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Post-traumatic stress disorder

Best practice GP guidelines

Background
Approximately 50–65% of Australians are exposed to a traumatic event during their lifetime. Approximately 250 000 Australians suffer from post-traumatic stress disorder (PTSD) at any given time, making it one of the most common anxiety disorders. In May 2007, the *Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder* was published. In order to facilitate translation of evidence regarding PTSD into busy clinical practice, and particularly for general practitioners, a more succinct version of the guidelines has been developed.

Objective
This article describes a brief algorithm based on the Australian guidelines and outlines key recommendations.

Discussion
General practitioners are often the first point of contact with the health care system for someone who has experienced a traumatic event. Patients experiencing trauma within the past 2 weeks require psychological first aid, and monitoring and assessment for the development of acute stress disorder and symptoms of PTSD. If the patient wishes to talk about the event with you, support them in doing so. However, it is important not to push those who prefer not to talk about the event. Trauma focused psychological treatment is the first line of treatment for PTSD, although antidepressant medication may have an adjuvant role in some patients or in those with comorbidities.

In May 2007 the Australian Centre for Posttraumatic Mental Health (ACPMH), in collaboration with Australian trauma experts, published the *Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder*.[1] The guidelines have been approved by the National Medical Health and Research Council and endorsed by the Royal Australian and New Zealand College of Psychiatrists (RANZCP) and the Australian Psychological Society.

In addition to the full guidelines, which provide a comprehensive overview of the research on the treatment of traumatic stress syndromes and a set of key recommendations, a suite of guideline products was developed to facilitate improved outcomes for people with acute stress disorder (ASD) or post-traumatic stress disorder (PTSD). These include a brief practitioner guide and a guide for people diagnosed with ASD or PTSD and their families. Following the dissemination of these guidelines, the need for a succinct algorithm to aid general practitioners and mental health practitioners in their immediate clinical decision making was identified. In response to this demand, the ACPMH received funding from the Department of Veterans' Affairs to develop, test and disseminate a guidelines based algorithm. The ACPMH collaborated with The Royal Australian College of General Practitioners and the RANZCP to develop a brief algorithm that addresses key messages and key decision points in managing patients exposed to a significant psychological trauma (*Figure 1*, see *Resources*).

Recommendations for management and treatment

General practitioners are faced with many decisions when considering the management of a patient affected by trauma. In addition to the succinct summary of the guideline recommendations,

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the algorithm provides practical step-by-step advice on the management and treatment of people with ASD and PTSD. The algorithm addresses some of the following basic questions that can confront GPs.

How is trauma defined?

In diagnosing ASD or PTSD, an event is considered to be traumatic if it meets two criteria. The event must:

- involve actual or threatened death or serious injury (real or perceived) to self or others (eg. accidents, assault, natural disasters, wars), and
- must evoke feelings of fear, helplessness or horror in the person.

Certain events such as interpersonal violence, direct life threat and prolonged duration are more likely to result in a traumatic response.

What is PTSD?

Acute stress disorder and PTSD are disorders characterised by symptoms that include:

- distressing re-experiencing and active avoidance of the traumatic memories
- emotional numbing, and
- hyperarousal[2] (*Table 1*).

Acute stress disorder can be diagnosed from 2 days to 4 weeks after a traumatic event and PTSD can be diagnosed from 4 weeks onward.

How common is it?

About 250 000 Australians experience PTSD at any given point in time[3] and approximately 15–25% of people who experience a potentially traumatic event may develop PTSD, making it one of the most common anxiety disorders.

What can I expect to see in short term aftermath and what do I do?

While psychological distress in the immediate aftermath of trauma is common, most people will recover using their existing coping strategies and social supports. As such, during the first couple of weeks following trauma it is important for the GP to:

- monitor the patient's mental state
- encourage the patient to continue to engage in their usual routines to the extent that functioning allows, and
- use existing social supports and coping strategies.

The aim of this approach, known as 'psychological first aid', is to maximise the likelihood of natural spontaneous recovery, with intervention only provided as needed (*Table 2*). Obviously however, if the patient presents with severe distress, usual steps to stabilise the patient are required (see *What about pharmacotherapy?*). It is also important to ensure that the person's basic needs are met, such as housing and safety.

It is important to be aware of risk factors that may increase the likelihood of a patient having a more problematic response. These risk factors include:

- the severity of the traumatic exposure
- a history of past trauma or previous psychiatric disorder
- lack of social supports, or
- experience of further stressful life events.

Following the initial session, a review appointment should be scheduled in 1–2 weeks to check on the patient's progress.

Figure 1. Management algorithm for ASD/PTSD

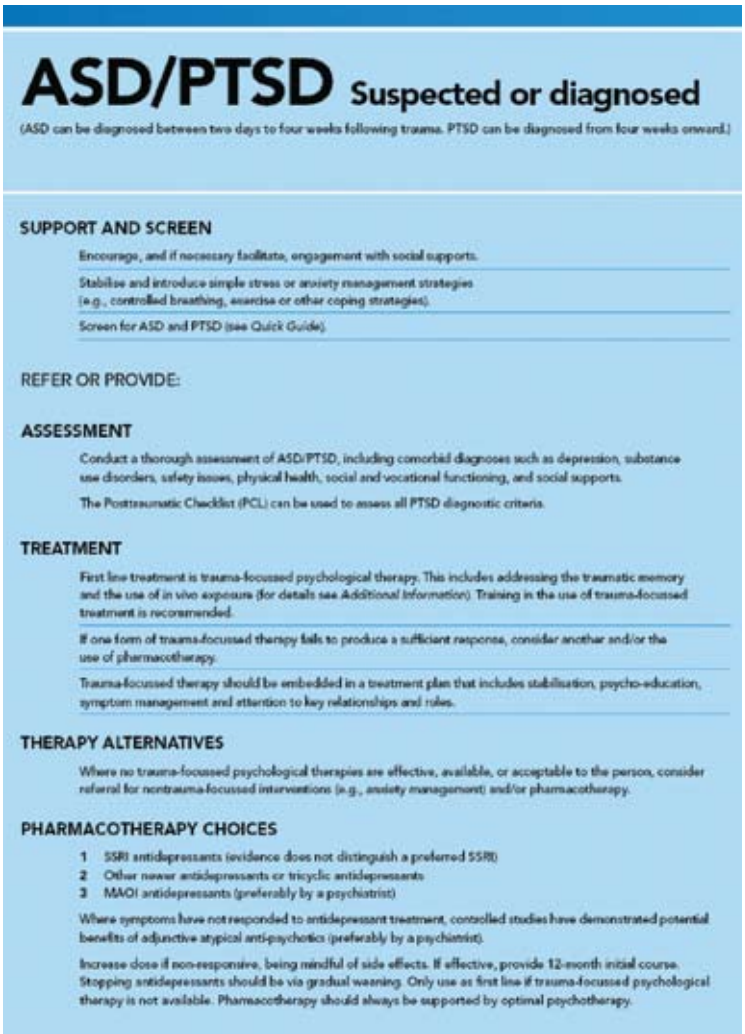

Table 1. Symptoms of PTSD

PTSD is characterised by three main types of symptoms that must be present for at least 1 month before a diagnosis can be made:[5]

- 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 (one symptom required)
- 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; psychogenic amnesia; sense of foreshortened future (three symptoms required)
- Hyperarousal – difficulty sleeping; irritability; difficulty concentrating; hypervigilance; exaggerated startle response (two symptoms required)

Table 2. Psychological first aid

For recent trauma (within the first 2 weeks)

- Monitor mental state and stabilise if required
- Encourage re-engagement in routines and use of social supports
- Ensure basic needs are met (eg. housing, safety)
- Review in 1–2 weeks

Should I get patients to talk about the traumatic event?

Survivors of trauma will often want to talk about the event as a way of coming to terms with it. Often they will spontaneously do so with existing trusted supports such as family and friends. If the patient wishes to talk about the event with you, support them in doing so. However, it is important not to push those who prefer not to talk about it. Everyone has different coping strategies and it is important to allow people an opportunity to cope with the event in their own way and in their own time.

Previously well publicised interventions commonly referred to as 'psychological debriefing' suggested that it is important that trauma survivors talk through their reactions to traumatic events with trauma professionals in the short term aftermath of the trauma, and that this process facilitated recovery and return to normal functioning. Current Australian and international guidelines however, reject this approach as a routine intervention for all as there is little evidence that it prevents mental health problems and, indeed, for some may interfere with their natural coping responses.

When should I provide a more clinical intervention?

If symptoms do not settle in 2 weeks, consider assessing for ASD or early indications of PTSD. A brief screen for PTSD is provided in *Table 3*. If a patient screens positively for PTSD, GPs are advised to conduct a more comprehensive assessment, specifically trying to identify the symptoms listed in *Table 1* (see *Resources*).

Where PTSD is diagnosed, the patient should then be offered trauma focused psychological therapy (TFPT), eg. cognitive behavioural therapy (CBT). This usually involves referral to a suitable mental health practitioner, unless the GP is trained in the delivery of this type of therapy. Even when the patient has been referred however, GPs should continue to monitor his or her progress. Management of patients with PTSD can involve the coordination of multidisciplinary health providers including psychologists providing TFPT, psychiatrists, and social/vocational rehabilitation consultants. The GP should also consider screening for other common mental health disorders that can develop following trauma such as depression, substance abuse and other anxiety disorders.

What is trauma focused psychological therapy?

Trauma focused psychological therapy is the intervention with the strongest evidence base for the effective treatment of ASD and PTSD and essentially consists of three elements.[4] The patient is assisted in a controlled, safe, systematic and repeated manner to confront the memory of the traumatic event until it no longer evokes the same level of distress. This is known as 'imaginal exposure'. In concert with this, the patient is assisted in systematically confronting situations, people and places that they may be avoiding due to their associations with the traumatic event. This is known as 'in vivo exposure'. Finally, TFPT also includes assisting the person address any unhelpful interpretations about the trauma and what it means about themselves, their relationships with others and the world more broadly, that might be interfering with their recovery. This is known as 'cognitive therapy'. These interventions usually take the form of CBT, or eye movement desensitisation and reprocessing in addition to in vivo exposure. The application of TFPT should be embedded in a treatment plan that includes stabilisation, psychoeducation, symptom management, relapse prevention, and attention to social and occupational functioning, ie. resuming key relationships and roles as soon as possible.

What about pharmacotherapy?

Generally, the guidelines recommend that pharmacotherapy not be used in place of TFPT where this therapy is suitable and available. However, there are a range of circumstances in which pharmacotherapy is indicated including:

- where it helps the patient achieve the level of stabilisation required to be suitable for TFPT, or
- where the patient
  - is unwilling to engage in TFPT
  - has not gained significant benefit from TFPT, or
  - has high levels of dissociative symptoms likely to be exacerbated by TFPT.

Where pharmacotherapy is considered, the best evidence is for selective serotonin reuptake inhibitors (SSRIs) as a class of medications, although existing evidence does not reliably

distinguish a preferred SSRI. Other newer antidepressants or tricyclic antidepressants would be considered as a second line pharmacological intervention. Third line treatment may involve the use of monoamine oxidase inhibitor (MAOI) antidepressants, although these should preferably be prescribed by a psychiatrist. Where symptoms have not responded to antidepressant treatment, controlled studies have demonstrated the potential benefits of adjunctive atypical antipsychotics. Again, these should preferably be prescribed by a psychiatrist.

Where pharmacotherapy is required in the acute management of a patient with PTSD, sedating, calming or antidepressant medication may be used. However, benzodiazepines are generally not recommended due to risk dependency and the possibility that they may interfere with natural recovery processes.

Table 3. Screening for PTSD[6]

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

- Have had nightmares about it or thought about it when you did not want to?
  YES/NO
- Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?
  YES/NO
- Were constantly on guard, watchful or easily startled?
  YES/NO
- Felt numb or detached from others, activities, or your surroundings?
  YES/NO

If two or more questions are answered with 'yes', a diagnosis of PTSD is probable

Table 4. Screening for past traumatic events

Where a person has repeated nonspecific health problems it is often helpful to ask about specific events that the person may have experienced, such as:

- Serious accident (eg. car accident or industrial accident)
- Natural disaster (eg. fire or flood)
- Physical attack or assault
- Sexual assault
- Witnessing someone being badly hurt or killed
- Domestic violence or abuse
- Physical or emotional abuse as a child
- Being threatened with a weapon or held captive
- War (as a civilian or in the military)
- Torture or an act of terrorism
- Any other extremely stressful or upsetting event

Who should I refer to for TFPT?

When referring for psychological therapy, mental health practitioners trained in TFPT should be the first choice (see *Resources*). Most commonly mental health practitioners with this type of training are psychologists, although psychiatrists and clinical social workers may also have received such training. Referrals to psychology, psychiatry and allied health care can be made under Medicare arrangements. Referrals for mental health care under third party funding arrangements should be considered where appropriate.

What about less obvious cases – how do I screen?

Many people who develop PTSD do not necessarily present in a straightforward manner. Instead, they may present with problems such as depression, anger, relationship problems and poor sleeping habits. They may present with repeated, nonspecific physical problems such as headaches, gastrointestinal problems, musculoskeletal pain syndromes and skin disorders. Patients with trauma histories who present with these problems may not report their exposure to a traumatic event. In such cases, GPs should consider asking about past traumatic events. The event may have taken place in the recent or distant past (eg. adult survivor of childhood sexual assault). This can be a difficult area for both GPs and patients to talk about. The guidelines algorithm provides brief screening and advice on how to ask this question (*Table 4*).

What are some of the issues in managing more complex presentations?

Post-traumatic stress disorder rarely occurs on its own. It is often accompanied by symptoms of depression and/or substance abuse. In such cases the sequencing of treatment is important. When PTSD and depression are both present, PTSD should be treated first because symptoms of depression often improve as PTSD symptoms reduce. However, if the depression is severe, it should be treated first to minimise suicide risk and improve the ability of the person to tolerate therapy. When PTSD and substance abuse are both present, they should be treated simultaneously because the two are likely to interact to maintain each other. In such cases, the substance abuse should be under control before the trauma focused component of therapy begins.

Summary

Post-traumatic stress disorder is a common treatable disorder. In the context of perceived stigma and shame associated with experiencing some traumatic events, many people may avoid mentioning them. As a result, traumatic stress reactions are often under diagnosed in routine clinical practice. As primary health providers, GPs are often the first, and at times the only, health practitioners available to people who have experienced a traumatic event. As such, they play a crucial role in identifying those with PTSD, managing their care, and referring them for specialised treatment when necessary.

Resources

- To order your free copy of the algorithm go to http://tinyurl.com/4286gd
- To download a PDF version of the algorithm go to www.acpmh.unimelb.edu.au/resources/resources-guidelines.html#1 (brief and full guidelines are also available at this website)
- The brief screen for PTSD is available at www.acpmh.unimelb.edu.au/trauma/ptsd.html#screening
- To find practitioners who provide TFPT go to www.psychology.org.au/findapsychologist or www.racgp.org.au/scriptcontent/ranzcpcomplex.cfm?section=psychiatrist_referral_directory.

Conflict of interest: none declared.

Disclaimer

It should be noted that irrespective of any funding provided by the Department of Veterans' Affairs (DVA), the content of the article is not necessarily the view of, and is not endorsed by, the Minister for Veterans Affairs or DVA.

References

1. Australian Centre for Posttraumatic Mental Health. Australian guidelines for the treatment of adults with acute stress disorder and posttraumatic stress disorder: Melbourne, Victoria: ACPMH, 2007.
2. American Psychiatric Association. Diagnostic and statistical manual of mental disorders. 4th edn. Washington DC: American Psychiatric Association, 1994.
3. Creamer M, Burgess P, McFarlane AC. Post-traumatic stress disorder: findings from the Australian National Survey of Mental Health and Well-being. Psychol Med 2001;31:1237–47.
4. Foa EB, Rothbaum BO. Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. NY: Guilford Press, 1998.
5. American Psychiatric Association. Practice guideline for the treatment of patients with acute stress disorder and posttraumatic stress disorder. Arlington: VA: American Psychiatric Association, 2004.
6. Prins A, Ouimette P, Kimerling R, et al. The primary care PTSD screen (PC-PTSD): Development and operating characteristics. Primary Care Psychiatry 2004;9–14.

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