Mental health care in the perinatal period: Australian clinical practice guideline

2023 Update

Technical Report Part E:

Treatment and prevention of mental health problems arising from traumatic birth experience

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clinical evidence for the real world

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TABLES

Abbreviations

ACOG	American College of Obstetricians and Gynecologists
ASD	acute stress disorder
CALD	culturally and linguistically diverse
CASA	Centres Against Sexual Assault
CBT	cognitive behavioural therapy
CPT	cognitive processing therapy
EMDR	eye movement desensitisation and reprocessing
EWG	Expert Working Group
GAD	generalised anxiety disorder
GIN	Guidelines International Network
GRADE	Grading of Recommendations, Assessment, Development and Evaluation
IPV	intimate partner violence
MoH	Ministry of Health
NICE	National Institute for Health and Care Excellence
NA	not available
NR	not reported
NHMRC	National Health and Medical Research Council
OCD	obsessive-compulsive disorder
PE	prolonged exposure
PNDA	postnatal depression and/or anxiety
POP	pelvic organ prolapse
PPH	postpartum haemorrhage
PTSD	post-traumatic stress disorder
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCT	randomised controlled trial
RCOG	Royal College of Obstetricians and Gynecologists
SR	systematic review
SSRI	selective serotonin reuptake inhibitor
TCA	tricyclic antidepressants

E1 Introduction

The aim of this report is to describe the approach to developing recommendations on managing mental health problems after traumatic birth experience. A guideline reference group recommended this as a new topic for inclusion in the 2023 *Australian Perinatal Mental Health Clinical Practice Guideline*.

This report presents the findings of a review undertaken to identify and evaluate existing national and international clinical practice guidelines covering birth trauma or post-traumatic stress disorder (PTSD). This existing guidance was used to support the development of guidance on the management and prevention of mental health problems (including PTSD) following traumatic birth in the perinatal period for inclusion in the 2023 *Australian Perinatal Mental Health Clinical Practice Guideline*.

E2 Background

Birth trauma is defined as a wound, serious injury or damage relating to the birthing experience. Birth trauma can be physical trauma or psychological trauma, or a combination of both[1]. Both mother and/or the father or non-birthing partner can be affected by birth trauma[1]. In some, but not all cases, a parent may develop postnatal mental health problems from the traumatic events experienced during labour or childbirth. In some instances, traumatic birth can cause ongoing distress, and impact postnatal mental health and family relationships.

E2.1 Definitions of birth trauma (physical and psychological trauma)

Physical trauma (birth injuries) can present as: perineal tears, pelvic floor muscle damage, pelvic organ prolapse (POP), pelvic fractures (public bone, coccyx, sacrum) or caesarean wounds. Physical birth trauma may or may not be identified straight away.

Psychological trauma: some people can experience severe emotional distress after a traumatic birth even though there was no physical trauma, and this can continue long after the birth.

Psychological trauma can present as several mental health problems including postnatal depression and/or anxiety; clinically important post-traumatic stress symptoms that fail to meet the diagnostic threshold; PTSD or obsessive-compulsive disorder (OCD) (e.g., obsessive thoughts that can affect our behaviour such as checking on baby constantly or recurring thoughts that impact on enjoyment of daily life).

E2.2 Risk factors for developing PTSD following birth trauma

PTSD refers to a range of symptoms or reactions that can develop if a person has experienced or witnessed a traumatic event. For some people, childbirth can also fit into this category. Both men and women can experience PTSD after experiencing or watching a birth. PTSD following birth can happen to anyone, particularly those who have experienced:

- A previous traumatic or difficult birth
- Rape or sexual assault in the past – as birth can remind them of their previous experiences where they felt sexually violated, assaulted, or invaded
- Intimate partner violence, or other traumas

E2.3 Symptoms of PTSD following birth trauma

PTSD following birth trauma may present as one or more of the following:

- Re-living the birth/traumatic event through unwanted and recurring memories, including vivid images and/or nightmares. This may cause intense emotional or physical reactions, such as sweating, heart palpitations or panic when reminded of or discussing the birth or events.
- Being overly alert or wound up which can lead to sleeping difficulties, irritability and lack of concentration, becoming easily startled and constantly on the lookout for signs of danger.

[1] As defined by the Australasian Birth Trauma Association (https://www.birthtrauma.org.au/what-is-birth-trauma/)

- Avoiding reminders of the event - some parents might find themselves wanting to deliberately avoid activities, places, people, thoughts, or feelings associated with the birth or aftercare event because it brings back painful memories.
- Feeling emotionally numb – parents with PTSD following birth may lose interest in day-to-day activities, feel cut off and detached from friends and family, or feel emotionally flat and numb.

E2.4 Prevention of PTSD following birth trauma

In current practice the main preventative options for PTSD or clinically important symptoms of PTSD following a traumatic birth are trauma-focused cognitive behavioural therapy, or pharmacological interventions.

E2.5 Treatment of PTSD following birth trauma

In current practice the treatment of PTSD or clinically important symptoms of PTSD following a traumatic birth involves a range of approaches, including psychological treatments (such as trauma-focused cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing [EMDR]), or pharmacological treatments.

E2.5.1 Trauma-focused CBT

Trauma-focused CBT is an evidence-based treatment model to overcome the negative effects of a traumatic experience. Trauma-focused CBT interventions include:

- Cognitive processing therapy
- Cognitive therapy for PTSD
- Narrative exposure therapy
- Prolonged exposure therapy

CBT may be administered in person or online.

E2.5.2 Eye movement desensitisation and reprocessing (EMDR)

EMDR is a technique used specifically to treat PTSD by getting the person to recall distressing images while using an external stimulus, such as eye movement or tapping. This treatment works by helping to process distressing memories, reduce their lingering effects to allow the development of effective coping strategies.

E2.5.3 Pharmacological treatment options

Antidepressant medication, particularly selective serotonin reuptake inhibitors (SSRIs) can be used to treat PTSD. [1] The use of antidepressants, including SSRIs, during pregnancy and while breast-feeding is addressed in other topics within the perinatal mental health guideline. Where disabling symptoms or behaviours are present, antipsychotics are another treatment option that can be used in addition to psychological therapies to manage those diagnosed with PTSD.

E3 Methodology

E3.1 Clinical questions

Treatment of PTSD following traumatic birth can be treated with a range of approaches, whether the birth trauma was recent or occurred some time ago[2]. The Research Protocol for this review of existing guidelines on birth trauma or PTSD outlined two main research questions: one relating to prevention of birth trauma and one relating to treatment of birth trauma. The birth trauma may have been associated with the current or a previous pregnancy. The target populations are women who have experienced birth trauma or fathers/non-birthing partners who have experienced birth trauma (regardless of gender, relationship status or connectedness to the child)

Main prevention research question

Q7. What is the efficacy and safety of interventions[3] in the perinatal period for the prevention of mental health problems for parents who have experienced birth trauma (associated with the current or a previous pregnancy)?

Sub-questions:

Q7a. What is the efficacy and safety of interventions[4] for the prevention of mental health problems in the birthing parent or non-birthing partners who have experienced birth trauma associated with the current or a previous pregnancy?

Q7b. What is the acceptability to birthing parents, health professionals, and the general public about interventions used to prevent mental health problems related to birth trauma?

Q7c. What are the implications (for resourcing, workforce, and models of care) of implementing prevention interventions for parents who have experienced birth trauma? *[Implementation question]*

Main treatment intervention research question

Q8. What is the efficacy and safety of interventions[4] for the treatment of mental health problems in the perinatal period for parents who have experienced birth trauma?

Sub-questions:

Q8a. What is the efficacy and safety of interventions[4] for the treatment of mental health problems in the perinatal period for parents who have experienced birth trauma?

Q8b. What is the acceptability to parents, health professionals, and the general public about interventions used to treat mental health problems related to birth trauma?

Q8c. What are the implications (for resourcing, workforce, and models of care) of implementing treatment interventions for parents who have experienced birth trauma? *[Implementation question]*

[2] https://www.cope.org.au/preparing-for-birth/things-dont-go-plan/post-traumatic-stress-disorder-ptsd-2/

[3] Prevention interventions include but are not limited to psychosocial interventions, psychological interventions (e.g., trauma-focused CBT), pharmacological interventions (anti-depressant medication such as SSRIs).

[4] Treatment interventions include but not limited to psychosocial interventions, psychological interventions (e.g., counselling; trauma focused CBT; Eye movement desensitisation and reprocessing [EMDR]), pharmacological interventions (anti-depressant medication such as SSRIs), complementary interventions or physical interventions.

E3.2 Approach to developing guidance on the prevention and treatment of mental health problems following a traumatic birth

A review was undertaken to identify and evaluate national and international birth trauma or PTSD clinical practice guidelines to support the development of recommendations on the management and prevention of mental health problems (including PTSD) following birth trauma in the 2023 *Australian Perinatal Mental Health Clinical Practice Guideline*.

Where existing high-quality guidance was available, the Expert Working Group (EWG) assessed the suitability of the recommendations within existing guidelines being sensibly applied as recommendations in the updated guideline, with or without modification. This approach avoided duplicating existing syntheses of the research literature and avoided the need to critically appraise primary research that had already been assessed using reliable processes and tailored to the Australian setting. Australian guidelines took precedence because they were likely to be the most relevant to Australian clinical practice. If appropriate high-quality Australian birth trauma or PTSD guidelines were not identified as source guidelines, international birth trauma or PTSD guidelines were considered for inclusion.

The aim of the guideline assessment process was to identify the highest quality, most relevant guidelines on birth trauma or PTSD. There was a preference for Australian guidelines over international guidelines as they are more likely to be relevant to the Australian health care context.

E3.3 Search for existing birth trauma and PTSD guidelines

A variety of guideline-related electronic databases and websites were searched for potentially relevant national or international guidelines published and/or endorsed by reputable organisations since 1 January 2006, with the aim of covering all of the topics in scope (birth trauma and PTSD). The search was conducted between the 10-14 September 2021 using the search terms 'birth trauma', 'PTSD' and 'posttraumatic stress disorder', and was restricted to English-language clinical practice guidelines. The guideline databases searched included the National Health and Medical Research (NHMRC) Australian Clinical Practice Guidelines Portal (now decommissioned), the Trip database[5] and the Guidelines International Network (GIN) International Guidelines Library[6]. A Google search was also caried out to identify any birth trauma or PTSD guidelines developed by Australian medical colleges or State health departments. Further to electronic searches, EWG members were consulted to identify any other current clinical practice guidelines or appropriate sources to search for such guidelines, such as Australian peak health body websites.

After removing duplicate records between the birth trauma and PTSD guideline searches, unique records were assessed by the hereco team to determine eligibility (with assessment based on whether the recommendations contained within these guidelines could be sensibly applied to the clinical questions for birth trauma). Following this, the potential source guidelines or relevant documents were reviewed by the EWG to assess whether the recommendations contained within these guidelines could be sensibly applied to the clinical questions for birth trauma posed here (see E3.1).

The searches did not specifically aim to identify or limit retrieval of guidelines that addressed socioeconomic, Aboriginal or Torres Strait Islander populations. However, the reviewers were required to document any guidelines addressing these populations for specific consideration by the EWG. Implications for rural and remote areas, and the Aboriginal and Torres Strait population have been considered and documented in the summary of retrieved clinical guidance.

[5] https://www.tripdatabase.com/
[6] https://g-i-n.net/international-guidelines-library/

E3.4 Evidence to recommendations process

A structured evidence-to-decision framework was used to assist the EWG to develop new recommendations on the management of PTSD following traumatic birth for inclusion in the 2023 *Australian Perinatal Mental Health Clinical Practice Guideline*.

The EWG were provided with a summary of the potential source guideline recommendations, the level of evidence supporting the source recommendations (as reported in the guideline), the strength of the recommendation and the methods used to develop those recommendations. Elements of the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) approach were considered by the EWG when formulating recommendations, including benefits and harms, preferences and values, resources, equity, acceptability, and feasibility. Recommendations were discussed at a formal EWG meeting where the suitability of adopting the recommendations unchanged was considered or whether modifications were required. Completed evidence-to-decision tables are provided as an Appendix to the Guideline.

E4 Results

E4.1 Guideline search results

A total of **sixteen national** and **thirty-three international** clinical practice guidelines were identified with relevance to birth trauma or PTSD. In addition, **three position statements** produced by Australian medical colleges or State health departments with relevance to birth trauma or PTSD were identified.

Table 1 Australian and international birth trauma and PTSD guidelines

Search for	Australian	International
Birth trauma guidelines	2	5
Birth trauma statements or State health department practice guidelines	1	0
PTSD guidelines	14	28
PTSD statements or State health department practice guidelines	2	0
TOTAL	16 guidelines, 3 statements	33 guidelines

E4.2 Assessment of the retrieved guidelines

E4.2.1 Australian guidelines on birth trauma

E4.2.1.1 Summary of the retrieved Australian clinical practice guidelines relating to birth trauma

The search for Australian birth trauma guidelines retrieved two guidelines, and one State health department practice guideline (see Table App. 1 (included guidelines) and Table App. 2 (excluded guidelines). The *South Australian Perinatal Practice Guideline* was developed by the Government of South Australia (SA Health) in 2018 and provides the most relevant recommendations for managing birth trauma with Australian contextualisation. Although the content is relevant to the questions posed for this review, it is unclear what certainty of evidence the practice recommendations are based on, and an explicit methodology to grade the level of evidence or strength of recommendations was not reported.

The *Clinical practice guide on instrumental vaginal birth* published by Queensland Health in 2020 includes a recommendation on post-intervention psychological care (specifically to offer an opportunity to discuss the implications of future birth and considers that instrumental birth is associated with fear of subsequent birth and post-traumatic stress).

The *Stillbirth Care Guideline* published by Queensland Health in 2019 contains a generic post birth recommendation to '*Provide the woman and partner with appropriate debriefing, support, referral and follow-up to reduce the risk of postnatal depression, anxiety and post-traumatic stress disorder'* but contained no further relevant information so was excluded from further analysis.

E4.2.1.2 Summary of the included Australian birth trauma guidelines for EWG consideration

Of the retrieved Australian guidelines on birth trauma, there was possibly relevant content identified in one Australian guideline and one State health department practice guideline. A summary of the included Australian birth trauma guidelines (including their characteristics) is listed in Table App. 1. None of the identified guidelines were developed specifically for the management or prevention of mental health

problems following birth trauma, however specific recommendations, practice points and background information regarding birth trauma were identified in these documents. The SA Health Practice Guideline *Managing women in distress after a traumatic birth experience* was included for consideration by the EWG as the scope is similar to the scope for this review. The recommendations on post-intervention psychological care contained within the clinical practice guide on instrumental vaginal birth published by Queensland Health (2020) were also included for EWG consideration (i.e., to offer an opportunity to discuss the implications of future births). All relevant recommendations from these guidelines have been extracted and ordered by theme in section E6.

E4.2.2 International guidelines on birth trauma

E4.2.2.1 Summary of the retrieved international birth trauma guidelines

The search for international guidelines on birth trauma did not identify any guidelines specific to the management and prevention of mental health problems following birth trauma. However, five guidelines were identified that included recommendations, practice points and background information on birth trauma (see Table App. 1 (included guidelines) and Table App. 2 (excluded guidelines). These guidance documents included trauma-informed care information from the American College of Obstetricians and Gynecologists (2021) and the National Institute for Health and Clinical Excellence's *Antenatal and Postnatal Mental Health guideline* from 2014 (which contains information on considerations for women in the postnatal period following a traumatic birth, stillbirth and miscarriage). The *Guideline on operative vaginal delivery* from the Royal College of Obstetricians and Gynaecologists (2011) addresses psychological morbidity for the mother and the association of fear of subsequent childbirth and tocophobia with operative vaginal delivery. The Committee Opinion from the American College of Obstetricians and Gynecologists (2018) and the British Association for Psychopharmacology (2017) include statements on how the experience of childbirth and/or a traumatic birth can cause post-traumatic stress symptoms and/or disorder. The latter also states that a woman may experience a birth as traumatic even though she and her infant are healthy.

E4.2.2.2 Summary of the included international birth trauma guidelines for EWG consideration

A summary of the included international birth trauma guidelines (including their characteristics) is listed in Table App. 1. Of the international birth trauma guidelines, only the traumatic birth recommendations contained within the 2014 NICE Guideline *Antenatal and postnatal mental health: clinical management and service guidance* and the recommendations and conclusions regarding a trauma-informed approach to the health care visit contained within the American College of Obstetricians and Gynecologists Committee Opinion (2021) were considered useful. Relevant recommendations were extracted and ordered thematically in section E6 for EWG consideration (with all recommendations from these guidelines extracted into E6.6Appendix 3).

E4.2.3 Australian PTSD guidelines

E4.2.3.1 Summary of the retrieved Australian PTSD guidelines

The search for Australian clinical guidelines on PTSD identified 14 guidelines and two medical college or society position statements see Table App. 1 (included guidelines) and Table App. 2 (excluded guidelines). Of the identified guidelines, only the 2021 *Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder*, *Posttraumatic Stress Disorder and Complex PTSD* were developed specifically for the prevention and treatment of PTSD (developed by Phoenix Australia and the Centre of Posttraumatic Mental Health). They are a synthesis of the current research and best practice recommendations on mental health care for people who have developed, or are at risk of developing, symptoms of acute stress disorder (ASD)

or PTSD after a traumatic event. These Guidelines are NHMRC approved, developed using the GRADE approach and are a living guideline which means that the evidence and recommendations are regularly reviewed. The guideline includes a research recommendation as there is insufficient evidence to make a recommendation on trauma-focused counselling for adults within the first three months following exposure to a potentially traumatic event (e.g., traumatic birth). This guideline was also endorsed by the Royal Australian and New Zealand College of Psychiatrists (2021) in their position statement on PTSD.

The remaining guidelines provide background information on PTSD and additional background information on the psychological effects on subsequent pregnancies following stillbirth (Centre of Research and Excellence in Stillbirth [2021]) and psychological issues from previous perineal injury (Queensland Health [2020]). Two guidelines from the Royal Australian and New Zealand College of Psychiatrists (2016) and Mental Health First Aid Australia (2008) provide background information on psychosis management in Aboriginal and Torres Strait Islander populations and trauma and treatment options including traditional Ngungkari healing for Aboriginal and Torres Strait Islander, respectively. The former also includes background information on the higher prevalence of PTSD in culturally and linguistically diverse (CALD) populations and a statement on misdiagnosing PTSD as psychosis.

Of the search results for PTSD guidelines from medical colleges and State health departments, there was a position statement on mental health problems including PTSD in the perinatal period published by the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2018) and a PTSD practice guide produced by the Australian Psychological Society (2021) see Table App. 1 (included guidelines).

E4.2.3.2 Summary of the included Australian PTSD guidelines for EWG consideration

A summary of the included Australian PTSD guidelines including their characteristics are listed in Table App. 1. Relevant recommendations from the *Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex PTSD (2021)* and the Australian Psychological Society *PTSD practice guide* (2021) have been extracted for EWG consideration (and ordered thematically in Section E6, with all recommendations from these guidelines extracted into Table App. 4.

The background information on psychosis management and trauma and treatment recommendations in Aboriginal and Torres Strait Islander populations were extracted from the following two guidelines for EWG consideration: the Royal Australian and New Zealand College of Psychiatrists (2016) and Mental Health First Aid Australia (2008) guidelines.

E4.2.4 International guidelines on PTSD

E4.2.4.1 Summary of the retrieved International clinical practice guidelines relating to PTSD

The search for international clinical guidance on PTSD identified 28 international guidelines with reference to PTSD (Table App. 1 (included guidelines) and Table App. 2 [excluded guidelines]). Of these, 11 clinical practice guidelines included statements on PTSD in relation to pregnancy and childbirth experiences (including injuries). Two of these 11 had information relevant to birth trauma (the postnatal care guideline from the National Institute for Health and Clinical Excellence – Guidelines [2021] and *Optimizing Postpartum Care* Committee Opinion from the American College of Obstetricians and Gynecologists [2021]). Six of the identified guidelines were developed as guidelines for the prevention and management of PTSD. These guidelines included recommendations and practice points on the recognition of PTSD, principles of care, research recommendations, and the psychological and pharmacological interventions for the prevention and treatment of PTSD. The remaining guidelines provide background information on PTSD in relation to several topics including trauma-informed care, the relationship between PTSD and physical injury, and PTSD resulting from sexual assault. Guidance retrieved as part of the search for international birth trauma guidelines which was also retrieved in the international PTSD guideline search has been italicised in Table App. 1 and Table App. 2. Other relevant guidelines for EWG consideration include: *Clinical*

Practice Guidelines on Anxiety Disorders (Ministry of Health, Singapore) (2015) and the *Best Practice Guidelines for Mental Health Disorders in the Perinatal Period* (British Columbia Perinatal Health Program) (2014).

E4.2.4.2 Summary of the included International PTSD guidelines for EWG consideration

A summary of the included International PTSD guidelines including their characteristics are listed in Table App. 1 (included guidelines). Relevant recommendations have been extracted for EWG consideration (and ordered thematically in Section E6, with all recommendations from these guidelines extracted into Table App. 4.

E5 Final included guidelines

E5.1 Final included Australian and International birth trauma and PTSD guidelines

Of the total eight Australian and international guidelines or Australian State health department statements covering birth trauma, four have been included (see Table App. 1). Relevant recommendations have been extracted from these four documents (see Section E6 for a summary of the recommendations by theme, or the full list of recommendations in Table App. 3).

Of the total 44 Australian and international PTSD guidelines or Australian State health department statements covering PTSD, nine have been included and relevant recommendations extracted (see Table App. 1 for included guidelines/statements). See Section E6 for a summary of the recommendations by theme, or the full list of recommendations in Table App. 4)

E5.2 Methodological approaches reported in the included guidelines

The methodological approaches used in the development of the included birth trauma and PTSD guidelines are reported in Table App. 1 and Table App. 2. Most of the included guidelines did not report their development methods (which makes these guidelines of poor methodological quality). Exceptions to this are the *Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder*, *Posttraumatic Stress Disorder and Complex PTSD* (produced by the Centre for Posttraumatic Mental Health in 2021) which used the GRADE approach to assess the evidence base and link the evidence to the strength of the recommendations. Additionally, the *Clinical guidelines on antenatal and postnatal mental health* produced by the National Institute for Health and Clinical Excellence in 2014 used NICE guideline development methods which are considered of high methodological rigour.

These two guidelines were of good quality due to their use of systematic review methodology to identify the evidence and their explicit grading of the level of evidence and/or the strength of their recommendations. All other included guidelines were of poor quality due to the lack of information on the methodology used to identify the evidence base, or because they explicitly stated that they performed a selective review of the evidence.

The Royal Australian and New Zealand College of Psychiatrists guidance on addressing all aspects of care of people with schizophrenia used NHMRC levels of evidence to grade the retrieved literature but there was no explicit link between the evidence and recommendations. Most of the other guidelines that used an explicit method to grade the level of evidence or strength of recommendations used their own in-house methods (e.g., American College of Obstetricians and Gynecologists (ACOG), Royal College of Obstetricians and Gynecologists (RCOG), Ministry of Health Singapore (MoH Singapore)).

E5.3 Topics and sub-topics covered by the included guidelines

Examination of the recommendations in the included guidelines identified the following major topics: managing distress after traumatic birth experience; treatment of PTSD; considerations for subsequent pregnancy following a traumatic birth experience; background information on the trauma-informed approach to the health care visit; risk factors for the development of PTSD; adjustment disorder; and pharmacological treatments for PTSD. The coverage of the major topics by the included guidelines varied.

Some had a broad scope across most of the topics, while others were limited to a single specific topic or sub-topic.

E6 Extracted guidance

E6.1 Definitions of PTSD, acute stress disorder, adjustment disorder and birth trauma from the included guidelines

Several definitions of PTSD, acute stress disorder, adjustment disorder and birth trauma were reported across the included guidelines. These have been extracted into **Table 2** for EWG consideration. The definitions were not explicitly linked to evidence.

Table 2 Definitions of birth trauma, PTSD, acute stress disorder, adjustment disorder (from the included guidelines)

CPG, date (Country/region)	Definition/s
NICE 2014 (UK)	**NICE definition of birth trauma** (taken from *Antenatal and postnatal mental health: clinical management and service guidance*) • This includes births, whether preterm or full term, which are physically traumatic (for example, instrumental or assisted deliveries or emergency caesarean sections, severe perineal tears, postpartum haemorrhage) and births that are experienced as traumatic, even when the delivery is obstetrically straightforward. **NICE's General statement on PTSD** (taken from *Antenatal and postnatal mental health: clinical management and service guidance*) • During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can co-exist with depression. Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth.
SA Health 2018 (AU)	**SA Health definition of PTSD** (taken from *Managing distress after traumatic birth experience*) • Post-Traumatic Stress Disorder is a form of anxiety disorder. It can develop after vicarious exposure to, or the experience of a traumatic event
Mental Health First Aid Australia 2008 (AU)	**Mental Health First Aid Australia definition of Trauma in Aboriginal and Torres Strait Islander People** (taken from the *Guideline for Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander person*) • Trauma is a reaction to an extremely distressing event. Trauma can occur when someone experiences, witnesses, or hears unexpectedly about, a situation involving actual or threatened death or serious injury. • An event that is traumatic for one person may not be traumatic for another.
Australian Psychological Society 2021 (AU)	**Australian Psychological Society definition of acute stress disorder** (taken from the *PTSD Practice guideline*) • While acute stress disorder and PTSD share the same physiological and stress symptoms, acute stress disorder is differentiated from PTSD by its limited duration, with symptoms present for more than three days, but less than one month. Where symptoms persist beyond a month, a diagnosis of PTSD should be considered **Australian Psychological Society definition of adjustment disorders** (taken from the *PTSD Practice guideline*) • The essential feature of an adjustment disorder is marked distress in response to a stressor, which is considered out of proportion to that expected for the severity or intensity of the stressor. • Unlike PTSD, the stressor can be of any severity or type. Where the stressor is considered potentially traumatic, a diagnosis of an adjustment disorder is made where the other criteria of PTSD (such as intrusive thoughts or images, avoidance or numbing and alterations in cognitions and mood) are not present.

CPG, date (Country/region)	Definition/s
British Columbia Perinatal Health Program 2014 (Canada)	**British Columbia Perinatal Health Program definition of PTSD** (taken from *Best Practice Guidelines for Mental Health Disorders in the Perinatal Period*) • PTSD occurs when a person has persistent symptoms after a traumatic event (e.g., physical, sexual and/or psychological abuse, natural disaster, accident). A history of unresolved trauma may increase the risk of PTSD in the perinatal period. • PTSD symptoms cause clinically significant distress and/or impairment in social, occupational or other important areas of functioning.
National Institute for Health and Clinical Excellence – Clinical Guidelines 2014 (UK)	**NICE's General statement on PTSD** (taken from *Antenatal and postnatal mental health: clinical management and service guidance*) • During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can co-exist with depression. Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth.

Abbreviations: NICE, National Institute for Health and Clinical Excellence; MoH, Ministry of Health

E6.2 Symptoms of psychological distress/PTSD reported in the included guidelines

Symptoms of psychological distress/PTSD were reported in some of the included guidelines. These were extracted into Table 3 below for EWG consideration. Some of the symptoms reported below were linked to evidence (denoted with a *).

Table 3 Symptoms of psychological distress/PTSD (from the included guidelines)

CPG, date (Country/region)	Symptoms
SA Health 2018 (AU)	**SA Health description of symptoms of psychological distress following childbirth** (taken from *Managing distress after traumatic birth experience*) • appearing dazed • reduced conscious state • agitated or overactive • withdrawn • autonomic anxiety symptoms – increased heart rate, palpitations, sweating, jelly legs, "butterflies in stomach" and dry mouth • some amnesia-blocked memories • disoriented • depressed These symptoms can be a precursor to the more severe Post-Traumatic Stress Disorder (PTSD)*

CPG, date (Country/region)	Symptoms
	SA Health description of symptoms of PTSD following childbirth (taken from *Managing distress after traumatic birth experience*) • flashbacks, depersonalization, hypervigilance* • nightmares* • emotionally numbed* • intrusive memories, depression • anxiety • bonding difficulties • fear of sexual intimacy • avoidance of normal vaginal birth or future pregnancy* • increased psychological arousal • avoidant of baby*
ACOG 2021 (US)	**Signs and Symptoms of Trauma** (taken from Committee Opinion: *Caring for Patients Who Have Experienced Trauma)* • agitation • irritability, emotional swings • anxiety, depression, fear • outbursts of anger • easily startled by noise or touch • sudden sweating and/or heart palpitations • flashbacks—re-experiencing the trauma • difficulty concentrating • difficulty trusting • self-blame, guilt or shame • feeling disconnected or numb
British Columbia Perinatal Health Program 2014 (Canada)	**British Columbia Perinatal Health Program information on symptoms of PTSD** (taken from *Best Practice Guidelines for Mental Health Disorders in the Perinatal Period*) • PTSD symptoms cause clinically significant distress and/or impairment in social, occupational or other important areas of functioning. • Symptoms include persistent "reliving" of the traumatic event (e.g. flashbacks or nightmares); avoidance of feelings, people or places associated with the event (e.g., emotional "numbing", feeling detached, showing less emotions); and hyper arousal or a high general level of anxiety (e.g., insomnia, difficulty concentrating, startling easily, feeling irritable and/or having outbursts of anger).

Abbreviations: ACOG, American College of Obstetricians and Gynaecologists; NICE, National Institute for Health and Clinical Excellence; MoH, Ministry of Health

E6.3 Risk factors reported in the included guidelines

Risk factors for developing PTSD were reported in the Australian Psychological Society *PTSD practice guideline* and the SA Health guideline *Managing distress after traumatic birth experience*. These were extracted into Table 4 below for EWG consideration. Some of the risk factors reported below were in some cases linked to evidence (denoted with a *).

Table 4 Risk factors for the development of PTSD (from the included guidelines)

CPG, date (Country/region)	Risk factors
Australian Psychological Society 2021 (AU)	**Risk factors for the development of PTSD** (taken from the *PTSD Practice guideline*) Several key risk factors for the development of PTSD have been identified in the clinical and research literature. The type of trauma experienced is one of the most important risk factors, with higher rates of PTSD found in victims of rape or sexual molestation, survivors of military combat and terrorist acts, while comparatively low prevalence rates have been observed in survivors of road traffic accidents and natural disasters. A meta-analysis that reviewed risk factors for the development of PTSD, identified the most significant risk factors as: • trauma severity • lack of social support and • Various demographic variables had slightly smaller effect sizes, including: o social/educational/intellectual disadvantage o personal or familial psychiatric history o abuse or childhood adversity and o race or minority status*. Marital status was found to be associated with an increased risk of developing PTSD following a traumatic event*. At greater risk are those who have: o never been married and o been previously, but not currently, married*.
SA Health 2018 (AU)	**SA Health Risk factors for experiencing birth as traumatic** (taken from *Managing distress after traumatic birth experience*) Summary of practice recommendations: • A history of previous trauma predisposes women to experience birth as traumatic. A history of previous trauma predisposes women to experience further trauma or distress during the perinatal period. Previous trauma may include domestic violence, childhood sexual abuse, rape, and migrant trauma.* For further information refer to Sexual Abuse in Childhood perinatal practice guideline available at www.sahealth.sa.gov.au/perinatal. Women who have experienced childhood sexual abuse are 12 times more likely to experience childbirth as traumatic*

CPG, date (Country/region)	Risk factors

	• Other predisposing factors to trauma include:
	  ○ lack of social support
	  ○ poor coping strategies
	  ○ feelings of powerlessness
	  ○ extreme pain
	  ○ unexpected outcomes of labour and birth including ill or stillborn infant
	  ○ perception of hostile or uncaring staff
	  ○ loss of control
	  ○ medical interventions
	  ○ lack of information
	  ○ past traumatic birth*

British Columbia Perinatal Health Program 2014 (Canada)	**British Columbia Perinatal Health Program risk factors for PTSD** (taken from *Best Practice Guidelines for Mental Health Disorders in the Perinatal Period*) • A history of unresolved trauma may increase the risk of PTSD in the perinatal period.

E6.4 Prevention recommendations reported in the included guidelines

There were some recommendations regarding prevention of PTSD reported in the SA Health guideline *Managing distress after traumatic birth experience and the* 2020 Queensland Health *Clinical Guidelines Instrumental vaginal birth.* These were extracted into Table 5 below for EWG consideration. Some of the preventative measures reported below were in some cases linked to evidence (denoted with a *). All the recommendations were consensus-based.

Table 5 Prevention of PTSD (from the included guidelines)

CPG, date (Country/region)	Prevention recommendation
SA Health 2018 (AU)	**SA Health preventative measures in current pregnancy** (taken from *Managing distress after traumatic birth experience*) Informed decision-making by the woman in labour reduces the likelihood of the woman perceiving birth as traumatic.
	SA Health preventative measures in current pregnancy (taken from *Managing distress after traumatic birth experience*) • maximise the woman's control in labour • Provide adequate information • Inform woman of all procedures • Involve the woman in the decision making

CPG, date (Country/region)	Prevention recommendation
	SA Health preventative measures in subsequent pregnancy (Antepartum) (taken from *Managing distress after traumatic birth experience*) • Thorough history taking • Carefully discuss and document mode of birth / pain relief / maternal requests for next birth • Watch for avoidant behaviour • Aim for continuity model of care and carer • Consider consultant review • Gain knowledge from routine screening about psychiatric history including depression, anxiety, trauma or previous / current PTSD • Throughout antenatal care, previous labour and birth may need to be revisited • Refer for counselling as needed
	SA Health preventative measures in subsequent pregnancy (Intrapartum) (taken from *Managing distress after traumatic birth experience*) • Maximise the woman's control in labour by o Providing adequate information o Involve in decision making o Provide adequate information of all procedures and gain the woman's permission (verbal consent) before proceeding o Stop procedure if woman requests this o Pain control as a preventative strategy • Being alert to what situations may lead to trauma • Encourage the woman to articulate her experiences
	SA Health preventative measures in subsequent pregnancy (Postpartum) (taken from *Managing distress after traumatic birth experience*) • **Care the same as for postpartum care of current birth, plus …** o Discuss events of this birth and ensure psychological wellbeing is maintained o Refer for counselling as needed **A positive birth experience following a traumatic one can have a therapeutic effect.***
Queensland Health 2020 (AU)	**Queensland Health psychological care recommendations** (taken from *Clinical Guidelines Instrumental vaginal birth*) **Psychological care recommendation following post-intervention for instrumental vaginal birth** Offer an opportunity to discuss the indications for the instrumental birth, the management of any complications and implications for future births • Instrumental birth is associated with fear of subsequent birth and post-traumatic stress
	Ask about psychological wellbeing in the postnatal period and offer referral if indicated

E6.5 Treatment recommendations reported in the included guidelines

There were treatment recommendations reported in the included guidelines and these were extracted into Table 6 below for EWG consideration. The quality of the source guidelines, including the level of evidence and grade of recommendations were also extracted.

Table 6 Treatment recommendations and practice points from the included guidelines

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
	General recommendations				
SA Health 2018 AU (NR)	**Summary of Practice Recommendations** *(taken from Managing women in distress after a traumatic birth experience)*				
	1. Birth trauma can intensify into Post Traumatic Stress Disorder (PTSD) unless identified and treated early.	NR	NR	NR	NR
	2. A history of previous trauma predisposes women to experience birth as traumatic.	NR	NR	NR	NR
	3. Informed decision-making by the woman in labour reduces the likelihood of the woman perceiving birth as traumatic.	NR	NR	NR	NR
	Healthcare professional's role: Postpartum care of current birth *(taken from Managing women in distress after a traumatic birth experience)*				

	• Encourage discussion of birth experience
	  ○ Accoucher or appropriately experienced health professional should explain and discuss the events of the labour and birth. This should be done in terms that the woman can understand.
	  ○ Encourage articulation of the birth experience by the woman as she requires
	  ○ A clear summary of the discussion and explanations given to the woman should be documented in the case notes.
		NR	NR	NR	NR

	Healthcare professional's role: Ongoing postpartum care *(taken from Managing women in distress after a traumatic birth experience)*				

	• Empathetic care
	• Early recognition of signs and symptoms of distress
	  ○ Anger
	  ○ Persistent vague pain
	  ○ Failure to interact with baby
	• Refer to appropriate specialised care – perinatal mental health team or social work and counselling services
	• Rule out postnatal depression
		NR	NR	NR	NR

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
	• Consider postnatal review appointment at 4-6 weeks to provide time for any further clarification of the birth experience				
NICE 2014 UK (April 2014)	**Traumatic birth recommendations** (taken from *Antenatal and postnatal mental health: clinical management and service guidance*)				
	1.9.4 Offer advice and support to women who have had a traumatic birth or miscarriage and wish to talk about their experience. Take into account the effect of the birth or miscarriage on the partner and encourage them to accept support from family and friends.	NICE methods	NICE methods	NICE methods	NR
	1.9.6 Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth.	NICE methods	NICE methods	NICE methods	NR
ACOG 2021 US (NR)	**Psychological care recommendation following post-intervention for instrumental vaginal birth** (taken from Committee Opinion: *Caring for Patients Who Have Experienced Trauma*)				
	Obstetrician-gynecologists should build a trauma-informed workforce by training clinicians and staff on how to be trauma-informed.	NR	NR	NR	ACOG Committee Opinion
	Feelings of physical and psychological safety are paramount to effective care relationships with trauma survivors, and obstetrician-gynecologists should create a safe physical and emotional environment for patients and staff.	NR	NR	NR	ACOG Committee Opinion
	Obstetrician-gynecologists should implement universal screening for current trauma and a history of trauma.	NR	NR	NR	ACOG Committee Opinion
	In the medical education system, the benefit of trainee experience must be balanced with the potential negative effect on and re-traumatization of patients through multiple interviews and examinations.	NR	NR	NR	ACOG Committee Opinion
Royal College of Obstetricians and Gynecologists 2020 UK	**How can psychological morbidity be reduced for the woman?** (Taken from RCOG Green-top Guideline: *Assisted Vaginal Birth)*				
	Offer women with persistent post-traumatic stress disorder (PTSD) symptoms at 1 month referral to skilled professionals as per the NICE guidance on PTSD. [New 2020] **Rationale:** Factors that influence the ongoing psychological wellbeing of a woman after assisted vaginal birth are complex. A large prospective study from the Norwegian Mother and Child Cohort study reported that mode of birth was not significantly associated with a change in emotional distress (as measured by the eight-item dichotomised version of the Symptoms Check List) from 30 weeks of gestation to 6 months postpartum or with the presence of emotional distress at 6 months. The biggest predictor of emotional distress postnatally was antenatal emotional distress.(ref 143 in guideline)	RCOG Green-top methods	RCOG methods	RCOG methods	Evidence level 2+/RCOG (Grade D)
	Offer advice and support to women who have had a traumatic birth and wish to talk about their experience. The effect on the birth partner should also be considered.	RCOG Green-top methods	RCOG methods	RCOG methods	Good practice point

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
	Do not offer single session, high-intensity psychological interventions with an explicit focus on 'reliving' the trauma.	RCOG Green-top methods	RCOG methods	RCOG methods	Good practice point
	EMDR				
NICE 2014 UK (SR April 2014)	**1.9.5** Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a high-intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) in line with the NICE guideline on post-traumatic stress disorder.	NICE methods	NICE methods	NICE methods	NR
Centre for Posttraumatic Mental Health 2021 AU (June 2019)	**Early psychosocial treatment interventions for adults** (taken from *Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder*)				
	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. **Remark:** Brief EMDR can range from one to three sessions and involves clients focusing on fragments of their trauma memory whilst simultaneously engaging in dual attention stimulation using eye movements. **Benefits and Harms** Evidence from 6 small RCTs suggests large clinically important benefit of 1-3 sessions of brief EMDR on PTSD symptom severity relative to waitlist in adults who have experienced a community critical incident e.g., workplace violence, earthquake, factory explosion, missile attack, intense rocket attacks or traumatic childbirth.	GRADE	GRADE	GRADE	Low/ Conditional
	EMDR (single session) For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on delivering a single session of EMDR.	GRADE	GRADE	GRADE	Research recommendation
	Internet-based guided self-help vs EMDR 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.	GRADE	GRADE	GRADE	Research recommendation
Ministry of Health Singapore (2015) Singapore (NR)	Eye Movement Desensitisation and Reprocessing therapy may be used as second-line treatment for post-traumatic stress disorder.	NR	MoH Singapore methods	MoH Singapore methods	Grade B, Level 2++
	Pharmacological interventions				
Ministry of Health Singapore 2015 Singapore (NR)	**Pharmacological treatments for PTSD** (taken from *Clinical Practice Guidelines, Anxiety Disorders*)				
	1. Either SSRIs or venlafaxine may be used as a first-line pharmacological treatment for PTSD.	NR	MoH Sing	MoH Sing	Grade A, Level 1++
	2. Mirtazapine may be considered as a second-line treatment for PTSD.	NR	MoH Sing	MoH Sing	Grade B, Level 1+

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
	3. Either amitriptyline or imipramine may be considered for post-traumatic stress disorder if the first-line and second-line treatments are ineffective or poorly tolerated.	NR	MoH Sing	MoH Sing	Grade A, Level 1+
	4. Benzodiazepines should not be used for the treatment of PTSD.	NR	MoH Sing	MoH Sing	Grade A, Level 1+
	5. Risperidone, olanzapine, quetiapine, and lamotrigine may be prescribed as adjunctive treatments for PTSD in conjunction with the SSRIs	NR	MoH Sing	MoH Sing	Grade B, Level 1+
	6. Pharmacological treatment for PTSD should be continued for at least 12 months.	NR	MoH Sing	MoH Sing	Grade D, Level 4
	Cognitive behavioural interventions/trauma focused counselling				
SA Health 2018 AU (NR)	**Summary of Practice Recommendations** (taken from *Managing distress after traumatic birth experience)*				
	4. Postnatal debriefing provides women with the opportunity to make sense of their birth experience and strengthens them psychologically.	NR	NR	NR	NR
	5. Early recognition of signs and symptoms of distress, with referral to appropriate care services is essential.	NR	NR	NR	NR
	6. A positive birth experience following a traumatic one can have a therapeutic effect.	NR	NR	NR	NR
	Treatment: Debriefing				
	• Listening empathetically • Identify and report any problems with the service • Provide feedback to staff involved	NR	NR	NR	NR
Centre for Posttraumatic Mental Health 2021 AU (June 2019)	**Trauma-focused counselling** (taken from *Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder*)				
	For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on trauma-focused counselling. **Remark:** Brief trauma-focused counselling comprised of a single session of individual counselling within 48 hours of experiencing a PTE (e.g., traumatic birth or myocardial infarction), covering techniques for managing anxiety, social skills and problem solving, relaxation, cognitive coping.	GRADE	GRADE	GRADE	NR
ACOG 2021 US (NR)	**Four C's: Skills in Trauma-informed care**				
	Calm: Pay attention to how you are feeling while caring for the patient. Breathe and calm yourself to help model and promote calmness for the patient and care for yourself.	NR	NR	NR	NR

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
	Contain: Ask the level of detail of trauma history that will allow patient to maintain emotional and physical safety, respect the time frame of your interaction, and will allow you to offer patients further treatment. **Care:** Remember to emphasize, for patient and yourself, good self-care and compassion. **Cope**: Remember to emphasize, for patient and yourself, coping skills to build upon strength, resilience, and hope.				
	Psychological care recommendation following post-intervention for instrumental vaginal birth				
	It is important for obstetrician-gynecologists and other health care practitioners to recognize the prevalence and effect of trauma on patients and the health care team and incorporate trauma-informed approaches to delivery of care.	NR	ACOG Committee Opinion	ACOG Committee Opinion	NR
	Obstetrician-gynecologists should become familiar with the trauma-informed model of care and strive to universally implement a trauma-informed approach across all levels of their practice with close attention to avoiding stigmatization and prioritizing resilience.	NR	ACOG Committee Opinion	ACOG Committee Opinion	NR
Australian Psychological Society (2021) AU (NR)	**Addressing multiple traumas**				
	Other evidence-based treatment considerations for psychologists include the following: • group CBT should not be considered an alternative to individual CBT treatment • self-help programs should not be used where psychologist-directed interventions are viable • pharmacological therapy should not be used in place of psychological treatment, but might be used as an adjunct to this treatment • interventions to improve social, familial and occupational functioning should be delivered alongside trauma-focused interventions to prevent or reduce disability.	NR	NR	NR	NR
	Population Interventions				
	• In the early aftermath of trauma, structured interventions, such as psychological debriefing, with a focus on recounting the traumatic event and ventilation of feelings, should not be offered on a routine basis. Instead, individuals should be provided with practical and emotional support and encouraged to use their existing personal resources and social supports. However, some individuals may want to discuss their experiences shortly after the trauma and, in these cases, they should be supported in doing so. • Immediate psychological support should be offered to adults who exhibit extremely high levels of distress or are at risk of harming themselves or others.	NR	NR	NR	NR
Ministry of Health Singapore 2015 Singapore (NR)	**Psychotherapies**				
	1. Cognitive behaviour therapy should be used as the first-line psychological treatment for post-traumatic stress disorder.	NR	MoH Singapore methods	MoH Singapore methods	Grade A, Level 1

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
	2. Eye Movement Desensitisation and Reprocessing therapy may be used as second-line treatment for post-traumatic stress disorder.	NR	MoH Singapore methods	MoH Singapore methods	Grade B, Level 2++
	Combined therapy				
Ministry of Health Singapore 2015 Singapore (NR)	If cognitive behaviour therapy or eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder are contraindicated or have failed, combination therapy (i.e. cognitive behaviour therapy plus pharmacotherapy) may be used as an alternative treatment.	NR	MoH Singapore methods	MoH Singapore methods	Grade B, Level 1+

Abbreviations: ACOG, American College of Obstetricians and Gynaecologists; NICE, National Institute for Health and Clinical Excellence; MoH, Ministry of Health

E6.6 Specific recommendations for Aboriginal and Torres Strait Islander people or those from Culturally and Linguistically Diverse Backgrounds

Table 7 Specific recommendations for Aboriginal and Torres Strait Islander people or those from culturally and linguistically diverse backgrounds from the included guidelines

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
RANZCP 2016 AU (NR)	Refugees and migrants have higher rates of substance abuse and post-traumatic stress disorder than the general population, so assessment and treatment of these comorbidities is often needed.	NR	NHMRC LoE	NR	NR
	181. Clinicians should take a history of trauma into consideration when organising care, such as choosing the gender of the therapist, and when facing challenges in establishing a trusting therapeutic alliance.	NR	NHMRC LoE	NR	Consensus-based recommendation
	182. Clinicians should be mindful that exposure to trauma is associated with an increased likelihood of symptoms of depression and anxiety.	NR	NHMRC LoE	NR	Consensus-based recommendation
Mental Health First Aid Australia 2008 AU (NR)	**Trauma in Aboriginal and Torres Strait Islander People**				
	In the days and weeks after a traumatic event or loss				
	You can help the person by simply being there for them; be available, attentive, and let them know that you care. Allow the person to make their own decisions, without nagging, judging or blaming them for their feelings or behaviours.	NR	Expert opinion	Expert opinion	NR
	The person's reaction				
	Each person will differ in how they react to a trauma or loss. Be aware that the person might not be as distressed about the trauma or loss as could be expected. Try to be tolerant of any strong emotion expressed by the person, except if they become threatening, abusive or violent. Behaviours such as withdrawal, irritability and bad temper may be a response to the trauma or loss, so try not to take them personally. Respect the person's need to be alone at times. Encourage the person to let others know when they need or want something, rather than just assume that others will know what they want. Also suggest the person doesn't let small day-to-day hassles build up and add to their stress.	NR	Expert opinion	Expert opinion	NR
	Try to avoid saying things that minimise the person's feelings, such as "don't cry", "calm down" or "get over it". Also avoid statements that may minimise the person's experience, such as "you should just be glad you're alive" and the use of clichés like "life goes on" or "you must be strong now". Be patient with the person, and don't expect that they will be 'over it' in a few weeks. If the person is experiencing changes in their mood or loss of energy, reassure them that it is common after trauma or loss to have good and bad days. Do not say to the person "I know how you feel" or try to tell them how they should be feeling	NR	Expert opinion	Expert opinion	NR
	How do I know if professional help is needed?				

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
	You should suggest the person seek professional help straight away if they: • become suicidal • are overwhelmed by intense or distressing feelings • feel their important relationships are suffering as a result of the trauma or loss • abuse alcohol or other drugs to deal with the trauma or loss • feel jumpy or have nightmares relating to the trauma or loss • are unable to enjoy life at all as a result of the trauma or loss • feel like no-one understands them • start picking arguments with friends or getting into fights You should suggest the person seek professional help, if for two weeks or more, they: • feel very upset or fearful • can't get on with their usual activities • can't stop thinking about the trauma or loss After 4 weeks, if the person is acting very differently compared to before the trauma or loss, it is best that they seek professional help	NR	Expert opinion	Expert opinion	NR
	Professional help: What kind of professional help?				
	Be aware of the different types of professionals who can help the person. These may include psychologists, healing circles or cultural healing groups, bereavement support groups, doctors or religious leaders. Know the range of specialist services that can provide help and assistance for specific types of trauma or loss. For instance, Centres Against Sexual Assault (CASA), Link-Up or Bringing Them Home counsellors who specialise in Stolen Generations issues, and counselling services for victims of crime.	NR	Expert opinion	Expert opinion	NR
	Suggest that the person see a professional who is trained or has experience in working with Aboriginal people and their experiences of trauma and loss. It is important to note that counselling suitable for Aboriginal people may be quite difficult to find or gain access to, as there is a shortage of appropriately trained Aboriginal psychologists and counsellors. If this is the case, you can engage other options. For instance, you could suggest the person find a service that specialises in assisting with the type of trauma or loss the person has experienced. Most importantly however, encourage the person to find someone who will help them tell their story and who the person can trust and feel comfortable talking to.	NR	Expert opinion	Expert opinion	NR
	What if the person doesn't want professional help?				
	Sometimes people will not want professional help, even if they need it. If this is the case, you should reassure the person that they may benefit from professional help. Tell them that reaching out for help is not a sign of weakness and that there is no need to feel shame about having a yarn with a doctor or health worker to help them through their healing. Reassure the person that a lot of people need help after experiencing a trauma or loss, and that seeking professional help is normal.	NR	Expert opinion	Expert opinion	NR

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
	Be aware that where there has been ongoing trauma of any kind, the sooner professional help is sought, the better. If the person has been experiencing ongoing trauma, such as family violence, or if the person experienced trauma a very long time ago, such as child abuse, reassure them that it is never too late to benefit from professional help.	NR	Expert opinion	Expert opinion	NR
	What else can I do? Encourage other supports				
	Be aware that the person may find particular times stressful. Some occasions that might be difficult, particularly if the person has lost a loved one, are anniversaries, celebrations such as Christmas or birthdays, or hearing about situations that remind them of the trauma or loss. It is a good idea to help the person develop a list of people, services or places that they can contact when the going gets tough. Also be aware that it is possible that the person may feel guilty or worried about being happy. If this is the case, reassure them that it is okay for them to enjoy themselves and the company of others.	NR	Expert opinion	Expert opinion	NR
	Treatment options including traditional Ngungkari healing examples				
	When assisting someone who has experienced trauma or loss, it is important not to misinterpret the person's behaviours or experiences as symptoms of mental illness. Be aware of what constitutes culturally appropriate behaviour after trauma or loss. For instance, it is not unusual for Aboriginal people to see, hear or talk to spirits of deceased loved ones. If the person you are assisting believes they have been visited by the spirit of a loved one, reassure them that this is a common experience for many Aboriginal people and encourage them not to feel frightened or to feel shame. If the person remains afraid of a spirit, encourage them to seek appropriate help, for example by seeing an Aboriginal health worker, Ngungkari/Traditional Healer, Elder, family member or someone strong within the person's community who can help them with the issue	NR	Expert opinion	Expert opinion	NR
	Expressing feelings				
	Do not discourage the person from expressing their feelings of trauma or loss. Instead, encourage the person to allow themselves to feel sadness and grief over what has happened and to express their feelings when they feel they need to. You could tell the person that you are okay with them expressing their feelings in front of you, even though it may be hard to see them upset.	NR	Expert opinion	Expert opinion	NR
	Suggest the person try to find a way to express their feelings that is meaningful to them, such as physical activity, music, writing or journaling, art, praying or meditating, story telling, cultural activities or ceremonies. Make sure you encourage ways that do not cause harm to the person or harm to others.	NR	Expert opinion	Expert opinion	NR
	Provide the person with information and resources about dealing with trauma or loss. Help the person identify other sources of support, such as loved ones and friends. Encourage the person to fulfil their cultural practices for dealing with trauma or loss, for example, by going home to country and participating in sorry business.	NR	Expert opinion	Expert opinion	NR
	Talking about the trauma or loss				

CPG ID Country/region (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec. assigned by the developer
	It is important that you acknowledge the person's trauma or loss and what it means to them. Reassure the person that everyone has their own pace for dealing with trauma or loss, and that they can come and talk to you another time if they don't want to do it now. If the person does not want to talk to you at all, encourage them to consider calling a crisis line, going to a crisis center or using other community resources. You should never force the person to tell their story or probe for more details, and avoid repeatedly asking about the event. Also be aware that it is not unusual for men to not want to express their feelings verbally or to avoid having to talk it out.	NR	Expert opinion	Expert opinion	NR
	If the person wants to tell their story, give them lots of time and listen to them in a non-judgmental and accepting way. Do not interrupt the person, allow for moments of silence and reflection. If you feel that you cannot listen to the details of the trauma, let the person know, while offering your support and understanding. If you do not know what to say in response to the person, let them know that this is the case. Once the person has told their story, you should respect their right to confidentiality by not telling others what they said without their permission.	NR	Expert opinion	Expert opinion	NR
	If the trauma involved the recent death of a loved one, and the person thinks that they might have seen their loved one, or talks about them as if they are still alive, the first aider should reassure the person that this is normal.	NR	Expert opinion	Expert opinion	NR
	Encourage positive coping strategies				
	To help the person recover, it is important that you encourage the person to take care of themselves by getting some exercise, having plenty of rest when they are tired and eating well and regularly. Encourage the person to be patient with themselves and to either take time out from normal activities or maintain their routine, depending on what feels best to them.	NR	Expert opinion	Expert opinion	NR
	Help the person to find some effective coping strategies. For instance, you could suggest that the person think about and use strategies which have helped in the past.	NR	Expert opinion	Expert opinion	NR
	You could help the person find some ways to relax, such as practicing slow deep breathing, or finding somewhere they can spend time feeling safe and comfortable. Above all, encourage the person to do the things that feel good to them, even if it is as simple as taking a walk, going fishing or watching television. In addition, you should discourage the person from using negative coping strategies such as working too hard, using alcohol and other drugs, or engaging in self-destructive behaviour. Let the person know that excessive intake of alcohol or other drugs is not likely to be helpful.	NR	Expert opinion	Expert opinion	NR

Abbreviations: RANZCP, Royal Australian and New Zealand College of Psychiatrists; NHMRC LoE, NHMRC Levels of Evidence and Grades of Recommendations

Appendix 1 Included guidelines list

Table App. 1 Included Australian and international birth trauma and PTSD guidelines[7]

No.	Title & link (source)	Year	Developer	Country/region	Method used to identify evidence base (search date)	Method used to assess the level/quality/ certainty of the evidence base	Method used to link evidence to recommendation	Comments/guideline coverage
Australian and International birth trauma guidelines (included)								
Australian birth trauma guidelines (included)								
1	Managing women in distress after a traumatic birth experience (Google search)	2018	Government of South Australia, SA Health	AU	NR	NR	NR	SA Health perinatal practice guideline on managing distress after traumatic birth experience.
2	ShortGUIDE: Instrumental vaginal birth (Trip database)	2020	Queensland Health	AU	NR	NR	NR	Psychological care recommendation following instrumental vaginal birth.
International birth trauma guidelines (included)								
3	*Caring for Patients Who Have Experienced Trauma (Trip database)*	*2021*	*American College of Obstetricians and Gynecologists*	*US*	*NR*	*NR*	*Committee opinion (published April 2021)*	*Trauma-informed approaches to delivery of care. Background information on the importance of the obstetrician–gynecologists and other health care practitioners recognising the prevalence and effect of trauma on patients and the health care team.*
4	*Antenatal and postnatal mental health: clinical management and service guidance* (Trip database)	2014	*National Institute for Health and Clinical Excellence (NICE)*	*UK*	*SR (2006 to April 2014)*	*NICE methods*	*NICE methods*	*Traumatic birth recommendations. Statement on PTSD*

[7] Guidelines in italics signal duplicate guidelines that were retrieved as part of different searches. The American College of Obstetricians and Gynecologists Committee Opinion and the National Institute of Health and Clinical Excellence Antenatal and Postnatal Mental Health guidelines in italics were retrieved in both the birth trauma and PTSD guideline searches. The Royal Australian and New Zealand College of Psychiatrists document Guidance addressing all aspects of the care of people with schizophrenia and related disorders is italicised because it was retrieved as part of the searches for Australian and International for PTSD guidelines.

No.	Title & link (source)	Year	Developer	Country/region	Method used to identify evidence base (search date)	Method used to assess the level/quality/ certainty of the evidence base	Method used to link evidence to recommendation	Comments/guideline coverage
Australian and International PTSD guidelines (included)								
Australian PTSD guidelines (included)								
5	Australian Guidelines for the Prevention and Treatment of Acute Stress Disorder, Posttraumatic Stress Disorder and Complex Posttraumatic Stress Disorder (GIN Database, Trip database and NHMRC portal)	2021	Centre for Post-traumatic Mental Health	AU	SR (January 2008 to October 2018) updated (October 2018 to June 2019)	GRADE	GRADE	Phoenix Guideline on PTSD. Information on acute stress disorder, PTSD. These Guidelines provide recommendations on the best interventions for children, adolescents and adults who have been exposed to potentially traumatic events as well as those who have developed acute stress disorder (ASD) or posttraumatic stress disorder (PTSD).
6	PTSD practice guide (Google search)	2021	Australian Psychological Society	AU	NR	NR	NR	PTSD guideline includes information on screening, diagnosis, risk factors and treatment of PTSD.
7	*Guidance addressing all aspects of the care of people with schizophrenia and related disorders. Includes correct diagnosis, symptom relief and recovery of social function (Trip database)*	*2016*	*Royal Australian and New Zealand College of Psychiatrists*	*AU and NZ*	*SRs and informal literature reviews*	*NHMRC*	*NR*	*Background information on psychosis management in Aboriginal and Torres Strait Islander populations and psychosocial therapies. Statement on PTSD in CALD Statement on misdiagnosing PTSD as psychosis*
8	Trauma and loss. Guidelines for providing mental health first aid to an Aboriginal and Torres Strait Islander person (Trip database)	2008	Mental Health First Aid Australia	AU	NR	NR	Based on the expert opinions of Aboriginal clinicians from across Australia	Background information on trauma and treatment options including traditional Ngungkari healing for Aboriginal and Torres Strait Islander people.

No.	Title & link (source)	Year	Developer	Country/region	Method used to identify evidence base (search date)	Method used to assess the level/quality/ certainty of the evidence base	Method used to link evidence to recommendation	Comments/guideline coverage
International PTSD guidelines (included)								
9	*Guidance addressing all aspects of the care of people with schizophrenia and related disorders. Includes correct diagnosis, symptom relief and recovery of social function* *(Trip database)*	*2016*	*Royal Australian and New Zealand College of Psychiatrists*	*AU and NZ*	*SRs and informal literature reviews*	*NHMRC*	*NR*	*Background information on psychosis management in Aboriginal and Torres Strait Islander populations and psychosocial therapies.* *Statement on PTSD in CALD populations.* *Statement on misdiagnosing PTSD as psychosis.*
10	*Caring for Patients Who Have Experienced Trauma* (Trip database)	*2021*	*American College of Obstetricians and Gynecologists*	*US*	*NR*	*NR*	*Committee opinion (published April 2021)*	*Trauma-informed approaches to delivery of care. Background information on the importance of the obstetrician–gynecologists and other health care practitioners recognising the prevalence and effect of trauma on patients and the health care team.*
11	Assisted Vaginal Birth (Trip database)	2020	Royal College of Obstetricians and Gynaecologists (RCOG)	UK	RCOG Green-top Guideline methodology for SRs (until May 2019)	RCOG methods	RCOG methods	Generic recommendation to offer women with persistent PTSD symptoms at 1 month after assisted vaginal birth referral to skilled professionals (as per the NICE guidance on PTSD). No other directly relevant information in this document.
12	Clinical Practice Guidelines on Anxiety Disorders (Trip database)	2015	Ministry of Health, Singapore	Singapore	NR	Ministry of Health Singapore guideline development methodology	Ministry of Health Singapore guideline development methodology	Guideline on PTSD management (general treatment recommendations).
13	Best Practice Guidelines for Mental Health Disorders in the Perinatal Period (Trip database)	2014	British Columbia Perinatal Health Program	Canada	NR	NR	NR	Background information on PTSD. Section 4.1.1 contains useful information regarding PTSD.
14	*Antenatal and postnatal mental health: clinical management and service guidance* (Trip database)	*2014*	*National Institute for Health and Clinical Excellence – Clinical Guidelines*	*UK*	*SR (2006 to April 2014)*	*NICE methods*	*NICE methods*	*Traumatic birth recommendations. Statement on PTSD.*

Abbreviations: ASD, acute stress disorder; CALD, culturally and linguistically diverse; PPH, postpartum haemorrhage; PTSD, posttraumatic stress disorder.

Appendix 2 Excluded birth trauma and PTSD guidelines list

The following guidelines and guidance documents were excluded during screening (with the reasons for exclusion listed). Guidelines in italics signal duplicate guidelines that were retrieved as part of different searches (e.g., searches for Australian or International guidelines, searches for birth trauma or PTSD guidelines).

Table App. 2 Excluded Australian and international birth trauma and PTSD guidelines

No.	Source	Title & link	Year	Developer	Comments/reasons for exclusion
Australian and International birth trauma guidelines (excluded)					
Australian birth trauma guidelines (excluded)					
1	Trip Database	Stillbirth care	2019	Queensland Health	Generic post birth recommendation to reduce anxiety, depression, and PTSD, "Provide the woman and partner with appropriate debriefing, support, referral and follow-up to reduce the risk of postnatal depression, anxiety and post-traumatic stress disorder". Not detailed enough information to warrant inclusion of this guideline.
International birth trauma guidelines (excluded)					
2	*Trip Database*	*Optimizing Postpartum Care*	*2018*	*American College of Obstetricians and Gynecologists*	*Generic postpartum care recommendations. No directly relevant information in this document.*
3	*Trip Database*	*British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum*	*2017*	*British Association for Psychopharmacology*	*Generic statement about the possibility of development of PTSD after traumatic birth. No directly relevant information in this document.*
4	*Trip Database*	*Operative Vaginal Delivery*	*2011*	*Royal College of Obstetricians and Gynaecologists*	*Generic statement about the possibility of developing tocophobia following operative vaginal delivery. No directly relevant information in this document.*
Australian and International PTSD guidelines (excluded)					
Australian PTSD guidelines (excluded)					
5	Trip Database	Clinical Practice Guideline for Care Around Stillbirth and Neonatal Death	2021	Centre of Research Excellence in Stillbirth	Background information on psychological effects on subsequent pregnancies following stillbirth but does not directly address PTSD.
6	Trip Database	Guideline: Perineal care	2020	Queensland Health	Background information on psychological issues from previous perineal injury but not directly relevant.
7	Trip Database	Stillbirth care	2019	Queensland Health	Generic statement to provide the woman and partner with appropriate debriefing, support, referral, and follow-up to reduce the risk of postnatal depression, anxiety and post-traumatic stress disorder, but not directly relevant.

No.	Source	Title & link	Year	Developer	Comments/reasons for exclusion
8	Trip Database	ShortGUIDE: Instrumental vaginal birth	2019	Queensland Health	Statement on the effect of instrumental birth in relation to posttraumatic stress ("Instrumental birth is associated with fear of subsequent birth and post-traumatic stress", ref Ayers S, Bond R, Bertullies S, Wijma K. The aetiology of post-traumatic stress following childbirth: a meta-analysis and theoretical framework. Psychological Medicine 2016;46(6):1121-34). Does not directly address birth trauma/PTSD.
9	Trip Database	Guidance on the clinical management of anxiety disorders, specifically focusing on diagnosis and treatment strategies	2018	Royal Australian and New Zealand College of Psychiatrists	Background information on PTSD but no recommendations for people who have PTSD.
10	Trip Database	Guidance on the clinical management of depressive and bipolar disorders, specifically focusing on diagnosis and treatment strategies	2015	Royal Australian and New Zealand College of Psychiatrists	Background information on traumatic events in reference to hospitalisation (p.118) but no recommendations for people who have experienced a traumatic birth or subsequent PTSD.
11	Trip Database	Abuse and violence - working with our patients in general practice	2014	Royal Australian College of General Practitioners	Background information on association between intimate partner violence and PTSD. Not directly relevant as recommendations are related to Intimate Partner Violence (IPV) as the source of trauma, not birth trauma.
12	Trip Database	Psychosocial Adjustment after Spinal Cord Injury (updated 2014)	2014	Agency for Clinical Innovation	Background information on PTSD. Not directly relevant as recommendations are related to the spinal cord injury as the source of trauma, not birth trauma.
13	Trip Database	Guide for Health Professionals on the Psychosocial Care of People with Spinal Cord Injury (updated 2014)	2014	Agency for Clinical Innovation	Interventions for PTSD developed following Spinal Cord Injury, not directly relevant.
14	Trip Database	Australian guidelines for the treatment of acute stress disorder and posttraumatic stress disorder	2013	Centre for Posttraumatic Mental Health	2013 version of the Phoenix guideline for PTSD. Excluded as an updated version of this guideline has been included (published in 2021).
Australian PTSD guidance from medical colleges or State health departments (excluded)					
15	Google	Position statement on PTSD	2021	The Royal Australian and New Zealand College of Psychiatrists	Endorses the Phoenix Guideline on PTSD, no unique recommendations in this resource.
16	Google	Mental health care in the perinatal period	2018	The Royal Australian and New Zealand College of Obstetricians and Gynaecologists	PTSD prevalence after childbirth discussed on p.5, no directly relevant recommendations.
International PTSD guidelines (excluded)					
17	Trip Database	Postnatal care	2021	National Institute for Health and Clinical Excellence – Guidelines	Refers reader to the section on traumatic birth and PTSD in the 2014 NICE guideline "Antenatal and postnatal mental health". No directly relevant information in this document.
18	Trip Database	Assessing the risk of maternal morbidity and mortality	2021	Society for Maternal-Fetal Medicine	Background information on pregnancy complications and fetal anomaly on traumatic stress prevalence. No directly relevant information in this document.
19	Trip Database	Sexual Assault	2019	American College of Obstetricians and Gynecologists	Information on PTSD from sexual assault and providing trauma-informed care. No directly relevant information in this document.

No.	Source	Title & link	Year	Developer	Comments/reasons for exclusion
20	Trip Database	Child Abuse, Elder Abuse, and Intimate Partner Violence	2019	American College of Surgeons	Background information on trauma-informed care. No directly relevant information in this document.
21	GIN	Evaluation of Psychosocial Factors Influencing Recovery from Adult Orthopaedic Trauma	2019	American Academy of Orthopaedic Surgeons	Background information on the relationship between PTSD and physical injury. No directly relevant information in this document.
22	*Trip Database*	*Optimizing Postpartum Care*	*2018*	*American College of Obstetricians and Gynecologists*	*Generic postpartum care recommendations. No directly relevant information in this document.*
23	Trip Database	Post-traumatic stress disorder	2018	National Institute for Health and Clinical Excellence – Clinical Guidelines	Generic information on risk of developing PTSD from traumatic birth. No other directly relevant information in this document.
24	GIN and Trip database	Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults	2017	American Psychological Association	Guideline on PTSD. To be updated in 2022. No directly relevant information in this document.
25	*Trip Database*	*British Association for Psychopharmacology consensus guidance on the use of psychotropic medication preconception, in pregnancy and postpartum*	2017	British Association for Pharmacology	Generic statement about the possibility of development of PTSD after traumatic birth. No directly relevant information in this document.
26	Trip Database	Crisis Intervention for Adults Using a Trauma-Informed Approach: Initial Four Weeks of Management Third Edition	2017	Registered Nurses' Association of Ontario	Interventions for the management of PTSD. No directly relevant information in this document.
27	Trip Database	Depression: Adult and Adolescent	2017	Kaiser Permanente Clinical Guidelines	Screening question investigating possible PTSD as part of a screen for adult depression. No directly relevant recommendations for PTSD.
28	Trip Database	Management of Posttraumatic Stress Disorder and Acute Stress Disorder	2017	VA/DoD Clinical Practice Guidelines	Background information on PTSD and acute stress disorder in military personnel. No directly relevant information in this document.
29	Trip Database	Postpartum Hemorrhage	2016	Ontario Midwives	Prevalence data on development of PTSD from postpartum hemorrhage (PPH). No directly relevant information on management of PTSD in this document.
30	Trip Database	Canadian clinical practice guidelines for the management of anxiety, posttraumatic stress and obsessive-compulsive disorders	2014	Anxiety Disorders Association of Canada	Guideline on PTSD manifestation and management, management of anxiety, posttraumatic stress and obsessive-compulsive disorders. No directly relevant information on birth trauma in this document.
31	Trip Database	Evidence-based pharmacological treatment of anxiety disorders, post-traumatic stress disorder and obsessive-compulsive disorder	2014	British Association for Psychopharmacology	Pharmacological interventions for PTSD. Management of post-traumatic stress disorder. No directly relevant information on birth trauma in this document.
32	Trip Database	Umbilical Cord Prolapse	2014	Royal College of Obstetricians and Gynaecologists	Statement on umbilical cord prolapse and PTSD. No directly relevant information on management of PTSD in this document.
33	Trip Database	Cultural Competency	2013	American Academy of Child and Adolescent Psychiatry	Background information on increased prevalence of PTSD in immigrants. No directly relevant information on management of PTSD in this document.
34	Trip Database	Caesarean section	2011	National Institute for Health and Clinical Excellence – Clinical Guidelines	Statement about no increase in risk of PTSD following a c-section. No directly relevant information on management of PTSD in this document.

No.	Source	Title & link	Year	Developer	Comments/reasons for exclusion
35	Trip Database	Common mental health problems: identification and pathways to care	2011	National Institute for Health and Clinical Excellence – Clinical Guidelines	Intervention pathways for PTSD. No directly relevant information on management of PTSD in this document.
36	*Trip Database*	*Operative Vaginal Delivery*	*2011*	*Royal College of Obstetricians and Gynaecologists*	*Generic statement about the possibility of developing tocophobia following operative vaginal delivery. No directly relevant information in this document*
37	Trip Database	Maternal Collapse in Pregnancy and the Puerperium	2011	Royal College of Obstetricians and Gynaecologists	Recommendation on maternal collapse and subsequent PTSD. No directly relevant information on management of PTSD in this document.
38	Trip Database	Late Intrauterine Fetal Death and Stillbirth	2010	Royal College of Obstetricians and Gynaecologists	Recommendations for PTSD manifestation. No directly relevant information on management of PTSD in this document.

Abbreviations: CALD, culturally and linguistically diverse; PPH, postpartum haemorrhage; PTSD, post-traumatic stress disorder.

Appendix 3 Full list of extracted recommendations and practice points from the included guidelines

Table App. 3 Full list of extracted recommendations and practice points from the included birth trauma guidelines

CPG ID (Evidence review search date)	Recommendation/s[8]	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.[9]
Queensland Health 2020 (NR)	Psychological care recommendation following post-intervention for instrumental vaginal birth				
	Offer an opportunity to discuss the indications for the instrumental birth, the management of any complications and implications for future births • Instrumental birth is associated with fear of subsequent birth and post-traumatic stress	NR	NR	NR	NR
	Ask about psychological wellbeing in the postnatal period and offer referral if indicated	NR	NR	NR	NR
SA Health 2018 (NR)	Managing distress after traumatic birth experience				
	Summary of Practice Recommendations				
	1. Birth trauma can intensify into Post Traumatic Stress Disorder (PTSD) unless identified and treated early.	NR	NR	NR	NR
	2. A history of previous trauma predisposes women to experience birth as traumatic.	NR	NR	NR	NR
	3. Informed decision-making by the woman in labour reduces the likelihood of the woman perceiving birth as traumatic.	NR	NR	NR	NR
	4. Postnatal debriefing provides women with the opportunity to make sense of their birth experience and strengthens them psychologically.	NR	NR	NR	NR
	5. Early recognition of signs and symptoms of distress, with referral to appropriate care services is essential.	NR	NR	NR	NR
	6. A positive birth experience following a traumatic one can have a therapeutic effect.	NR	NR	NR	NR
	Risk factors				
	• A history of previous trauma predisposes women to experience further trauma or distress during the perinatal period. Previous trauma may include domestic violence, childhood sexual abuse, rape, and migrant trauma.* For further information refer to *Sexual Abuse in Childhood perinatal practice guidelines* available at www.sahealth.sa.gov.au/perinatal.	NR	NR	NR	NR (some refs supplied)

[8] Includes CPG recommendation number where available.
[9] Grade of level of evidence or recommendation where available (see Appendix B).
*an asterisk denotes risk factors linked to evidence.

CPG ID (Evidence review search date)	Recommendation/s[8]	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.[9]
	• Women who have experienced childhood sexual abuse are 12 times more likely to experience childbirth as traumatic*	NR	NR	NR	NR (some refs supplied)

	• Other predisposing factors to trauma include:
	  ○ Lack of social support
	  ○ Poor coping strategies
	  ○ Feelings of powerlessness
	  ○ Extreme pain
	  ○ Unexpected outcomes of labour and birth including ill or stillborn infant
	  ○ Perception of hostile or uncaring staff
	  ○ Loss of control
	  ○ Medical interventions
	  ○ Lack of information
	  ○ Past traumatic birth*
		NR	NR	NR	NR (some refs supplied)

	Symptoms of psychological distress following childbirth				
	• Appearing dazed • Reduced conscious state • Agitated or overactive • Withdrawn • Autonomic anxiety symptoms – increased heart rate, palpitations, sweating, jelly legs, “butterflies in stomach” and dry mouth • Some amnesia-blocked memories • Disoriented • Depressed These symptoms can be a precursor to the more severe Post-Traumatic Stress Disorder (PTSD)	NR	NR	NR	NR
	Definition of PTSD				
	Post-Traumatic Stress Disorder is a form of anxiety disorder. It can develop after vicarious exposure to, or the experience of a traumatic event	NR	NR	NR	NR
	Symptoms of PTSD				

CPG ID (Evidence review search date)	Recommendation/s[8]	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.[9]
	• Flashbacks, depersonalization, hypervigilance • Nightmares • Emotionally numbed • Intrusive memories, depression • Anxiety • Bonding difficulties • Fear of sexual intimacy • Avoidance of normal vaginal birth or future pregnancy • Increased psychological arousal • Avoidant of baby	NR	NR	NR	NR
	Preventative measures				
	• Maximise the woman's control in labour • Provide adequate information • Inform woman of all procedures • Involve the woman in the decision making	NR	NR	NR	NR
	Treatment: Debriefing				
	Components of debriefing				
	• Listening empathetically • Identify and report any problems with the service • Provide feedback to staff involved	NR	NR	NR	NR
	(Why debrief) The benefits for the women are to:				

CPG ID (Evidence review search date)	Recommendation/s[8]	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.[9]
	• Decreased mental distress • Acknowledge grief and loss • Educate • Provide health promotion • Help with memory gaps • Understand medical aspects of interventions • Talk about unmet expectations • Reconstruct the whole birth story • Evoke an emotional response	NR	NR	NR	NR
	Healthcare professional's role				
	Postpartum care of current birth				

	• Encourage discussion of birth experience
	  ○ Accoucher or appropriately experienced health professional should explain and discuss the events of the labour and birth. This should be done in terms that the woman can understand.
	  ○ Encourage articulation of the birth experience by the woman as she requires
	  ○ A clear summary of the discussion and explanations given to the woman should be documented in the case notes.
		NR	NR	NR	NR

	Ongoing postpartum care				

	• Empathetic care
	• Early recognition of signs and symptoms of distress
	  ○ Anger
	  ○ Persistent vague pain
	  ○ Failure to interact with baby
	• Refer to appropriate specialised care – perinatal mental health team or social work and counselling services
	• Rule out postnatal depression
	• Consider postnatal review appointment at 4-6 weeks to provide time for any further clarification of the birth experience
		NR	NR	NR	NR

	Subsequent pregnancy				
	Antepartum				

CPG ID (Evidence review search date)	Recommendation/s[8]	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.[9]
	• Thorough history taking • Carefully discuss and document mode of birth / pain relief / maternal requests for next birth • Watch for avoidant behaviour • Aim for continuity model of care and carer • Consider consultant review • Gain knowledge from routine screening about psychiatric history including depression, anxiety, trauma or previous / current PTSD • Throughout antenatal care, previous labour and birth may need to be revisited • Refer for counselling as needed	NR	NR	NR	NR
	Subsequent pregnancy: Intrapartum				

	• Maximise the woman's control in labour by:
	  ○ Providing adequate information
	  ○ Involve in decision making
	  ○ Provide adequate information of all procedures and gain the woman's permission (verbal consent) before proceeding
	  ○ Stop procedure if woman requests this
	• Pain control as a preventative strategy
	• Being alert to what situations may lead to trauma
	• Encourage the woman to articulate her experiences
		NR	NR	NR	NR

	Subsequent pregnancy: Postpartum				

	• Care the same as for postpartum care of current birth, plus …
	  ○ Discuss events of this birth and ensure psychological wellbeing is maintained
	  ○ Refer for counselling as needed
	• A positive birth experience following a traumatic one can have a therapeutic effect.
		NR	NR	NR	NR

ACOG 2021 (NR)	Background information on the trauma-informed approach to the health care visit				
	1. It is important for obstetrician–gynecologists and other health care practitioners to recognize the prevalence and effect of trauma on patients and the health care team and incorporate trauma-informed approaches to delivery of care.	NR	NR	NR	NR/Committee opinion
	2. Obstetrician–gynecologists should become familiar with the trauma-informed model of care and strive to universally implement a trauma-informed approach across all levels of their practice with close attention to avoiding stigmatization and prioritizing resilience.	NR	NR	NR	NR/Committee opinion
	3. Obstetrician–gynecologists should build a trauma-informed workforce by training clinicians and staff on how to be trauma-informed.	NR	NR	NR	NR/Committee opinion

CPG ID (Evidence review search date)	Recommendation/s[8]	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.[9]
	4. Feelings of physical and psychological safety are paramount to effective care relationships with trauma survivors, and obstetrician gynecologists should create a safe physical and emotional environment for patients and staff.	NR	NR	NR	NR/Committee opinion
	5. Obstetrician–gynecologists should implement universal screening for current trauma and a history of trauma.	NR	NR	NR	NR/Committee opinion
	6. In the medical education system, the benefit of trainee experience must be balanced with the potential negative effect on and re-traumatization of patients through multiple interviews and examinations.	NR	NR	NR	NR/Committee opinion
	Four C's: Skills in Trauma-informed care				
	Calm: Pay attention to how you are feeling while caring for the patient. Breathe and calm yourself to help model and promote calmness for the patient and care for yourself. **Contain**: Ask the level of detail of trauma history that will allow patient to maintain emotional and physical safety, respect the time frame of your interaction, and will allow you to offer patients further treatment. **Care:** Remember to emphasize, for patient and yourself, good self-care and compassion. **Cope**: Remember to emphasize, for patient and yourself, coping skills to build upon strength, resilience, and hope.	NR	NR	NR	NR
NICE 2014 SR (2006 to April 2014)	Traumatic birth recommendations				
	1.9.4 Offer advice and support to women who have had a traumatic birth or miscarriage and wish to talk about their experience. Take into account the effect of the birth or miscarriage on the partner and encourage them to accept support from family and friends. [2014]	NICE methods	NICE methods	NICE methods	NR
	1.9.5 Offer women who have post-traumatic stress disorder, which has resulted from a traumatic birth, miscarriage, stillbirth or neonatal death, a high-intensity psychological intervention (trauma-focused CBT or eye movement desensitisation and reprocessing [EMDR]) in line with the NICE guideline on post-traumatic stress disorder. [2014]	NICE methods	NICE methods	NICE methods	NR
	1.9.6 Do not offer single-session high-intensity psychological interventions with an explicit focus on 're-living' the trauma to women who have a traumatic birth. [2014]	NICE methods	NICE methods	NICE methods	NR
	NICE definition of birth trauma				
	This includes births, whether preterm or full term, which are physically traumatic (for example, instrumental or assisted deliveries or emergency caesarean sections, severe perineal tears, postpartum haemorrhage) and births that are experienced as traumatic, even when the delivery is obstetrically straightforward.	N/A	N/A	N/A	N/A

Table App. 4 Full list of relevant recommendations and practice points from the included PTSD guidelines

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
Centre for Posttraumatic Mental Health 2021 (Jan 2009 – 0ctober 2018, updated to June 2019)	**PTSD treatment recommendation (EMDR)**				
	Early psychosocial treatment interventions for adults 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. (Conditional recommendation)	GRADE	GRADE	GRADE	Low/ Conditional
	Brief EMDR can range from one to three sessions and involves clients focusing on fragments of their trauma memory whilst simultaneously engaging in dual attention stimulation using eye movements. **Benefits and Harms** Evidence from 6 small RCTs suggests large clinically important benefit of 1-3 sessions of brief EMDR on PTSD symptom severity relative to waitlist in adults who have experienced a community critical incident e.g. workplace violence, earthquake, factory explosion, missile attack, intense rocket attacks or traumatic childbirth.	GRADE	GRADE	GRADE	Low
	Trauma-focused counselling For adults within the first three months following exposure to a potentially traumatic event, there was insufficient evidence to make a recommendation on trauma-focused counselling. **Remark**: Brief trauma-focused counselling comprised of a single session of individual counselling within 48 hours of experiencing a PTE (e.g., traumatic birth or myocardial infarction), covering techniques for managing anxiety, social skills and problem solving, relaxation, cognitive coping.	GRADE	GRADE	GRADE	NR
RANZCP 2016 (NR)	**Relating to trauma**				
	Refugees and migrants have higher rates of substance abuse and post-traumatic stress disorder than the general population, so assessment and treatment of these comorbidities is often needed.	NR	NHMRC Levels of Evidence	NR	NR
	Clinicians should take a history of trauma into consideration when organising care, such as choosing the gender of the therapist, and when facing challenges in establishing a trusting therapeutic alliance. (Consensus-bases recommendation).	NR	NHMRC Levels of Evidence	NR	NR
	Clinicians should be mindful that exposure to trauma is associated with an increased likelihood of symptoms of depression and anxiety. (Consensus-bases recommendation).	NR	NHMRC Levels of Evidence	NR	NR
Trauma in Aboriginal and Torres Strait Islander People					
Mental Health First Aid Australia 2008 (NR)	**Definition of trauma**				
	Trauma is a reaction to an extremely distressing event. Trauma can occur when someone experiences, witnesses, or hears unexpectedly about, a situation involving actual or threatened death or serious injury.	NR	Expert opinion	Expert opinion	NR

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	Cultural Competence				
	You should demonstrate cultural respect when assisting an Aboriginal person who has experienced trauma or loss. Be aware of the cultural practices used in the person's community. For instance, many Aboriginal people participate in 'sorry business', or traditional ceremonies, to help them resolve their grief or trauma. Be sensitive to the cultural practices of the person's community so you do not do or say something that causes the person shame. For instance, some communities avoid referring to deceased loved ones by name. For more information on culturally competent first aid, see the other guideline in this series Cultural Considerations and Communication Techniques: Providing Mental Health First Aid to an Aboriginal or Torres Strait Islander Person.	NR	Expert opinion	Expert opinion	NR
	What are traumatic events?				
	An event that is traumatic for one person may not be traumatic for another.	NR	Expert opinion	Expert opinion	NR
	Treatment options including traditional Ngungkari healing examples				
	When assisting someone who has experienced trauma or loss, it is important not to misinterpret the person's behaviours or experiences as symptoms of mental illness. Be aware of what constitutes culturally appropriate behaviour after trauma or loss. For instance, it is not unusual for Aboriginal people to see, hear or talk to spirits of deceased loved ones. If the person you are assisting believes they have been visited by the spirit of a loved one, reassure them that this is a common experience for many Aboriginal people and encourage them not to feel frightened or to feel shame. If the person remains afraid of a spirit, encourage them to seek appropriate help, for example by seeing an Aboriginal health worker, Ngungkari/Traditional Healer, Elder, family member or someone strong within the person's community who can help them with the issue.	NR	Expert opinion	Expert opinion	NR
	In the days and weeks after a traumatic event or loss				
	You can help the person by simply being there for them; be available, attentive, and let them know that you care. Allow the person to make their own decisions, without nagging, judging or blaming them for their feelings or behaviours.	NR	Expert opinion	Expert opinion	NR
	The person's reaction Each person will differ in how they react to a trauma or loss. Be aware that the person might not be as distressed about the trauma or loss as could be expected. Try to be tolerant of any strong emotion expressed by the person, except if they become threatening, abusive or violent. Behaviours such as withdrawal, irritability and bad temper may be a response to the trauma or loss, so try not to take them personally. Respect the person's need to be alone at times. Encourage the person to let others know when they need or want something, rather than just assume that others will know what they want. Also suggest the person doesn't let small day-to-day hassles build up and add to their stress.	NR	Expert opinion	Expert opinion	NR

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	Try to avoid saying things that minimise the person's feelings, such as "don't cry", "calm down" or "get over it". Also avoid statements that may minimise the person's experience, such as "you should just be glad you're alive" and the use of clichés like "life goes on" or "you must be strong now". Be patient with the person, and don't expect that they will be 'over it' in a few weeks. If the person is experiencing changes in their mood or loss of energy, reassure them that it is common after trauma or loss to have good and bad days. Do not say to the person "I know how you feel" or try to tell them how they should be feeling.	NR	Expert opinion	Expert opinion	NR
	Expressing feelings				
	Do not discourage the person from expressing their feelings of trauma or loss. Instead, encourage the person to allow themselves to feel sadness and grief over what has happened and to express their feelings when they feel they need to. You could tell the person that you are okay with them expressing their feelings in front of you, even though it may be hard to see them upset.	NR	Expert opinion	Expert opinion	NR
	Suggest the person try to find a way to express their feelings that is meaningful to them, such as physical activity, music, writing or journaling, art, praying or meditating, story telling, cultural activities or ceremonies. Make sure you encourage ways that do not cause harm to the person or harm to others.	NR	Expert opinion	Expert opinion	NR
	Provide the person with information and resources about dealing with trauma or loss. Help the person identify other sources of support, such as loved ones and friends. Encourage the person to fulfil their cultural practices for dealing with trauma or loss, for example, by going home to country and participating in sorry business.	NR	Expert opinion	Expert opinion	NR
	Talking about the trauma or loss				
	It is important that you acknowledge the person's trauma or loss and what it means to them. Reassure the person that everyone has their own pace for dealing with trauma or loss, and that they can come and talk to you another time if they don't want to do it now. If the person does not want to talk to you at all, encourage them to consider calling a crisis line, going to a crisis center or using other community resources. You should never force the person to tell their story or probe for more details, and avoid repeatedly asking about the event. Also be aware that it is not unusual for men to not want to express their feelings verbally or to avoid having to talk it out.	NR	Expert opinion	Expert opinion	NR
	If the person wants to tell their story, give them lots of time and listen to them in a non-judgmental and accepting way. Do not interrupt the person, allow for moments of silence and reflection. If you feel that you cannot listen to the details of the trauma, let the person know, while offering your support and understanding. If you do not know what to say in response to the person, let them know that this is the case. Once the person has told their story, you should respect their right to confidentiality by not telling others what they said without their permission.	NR	Expert opinion	Expert opinion	NR
	If the trauma involved the recent death of a loved one, and the person thinks that they might have seen their loved one, or talks about them as if they are still alive, the first aider should reassure the person that this is normal.	NR	Expert opinion	Expert opinion	NR

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	How do I know if professional help is needed?				
	You should suggest the person seek professional help straight away if they: • become suicidal • are overwhelmed by intense or distressing feelings • feel their important relationships are suffering as a result of the trauma or loss • abuse alcohol or other drugs to deal with the trauma or loss • feel jumpy or have nightmares relating to the trauma or loss • are unable to enjoy life at all as a result of the trauma or loss • feel like no-one understands them • start picking arguments with friends or getting into fights You should suggest the person seek professional help, if for two weeks or more, they: • feel very upset or fearful • can't get on with their usual activities • can't stop thinking about the trauma or loss After 4 weeks, if the person is acting very differently compared to before the trauma or loss, it is best that they seek professional help.	NR	Expert opinion	Expert opinion	NR
	Professional help: What kind of professional help?				
	Be aware of the different types of professionals who can help the person. These may include psychologists, healing circles or cultural healing groups, bereavement support groups, doctors or religious leaders. Know the range of specialist services that can provide help and assistance for specific types of trauma or loss. For instance, Centres Against Sexual Assault (CASA), Link-Up or Bringing Them Home counsellors who specialise in Stolen Generations issues, and counselling services for victims of crime.	NR	Expert opinion	Expert opinion	NR
	Suggest that the person see a professional who is trained or has experience in working with Aboriginal people and their experiences of trauma and loss. It is important to note that counselling suitable for Aboriginal people may be quite difficult to find or gain access to, as there is a shortage of appropriately trained Aboriginal psychologists and counsellors. If this is the case, you can engage other options. For instance, you could suggest the person find a service that specialises in assisting with the type of trauma or loss the person has experienced. Most importantly however, encourage the person to find someone who will help them tell their story and who the person can trust and feel comfortable talking to.	NR	Expert opinion	Expert opinion	NR

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	What if the person doesn't want professional help?				
	Sometimes people will not want professional help, even if they need it. If this is the case, you should reassure the person that they may benefit from professional help. Tell them that reaching out for help is not a sign of weakness and that there is no need to feel shame about having a yarn with a doctor or health worker to help them through their healing. Reassure the person that a lot of people need help after experiencing a trauma or loss, and that seeking professional help is normal.	NR	Expert opinion	Expert opinion	NR
	Be aware that where there has been ongoing trauma of any kind, the sooner professional help is sought, the better. If the person has been experiencing ongoing trauma, such as family violence, or if the person experienced trauma a very long time ago, such as child abuse, reassure them that it is never too late to benefit from professional help.	NR	Expert opinion	Expert opinion	NR
	What else can I do? Encourage other supports				
	Be aware that the person may find particular times stressful. Some occasions that might be difficult, particularly if the person has lost a loved one, are anniversaries, celebrations such as Christmas or birthdays, or hearing about situations that remind them of the trauma or loss. It is a good idea to help the person develop a list of people, services or places that they can contact when the going gets tough. Also be aware that it is possible that the person may feel guilty or worried about being happy. If this is the case, reassure them that it is okay for them to enjoy themselves and the company of others.	NR	Expert opinion	Expert opinion	NR
	Encourage positive coping strategies				
	To help the person recover, it is important that you encourage the person to take care of themselves by getting some exercise, having plenty of rest when they are tired and eating well and regularly. Encourage the person to be patient with themselves and to either take time out from normal activities or maintain their routine, depending on what feels best to them.	NR	Expert opinion	Expert opinion	NR
	Help the person to find some effective coping strategies. For instance, you could suggest that the person think about and use strategies which have helped in the past.	NR	Expert opinion	Expert opinion	NR
	You could help the person find some ways to relax, such as practicing slow deep breathing, or finding somewhere they can spend time feeling safe and comfortable. Above all, encourage the person to do the things that feel good to them, even if it is as simple as taking a walk, going fishing or watching television. In addition, you should discourage the person from using negative coping strategies such as working too hard, using alcohol and other drugs, or engaging in self-destructive behaviour. Let the person know that excessive intake of alcohol or other drugs is not likely to be helpful.	NR	Expert opinion	Expert opinion	NR

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
Australian Psychological Society 2021 (NR)	**Risk factors**				
	Several key risk factors for the development of PTSD have been identified in the clinical and research literature. The type of trauma experienced is one of the most important risk factors, with higher rates of PTSD found in victims of rape or sexual molestation, survivors of military combat and terrorist acts, while comparatively low prevalence rates have been observed in survivors of road traffic accidents and natural disasters. A meta-analysis that reviewed risk factors for the development of PTSD, identified the most significant risk factors as: • trauma severity • lack of social support and Various demographic variables had slightly smaller effect sizes, including: • social/educational/intellectual disadvantage • personal or familial psychiatric history • abuse or childhood adversity and • race or minority status. Marital status was found to be associated with an increased risk of developing PTSD following a traumatic event. At greater risk are those who have: • never been married and • been previously, but not currently, married.	NR	NR	NR	NR
	Assessment objectives				
	There are various fundamental objectives associated with the assessment of PTSD. These objectives include: • establishing rapport • identifying the client's presenting concern and reason for seeking treatment • clarifying the client's symptoms, history of presenting complaint and degree of impairment/distress • building a profile of the client's coping skills and strategies • understanding the client's cognitive style, communication, problem-solving or other aspects of functioning that may be relevant to understanding their symptoms • evaluating relationships, family involvement and other social supports • clarifying short, medium and long-term goals and the impact of the presenting complaint on such goals • assessing readiness to change and degree of motivation • clarifying expectations of therapy and previous treatment experiences • developing a case formulation to inform treatment planning	NR	NR	NR	NR

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	• synthesising and integrating the practitioner's and client's understanding of the aetiology and maintenance of the condition and how it, or symptoms of it, might impact on their life, and ongoing monitoring regarding the impact of the interventions utilised against the client's goals.				
	Acute stress disorder				
	While acute stress disorder and PTSD share the same physiological and stress symptoms, acute stress disorder is differentiated from PTSD by its limited duration, with symptoms present for more than three days, but less than one month. Where symptoms persist beyond a month, a diagnosis of PTSD should be considered.	NR	NR	NR	NR
	Adjustment disorders				
	The essential feature of an adjustment disorder is marked distress in response to a stressor, which is considered out of proportion to that expected for the severity or intensity of the stressor. Unlike PTSD, the stressor can be of any severity or type. Where the stressor is considered potentially traumatic, a diagnosis of an adjustment disorder is made where the other criteria of PTSD (such as intrusive thoughts or images, avoidance or numbing and alterations in cognitions and mood) are not present.	NR	NR	NR	NR
	Treatment				
	Objectives				
	There are various fundamental psychological objectives that underpin the treatment of PTSD and involve not only the client, but, where appropriate, their family and supporters. These objectives include: • sharing the practitioner's understanding of the presenting concern(s) with the client and family • providing education about PTSD and its comorbidities • describing a compelling rationale for the treatment approach to be deployed • establishing collaborative and tailored treatment planning that establishes client goals for treatment and outcome indicators • sequentially addressing matters, problems and goals salient to the client • increasing the client's self-efficacy • implementing and translating evidence-based treatment/interventions • monitoring for and maintaining the effectiveness and efficacy of treatment • developing a plan to assist the client return to functionality (including, but not limited to, the maintenance of or a return to occupational functioning) • appropriately scheduling sessions, including frequency and duration of sessions, and the titration based on progress and • reviewing progress and actively planning for closure.	NR	NR	NR	NR

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	Evidence				
	Across time various meta-analyses and systematic reviews have demonstrated that there are several evidence-based treatments for PTSD; namely, trauma-focused cognitive therapy (CTPTSD), prolonged exposure (PE), eye movement desensitisation and reprocessing (EMDR) and cognitive processing therapy (CPT). Collectively, these interventions fall under the umbrella of trauma-focused cognitive-behavioural therapy. Where PTSD symptoms do not respond to such trauma-focused interventions, other evidence supported interventions may be utilised, such as interpersonal psychotherapy for depression and stress inoculation training for anxiety and anger. Adjunctive pharmacotherapy should be considered.	NR	NR	NR	NR
	Hierarchy				
	Where there are comorbid diagnoses of PTSD and depression, PTSD should be treated first as the depression often resolves with improvements in PTSD symptoms. In the context of a comorbidity of substance use disorders with PTSD, psychologists should consider: • treating both conditions simultaneously and • delaying the commencement of the trauma-focused component of PTSD treatment until the client has demonstrated skills to manage distress or attend therapy sessions without recourse to substance use. To reiterate observations above in relation to the issue of risk, the Australian Guidelines for the Treatment of ASD and PTSD - emphasise that where suicidality is suspected for individuals suffering from PTSD, this must be managed and effectively addressed prior to attention being directed toward any other treatment objectives.	NR	NR	NR	NR
	Scheduling				
	Following diagnosis, assessment and treatment planning, eight to 12 sessions of trauma-focused treatment is usually sufficient.	NR	NR	NR	NR
	Addressing multiple traumas				
	Other evidence-based treatment considerations for psychologists include the following: • group CBT should not be considered an alternative to individual CBT treatment • self-help programs should not be used where psychologist-directed interventions are viable • pharmacological therapy should not be used in place of psychological treatment, but might be used as an adjunct to this treatment • interventions to improve social, familial and occupational functioning should be delivered alongside trauma-focused interventions to prevent or reduce disability.	NR	NR	NR	NR

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	Evidence-based treatments				
	There are effective treatments for PTSD with a strong evidence base. Collectively, these interventions fall under the umbrella of trauma-focused cognitive-behavioural therapy and commonly require the individual to confront the memories of traumatic experiences they have, most likely, been avoiding for some and possibly years. To successfully engage clients in treatment, practitioners must pay considerable attention to psychoeducation, the development of a treatment model and providing a compelling rationale for the intended treatment approaches. Four such evidenced-based treatment interventions exist; namely, Trauma-focused cognitive therapy (CT-PTSD). Prolonged exposure (PE) Eye movement desensitization and reprocessing (EMDR) and Cognitive processing therapy (CPT).	NR	NR	NR	NR
	Population Interventions				
	In the early aftermath of trauma, structured interventions, such as psychological debriefing, with a focus on recounting the traumatic event and ventilation of feelings, should not be offered on a routine basis. Instead, individuals should be provided with practical and emotional support and encouraged to use their existing personal resources and social supports. However, some individuals may want to discuss their experiences shortly after the trauma and, in these cases, they should be supported in doing so. Immediate psychological support should be offered to adults who exhibit extremely high levels of distress or are at risk of harming themselves or others.	NR	NR	NR	NR

Table App. 5 Full list of recommendations from the included International PTSD guidelines

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
Psychological care recommendation following post-intervention for instrumental vaginal birth					
ACOG 2021 (NR)	It is important for obstetrician-gynecologists and other health care practitioners to recognize the prevalence and effect of trauma on patients and the health care team and incorporate trauma-informed approaches to delivery of care.	NR	ACOG Committee Opinion	ACOG Committee Opinion	NR
	Obstetrician-gynecologists should become familiar with the trauma-informed model of care and strive to universally implement a trauma-informed approach across all levels of their practice with close attention to avoiding stigmatization and prioritizing resilience.	NR	ACOG Committee Opinion	ACOG Committee Opinion	NR

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	Obstetrician-gynecologists should build a trauma-informed workforce by training clinicians and staff on how to be trauma-informed.	NR	ACOG Committee Opinion	ACOG Committee Opinion	NR
	Feelings of physical and psychological safety are paramount to effective care relationships with trauma survivors, and obstetrician-gynecologists should create a safe physical and emotional environment for patients and staff.	NR	ACOG Committee Opinion	ACOG Committee Opinion	NR
	Obstetrician-gynecologists should implement universal screening for current trauma and a history of trauma.	NR	ACOG Committee Opinion	ACOG Committee Opinion	NR
	In the medical education system, the benefit of trainee experience must be balanced with the potential negative effect on and re-traumatization of patients through multiple interviews and examinations.	NR	ACOG Committee Opinion	ACOG Committee Opinion	NR
American College of Obstetricians and Gynecologists 2020 (until May 2019)	Offer women with persistent post-traumatic stress disorder (PTSD) symptoms at 1 month referral to skilled professionals as per the NICE guidance on PTSD. [New 2020]	RCOG Green-top Guideline methodology for SRs	RCOG methods	RCOG methods	RCOG (Grade D)
Ministry of Health Singapore 2015 (NR)	**Pharmacological treatments**				
	Either SSRIs or venlafaxine may be used as a first-line pharmacological treatment for post-traumatic stress disorder.	NR	MoH Singapore methods	MoH Singapore methods	Grade A, Level 1++
	Mirtazapine may be considered as a second-line treatment for post-traumatic stress disorder.	NR	MoH Singapore methods	MoH Singapore methods	Grade B, Level 1+
	Either amitriptyline or imipramine may be considered for post-traumatic stress disorder if the first-line and second-line treatments are ineffective or poorly tolerated.	NR	MoH Singapore methods	MoH Singapore methods	Grade A, Level 1+
	Benzodiazepines should not be used for the treatment of post-traumatic stress disorder.	NR	MoH Singapore methods	MoH Singapore methods	Grade A, Level 1+
	Risperidone, olanzapine, quetiapine, and lamotrigine may be prescribed as adjunctive treatments for post-traumatic stress disorder in conjunction with the SSRIs.	NR	MoH Singapore methods	MoH Singapore methods	Grade B, Level 1+

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	Pharmacological treatment for post-traumatic stress disorder should be continued for at least 12 months.	NR	MoH Singapore methods	MoH Singapore methods	Grade D, Level 4
	Psychotherapies				
	Cognitive behaviour therapy should be used as the first-line psychological treatment for post-traumatic stress disorder.	NR	MoH Singapore methods	MoH Singapore methods	Grade A, Level 1
	Eye Movement Desensitisation and Reprocessing therapy may be used as second-line treatment for post-traumatic stress disorder.	NR	MoH Singapore methods	MoH Singapore methods	Grade B, Level 2++
	Combined Therapy				
	If cognitive behaviour therapy or eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder are contraindicated or have failed, combination therapy (i.e. cognitive behaviour therapy plus pharmacotherapy) may be used as an alternative treatment.	NR	MoH Singapore methods	MoH Singapore methods	Grade B, Level 1+
British Columbia Perinatal Health Program 2014 (NR)	**Background information**				
	PTSD occurs when a person has persistent symptoms after a traumatic event (e.g. physical, sexual and/or psychological abuse, natural disaster, accident). A history of unresolved trauma may increase the risk of PTSD in the perinatal period.	NR	NR	NR	NR
	PTSD symptoms cause clinically significant distress and/or impairment in social, occupational or other important areas of functioning.	NR	NR	NR	NR
	Symptoms include: persistent “reliving” of the traumatic event (e.g.2, flashbacks or nightmares); avoidance of feelings, people or places associated with the event (e.g., emotional “numbing”, feeling detached, showing less emotions); and hyper arousal or a high general level of anxiety (e.g., insomnia, difficulty concentrating, startling easily, feeling irritable and/or having outbursts of anger).	NR	NR	NR	NR
	Treatment for PTSD includes psychoeducation, peer support, trauma-focused psychotherapy (e.g., CBT and “desensitization” therapy”) and pharmacotherapy. Antidepressants, including SSRIs have been shown to be effective.	NR	NR	NR	NR
	PTSD is less common than GAD, PD and OCD in the perinatal period. It will not be detailed further in this guideline but it is important to consider in women with anxiety symptoms.	NR	NR	NR	NR
National Institute for Health and Clinical Excellence – Clinical Guidelines 2014 (2006 to April 2014)	General statement on PTSD				

CPG ID (Evidence review search date)	Recommendation/s	Method used to identify evidence	Method used to appraise evidence base	Method used to link evidence to rec.	Level of evidence/ strength of rec.
	During pregnancy and the postnatal period, anxiety disorders, including panic disorder, generalised anxiety disorder (GAD), obsessive-compulsive disorder (OCD), post-traumatic stress disorder (PTSD) and tokophobia (an extreme fear of childbirth), can occur on their own or can co-exist with depression. Psychosis can re-emerge or be exacerbated during pregnancy and the postnatal period. Postpartum psychosis affects between 1 and 2 in 1000 women who have given birth.	NICE	NICE	NICE	NR