





Acute Stress Disorder & Posttraumatic Stress Disorder

Guidelines Summary









The Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder were approved by the National Health and Medical Research Council, July 2013.

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Copies of the full set of the Guidelines, this guideline summary, and booklets for adults, children and adolescents with ASD and PTSD, their families and carers, are available online: www.acpmh.unimelb.edu.au

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Acknowledgments

This guidelines summary is a companion document to the Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder. The Guidelines were developed by ACPMH in collaboration with key trauma experts from around Australia and in consultation with a panel representing the public, regulatory bodies, trauma specialists and generalists from a range of health professions. A list of members of the Guideline Development Group is available in the full Guidelines document.



Australian Guidelines for the Treatment of

Acute Stress Disorder & Posttraumatic Stress Disorder

Guidelines Summary

The Guidelines are endorsed by
The Australian Psychological Society
The Royal Australian College of General Practitioners
The Royal Australian and New Zealand College of Psychiatrists







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Introduction

This booklet is a synopsis of the *Australian Guidelines for the Treatment of Acute Stress Disorder and Posttraumatic Stress Disorder* (the Guidelines) developed by the Australian Centre for Posttraumatic Mental Health (ACPMH). For more comprehensive information about interventions or the review of the evidence literature, a full-text version of the Guidelines is available at www.acpmh.unimelb.edu.au. Hard copies of this summary can be ordered from the same website. Organisations and health practitioners can contact ACPMH at acpmh-info@unimelb.edu.au to discuss briefings and training about the Guidelines.

This Guidelines Summary 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 aim to support high quality treatment of people with PTSD by providing a framework of best practice around which to structure treatment. They 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 the understanding of traumatic stress has grown in recent years, approaches to 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 two 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 considering 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 approved 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 have been formulated with the assumption that treatment will be provided by qualified professionals who are skilled in the relevant psychosocial and medical interventions, as assessed against the prevailing professional standards. The Guidelines do not substitute for the knowledge and skill of competent individual practitioners. They should not be regarded as an inflexible prescription for the content or delivery of treatment, but interpreted and implemented in the context of good clinical judgement. They should not limit treatment innovation and development that is based upon scientific evidence, expert consensus, practitioner judgment of the needs of the person, and the person's preferences. Practitioners should use their experience and expertise in applying these Guidelines in routine clinical practice and all clinical interventions should be provided with compassion and sensitivity. Whenever possible, decisions about treatment should be made collaboratively with the individual, their family, carers, and other professionals involved in their care.

The Guideline developers recognise that there are a number of interventions that are widely used in clinical practice that have not been adequately tested, and it is important to acknowledge that the absence of evidence does not necessarily mean that these interventions are ineffective. The gap between evidence-based interventions and clinical practice should help define the research agenda into the future. Equally, these Guidelines should be used to drive the delivery of first and second line evidence-based treatment approaches unless there is a strong justification for not doing so in a particular case.

While those who have PTSD in combination with broader posttraumatic mental health problems or other mental health problems may require additional treatment and care, the recommendations in these Guidelines are still relevant and applicable. Recommendations are provided on the management of people with PTSD and common comorbid conditions.

Information booklets designed for adults and children diagnosed with ASD or PTSD, their carers and families can be downloaded or ordered via www.acpmh.unimelb.edu.au or by emailing acpmh-info@unimelb.edu.au.

Trauma and Trauma Reactions in Adults

Exposure to a potentially traumatic event (PTE) is a common experience. Large community surveys in Australia and overseas reveal that 50–75% of people report at least one traumatic event in their lives. PTEs include any threat, actual or perceived, to the life or physical safety of a person, their loved ones or those around them. PTEs include, but are not limited to, events such as war, torture, sexual assault, physical assault, natural disasters, accidents and terrorism. Exposure to a PTE may be direct (i.e., actually experienced or witnessed), or indirect (i.e., confronted with or learnt about), and may be experienced on a single occasion, or repeatedly.

A degree of psychological distress is very common in the early aftermath of traumatic exposure and can be considered a part of the normal response. In cases of severe traumatic events, most people may be symptomatic in the initial fortnight after the event. Traumatised people are likely to experience emotional upset, increased anxiety, and sleep and appetite disturbance. Some will have additional reactions such as fear, sadness, guilt or anger. In most cases, psychological symptoms of distress settle down in the days and weeks following the traumatic event as people make use of their customary coping strategies and naturally occurring support networks to come to terms with the experience. However, in a minority of people the symptoms persist. Individuals may develop a range of psychological problems following exposure to trauma, including depression, anxiety, and substance misuse, as well as ASD and PTSD.

It is estimated that between 5 and 10 per cent of people in the general population will suffer from PTSD at some point in their lives. The rate of PTSD in trauma survivors depends on the type of trauma experienced. Intentional acts of interpersonal violence, such as torture and assault, and prolonged and/or repeated events, such as childhood sexual abuse and concentration camp experiences, are more likely than natural events or accidents to result in PTSD.

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

In the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), PTSD was characterised by three main groups of symptoms (see DSM-IV PTSD diagnostic criteria at the back of this booklet). In order for a diagnosis to be made, a number of symptoms in each of the categories below were required to 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.

Several revisions to the PTSD diagnostic criteria have been introduced in DSM-5 (see DSM-5 PTSD diagnostic criteria at the back of this booklet). Most significantly, the definition of 'traumatic event' has been narrowed to exclude exposure to images or details of a traumatic event through media, pictures, television, or movies, unless this exposure is work-related. Learning of the unexpected death of a close family member or friend is counted as traumatic only if the death was violent or accidental; unexpected deaths due to natural causes are excluded in DSM-5. The other major revision to the PTSD diagnostic criteria is the inclusion of four symptom clusters rather than the three listed above. This change has been achieved by dividing the avoidance and numbing cluster into two, based on research showing active and passive avoidance to be independent phenomena.

Acute stress disorder

While a diagnosis of 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. In DSM-IV (see DSM-IV ASD diagnostic criteria at the back of this booklet), there were two key differences between ASD and PTSD. First, unlike PTSD, ASD places a heavy emphasis on dissociation, requiring symptoms such as feeling detached or dazed, depersonalisation, or derealisation. The second difference was the duration of symptoms, as described above.

However, in DSM-5 (see DSM-5 ASD diagnostic criteria at the back of this booklet) the requirement for dissociative symptoms has been removed from the ASD criteria, so that ASD is now conceptualised as an acute stress response that does not require specific symptom clusters to be present, but rather, requires a certain number from a broad list of dissociative, re-experiencing, avoidance, and arousal symptoms.

Importantly, while people who experience ASD are at high risk of developing PTSD, the majority of people who develop PTSD did not previously meet criteria for ASD. Thus, having an ASD diagnosis is moderately predictive of PTSD, but not having an ASD diagnosis should not necessarily be interpreted as indicating a good prognosis.

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

Trauma and Trauma Reactions in Children and Adolescents

Children and adolescents are commonly exposed to potentially traumatic events, with more than two-thirds of children in the US reporting exposure to at least one traumatic event by the age of 16 years. Lifetime estimates of PTSD in children and adolescents in the overall population range from 1 to 6 per cent. Among those exposed to trauma, around one third can be expected to develop PTSD.

Two broad categories of childhood trauma have been delineated: Type I trauma in which a child experiences a single event (such as a physical assault, a natural or man-made disaster, traffic accident, other accidental injury, house fire, terrorist attack, or witnessing a single episode of violence); and Type II trauma, in which a child experiences multiple repeated exposures to the traumatic event (such as physical and/or sexual abuse, neglect, domestic violence, or war).

Posttraumatic stress disorder

The DSM-IV criteria for PTSD (see DSM-IV PTSD diagnostic criteria at the back of this booklet) as applied to children and adolescents are identical to those used with adults, with a few caveats. In assessing children and adolescents using the DSM-IV criteria, clinicians are asked to consider the following caveats:

- A2 'In children, this [the person's response] may be expressed instead by disorganised or agitated behavior'.
- B1 'In young children, repetitive play may occur in which themes or aspects of the trauma are expressed'.
- B2 'In children, there may be frightening dreams without recognisable content'.
- B3 'In young children, trauma-specific re-enactment may occur'.

In relation to PTSD in children and adolescents, a number of important changes have been introduced in DSM-5. For children aged six years and over, the criteria for diagnosis of PTSD are the same as those for adults, bearing in mind the caveats above. For children under the age of six years, DSM-5 introduces the age-related PTSD sub-type – PTSD in Preschool Children (see DSM-5 PTSD diagnostic criteria at the back of this booklet). Under this sub-type, the definition of learning about events has been restricted to those that occurred to parents or caregivers, rather than family or friends more broadly. A diagnosis of PTSD in preschool children requires fewer symptoms than in older children or adolescents, with one symptom required from Criterion B (intrusion), one symptom from Criterion C (avoidance or negative alterations in cognitions), and two symptoms from Criterion D (arousal).

It is important to bear in mind that PTSD may present differently in children and adults, and a broad range of potential indicators of distress should be considered. Disturbances in sleep are often seen – including nightmares (where the content is not necessarily able to be articulated, or where it is not necessarily linked in an obvious way to the traumatic event), fear of the dark, fear of going to sleep and risking the possibility of a nightmare, and waking during the night. Separation anxiety is common in young children and even among adolescents. As in adults, irritability, anger and aggression are common, often manifested as temper tantrums in preschool-aged children. Many primary school-aged children and adolescents are able to articulate a desire to talk about their experiences, but also note that they find it difficult to speak about what happened with their parents and peers. Children and adolescents frequently report, and demonstrate, difficulties in concentration and memory. Hypervigilance to danger in their environment (including increased awareness of trauma-related reminders in the media) is typical.

The development of increased general anxiety, as well as specific fears related to aspects of their trauma experience, is common – although the link between the feared stimulus and the trauma experience is not always immediately obvious (for instance, a child who develops a fear of helicopters after being involved in a natural disaster where helicopters were used to rescue people). Some primary school-aged children and adolescents will describe feeling survivor guilt, while depression and increased substance use is often reported by adolescents exposed to PTEs. Other important aspects of clinical presentation in preschool-aged children include new oppositional behaviour, regression in, or loss of, previously mastered developmental skills (e.g., speech, toileting), and new fears not associated with the traumatic event (e.g., fear of going to the toilet alone).

Acute stress disorder

The diagnostic criteria for ASD do not differ depending on whether the individual in question is an adult, adolescent or child in either DSM-IV or DSM-5.

Key Recommendations - Adults

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

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 other health professional. They may present with any of a range of problems including mood disorders, anger, relationship problems, poor sleep, sexual dysfunction, or physical health complaints such as fatigue, headaches, pain, or gastrointestinal problems. The distress and stigma associated with mental health problems or traumatic events may prevent some people from talking about their experience. The avoidance that is characteristic of PTSD may also prevent people from speaking about it or seeking assistance.

If people presenting to primary care services such as GP surgeries or community health centres report repeated non-specific physical health problems, practitioners should routinely enquire about any stressful or traumatic experiences, recently or in the past. A traumatic events checklist (such as the one included at the back of this booklet) can be helpful in this regard. If posttraumatic mental health problems are suspected, it is recommended that a brief screening measure such as the one provided below be used to screen for PTSD.

Screening measures

There is a range of PTSD screening measures currently available. 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

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

- 1. have had nightmares about it or thought about it when you did not want to?
- 2. tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
- 3. were constantly on guard, watchful, or easily startled?
- 4. felt numb or detached from others, activities, or your surroundings?

If a person says "yes" to two or more of these questions, further assessment is recommended.

¹Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., . . . Sheikh, J. I. (2003). The primary care PTSD screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry*, 9(1), 9-14.

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 comprehensive assessment is recommended. Assessment should include a trauma history covering prior traumatic experiences as well as the 'index' traumatic event, 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 services 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: 86% of men and 77% of women with PTSD are likely to have another disorder such as depression, substance misuse or 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. These include: impaired emotional control; self-destructive and impulsive behaviour; impaired relationships with others; hostility; social withdrawal; feeling constantly threatened; dissociation; somatic complaints; feelings of ineffectiveness, shame, despair or hopelessness; feeling permanently damaged; and a loss of prior beliefs and assumptions about their safety and the trustworthiness of others. 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 (see table next page). 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 have 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 considered the 'gold standard' of PTSD assessment, although it is a little complex for use in routine clinical practice. Each DSM-IV PTSD symptom is rated for intensity and frequency.
- Alternative interviews, the PTSD Symptom Scale Interview (PSS-I) and Structured Interview for PTSD (SIP), provide a single estimate of severity for each DSM-IV PTSD symptom.

Self-report questionnaires

- PTSD Checklist (PCL) assesses the severity of the 17 DSM-IV PTSD symptoms.
 The scale takes only five minutes to complete and possesses excellent psychometric qualities, demonstrating a high level of validity when tested against the CAPS. A score of 50 is recommended as the diagnostic cut-off.
- The Posttraumatic Diagnostic Scale (PDS) assesses the 17 DSM-IV PTSD symptoms in addition to enquiring about traumatic events experienced, the duration of symptoms, and effect of symptoms on daily functioning.
- The Davidson Trauma Scale (DTS) rates each DSM-IV PTSD symptom on frequency and severity.
- The Detailed Assessment of Posttraumatic Stress (DAPS) provides detailed information on the person's trauma history, immediate psychological reactions, enduring posttraumatic stress symptoms, and level of posttraumatic impairment.
- The Harvard Trauma Questionnaire (HTQ) provides a culturally sensitive assessment of trauma and PTSD, with several versions available (e.g., for South-East Asian, Japanese, Bosnian, Croatian trauma survivors).
- The Trauma Symptom Inventory (TSI) evaluates the relative level of various forms of posttraumatic distress. It does not generate DSM-IV diagnoses.
- The Impact of Event Scale Revised (IES-R) does not correspond directly with DSM-IV PTSD criteria, and therefore does not provide direct information about PTSD diagnosis or severity.

Intervention planning

Several factors that have been found to potentially influence treatment outcome and dropout should be considered when planning interventions. These factors include: chronicity of PTSD; comorbid psychological; cognitive and physical conditions; therapeutic alliance; treatment expectancy; and treatment setting.

Research has found no differences in treatment outcome between those receiving early and delayed treatment. From a clinical perspective, it is reasonable to assume that longer duration of illness will be associated with a range of other social and occupational problems, as well as significant distress. For that reason alone, it would be sensible to encourage those with PTSD to access treatment as early as reasonably possible. Equally, it is important to emphasise to people who experienced trauma some time ago that treatment can be effective regardless of the duration of illness.

Where comorbidity is present, the extent to which it should become a focus of treatment before, alongside, or following the PTSD treatment is a decision to be made by the clinician. Recommended approaches to treating common comorbidities (i.e., substance use and depression) are discussed on page 15. Limited research has examined the treatment of PTSD in the context of physical comorbidity, such as mild traumatic brain injury or pain, however there is general recognition that standard treatment approaches are appropriate, with modifications as required (e.g., scheduling regular breaks).

The establishment of a good therapeutic alliance has been found to improve the outcome of PTSD treatment. There is also evidence that a person's expectation of the outcome of their treatment is positively related to actual outcomes. These findings highlight the importance of taking the time in the early stages to clearly explain the nature and expected outcomes of treatment, generating a collaborative and (realistically) optimistic approach.

There are times when treatment for PTSD needs to be delivered in settings where there is exposure to ongoing stress and trauma (e.g., immigration detention facilities and refugee camps, corrective facilities, theatres of combat, and where there is threat of domestic violence). As well as the degree of stress inherent in these settings, treatment delivery can be further complicated by potential for exposure to further trauma, short and unpredictable lengths of stay, lack of access to mental health history, and the client's reluctance to disclose information. Few studies have examined the implementation and effectiveness of interventions under such conditions, although the available research is promising.

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 ensure the person's safety and security, provide ongoing
 monitoring, practical assistance and information, and encourage the person 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 focussed 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 consider offering individual trauma-focussed cognitive behavioural therapy, including exposure and/or cognitive therapy
- 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 desensitisation and reprocessing (EMDR).
- 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 and more attention to teaching emotional regulation skills 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, or when the person has a comorbid condition where medication is indicated.
- Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor (SSRI) antidepressants should be the first choice.

Trauma-focussed treatments

Recommended treatments (trauma-focussed TF-CBT and EMDR) share two key elements. They involve helping PTSD sufferers:

- confront the memory of their traumatic experience/s in a controlled and safe environment
- 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 TF-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. Psychosocial interventions help an individual compensate for the negative effects of disability by reducing some of the problems associated with PTSD, such as lack of self-care/independent living skills, homelessness, high-risk behaviours, interactions with family or friends who do not understand PTSD, social inactivity, unemployment, and other barriers to receiving various forms of treatment or rehabilitation

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, military and ex-military personnel, emergency services personnel, and older people, 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.



Key Recommendations – Children and Adolescents

Note that many of the screening, assessment, and diagnosis issues discussed with reference to adults are relevant for children and adolescents also. Clearly, clinical judgement is required to make adjustments as necessary. This section highlights some specific issues to be considered when working with children and adolescents.

Assessment and diagnosis

Children and adolescents very rarely decide themselves that they require professional help with a psychological problem. Typically, children and adolescents require their parent or caregiver to make the decision that professional help is warranted and then to assist them to access that help. It is therefore equally important to engage with parents and caregivers as it is to engage with the child or adolescent.

Parents' and caregivers' mental health can also influence and be influenced by the child or adolescent's mental health. In assessing children and adolescents in the aftermath of trauma, consideration should also be given to the functioning of other family members and the family system in general.

Clinicians should routinely ask children about exposure to commonly experienced traumatic events, even if trauma is not the reason for referral. If such exposure is endorsed, the child should be screened for the presence of PTSD symptoms.

In assessing children and adolescents, priority is often given to the parent's report of trauma exposure and subsequent symptomatology. Unfortunately, the rate of agreement between parents/caregivers and children is very low. Clinicians should gather information from both the parent and child, even if the child is preschool-aged. For very young children, assessment should include evaluation of behaviour in the context of developmental stage and attachment status.

In children of all ages, PTSD is commonly comorbid with other disorders, including behavioural and attentional problems (such as oppositional defiant disorder and attention deficit hyperactivity disorder) as well as anxiety disorders (such as separation anxiety disorder) and affective disorders. In adolescents, suicidal ideation and substance dependence may also be present. Thus, assessment should go beyond PTSD to examine the child or adolescent's mental health more broadly.

A number of PTSD assessment measures have been developed for children and adolescents. Unfortunately, many fail to take developmental considerations into account, have not been adequately tested for validity, and lack different versions for different informants. The table below lists some of the more commonly used measures. Generally speaking, although many of the clinical interviews require training and are quite time-intensive, a structured interview is regarded as a better assessment measure for diagnostic purposes than a questionnaire. Questionnaires, on the other hand, can be very useful for repeated assessments when monitoring treatment progress over time.

Common PTSD measures

There are several PTSD measures that you can use for children and adolescents. They are listed in the assessment section of the Guidelines located at www.acpmh.unimelb.edu.au.

Structured interviews

- The Preschool Age Psychiatric Assessment (PAPA) and Diagnostic Infant Preschool
 Assessment (DIPA) are structured diagnostic interviews completed with caregivers,
 designed for children aged 2-5 and 1-6 years respectively. They allow diagnosis of
 most common childhood psychiatric disorders and include validated developmental
 modifications to PTSD criteria.
- The Clinician Administered PTSD Scale for Children and Adolescents (CAPS-CA) is an interview completed by children and adolescents aged 8-15 years. It represents a downward modification of the adult CAPS and assesses trauma exposure and provides frequency and intensity ratings of PTSD symptoms.
- The Children's PTSD Inventory (CPTSDI) is an interview completed by children and adolescents aged 7-18 years. It assesses the presence of DSM-IV PTSD symptoms relative to specific events.
- The Anxiety Disorders Interview Schedule for Children Child and Parent Versions
 (ADIS-IV-C/P) is an interview with parallel versions for children/adolescents aged 7-17
 years and their caregivers. The child and caregiver are interviewed separately, with
 diagnoses reached on the basis of combined information. The ADIS-IV-C/P allows for
 diagnosis of all DSM-IV anxiety, depressive, and behavioural disorders, although the
 PTSD module lacks specificity around symptom clusters, frequency, and duration of
 symptoms.
- The Kiddie Schedule for Affective Disorders and Schizophrenia for School-Aged Children – Parent and Lifetime Version (K-SADS-PL) is an interview completed separately with caregivers and children/adolescents aged 7-17 years. It assesses a range of DSM-IV psychopathology, including trauma exposure and lifetime and current PTSD or partial PTSD.

Self-report questionnaires

- The Trauma Exposure Symptom Inventory Parent Report (TESI-PR) and Trauma
 Exposure Symptom Inventory Parent Report Revised (TESI-PRR) are checklists of
 potentially traumatic events to which a child may have been exposed. Caregivers of
 children aged 3-18 and 0-6 years respectively indicate the child's age at the time of
 exposure and whether the child experienced reactions to each event.
- The Trauma Symptom Checklist for Young Children (TSCYC) is a questionnaire completed by caregivers of children aged 3-12 years. It provides a tentative PTSD diagnosis and yields several scales designed to ascertain the validity of caregiver reports.
- The Trauma Symptom Checklist for Children (TSCC) is a questionnaire completed by children/adolescents aged 8-16 years. It is typically used to assess PTSD symptoms following sexual-related trauma, but can also be used more generally.

Treating PTSD

As with adults, trauma-focussed psychological therapy is the treatment of choice for children and adolescents with PTSD. Developmentally appropriate trauma-focussed cognitive behavioural therapy should generally be considered in the first instance. The effectiveness of eye movement desensitisation and reprocessing for PTSD in children is less well established.

The delivery of services in schools may be an effective strategy for engaging children, adolescents, and families in treatment, particularly for community-wide events such as natural disasters.

In general, the core principles of the major therapeutic approaches used to treat adults with PTSD are also relevant for children and adolescents. Specific considerations to keep in mind include:

- the involvement of parents and caregivers who can ensure that children and adolescents attend therapy sessions and complete homework, encourage the use of strategies learnt in therapy, and provide information on child and family functioning. In addition, it is important for clinicians to assess how parents themselves are functioning.
- the use of developmentally appropriate treatment programs. Validated protocols for children and adolescents should be used in preference to modifying an adult program.
- the use of highly visual materials and, for adolescents in particular, a variety of media.







Full List of Recommendations

The following section gives a list of all the recommendations made in the Guidelines for the treatment of adults, and children and adolescents. Recommendations (**R**) are graded according to the strength of the evidence upon which they are based. The gradings range from **A** for the strongest evidence through to **D** for the weakest evidence. **Grade A** recommendations indicate that the body of evidence can be trusted to guide practice. **Grade B** indicates that the body of evidence can be trusted to guide practice in most situations. **Grade C** indicates that the body of evidence provides some support for the recommendation but care should be taken in its application. **Grade D** indicates that the body of evidence is weak and the recommendation must be applied with caution.

In areas for which there was insufficient research evidence to generate a recommendation, expert clinical consensus is indicated by the designation Consensus Point (**CP**; used when a research question was asked, but no evidence found) or Good Practice Point (**GPP**; used where a research question was not asked). Areas identified as in need of further research are noted as Research Recommendations (**RR**).

Trauma and trauma reactions

Screening, assessment and diagnosis

- **GPP1** 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 describe some examples of such events.
- **GPP**2 Service planning should consider the application of screening (case finding) of individuals at high risk for PTSD after major disasters or incidents, as well as those in high risk occupations.
- **GPP**³ The choice of screening tool should be determined by the best available evidence, with a view to selecting the best performing screen for the population of interest. Application of an inappropriate screening tool may result in over- or under-identification of problems.
- **GPP**⁴ Different populations may require different screening procedures. Programs responsible for the management of refugees should consider the application of culturally appropriate screening for refugees and asylum seekers at high risk of developing PTSD. Similarly, screening of children will require the use of developmentally sensitive tools designed for the purpose.

- **GPP**5 Screening should be undertaken in the context of a service system that includes adequate provision of services for those who require care.
- **GPP**6 Any individual who screens positive should receive a thorough diagnostic assessment.

Comprehensive assessment of PTSD

- **GPP**7 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**8 Assessment should include assessment of strengths and resilience, as well as responses to previous treatment.
- **GPP**9 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**10 As part of good clinical practice, assessment needs to occur at multiple time points following trauma exposure, particularly if the person displays signs of ongoing difficulties or psychological deterioration.
- **GPP**11 Assessment and monitoring should be undertaken throughout treatment. When adequate progress in treatment is not being made, the practitioner should revisit the case formulation, reassess potential treatment obstacles, and implement appropriate strategies, or refer to another practitioner. Effective inter-professional collaboration and communication is essential at such times.

Diagnosis

GPP12 Assessment should cover the broad range of potential posttraumatic mental health problems beyond PTSD, including other anxiety disorders, depression and substance abuse.

Assessment instruments

- **GPP**13 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**14 It is recommended that practitioners also use validated, user-friendly self-report measures to support their assessments of treatment outcomes over time.

Intervention planning

- **GPP**15 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. (*Please note also recommendations regarding PTSD and comorbidity*)
- **GPP**16 Residual symptomatology should be addressed after the symptoms of PTSD have been treated.
- **GPP**17 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**18 Mental health practitioners should provide a clear rationale for treatment and promote realistic and hopeful outcome expectancy.
- **GPP**19 Mental health practitioners and rehabilitation practitioners should work together to promote optimal psychological and functional outcomes.
- GPP20 In most circumstances, establishing a safe environment is an important precursor to commencement of trauma-focussed therapy or, indeed, any therapeutic intervention. However, where this cannot be achieved (for example, the person is seeking treatment for their PTSD whilst maintaining a work role or domestic situation that may expose them to further trauma), some benefit may still be derived from trauma-focussed therapy. This should follow careful assessment of the person's coping resources and available support.

Treatment goals

- **GPP**21 The practitioner should assess immediate needs for practical and social support and provide education and referrals accordingly.
- **GPP**22 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**23 From the outset, there should be a collaborative focus on recovery and rehabilitation between the person and practitioner, and where appropriate, family members.

Cultural and linguistic diversity

- **GPP**24 Recommended treatments for PTSD should be available to all Australians, recognising their different cultural and linguistic backgrounds.
- RR1 The conceptualisation of psychological trauma in different and diverse cultural contexts needs to be further researched so that this can inform processes of assessment and management of such trauma syndromes for people of culturally and linguistically diverse backgrounds.

The impact of PTSD on family

GPP25 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.

General professional issues

- GPP26 Practitioners who provide mental health care 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**27 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, as well as access to specialist advice and supervision where possible.
- **GPP**28 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 people with PTSD, and effective self-care. This includes maintaining a balanced and healthy lifestyle and responding early to signs of stress.
- **GPP**29 For those practitioners who work in an organisational context, broader policies and practices should support individual practitioners in these self-care measures.
- RR2 In recognition of the developing science around dissemination and implementation of evidence-based treatment, future research should explore the most effective ways of generating reliable and sustainable change in policies and practice for areas covered in these Guidelines.

General considerations when working with children and adolescents

Assessment

- **GPP**30 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**31 Children and adolescents are typically dependent upon an adult to present them for assistance. This means that it is equally important to engage with and maintain the relevant adults' motivation to pursue assistance, as it is the child or adolescent's.

- **GPP**32 Assessment of children and adolescents should include assessment of the system (typically the family) in which they live, as their symptoms will both influence and be influenced by what else is happening within the system.
- GPP33 The rate of agreement between parents/caregivers and children in relation to internalising symptoms of posttraumatic mental health problems may be very low. Practitioners should not rely solely on an adult's report of a child's internalising symptoms even if the child is preschool-aged. Where assessment involves very young children (aged 0-3) this should include an evaluation of the behaviour of the child with particular reference to developmental stage, and attachment status. Some symptoms of PTSD such as sense of foreshortened future and inability to recall some aspects of the trauma are unlikely to be usefully assessed in this age group.
- **GPP**34 In children, the range of potential posttraumatic mental health problems includes behavioural and attentional problems (such as oppositional defiant disorder and attention deficit hyperactivity disorder) as well as anxiety disorders (such as separation anxiety disorder) and affective disorders.
- **GPP**35 For children and adolescents, a structured clinical interview is regarded as a better assessment measure than a questionnaire for making a diagnosis.

Intervention planning

- GPP36 As noted in reference to assessment, children and adolescents are typically dependent upon an adult to present them for treatment and ensure that they attend subsequent appointments. This means that it is equally important to engage with and maintain the relevant adults' motivation to pursue treatment, as it is the child or adolescent's.
- **GPP**37 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**38 When the adult caregiver of a child with PTSD is also experiencing posttraumatic mental health problems, their symptoms may exacerbate each other's. For this reason, it may be preferable to treat the caregiver first or in parallel.
- GPP39 In the treatment of children and adolescents, parents/caregivers need to be involved to some degree, not only because of their gatekeeper role in terms of access to and continued engagement in therapy, but also because of their role in helping to generalise and maintain treatment gains, direct participation in homework tasks (e.g., reward systems), and providing important information that the child may have forgotten, be unaware of, or not recognise the importance of.

- **GPP**40 The delivery of services in schools may be an effective strategy for engaging and keeping children, adolescents and families in treatment.
- **GPP**41 Parent/caregiver involvement in assessment and treatment is desirable for children and adolescents with ASD or PTSD.
- **GPP**42 Practitioners who provide mental health care 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.

Evidence review and treatment recommendations

GPP43 Best practice procedures should be adopted when using psychological, psychosocial or pharmacological treatments, including provision of information prior to commencement, monitoring and management of side effects, monitoring of suicide risk, and in the case of pharmacological intervention, appropriate discontinuation and withdrawal practices.

Early psychological interventions for adults

Pre-incident preparedness training

- **CP1** For adults likely to be exposed to a potentially traumatic event, pre-incident preparedness training may facilitate psychological adaptation following the event.
- **RR**3 There is an urgent need for carefully controlled research to study the content and possible benefits of preparedness training prior to trauma exposure.

Early psychological interventions for all

Grade B

- R1 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.
- **GPP**44 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**45 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**46 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**47 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.
- RR4 In view of the importance of providing a best practice response for adults exposed to a potentially traumatic event for high risk industries and for the general community, future research should examine the most effective strategy to adopt for all those exposed to a traumatic event.

Psychological treatment for adults with ASD or acute PTSD Grade

R2 For adults displaying symptoms consistent with ASD or PTSD in the initial four weeks after a potentially traumatic event, individual exposure and/or cognitive therapy, should be considered if indicated by a thorough clinical assessment.

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Psychological interventions for adults with PTSD Grade

- R3 Adults with PTSD should be offered trauma-focussed cognitive behavioural interventions or eye movement desensitisation and reprocessing.
- Α
- **R**4 Where symptoms have not responded to a range of trauma-focussed **D** interventions, evidence-based non-trauma-focussed psychological interventions (such as stress inoculation training) should be considered.
- **CP**2 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.
- **GPP**48 Where symptoms have not responded to one form of first line traumafocussed intervention (trauma-focussed cognitive behavioural therapy or eye movement desensitisation and reprocessing), health practitioners may consider the alternative form of trauma-focussed intervention.
- **GPP**49 For adults with PTSD with several problems arising from multiple traumatic events, traumatic bereavement, or where PTSD is chronic and associated with significant disability and comorbidity, sessions using specific treatments to address those problems may be required.

GPP50 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 and more attention to teaching emotional regulation skills may be required.

GPP51 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.

GPP52 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.

RR5 Mechanisms underpinning effective treatments should be subject to systematic research.

RR6 There should be large and well-controlled trials of new and emerging interventions for PTSD.

Further research is required that evaluates the extent to which treatments with demonstrated efficacy are effective when delivered by non-specialist practitioners in real-world settings. The focus of research should not be restricted to outcomes only, but should also include factors such as cost-effectiveness, acceptability for practitioners and clients, treatment fidelity, and success of practitioner training.

Individual vs group therapy

Grade

R5 Group cognitive behavioural therapy (trauma-focussed or non-trauma-focussed) may be provided as adjunctive to, but not be considered an alternative to, individual trauma-focussed therapy.

Self-delivered interventions

Grade

R6 Internet-delivered trauma-focussed therapy involving trauma-focussed cognitive behavioural therapy may be offered in preference to no intervention.

Early pharmacological interventions for adults

Early pharmacological interventions for all

Grade

R7 For adults exposed to a potentially traumatic event, drug treatments should not be used for all those exposed as a preventive intervention.

GPP53. Where significant sleep disturbance does not settle in response to reassurance, sleep hygiene and appropriate psychological interventions, cautious and time-limited use of appropriate sleep medication may be helpful for adults.

Pharmacological treatment for adults with ASD or acute PTSD	Grade
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- R8 The routine use of pharmacotherapy to treat ASD or early PTSD (i.e., within four weeks of symptom onset) in adults is not recommended.
- **GPP**54 Pharmacotherapy may be indicated if the severity of the person's distress cannot be managed by psychological means alone, particularly when there is a pattern of extreme hyperarousal, sleep disturbance or nightmares.
- **GPP**55 For people who have a prior psychiatric history that has responded well to medication, the prescription of an appropriate medication should be considered if a progressive pattern of clinically significant symptoms, such as persistent intrusions with increasing affective distress, begin to emerge.
- **GPP**56 For adults with ASD or early PTSD, where significant sleep disturbance does not settle in response to reassurance, sleep hygiene and appropriate psychological interventions, cautious and time-limited use of appropriate sleep medication may be helpful.
- RR8 The effect of pharmacological treatment of ASD on subsequent PTSD status and severity following cessation of medication should be investigated. These studies may go beyond common psychotropic medication to include other agents that have shown promise such as narcotic analgesics, cortisol, and alcohol.

Pharmacological interventions for adults with PTSD

Grade

R 9	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	B
R 10	Where medication is considered for the treatment of PTSD in adults, selective serotonin reuptake inhibitor antidepressants should be considered the first choice.	С

- **GPP**57 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
 - 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
 - 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)
 - d) the person has not gained significant benefit from trauma-focussed psychological treatment.
- **GPP**58 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.
- GPP59 Where significant sleep disturbance or excessive distress does not settle in response to reassurance, sleep hygiene and evidence-based psychological interventions, or other non-drug intervention, cautious and time-limited use of appropriate sleep medication may be helpful. If the sleep disturbance is of more than one month's 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**60 Where symptoms have not responded adequately to pharmacotherapy, further consultation with a specialist in the field should be undertaken to determine the appropriateness of:
 - a) increasing the dosage within approved limits
 - b) switching to an alternative antidepressant medication
 - c) adding prazosin, risperidone or olanzapine as an adjunctive medication
 - d) reconsidering the potential for psychological intervention.
- **GPP**61 When an adult with PTSD has responded to drug treatment without experiencing any adverse effects, it should be continued for at least 12 months before gradual withdrawal.

- RR11 Given the extent to which adjunctive pharmacotherapy is used in routine clinical practice, particularly with chronic and treatment-resistant cases, it is recommended that large, well-controlled trials be conducted to clarify the benefits of multiple medications.
- **RR**12 Since preliminary evidence suggests that a range of medications may enhance psychological treatments, future research should further investigate this question.
- **RR**13 Further exploration is required of the potential benefits of combination and sequencing (pharmacological and trauma-focussed psychological) treatments.
- **RR**14 Future research should explore neurobiological and psychological markers that may be used in predicting likely treatment response. This research recommendation applies equally to pharmacological and psychological interventions.

Psychosocial rehabilitation

- **CP**3 Adult refugees with PTSD who have experienced war and famine may benefit from appropriate psychosocial support groups.
- **GPP**62 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**63 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**64 Health care and rehabilitation professionals should be aware of the potential benefits of psychosocial rehabilitation and promote practical advice on how to access appropriate information and services.
- **GPP**65 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.
- RR9 In adults with PTSD the impact of psychosocial rehabilitation on PTSD and social and occupational functioning should be investigated.

Exercise and physical therapies

Grade

R11 Acupuncture may be considered as a potential intervention for PTSD for people who have not responded to trauma-focussed psychological therapy or pharmacotherapy.

- **GPP**66 As part of general mental health care, practitioners may wish to advise people with PTSD that regular aerobic exercise can be helpful in managing their symptoms and as part of self-care practices more generally. Exercise may assist in the management of sleep disturbance and somatic symptoms that are common accompaniments of PTSD.
- **RR**10 Further research is needed into the effect of physical and exercise based interventions on PTSD.

Single vs multiple interventions

- **GPP**67 Psychosocial rehabilitation interventions should be used as an adjunctive therapy in combination with psychotherapy or pharmacotherapy.
- RR15 Large, well-controlled randomised trials comparing pharmacological with trauma-focussed psychological treatment across different trauma populations are required. This may be best achieved through coordinated international multi-site trials.

Sequencing comorbidities

- **CP**4 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**5 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**6 In the context of PTSD and substance use disorders, practitioners should consider integrated treatment of both conditions.
- CP7 In the context of PTSD and substance use disorders, the trauma-focussed 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.
- CP8 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.

Early psychological interventions for children and adolescents

Early psychological interventions for all

Grade

- R12 For children exposed to a potentially traumatic event, psychological debriefing should not be offered.
- **GPP**68 Children, ranging from infants and pre-schoolers to older children and adolescents can be affected significantly by traumatic events, at higher rates than adults. Practitioners need to be conscious of this risk, must be proactive in assessing the range of psychological impacts of trauma, and should be prepared to provide appropriate assistance, including referral to specialist services if needed.
- GPP69 Information is often provided to assist children following traumatic events. The content, when used, should be of high quality and tailored to the traumatic event type and the target audience. Information given following traumatic events may include: a) information about likely outcomes (most frequently positive); b) reinforcement of existing and new positive coping; c) advice on avenues for seeking further assistance if required; and d) possible indicators of a need for further assistance. Information following traumatic events may also include a recognition of the role of, and impact on, caregivers, siblings and teachers.
- **GPP**70 For children exposed to trauma, psychoeducation should be integrated into a stepped-care approach that involves parents and the range of health, education and welfare service providers, and includes monitoring, targeted assessment and intervention, if necessary.)
- **GPP**71 Psychological first aid may be appropriate with children in the immediate aftermath of trauma, however if it is used there must be access available to infant, child and adolescent mental health specialists if and when required.
- **GPP**72 Parents and caregivers provide a protective/buffering function against child traumatic stress. Clinicians should be aware of the potential for parents' own distress or other factors to compromise their capacity to provide a protective/buffering function. If distress or other relevant factors are identified, the clinician should respond accordingly.
- **RR**16 Research across a range of trauma-exposed child and adolescent populations is needed to improve understanding of the role and effectiveness of early intervention.

Early psychological interventions for children and adolescents with ASD or acute PTSD

CP9 Trauma-focussed cognitive behavioural therapy may be useful as an early psychological intervention for children with a diagnosis of ASD in the initial four weeks after the traumatic event, based on the positive evidence for cognitive behavioural therapy in children with PTSD. However, the effectiveness of this approach with ASD in children is not yet established.

Psychological interventions for children and adolescents with PTSD

R13 For children of school age and above with PTSD, developmentally appropriate trauma-focussed cognitive behavioural therapy should be considered.

GPP73 When assessing a child or adolescent for PTSD, healthcare professionals should ensure that they separately and directly assess the child or adolescent for the presence of PTSD symptoms. It is preferable not to rely solely on information from the parent or guardian in any assessment.

GPP74 Given that retention in therapy and the effectiveness of trauma-focussed cognitive behavioural therapy with children and adolescents both require strong parent and/or caregiver involvement, an initial phase of trauma-focussed cognitive behavioural therapy with this group is engagement of the parent(s) to improve their understanding and support of this treatment modality.

RR17 The effectiveness of trauma-focussed cognitive behavioural therapy on depression and other posttraumatic presentations (internalising and externalising behaviours) requires further investigation.

RR18 We recommend that further research examining eye movement desensitisation and reprocessing for PTSD in children is conducted.

RR20 The impact of treatment of trauma-related psychopathology in parents and/or caregivers of abused children prior to treatment of the children should be explored.

Individual vs group therapy

Grade C

R14 For children with PTSD, individual psychological interventions should be considered in preference to group interventions.

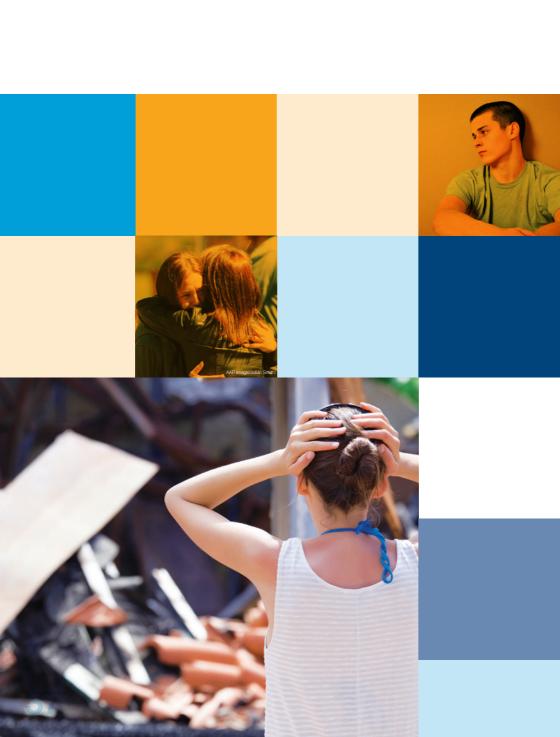
Early pharmacological interventions for children and adolescents

		Grade
R 15	For children exposed to a potentially traumatic event, pharmacotherapy should not be used as a preventive intervention for all those exposed.	D

Pharmacological interventions for children and adolescents with PTSD

		Grade
R 16	For children and adolescents with PTSD, pharmacotherapy should not be used as a routine first treatment over trauma-focussed cognitive behavioural therapy.	D
R 17	For children and adolescents with PTSD, pharmacotherapy should not be used routinely as an adjunct to trauma-focussed cognitive behavioural therapy.	D
GPP 75	Prescription of antidepressants in children should be guided by speci practice guidelines on depression, and practitioners should be aware	

	age-related side effects.	
School	-based interventions Grade	
R 18	For children exposed to trauma with symptoms of PTSD, where they were exposed to the same event, a school-based trauma-focussed cognitive-behavioural intervention aimed at reducing symptoms of PTSD should be considered.	
GPP 76	An integrated model between education and health providers that facilitates appropriate support and referral is recommended. It is recommended that schools provide a facilitative function in intervening with children following trauma, especially after large-scale traumas.	
RR 19	There is a need to understand how the impact of trauma presents for children in schools, and the role of the school community in providing support to affected children and assisting in referral if required.	



DSM-IV Criteria for PTSD

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
 - (2) The person's response involved intense fear, helplessness, or horror. Note: In children, this may be expressed instead by disorganized or agitated behavior.
- B. The traumatic event is persistently re-experienced in one (or more) of the following ways:
 - (1) Recurrent and intrusive distressing recollections of the event, including images, thoughts or perceptions. **Note:** In young children, repetitive play may occur in which themes or aspects of the trauma are expressed.
 - (2) Recurrent distressing dreams of the event. **Note:** In children, there may be frightening dreams without recognizable content.
 - (3) Acting or feeling as if the traumatic event were recurring (includes a sense of reliving the experience, illusions, hallucinations, and dissociative flashback episodes, including those that occur on awakening or when intoxicated). Note: In young children, trauma-specific re-enactment may occur.
 - (4) Intense psychological distress at exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
 - (5) Physiological reactivity on exposure to internal or external cues that symbolise or resemble an aspect of the traumatic event.
- C. Persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness (not present before the trauma), as indicated by three (or more) of the following:
 - (1) Efforts to avoid thoughts, feelings or conversations associated with the trauma.
 - (2) Efforts to avoid activities, places, or people that arouse recollections of the trauma.
 - (3) Inability to recall an important aspect of the trauma.
 - (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 a foreshortened future (e.g., does not expect to have a career, marriage, children, or a normal life span).

- D. Persistent symptoms of increased arousal (not present before the trauma), as indicated by two (or more) of the following:
 - (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 disturbance (symptoms in Criteria B, C, and D) is more than 1 month.
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Acute: If duration of symptoms is less than three months. **Chronic:** If duration of symptoms is three months or more.

Specify if:

With delayed onset: If onset of symptoms is at least six months after the stressor.

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.)
- B. Presence of one or more of the following intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
 - (1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). (Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.)
 - (2) Recurrent distressing dreams in which the content and/or affect of the dream is related to the event(s). (Note: In children, there may be frightening dreams without recognizable content.)
 - (3) Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). (Note: In children, trauma-specific reenactment may occur in play.)
 - (4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
 - (5) Marked physiological reactions exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

- C. Persistent avoidance of stimuli associated with the traumatic event(s), beginning after the traumatic event(s) occurred, as evidenced by avoidance or efforts to avoid one or both of the following:
 - (1) Distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
 - (2) External reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with, the traumatic event(s).
- D. Negative alterations in cognitions and mood associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two (or more) of the following:
 - Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).
 - (2) Persistent and exaggerated negative beliefs or expectations about oneself, others, or the world (e.g., "I am bad," "No one can be trusted," "The world is completely dangerous", "My whole nervous system is permanently ruined").
 - (3) Persistent, distorted cognitions about the cause or consequences of the traumatic event(s) that lead the individual to blame himself/herself or others.
 - (4) Persistent negative emotional state (e.g., fear, horror, anger, guilt, or shame).
 - (5) Markedly diminished interest or participation in significant activities.
 - (6) Feelings of detachment or estrangement from others.
 - (7) Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).
- E. Marked alterations in arousal and reactivity associated with the traumatic event(s), beginning or worsening after the traumatic event(s) occurred, as evidenced by two or more of the following:
 - (1) Irritable behavior and angry outbursts (with little or no provocation) typically expressed as verbal or physical aggression toward people or objects.
 - (2) Reckless or self-destructive behavior.
 - (3) Hypervigilance.
 - (4) Exaggerated startle response.
 - (5) Problems with concentration.
 - (6) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D, and E) is more than 1 month.
- G. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

H. The disturbance is not attributed to the direct physiological effects of a substance (e.g., medication, alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

- Depersonalization: Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream, feeling a sense of unreality of self or body or of time moving slowly).
- Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, or behavior during alcohol intoxication), or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).

Preschool children

- A. In children 6 years and younger, exposure to actual or threatened death, serious injury, or sexual violence in one (or more) of the following ways:
 - (1) Directly experiencing the event(s).
 - (2) Witnessing, in person, the event(s) as they occurred to others, especially primary caregivers. (Note: Witnessing does not include events that are witnessed only in electronic media, television, movies or pictures.)
 - (3) Learning that the traumatic event(s) occurred to a parent or caregiving figure.
- B. Presence of one (or more) intrusion symptoms associated with the traumatic event(s), beginning after the traumatic event(s) occurred:
 - (1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). (Note: Spontaneous and intrusive memories may not necessarily appear distressing and may be expressed as play reenactment.)
 - (2) Recurrent distressing dreams in which the content and/or affect of the dream is related to the traumatic event(s). (Note: it may not be possible to ascertain that the frightening content is related to the traumatic event.)

- (3) Dissociative reactions in which the child feels or acts as if the traumatic event(s) were recurring. (Such reactions may occur on a continuum with the most extreme expression being a complete loss of awareness of present surroundings.) Such trauma-specific re-enactment may occur in play.
- (4) Intense or prolonged psychological distress at exposure to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).
- (5) Marked physiological reactions to reminders of the traumatic event(s).
- C. One (or more) of the following symptoms, representing either persistent avoidance of stimuli associated with the traumatic event(s) or negative alterations in cognitions and mood associated with the traumatic event(s), beginning after the event(s) or worsening after the event(s):

Persistent avoidance of stimuli

- (1) Avoidance of or efforts to avoid activities, places, or physical reminders that arouse recollections of the traumatic event.
- (2) Avoidance of or efforts to avoid people, conversations, or interpersonal situations that arouse recollections of the traumatic event.

Negative alterations in cognitions

- (1) Substantially increased frequency of negative emotional states (e.g., fear, guilt, sadness, shame, confusion).
- (2) Markedly diminished interest or participation in significant activities, including constriction of play.
- (3) Socially withdrawn behavior.
- (4) Persistent reduction in expression of positive emotions.
- E. Alterations in arousal and reactivity associated with the traumatic event, beginning or worsening after the traumatic event occurred, as evidenced by two or more of the following:
 - Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects (including extreme temper tantrums).
 - (2) Hypervigilance.
 - (3) Exaggerated startle response.
 - (4) Problems with concentration.
 - (5) Sleep disturbance (e.g., difficulty falling or staying asleep or restless sleep).
- F. Duration of the disturbance (Criteria B, C, D and E) is more than 1 month.

- G. The disturbance causes clinically significant distress or impairment in relationships with parents, siblings, peers, or other caregivers or with school behavior.
- H. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition.

Specify whether:

With dissociative symptoms: The individual's symptoms meet the criteria for posttraumatic stress disorder, and in addition, in response to the stressor, the individual experiences persistent or recurrent symptoms of either of the following:

- 1. **Depersonalization:** Persistent or recurrent experiences of feeling detached from, and as if one were an outside observer of, one's mental processes or body (e.g., feeling as though one were in a dream, feeling a sense of unreality of self or body or of time moving slowly).
- Derealization: Persistent or recurrent experiences of unreality of surroundings (e.g., world around the individual is experienced as unreal, dreamlike, distant, or distorted).

Note: To use this subtype, the dissociative symptoms must not be attributable to the physiological effects of a substance (e.g., blackouts, or behavior during alcohol intoxication), or another medical condition (e.g., complex partial seizures).

Specify if:

With delayed expression: If the full diagnostic criteria are not met until at least 6 months after the event (although the onset and expression of some symptoms may be immediate).



DSM-IV Criteria for ASD

- A. The person has been exposed to a traumatic event in which both of the following were present:
 - (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or a threat to the physical integrity of self or others.
 - (2) The person's response involved intense fear, helplessness, or horror.
- B. Either while experiencing or after experiencing the distressing event, the individual has three (or more) of the following dissociative symptoms:
 - (1) A subjective sense of numbing, detachment, or absence of emotional responsiveness.
 - (2) A reduction in awareness of his or her surroundings (e.g., "being in a daze").
 - (3) Derealization.
 - (4) Depersonalization.
 - (5) Dissociative amnesia (i.e., inability to recall an important aspect of the trauma).
- C. The traumatic event is persistently re-experienced in at least one of the following ways: recurrent images, thoughts, dreams, illusions, flashback episodes, or a sense of reliving the experience; or distress on exposure to reminders of the traumatic event.
- D. Marked avoidance of stimuli that arouse recollections of the trauma (e.g., thoughts, feelings, conversations, activities, places, people).
- E. Marked symptoms of anxiety or increased arousal (e.g., difficulty sleeping, irritability, poor concentration, hypervigilance, exaggerated startle response, motor restlessness).
- F. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning or impairs the individual's ability to pursue some necessary task, such as obtaining necessary assistance or mobilizing personal resources by telling family members about the traumatic experience.
- G. The disturbance lasts for a minimum of 2 days and a maximum of 4 weeks and occurs within 4 weeks of the traumatic event.
- H. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition, is not better accounted for by Brief Psychotic Disorder, and is not merely an exacerbation of a pre-existing Axis I or Axis II disorder.

DSM-5 Criteria for ASD

- A. Exposure to actual or threatened death, serious injury, or sexual violation 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.)
- B. Presence of nine (or more) of the following symptoms from any of the five categories of intrusion, negative mood, dissociation, avoidance, and arousal, beginning or worsening after the traumatic event(s) occurred:

Intrusion symptoms

- (1) Recurrent, involuntary, and intrusive distressing memories of the traumatic event(s). (Note: In children, repetitive play may occur in which themes or aspects of the traumatic event(s) are expressed.)
- (2) Recurrent distressing dreams in which the content and/or affect of the dream is related to the event(s). (Note: In children, there may be frightening dreams without recognizable content.)
- (3) Dissociative reactions (e.g., flashbacks) in which the individual feels or acts as if the traumatic event(s) were recurring (such reactions may occur on a continuum, with the most extreme expression being a complete loss of awareness of present surroundings). (Note: In children, trauma-specific reenactment may occur in play.)
- (4) Intense or prolonged psychological distress or marked physiological reactions in response to internal or external cues that symbolize or resemble an aspect of the traumatic event(s).

Negative mood

(5) Persistent inability to experience positive emotions (e.g., inability to experience happiness, satisfaction, or loving feelings).

Dissociative symptoms

- (6) An altered sense of the reality of one's surroundings or oneself (e.g., seeing oneself from another's perspective, being in a daze, time slowing).
- (7) Inability to remember an important aspect of the traumatic event(s) (typically due to dissociative amnesia and not to other factors such as head injury, alcohol, or drugs).

Avoidance symptoms

- (8) Efforts to avoid distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).
- (9) Efforts to avoid external reminders (people, places, conversations, activities, objects, situations) that arouse distressing memories, thoughts, or feelings about or closely associated with the traumatic event(s).

Arousal symptoms

- (10) Sleep disturbance (e.g., difficulty falling or staying asleep, restless sleep).
- (11) Irritable behavior and angry outbursts (with little or no provocation), typically expressed as verbal or physical aggression toward people or objects.
- (12) Hypervigilance.
- (13) Problems with concentration.
- (14) Exaggerated startle response.
- C. Duration of the disturbance (symptoms in Criterion B) is 3 days to 1 month after trauma exposure. (Note: Symptoms typically begin immediately after the trauma, but persistence for at least 3 days and up to a month is needed to meet disorder criteria).
- D. The disturbance causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- E. The disturbance is not attributable to the physiological effects of a substance (e.g., medication or alcohol) or another medical condition (e.g., mild traumatic brain injury), and is not better explained by brief psychotic disorder.



Traumatic Events Checklist

Listed below are a number of difficult or stressful things that sometimes happen to people.

For each event, patient is to indicate:

- (a) it happened to patient personally,
- **(b)** patient *witnessed it* happen to someone else,
- (c) patient learned about it happening to someone close to them,
- (d) patient is not sure if it fits, or
- (e) it doesn't apply to patient.

Be sure patient considers their entire life (growing up as well as adulthood) as they go through the list of events.

Event

Natural disaster (e.g., flood, hurricane, tornado, earthquake)

Fire or explosion

Transportation accident (e.g., car accident, boat accident, train crash, plane crash)

Serious accident at work, home, or during recreational activity

Exposure to toxic substance (e.g., dangerous chemicals, radiation)

Physical assault (e.g., being attacked, hit, slapped, kicked, beaten up)

Assault with a weapon

(e.g., being shot, stabbed, threatened with a knife, gun, bomb)

Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)

Other unwanted or uncomfortable sexual experience

Combat or exposure to a war-zone (in the military or as a civilian)

Captivity (e.g., being kidnapped, abducted, held hostage, prisoner of war)

Life-threatening illness or injury

Severe human suffering

Sudden, violent death (e.g., homicide, suicide)

Sudden, unexpected death of someone close to you

Serious injury, harm, or death you caused to someone else

Any other very stressful event or experience







Promoting recovery after trauma

For more information, trauma resources and getting help

www.acpmh.unimelb.edu.au









