Phoenix AUSTRALIA

Treatment recommendations

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

The Guidelines do not substitute for the knowledge and skill of competent individual practitioners and are designed to guide appropriate interventions in the context of each person's unique circumstances and their overall mental health care needs. Practitioners should be enabled to interpret and implement treatment recommendations in the context of good clinical judgement, not as rigid rules.

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

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

Psychological interventions for children and adolescents with PTSD
Strong recommendation FOR trauma-focussed CBT (TF-CBT) For children and adolescents with symptoms of PTSD, we recommend trauma-focussed CBT.
Strong recommendation FOR trauma-focussed CBT for caregiver and child For children and adolescents with symptoms of PTSD, we recommend trauma-focussed CBT for caregiver and child.
Conditional recommendation FOR EMDR For children and adolescents with symptoms of PTSD, we suggest offering eye movement desensitisation and reprocessing (EMDR) where trauma-focused CBT is unavailable or unacceptable.
Pharmacological interventions for children and adolescents with PTSD
No recommendations made
Recommendations for adults
Interventions within the first three months of exposure to a traumatic event
Universal interventions (for all adults exposed to trauma)
Conditional recommendation AGAINST individual psychological debriefing For adults within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to individual psychological debriefing.
Conditional recommendation AGAINST group psychological debriefing For adults within the first three months after trauma exposure, we suggest providing information, emotional support, and practical assistance in preference to group psychological debriefing.
Indicated interventions (for those with PTSD symptoms)
Strong recommendation FOR a stepped/collaborative care model For adults with PTSD symptoms in the first three months following trauma, we recommend a stepped/collaborative care model, in which individuals receive evidence-based care commensurate with the severity and complexity of their need.
Conditional recommendation FOR trauma-focussed CBT (TF-CBT) For adults with PTSD symptoms in the first three months following trauma, we suggest offering trauma-focussed CBT (includes prolonged exposure, cognitive processing therapy, cognitive therapy) in preference to doing nothing.
Conditional recommendation FOR brief EMDR For adults with PTSD symptoms in the first three months following trauma, we suggest offering brief Eye Movement Desensitisation and Reprocessing (EMDR) in preference to doing nothing.
Psychological interventions for adults with PTSD
Strong recommendation FOR cognitive processing therapy (CPT) For adults with PTSD, we recommend cognitive processing therapy (CPT).
Strong recommendation FOR cognitive therapy (CT) For adults with PTSD, we recommend cognitive Therapy (CT).
Strong recommendation FOR EMDR For adults with PTSD, we recommend eye movement desensitisation and reprocessing (EMDR).

Strong recommendation FOR prolonged exposure (PE)

For adults with PTSD, we recommend prolonged exposure (PE).

Strong recommendation FOR trauma-focussed CBT (TF-CBT)

For adults with PTSD, we recommend trauma-focussed CBT.

Conditional recommendation FOR guided internet-based trauma-focussed CBT

For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest guided internet-based trauma-focussed CBT.

Conditional recommendation FOR narrative exposure therapy (NET)

For adults with PTSD where trauma is linked to genocide, civil conflict, torture, political detention, or displacement, we suggest narrative exposure therapy (NET).

Conditional recommendation FOR present-centred therapy (PCT)

For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest present-centred therapy (PCT).

Conditional recommendation FOR stress inoculation training (SIT)

For adults with PTSD where trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest stress inoculation training (SIT).

Conditional recommendation FOR trauma-focussed CBT (group)

For adults with PTSD where individual trauma-focussed cognitive behavioural therapies or EMDR are unavailable or unacceptable, we suggest group trauma-focussed CBT.

Pharmacological interventions for adults with PTSD

Conditional recommendation FOR SSRIs (sertraline, paroxetine, or fluoxetine)

For adults with PTSD, we suggest SSRIs (sertraline, paroxetine, or fluoxetine) in circumstances where any of the following applies:

- The person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR).
- The person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SSRIs are indicated.
- The person's circumstances are not sufficiently stable to commence recommended psychological therapy (as a result, for example, of significant ongoing life stress such as domestic violence).
- The person has not gained significant benefit from recommended psychological therapy.
- There is a significant wait time before psychological treatment is available.

Conditional recommendation FOR venlafaxine

For adults with PTSD, we suggest venlafaxine in circumstances where any of the following applies:

- The person is unwilling or not in a position to engage in or access recommended psychological therapy (TF-CBT, PE, CT, CPT or EMDR).
- The person has a comorbid condition or associated symptoms (e.g., clinically significant depression and high levels of dissociation) where SNRIs are indicated.
- The person's circumstances are not sufficiently stable to commence recommended psychological therapy (as a result, for example, of significant ongoing life stress such as domestic violence).
- The person has not gained significant benefit from recommended psychological therapy.
- There is a significant wait time before psychological treatment is available.

Implementation considerations

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

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

Availability of evidence-based psychological treatments

Trauma-focussed CBT and its variants CPT, CT, and PE, along with EMDR, are recommended as first line treatments for PTSD in adults; trauma-focussed CBT for the child alone or child and caregiver are recommended as first line treatment for PTSD in children and adolescents. These treatments require specialised training and, unfortunately, the availability of suitably qualified practitioners is limited, particularly in rural and remote regions of Australia. The risk is that in the absence of this expertise, practitioners fall back on supportive counselling, which has been found to be ineffective for people with PTSD. There are a series of conditional recommendations for treatment that should be considered if trauma-focussed therapy is not available. The emergence of guided internet-based trauma focussed CBT as an evidence-based treatment is a particularly important development in this context. Internet-based therapy provides an effective means of increasing access to evidence-based treatment for people living in rural and remote regions, or otherwise unable to access an appropriately qualified practitioner.

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

Role of medication

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

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

In clinical practice, medication is often the first if not the only treatment offered for PTSD in adults. This arises where TF-CBT is not available, not readily accessible, or not acceptable to the individual. Further, for those who receive trauma-focussed therapy, it is often delivered in conjunction with pharmacological

therapy. Indeed, combined medication and psychotherapy is the most common treatment practice for veterans with PTSD.[2] Despite this common practice, there is a lack of research evidence for the additive benefit of combined psychotherapy and medication in the treatment of PTSD. Given the strong evidence of the additive benefit of combined psychotherapy and medication in the treatment of anxiety and depression,[3] it is reasonable to suppose that the same would be true of PTSD. However, a recent randomised clinical trial found that combining sertraline with PE did not increase efficacy in a sample of combat veterans.[1] Of interest, this head-to-head study comparing three treatment conditions, PE + sertraline, PE + placebo, and sertraline + enhanced medication management (to balance clinical attention), found all conditions to be equally effective in the treatment of PTSD.

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

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

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

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

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

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

Pharmacotherapy for children and adolescents

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

Non-psychological and non-pharmacological therapies

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

Populations underrepresented in the research

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

Research recommendations

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

Research recommendations for children and adolescents
Interventions within the first three months of exposure to a potentially traumatic event
Universal interventions (for all children and adolescents exposed to trauma)
Self-directed online psychoeducation for caregivers and children For children and adolescents within the first three months after exposure to a potentially traumatic event, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for caregivers and children. There is emerging evidence for self-directed online psychoeducation in caregivers and children following traumatic physical injury, and it could be used in a research context.
Self-directed online psychoeducation for children For children and adolescents within the first three months after exposure to a potentially traumatic event, we suggest continuation of treatment as usual in preference to self-directed online psychoeducation for children. There is emerging evidence for self-directed online psychoeducation in children following an acute medical event, and it could be used in a research context.
Psychological interventions for children and adolescents with PTSD
Group trauma-focussed CBT for child For children and adolescents with symptoms of PTSD, we suggest doing trauma-focussed CBT in preference to group trauma-focussed CBT for child. There is emerging evidence for group trauma-focussed CBT for child following exposure to traumatic events, and it could be used in a research context.
Individual and group trauma-focussed CBT for caregiver and child For children and adolescents with symptoms of PTSD, we suggest doing trauma-focussed CBT in preference to individual and group trauma-focussed CBT for caregiver and child. There is emerging evidence for individual and group trauma-focussed CBT for caregiver and child following exposure to traumatic events, and it could be used in a research context.
Parent–child relationship enhancement (play therapy) For children and adolescents with symptoms of PTSD, we suggest continuation of treatment as usual in preference to parent–child relationship enhancement (play therapy). There is emerging evidence for parent–child relationship enhancement (play therapy) for children with symptoms with PTSD and it could be used in a research context.
Narrative exposure therapy for children (KidNET) For children and adolescents with symptoms of PTSD, we suggest continuation of treatment as usual in preference to narrative exposure therapy for children (KidNET). There is emerging evidence for KidNET following exposure to traumatic events, and it could be used in a research context.

Non-psychological and non-pharmacological interventions for children and adolescents with PTSD

Mind–body skills group

For children and adolescents with symptoms of PTSD, we suggest continuation of treatment as usual in preference to mind–body skills group. There is emerging evidence for mind–body skills group in refugee populations exposed to war-related traumatic events, and it could be used in a research context.

Recommendations for adults

Pre-incident preparedness

Attention bias modification training (ABMT)

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

Attention control training

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

Heart rate variability biofeedback (HRVB)

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

Interventions within the first three months of trauma

Universal interventions (for all adults exposed to trauma)

Group 512 PIM

For adults within the first three months following exposure to a potentially traumatic event, we suggest usual practice in preference to Group 512 PIM. There is emerging evidence for Group 512 PIM in Chinese military populations exposed to natural disaster and it could be used in a research context.

Brief dyadic therapies

For adults within the first three months following exposure to a potentially traumatic event, we suggest usual practice in preference to brief dyadic therapies. There is emerging evidence for brief dyadic therapies and it could be used in a research context.

Internet-based CBT

For adults within the first three months following exposure to a potentially traumatic event, we suggest usual practice in preference to internet-based CBT. There is emerging evidence for internet-based CBT and it could be used in a research context.

Indicated interventions (for those with PTSD symptoms)

Early psychological treatments

Helping to overcome PTSD through empowerment (HOPE)

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT, or brief EMDR in preference to helping to overcome PTSD through empowerment (HOPE). There is emerging evidence for HOPE and it could be used in a research context.

Internet-based guided self-help

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT, or brief EMDR in preference to internet-based guided self-help.

There is emerging evidence for Internet-based guided self-help and it could be used in a research context.

Structured writing therapy

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT, or brief EMDR in preference to structured writing therapy. There is emerging evidence for structured writing therapy and it could be used in a research context.

Early pharmacological treatments

Hydrocortisone

For adults with PTSD symptoms in the first three months after exposure to a traumatic event, we recommend offering TF-CBT, PE, CT, or brief EMDR in preference to hydrocortisone. There is emerging evidence for hydrocortisone and it could be used in a research context.

Psychological interventions for adults with PTSD

Couples TF-CBT

For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to couples TF-CBT. There is emerging evidence for couples TF-CBT and it could be used in a research context.

Group and individual (combined) TF-CBT

For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to group and individual (combined) TF-CBT. There is emerging evidence for group and individual (combined) TF-CBT and it could be used in a research context.

Meta-cognitive therapy

For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to meta-cognitive therapy. There is emerging evidence for meta-cognitive therapy and it could be used in a research context.

Non-trauma focussed CBT (affect regulation)

For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to non-trauma focussed CBT (affect regulation). There is emerging evidence for non-trauma focussed CBT (affect regulation) and it could be used in a research context.

Reconsolidation of traumatic memories (RTM)

For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to reconsolidation of traumatic memories (RTM). There is emerging evidence for RTM and it could be used in a research setting.

Single-session TF-CBT

For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to single-session TF-CBT. There is emerging evidence for single- session TF-CBT and it could be used in a research context.

Virtual Reality Therapy

For adults with PTSD, we recommend offering TF-CBT, CPT, or EMDR in preference to Virtual Reality Therapy. There is emerging evidence for Virtual Reality Therapy and it could be used in a research context.

Written Exposure Therapy (WET)

For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT or EMDR in preference to Written Exposure Therapy (WET). There is emerging evidence for WET and it could be used in a research context.

Pharmacological interventions for adults with PTSD
Ketamine Where medication is indicated for the treatment of PTSD, we suggest an SSRI or SNRI antidepressant. There is emerging evidence for the use of ketamine in the treatment of and it could be used in a research context.
Quetiapine Where medication is indicated for the treatment of PTSD, we suggest an SSRI or SNRI antidepressant. There is emerging evidence for the use of quetiapine in the treatment of PTSD and it could be used in a research context.
Non-psychological/non-pharmacological interventions for adults with PTSD
Acupuncture For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to acupuncture. There is emerging evidence for acupuncture and it could be used in a research context.
Mindfulness-based stress reduction (MBSR) For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to mindfulness-based stress reduction (MBSR). There is emerging evidence for MBSR and it could be used in a research context.
Neurofeedback For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to neurofeedback. There is emerging evidence for neurofeedback and it could be used in a research context.
Physical exercise For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to physical exercise. There is emerging evidence for physical exercise and it could be used in a research context.
Repetitive Transcranial Magnetic Stimulation (rTMS) For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to Repetitive Transcranial Magnetic Stimulation (rTMS). There is emerging evidence for rTMS and it could be used in a research context.
Transcendental Meditation (TM) For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to Transcendental Meditation (TM). There is emerging evidence for Transcendental Meditation and it could be used in a research context.
Yoga For adults with PTSD, we recommend offering TF-CBT, PE, CT, CPT, or EMDR in preference to yoga. There is emerging evidence for yoga and it could be used in a research context.

Comparison with recommendations in previous Guidelines

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

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

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

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

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