National PTSD and ASD Guidelines Explained.  
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The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder
Trauma exposure and PTSD prevalence

- Between 50% and 75% of people experience at least one traumatic event in their lives.
- Estimates of lifetime prevalence of PTSD in the general population range from 5% - 10% (or 15-25% of trauma exposed).
- Estimate of 12 month prevalence of PTSD is 4.4% in Australia (3.5% in the US).
PTSD prevalence

- Likelihood of developing PTSD varies according to the nature of the event
  - Highest rates associated with rape/child physical and sexual abuse
  - Lowest rates associated with natural disasters, witnessing injury or death
- Comorbidity common – 86% of men and 77% of women with PTSD have at least 1 other diagnosis. Children often present with internalising and/or externalising behaviours
Trauma and Trauma Reactions

- ASD and PTSD are characterised by four types of symptoms:
  - Re-experiencing
  - Avoidance
  - Negative mood and cognition
  - Increased arousal
- ASD diagnosed between 2 days and one month following traumatic event
- PTSD diagnosed at least one month following traumatic event
DSM-IV Criteria for PTSD

- Experience of a traumatic event
- Re-experiencing the trauma (1)
- Avoidance and numbing (3)
- Persistent hyperarousal (2)
- Duration > 4 weeks
- Social/occupational impairment or distress
DSM-5 Criteria for PTSD

• Moved from Anxiety Disorders to Trauma- and Stressor-Related Disorders
• Narrowing the definition of ‘traumatic event’ in Criterion A1
• Removal of criterion A2 (requires that the individual’s response involved intense fear, helplessness, or horror)
• Four symptom clusters made by dividing the avoidance and numbing cluster into two
DSM-5 Criteria for PTSD adults, adolescents, and children older than six

A. Exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:

1. Directly experiencing the traumatic event(s).
2. Witnessing, in person, the traumatic event(s) as they occurred to others.
3. Learning that the traumatic event(s) occurred to a close family member or close friend. **Note:** In cases of actual or threatened death of a family member or friend, the event(s) must have been violent or accidental.
4. Experiencing repeated or extreme exposure to aversive details of the traumatic event(s) (e.g. first responders collecting human remains, police officers repeatedly exposed to details of child abuse). **Note:** this does not apply to exposure through electronic media, television, movies, or pictures, unless this exposure is work-related.
**DSM-V Criteria for PTSD**

- Exposure to a traumatic event
- Intrusions (1)
- Avoidance of memories and/or reminders (1)
- Persistent hyperarousal (2)
  - inc reckless and self-destructive behaviours
- Negative mood and cognition (2) inc dissociative symptoms
- **Duration > 4 weeks**
- Social/occupational impairment or distress
DSM-5 and ASD

- Moved from Anxiety Disorders to Trauma- and Stressor-Related Disorders
- Removal of criterion A2 (requires that the individual’s response involved intense fear, helplessness, or horror)
- Removal of requirement for dissociative symptoms
- ASD conceptualised as an acute stress response
- **Nine (or more)** symptoms from **any** of the **five** categories of intrusion, negative mood, dissociation, avoidance, and arousal
What are clinical practice guidelines?

“Systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances” (Field & Lohr, 1990)

• Based on systematic review of the evidence
• Absence of evidence is not evidence of absence
• Support or recommend, not mandate
Guidelines Working Groups

**Steering Group**
- Professor Beverley Raphael
- Professor David Forbes

**Working Party**
- Chair Beverley Raphael
- Trauma Experts:
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  - Grant Devilly
  - David Forbes
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- Psychosocial Rehabilitation Expert:
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- Project Leader/Manager:
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**Methodologist (Dr Adele Weston)**

**Evidence Reviewers (AHTA)**

**Health Economists (Deakin University)**

**Multidisciplinary Panel (MDP)**
- Chair Beverley Raphael
- Representatives:
  - People affected by trauma
  - Professional associations, practitioners from:
    - Psychology
    - Psychiatry
    - General practice
    - Social work
    - Mental health nursing
    - Occupational therapy

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Purpose of the Guidelines

• To support high quality treatment for children, adolescents and adults with ASD and PTSD by providing a framework of best practice around which to structure treatment.

• Designed to be used by:
  a) General and mental health practitioners
  b) People affected by trauma
  c) Funding bodies
Australian PTSD Guidelines

Promoting recovery after trauma

- NHMRC approved
- Supported by the Australian Government
- Endorsed by professional associations (APS, RACGP, RANZCP)

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Guideline Recommendations
Strength of Recommendations

A: Body of evidence can be trusted to guide practice

B: Body of evidence can be trusted to guide practice in most situations

C: Body of evidence provides some support for recommendation(s) but care should be taken in its application

D: Body of evidence is weak and recommendation must be applied with caution

GPP: Good Practice Point - based on expert consensus opinion, in the absence of an evidence base
Screening

- For people presenting to primary care services with repeated non-specific physical health problems, it is recommended that the primary care practitioner consider screening for psychological causes, including asking whether the person has experienced a traumatic event and describing some examples of such events. [GPP]
Screening

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

• Any individual who screens positive should receive a thorough diagnostic assessment. [GPP]
Assessment

• A thorough assessment is required, covering relevant history (including trauma history), PTSD and related diagnoses, general psychiatric status (noting extent of comorbidity), physical health, substance use, marital and family situation, social and occupational functional capacity, and quality of life. [GPP]
Assessment

• Assessment should include assessment of strengths and resilience, as well as responses to previous treatment. [GPP]

• 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]
Questions about exposure to commonly experienced potentially traumatic events should be included as standard during any psychiatric assessment of children and adolescents. If such exposure is endorsed, the child should be screened for the presence of PTSD symptoms. [GPP]
For children and adolescents, a structured clinical interview is regarded as a better assessment measure than a questionnaire for making a diagnosis. [GPP]

Parent/caregiver involvement in assessment and treatment is desirable for children and adolescents with ASD or PTSD. [GPP]
Treatment 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]

- Residual symptomatology should be addressed after the symptoms of PTSD have been treated. [GPP]
Treatment planning

• 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]

• Appropriate goals of treatment should be tailored to the unique circumstances and overall mental healthcare needs of the individual and established in collaboration with the person. [GPP]
Treatment planning

- Recommended treatments for PTSD should be available to all Australians, recognising their different cultural and linguistic backgrounds. [GPP]
- Wherever possible, family members should be included in education and treatment planning, and their own needs for care considered alongside the needs of the person with PTSD. [GPP]
Practitioners who provide mental healthcare to children, adolescents or adults with ASD and PTSD, regardless of professional background, must be appropriately trained to ensure adequate knowledge and competencies to deliver recommended treatments. This requires specialist training, over and above basic mental health or counselling qualifications. [GPP]
Working with children and adolescents: Treatment Planning

• For children and adolescents, treatment needs to be tailored to meet the developmental needs of the individual. Protocols that have been designed specifically for children and adolescents should be used in preference to attempting to modify an adult treatment protocol. [GPP]
Treatment recommendations: Early psychological interventions for adults

• For adults likely to be exposed to a potentially traumatic event, pre-incident preparedness training may facilitate psychological adaptation following the event. [CP]

• For adults exposed to a potentially traumatic event, if required, provide practical and emotional support, facilitate ways to manage distress and access social supports, and promote positive expectations. [GPP]
Treatment recommendations: Early psychological interventions for adults

- For adults exposed to a potentially traumatic event, a one-session, structured, psychological intervention in the acute phase, such as psychological debriefing, should not be offered on a routine basis for the prevention of PTSD. [Grade C]
For adults displaying symptoms consistent with ASD or PTSD in the initial four weeks after a potentially traumatic event, individual trauma-focussed cognitive behavioural therapy, including exposure and/or cognitive therapy, should be considered if indicated by a thorough clinical assessment. [Grade C]
Treatment recommendations: Early psychological interventions for adults

• Adults exposed to a potentially traumatic event 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]
Treatment recommendations: Early psychological interventions for adults

• For adults exposed to a potentially traumatic event, a stepped care approach tailored to individual need is advised. This would involve ongoing monitoring of people who are more distressed and/or at heightened risk of adverse mental health impact, with targeted assessment and intervention when indicated. [GPP]

• For adults who develop an extreme level of distress or are at risk of harm to self or others, thorough diagnostic assessment and appropriate interventions should be provided. [GPP]
Psychological interventions for adults

- Adults with PTSD should be offered trauma-focused cognitive behavioural interventions or eye movement desensitisation and reprocessing. [Grade A]
Psychological interventions for adults

- On the basis of some evidence that in vivo exposure (graded exposure to feared/avoided situations) contributes to treatment gains, it is recommended that in vivo exposure be included in treatment. [CP]
Psychological interventions for adults

• Sessions that involve imaginal exposure may require up to 90 minutes to avoid premature termination of therapy while anxiety is still high, and to ensure appropriate management of distress. [GPP]
Psychological interventions for adults

- Prescribed medication can continue while people are undertaking psychological treatments and any changes should only occur in close consultation with the treating physician. However, some medications, such as benzodiazepines, may interfere with some effective psychological treatments. [GPP]
Psychological interventions for adults

• In the context of comorbid PTSD and mild to moderate depression, health practitioners may consider treating the PTSD first, as the depression will often improve with treatment of the PTSD. [CP]

• 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. [CP]

• In the context of PTSD and substance use disorders, practitioners should consider integrated treatment of both conditions. [CP]
Psychological interventions for adults

• In the context of PTSD and substance use disorders, the trauma-focused component of PTSD treatment should not commence until the person has demonstrated a capacity to manage distress without recourse to substance misuse and to attend sessions without being drug or alcohol affected. [CP]
Psychological interventions for adults

• In the context of PTSD and substance use disorders, where the decision is made to treat substance use disorders first, clinicians should be aware that PTSD symptoms may worsen due to acute substance withdrawal or loss of substance use as a coping mechanism. Treatment should include information on PTSD and strategies to deal with PTSD symptoms as the person controls their substance abuse. [CP]
Psychological interventions for adults

• Where symptoms have not responded to a range of trauma-focussed interventions, evidence-based non-trauma-focussed psychological interventions (such as stress inoculation training) should be considered. [Grade D]
Individual vs group therapy

- Group cognitive behavioural therapy (trauma-focussed or non-trauma-focussed) may be provided as adjunctive to, but should not be considered an alternative to, individual trauma-focussed therapy. [Grade C]
Self-delivered interventions

- Internet-delivered trauma-focussed therapy involving trauma-focussed cognitive behavioural therapy may be offered in preference to no intervention. [Grade C]
Treatment recommendations: Early pharmacological interventions for adults

• For adults exposed to a potentially traumatic event, drug treatments should not be used for all those exposed as a preventive intervention. [Grade C]

• The routine use of pharmacotherapy to treat ASD or early PTSD (i.e. within four weeks of symptom onset) in adults is not recommended. [Grade D]
Pharmacological interventions for adults

• Drug treatments for PTSD should not be preferentially used as a routine first treatment for adults, over trauma-focussed cognitive behavioural therapy or eye movement desensitisation and reprocessing. [Grade B]

• Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered the first choice. [Grade C]
Pharmacological interventions for adults

- Selective serotonin reuptake inhibitor antidepressant medication should be considered for the treatment of PTSD in adults when:

  a) the person is unwilling or not in a position to engage in or access trauma-focussed psychological treatment. [GPP]

  b) the person has a comorbid condition or associated symptoms (e.g. severe depression and high levels of dissociation) where selective serotonin reuptake inhibitors are indicated. [GPP]
Pharmacological interventions for adults

• Selective serotonin reuptake inhibitor antidepressant medication should be considered for the treatment of PTSD in adults when:

c) the person’s circumstances are not sufficiently stable to commence trauma-focussed psychological treatment (as a result, for example, of severe ongoing life stress such as domestic violence). [GPP]

d) the person has not gained significant benefit from trauma-focussed psychological treatment. [GPP]
There should be a focus on vocational, family, and social rehabilitation interventions from the beginning of treatment to prevent or reduce disability associated with the disorder, and to promote recovery, community integration and quality of life. [GPP]
Psychosocial rehabilitation

- In cases where people with PTSD have not benefited from a number of courses of evidence-based treatment, psychosocial rehabilitation interventions should be considered to prevent or reduce disability, and to promote recovery, community integration and quality of life. [GPP]
Psychosocial rehabilitation

• In cases of work-related trauma, management of any return-to-work process needs to occur in the context of a thorough risk assessment of the potential for exposure to further stressors, balanced with the potential benefits of return to work. [GPP]
Exercise and physical therapies

- Acupuncture may be considered as a potential intervention for PTSD for people who have not responded to trauma-focussed psychological therapy or pharmacotherapy. [Grade D]
Psychological interventions for children and adolescents

• For children exposed to a potentially traumatic event, psychological debriefing should not be offered. [Grade B]

• For children of school age and above with PTSD, developmentally appropriate trauma-focussed cognitive behavioural therapy should be considered. [Grade C]
Psychological interventions for children and adolescents

- For children with PTSD, individual psychological interventions should be considered in preference to group interventions. [Grade C]
Psychological interventions for children and adolescents

• For children exposed to trauma with symptoms of PTSD, where they were exposed to the same event, a school-based trauma-focused cognitive-behavioural intervention aimed at reducing symptoms of PTSD should be considered. [Grade C]
Pharmacological interventions for children and adolescents

• For children exposed to a potentially traumatic event, pharmacotherapy should not be used as a preventive intervention for all those exposed. [Grade D]

• For children and adolescents with PTSD, pharmacotherapy should not be used as a routine first treatment over trauma-focussed cognitive behavioural therapy. [Grade D]
Pharmacological interventions for children and adolescents

- For children and adolescents with PTSD, pharmacotherapy should not be used routinely as an adjunct to trauma-focused cognitive behavioural therapy. [Grade D]
The finished product(s)
Promoting recovery after trauma: The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder.

5 to 10 percent of people will suffer from PTSD at some point in their lives.

The Guidelines provide information about the most effective treatments for PTSD. They are the first national Guidelines that provide guidance on the treatment of children and teenagers who experience PTSD.