Australian Centre for
Posttraumatic Mental Health

Australian Government
National Health and Medical Research Council

Acute Stress Disorder and Posttraumatic Stress Disorder

KEY MESSAGES

Traumatic Events
Events that involve actual or threatened death or serious injury (real or perceived) to self or others (e.g., accidents, assault, natural disasters and wars) and evoke feelings of fear, helplessness or horror. Certain events (e.g., interpersonal violence, direct life threat and prolonged duration) are more likely to result in a traumatic response.

ASD and PTSD
ASD and PTSD are disorders characterised by symptoms that include distressing re-experiencing and active avoidance of the traumatic memories, emotional numbing and hyperarousal. (See *Additional Information* for diagnostic criteria).

Symptom Trajectory
Most people recover after a traumatic event without serious problems. Some develop more severe and persistent symptoms like PTSD. Those who develop chronic PTSD (i.e., lasting longer than three months) are unlikely to improve without effective treatment.

Prevalence
Around 15–25% of people who experience a potentially traumatic event (PTE) may develop PTSD making it one of the most common anxiety disorders.

Psychological First Aid
In the immediate aftermath of trauma, practitioners should monitor the person's mental state and provide tailored support. This includes attending to the person's practical needs and encouraging the use of existing coping strategies and social supports.

Screening
ASD and PTSD are treatable disorders often missed in clinical practice. Screening is an important means of rectifying this and facilitating appropriate care (see *Quick Guide*).

Therapy
Trauma-focussed psychological therapy is the most effective treatment for people who develop ASD and PTSD.

Medication
Where medication is required for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered as the first choice.

Other Disorders Following Trauma
Other common mental health disorders that people can develop following exposure to a traumatic event include depression, substance abuse and other anxiety disorders.

The Royal Australian College of General Practitioners
The Royal Australian and New Zealand College of Psychiatrists
The Australian Psychological Society Ltd
The University of Melbourne

This brochure is based on: **The Australian Guidelines for Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder.** For a complete copy of the Guidelines please refer to: www. acpmh.unimelb. edu.au/resources/ resources-guidelines.html

This brochure is intended to assist practitioners in providing best practice clinical care for persons with ASD and PTSD. It is to be followed subject to the medical practitioner's judgment in each individual case. The Guidelines include advice on issues pertaining to special populations and trauma types.

Please see the following publications for more information about the Guidelines:

Treating adults with acute stress disorder (ASD) and posttraumatic stress disorder (PTSD) in primary care: *A clinical update. The Medical Journal of Australia*, (2007) 187 (2), 120-123.

The Australian guidelines for the treatment of adults with acute stress disorder (ASD) and posttraumatic stress disorder (PTSD). *The Australia and New Zealand Journal of Psychiatry*, (2007) 41, 637-648.

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These Guidelines are endorsed by the Royal Australian College of General Practitioners, the Royal Australian and New Zealand College of Psychiatrists and the Australian Psychological Society.

For more information:
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Recent Trauma

(Within two weeks of trauma exposure)

PSYCHOLOGICAL FIRST AID

Monitor the person's mental state and screen for ASD and PTSD (see *Quick Guide*).

Support the person's use of adaptive coping strategies (e.g., enlisting the support of family and friends), as well as his or her own coping strategies if they seem helpful.

Encourage the person to re-engage in normal routines.

Also:

- Attend to any injuries or physical health concerns.
- Ensure basic needs are met (e.g., housing, safety).

CONTINUED DISTRESS

Most people recover from initial psychological distress. However, if distress/symptoms persist for more than two weeks, consider diagnosis of ASD/PTSD.

Symptoms may include:

- Distressing or unwanted memories of the trauma
- Avoidance of reminders and memories
- Hyperarousal

Risk factors for developing ASD/PTSD include:

- Exposure to severe trauma
- Lack of social supports and other stressful life events
- A past history of trauma and/or previous psychiatric disorder

TALKING ABOUT THE TRAUMA EXPERIENCE

Support those who want or need to talk about the experience.

Do not push those who prefer not to talk about the experience.

REFERRAL

GPs have an important role in referral and care coordination.

Referrals to psychiatry, psychology and allied health professionals can be made under Medicare arrangements which may include completion of a mental health care plan.

When referring for psychological interventions, consider referring to practitioners trained in trauma-focussed interventions (e.g., CBT).

Referral for mental health care under third party funding arrangements should be considered where appropriate.

ASD/PTSD Suspected or diagnosed

(ASD can be diagnosed between two days to four weeks following trauma. PTSD can be diagnosed from four weeks onward.)

SUPPORT AND SCREEN

Encourage, and if necessary facilitate, engagement with social supports.

Stabilise and introduce simple stress or anxiety management strategies (e.g., controlled breathing, exercise or other coping strategies).

Screen for ASD and PTSD (see *Quick Guide*).

REFER OR PROVIDE:

ASSESSMENT

Conduct a thorough assessment of ASD/PTSD, including comorbid diagnoses such as depression, substance use disorders, safety issues, physical health, social and vocational functioning, and social supports.

The Posttraumatic Checklist (PCL) can be used to assess all PTSD diagnostic criteria.

TREATMENT

First line treatment is trauma-focussed psychological therapy. This includes addressing the traumatic memory and the use of *in vivo* exposure (for details see *Additional Information*). Training in the use of trauma-focussed treatment is recommended.

If one form of trauma-focussed therapy fails to produce a sufficient response, consider another and/or the use of pharmacotherapy.

Trauma-focussed therapy should be embedded in a treatment plan that includes stabilisation, psycho-education, symptom management and attention to key relationships and roles.

THERAPY ALTERNATIVES

Where no trauma-focussed psychological therapies are effective, available, or acceptable to the person, consider referral for nontrauma-focussed interventions (e.g., anxiety management) and/or pharmacotherapy.

PHARMACOTHERAPY CHOICES

1. SSRI antidepressants (evidence does not distinguish a preferred SSRI)
2. Other newer antidepressants or tricyclic antidepressants
3. MAOI antidepressants (preferably by a psychiatrist)

Where symptoms have not responded to antidepressant treatment, controlled studies have demonstrated potential benefits of adjunctive atypical anti-psychotics (preferably by a psychiatrist).

Increase dose if non-responsive, being mindful of side effects. If effective, provide 12-month initial course. Stopping antidepressants should be via gradual weaning. Only use as first line if trauma-focussed psychological therapy is not available. Pharmacotherapy should always be supported by optimal psychotherapy.

PTSD with comorbidity

PRIORITIES FOR TREATMENT OF COMORBID DISORDERS

PTSD and Depression

Treat PTSD first when depression is mild to moderate as depression will often improve as PTSD symptoms reduce.

If depression symptoms are severe, however, they should be treated first to minimise suicide risk and improve the ability of the person to tolerate therapy.

PTSD and Substance Use Disorders:

Treat both simultaneously because the two are likely to interact to maintain each other.

When treating simultaneously, the substance use should be controlled before the trauma-focussed component of PTSD treatment begins.

When people present with substance dependence, intoxication or acute withdrawal, the substance disorder should be treated first.

MANAGING COMPLICATIONS AND PERSISTING PROBLEMS

Safety

People with PTSD may have fluctuating or continued severe distress and significant potential for self-harm (see *Severe Distress*). These people should be referred for urgent psychiatric care and stabilisation.

Treatment

Primary treatment interventions still apply but may involve multiple practitioners (e.g., GP, psychologist, psychiatrist and social/vocational rehabilitation consultants). A high level of communication and coordination of interventions is essential.

Treatment review

If a person's PTSD symptoms appear to be resistant to change, the following aspects of treatment should be revised where necessary:

- Consider whether the skill-set and experience of the treating practitioner are adequate for the treatment of the persisting problems.
- Consider referral for a second opinion.
- Consider whether the duration, intensity and setting of treatment are appropriate.

SEVERE DISTRESS

If a person presents with severe distress at any stage, particularly if they express thoughts about self-harm or suicide, appropriate steps to ensure safety include psychiatric care or hospitalisation.

Other indicators of severe distress include severe insomnia, agitation, dissociation and social withdrawal.

Acute treatment may involve pharmacotherapy using sedating, calming or antidepressant medication. Long term use of benzodiazepines is not recommended. They do not treat the underlying condition and involve risk of dependency.

ADDITIONAL INFORMATION

WHAT IS TRAUMA-FOCUSSED PSYCHOLOGICAL THERAPY?

First line treatment should be trauma-focussed therapy (trauma-focussed cognitive behaviour therapy (CBT) or eye movement desensitisation and reprocessing (EMDR) in addition to *in vivo* exposure).

KEY ELEMENTS OF TRAUMA-FOCUSSED PSYCHOLOGICAL THERAPY

Addressing the traumatic memory in a controlled and safe environment (imaginal exposure)

Confronting avoided situations, people or places in a graded and systematic manner (*in vivo* exposure)

Identifying, challenging and modifying biased or distorted thoughts and interpretations about the event and its meaning (cognitive therapy)

As the available evidence does not support the importance of the eye movements *per se* in EMDR, treatment gains are more likely to be due to the engagement with the traumatic memory, cognitive processing and rehearsal of coping and mastery responses

TREATMENT DURATION

Within the overall course of treatmment, 8–12 sessions of trauma-focussed treatment are generally needed but more may be required for more severe or complex cases.

Ninety minutes should be allowed for sessions that involve imaginal exposure.

The development of a robust therapeutic alliance may require extra time for people who have experienced prolonged and/or repeated traumatic exposure.

Further sessions may be required where:

- there are several problems that arise from multiple traumatic events;
- PTSD co-occurs with traumatic bereavement; or
- PTSD is chronic and associated with significant disability and comorbidity.

PSYCHOSOCIAL REHABILITATION

To reduce the likelihood of an enduring disability, people with ASD and PTSD should be actively encouraged to return to their normal social and occupational roles as quickly as they feel able and in an appropriately managed way. This may mean that they will continue to experience symptoms, albeit at reduced levels, as they return to previous roles. There should be a focus on psychosocial rehabilitation from the beginning of treatment.

SPECIFIC POPULATIONS AND TRAUMA TYPES

For more information on specific populations (Aboriginals and Torres Strait Islanders, refugees and asylum seekers, military and emergency service personnel, motor vehicle accident and other injury survivors, victims of crime, sexual assault, natural disasters, survivors of terrorism) download the PDF on these populations under publications and resources at www.acpmh.unimelb.edu.au/for_professionals.html

DSM-IV CRITERIA FOR PTSD

A1. The person experienced, witnessed, or was confronted with an event that involved actual or threatened death or serious injury to self or others.		
A2. The person's response involved intense fear, helplessness or horror.		
B. Re-experiencing (1 required)	**C.** Avoidance / Numbing (3 required)	**D.** Hypervigilance (2 required)
1. Recurrent and intrusive distresssing recollections of the event, including images, thoughts or perceptions **2.** Recurrent distressing dreams of the event **3.** Acting or feeling as if the event were re-occurring **4.** Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the event **5.** Psychological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the event	**1.** Efforts to avoid thoughts, feelings or conversations associated with the event **2.** Efforts to avoid activities, places or people that arouse recollections of the event **3.** Inability to recall an important aspect of the event **4.** Markedly diminished interest or participation in significant activities **5.** Feeling of detachment or estrangement from others **6.** Restricted range of affect (e.g., unable to have loving feelings) **7.** Sense of foreshortened future (e.g., does not expect to have a normal lifespan)	**1.** Difficulty falling or staying asleep **2.** Irritability or outbursts of anger **3.** Difficulty concentrating **4.** Hypervigilance **5.** Exaggerated startle response
E. Duration of the symptoms (criteria B, C and D) is more than 1 month.		
F. The symptoms cause clinically significant stress or impairment in social, occupational, or other important areas of functioning.		