventions such as interapy may be considered where face-to-face practitioner delivered interventions are not available. d

Self-delivered interventions may be useful as adjunctive to practitioner delivered interventions. gpp

Pharmacological interventions for adults with PTSD

Drug treatments for ptsd should not be used as a routine first-line treatment for adults, either by general medical practitioners or by specialist mental health professionals, in preference to a trauma-focussed psychological therapy. a

Where medication is considered for the treatment of ptsd in adults, ssri antidepressants should be the first choice for both general practitioners and mental health specialists. b

Other new generation antidepressants (notably mirtazapine) and the older tricyclic antidepressants should be considered as a second line option. Phenelzine should be considered for use by mental health specialists for people with treatment resistant symptoms. b

Antidepressant medication should be considered for the treatment of ptsd in adults when:

- the sufferer is unwilling to engage in trauma focused psychological treatment gpp
- the sufferer is not sufficiently stable to commence trauma focused psychological treatment (as a result, for example, of being actively suicidal or homicidal, or of severe on-going life stress such as domestic violence) gpp
- the sufferer has not gained significant benefit from trauma focused psychological treatment gpp
- the sufferer is experiencing a high level of dissociative symptoms that are likely to be significantly exacerbated by trauma-focussed therapy gpp

Where a decision has been made to commence pharmacotherapy, the person's mental state should be regularly monitored with a view to commencing adjunctive psychological treatment if/when appropriate. In the interim, supportive psychotherapy with a substantial psychoeducational component should be offered. gpp

Where significant sleep disturbance or excessive distress does not settle in response to reassurance, simple psychological first aid, or other non-drug intervention, cautious use of hypnotic medication may be appropriate in the short term. If the sleep disturbance is of more than one month duration and medication is likely to be of benefit in the management of the person's ptsd, a suitable antidepressant should be considered. The risk of tolerance and dependence are relative contraindications to the use of hypnotics for more than one month except if their use is intermittent. gpp

Antidepressant medication should be considered as an adjunct to psychological treatment in adults where core ptsd symptoms are of sufficient severity to significantly interfere with the sufferers ability to benefit from psychological treatment. gpp

Where conditions comorbid with the ptsd (e.g., depression, other anxiety conditions) are of sufficient severity to significantly interfere with the sufferer's ability to benefit from psychological treatment, or where a more rapid relief of symptoms is likely to offer significant clinical benefit, drug treatments that have a demonstrable evidence base for the treatment of that condition should be considered. gpp

Where symptoms have not responded adequately to pharmacotherapy, consideration should be given to:

- increasing the dosage within approved limits gpp
- switching to an alternative antidepressant medication gpp
- adding risperidone or olanzapine as an adjunctive medication gpp
- reconsidering the potential for psychological intervention gpp

When an adult sufferer with ptsd has responded to drug treatment, it should be continued for at least 12 months before gradual withdrawal. b

Best practice prescribing procedures should be adopted when using drug treatments for ptsd in adults, including provision of information prior to commencement, monitoring and management of side effects, monitoring of suicide risk, and appropriate discontinuation and withdrawal practices. gpp

Adult ptsd sufferers receiving pharmacotherapy should be seen at least weekly if there is a significant risk of suicide; if there is no significant risk of suicide, fortnightly contact is recommended initially, dropping to less frequent after three months if the response is good. The role of the clinician in providing information and support is an important component of the management. gpp

Combined pharmacological interventions

Where symptoms have not responded to pharmacotherapy, consideration should be given to adding olanzapine as an adjunctive medication. c

Initial psychological or pharmacological intervention

Drug treatments for ptsd should not be used as a routine first-line treatment for adults, either by general medical practitioners or by specialist mental health professionals, in preference to a trauma focused psychological therapy. b

Combined psychological and pharmacological interventions

In cases where the person has not gained benefit from first-line psychological treatments, health practitioners may wish to consider commencing adjunctive pharmacotherapy. gpp

Where a decision has been made to commence treatment pharmacotherapy, the person's mental state should be constantly monitored with a view to commencing adjunctive psychological treatment if/when appropriate. In the interim, supportive psychotherapy with a substantial psychoeducational component should be offered. gpp

Psychosocial rehabilitation

There should be a focus on vocational, family and social rehabilitation interventions from the beginning of treatment. gpp

Where symptoms of ptsd have been present for three months or longer, psychosocial rehabilitation should be considered as an intervention to prevent or reduce disability associated with the disorder. gpp

In cases where people with ptsd have not benefited from a number of courses of evidence-based treatment, psychosocial rehabilitation interventions may reduce disability, improve functioning and community tenure. gpp

Healthcare professionals should be aware of the potential benefits of psychosocial rehabilitation and promote practical advice on how to access appropriate information and services. gpp

Psychosocial rehabilitation interventions should be provided by competent and appropriately qualified practitioners who received regular supervision. gpp

Psychosocial rehabilitation may be used as an adjunctive therapy in combination with psychotherapy or pharmacotherapy. gpp

Physical therapies and exercise

As part of general mental health care, practitioners may wish to advise people with ptsd that regular aerobic exercise may be helpful in managing their symptoms and as part of self-care practices more generally. gpp

Sequencing treatment in the context of comorbidity

In the context of comorbid ptsd and depression, health practitioners may consider treating the ptsd first as the depression will often improve with treatment of the ptsd. b

Where the severity of comorbid depression precludes effective engagement in therapy and/or is associated with high risk suicidality, health practitioners are advised to manage the suicide risk and treat the depression prior to treating the ptsd. gpp

In the context of ptsd and substance use disorders, practitioners should consider treating both conditions simultaneously. c

In the context of ptsd and substance use disorders, the trauma-focussed component of ptsd treatment should not commence until the ptsd sufferer has demonstrated a capacity to manage distress without recourse to substance use and to attend sessions without being drug or alcohol affected. d

In the context of ptsd and substance use disorders where the decision is made to treat substance use disorders first, treatment should include information on ptsd and strategies to deal with ptsd symptoms as the person controls their substance abuse. gpp

Early Intervention

Treatment for all: Psychological interventions

For adults exposed to trauma, structured psychological interventions such as psychological debriefing should not be offered on a routine basis. c

For adults exposed to trauma, clinicians should implement psychological first aid in which survivors of potentially traumatic events are supported, their immediate needs are met, and are monitored over time. Psychological first aid includes provision of information, comfort, emotional and instrumental support to those seeking help. Psychological first aid should be provided in a step-wise fashion tailored to the person's needs. gpp

Adults exposed to trauma who wish to discuss the experience, and demonstrate a capacity to tolerate associated distress, should be supported in doing so. In doing this the practitioner should keep in mind the potential adverse effects of excessive ventilation in those who are very distressed. gpp

For adults who develop an extreme level of distress or are at risk of harm to self or others, immediate psychiatric intervention should be provided. gpp

Treatment for all: Pharmacological interventions

For adults exposed to trauma, drug treatments should not be used non-selectively as a preventive intervention. c

Treatment for ASD: Psychological interventions

Adults displaying asd or ptsd reactions at least two weeks after the traumatic event should be offered trauma focussed cognitive behaviour therapy including exposure and/or cognitive therapy once a clinical assessment has been undertaken. a

For adults with asd, treatment should be provided on an individual basis. b

For adults with asd, trauma focussed cbt should, under normal circumstances, be provided in five to ten sessions. c

For adults with asd, ninety minutes should be allowed for sessions that involve imaginal exposure. c

Trauma focussed interventions should not commence within two weeks of trauma exposure. gpp

Combination psychological interventions for asd should not be used routinely. c

Treatment for ASD: Pharmacological interventions

Drug treatments should generally not be used to treat asd or related conditions (i.e., within four weeks of symptoms onset) in adults unless the severity of the person's distress can not be managed by psychological means alone, particularly when there is a pattern of extreme hyperarousal. gpp

In individuals who have a prior history of depression that has responded well to medication, the prescription of an antidepressant should be considered if a progressive pattern of clinically significant symptoms, such as persistent intrusions with increasing affective distress, begin to emerge. gpp

Where significant sleep disturbance does not settle in response to reassurance and simple psychological first aid, cautious use of hypnotic medication or other drug treatment may be appropriate for adults in the short term. gpp

Combined interventions for adults with ASD

Trauma-focussed cbt should be used for the treatment of asd and acute ptsd. a

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- ☐ no

Will you refer people to the booklet designed for people diagnosed with asd or ptsd, their carers and families?

- ☐ yes
- ☐ no

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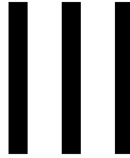

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