

Post-traumatic stress disorder (PTSD)

The management of PTSD in adults and children
in primary and secondary care

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Key priorities for implementation

Initial response to trauma

- For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident, should **not** be routine practice when delivering services.
- Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by people with post-traumatic stress disorder (PTSD), should be considered. A follow-up contact should be arranged within 1 month.

Trauma-focused psychological treatment

- Trauma-focused cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis.
- All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy [CBT] or eye movement desensitisation and reprocessing [EMDR]). These treatments should normally be provided on an individual outpatient basis.

Children and young people

- Trauma-focused CBT should be offered to older children with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.
- Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused CBT adapted appropriately to suit their age, circumstances and level of development.

Drug treatments for adults

- Drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy.

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- Drug treatments (paroxetine or mirtazapine for general use, and amitriptyline or phenelzine for initiation only by mental health specialists) should be considered for the treatment of PTSD in adults who express a preference not to engage in trauma-focused psychological treatment^[1].

Screening for PTSD

- For individuals at high risk of developing PTSD following a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month after the disaster.

^[1] Paroxetine is the only drug listed with a current UK product licence for PTSD at the date of publication (March 2005).

1 Guidance

1.1 Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) develops following a stressful event or situation of an exceptionally threatening or catastrophic nature, which is likely to cause pervasive distress in almost anyone. PTSD does not therefore develop following those upsetting situations that are described as 'traumatic' in everyday language, for example, divorce, loss of job, or failing an exam. PTSD is a disorder that can affect people of all ages. Around 25–30% of people experiencing a traumatic event may go on to develop PTSD.

1.2 The symptoms of PTSD

The most characteristic symptoms of PTSD are **re-experiencing symptoms**. PTSD sufferers involuntarily re-experience aspects of the traumatic event in a very vivid and distressing way. This includes flashbacks where the person acts or feels as if the event was recurring; nightmares; and repetitive and distressing intrusive images or other sensory impressions from the event. Reminders of the traumatic event arouse intense distress and/or physiological reactions. In children, re-experiencing symptoms may take the form of re-enacting the experience, repetitive play or frightening dreams without recognisable content.

Avoidance of reminders of the trauma is another core symptom of PTSD. This includes people, situations or circumstances resembling or associated with the event. People with PTSD often try to push memories of the event out of their mind and avoid thinking or talking about it in detail, particularly about its worst moments. On the other hand, many ruminate excessively about questions that prevent them from coming to terms with the event (for example, about why the event happened to them, about how it could have been prevented, or about how they could take revenge).

PTSD sufferers also experience symptoms of **hyperarousal** including hypervigilance for threat, exaggerated startle responses, irritability and difficulty concentrating, and sleep problems. Others with PTSD also describe symptoms of **emotional numbing**. These include lack of ability to experience feelings, feeling detached from other people, giving up previously significant activities, and amnesia for significant parts of the event.

Symptoms of PTSD often develop immediately after the traumatic event but in some (less than 15% of all sufferers) the onset of symptoms may be delayed. PTSD sufferers may not present for treatment for months or years after the onset of symptoms despite the considerable distress experienced, but PTSD is a treatable disorder even when problems present many years after the traumatic event. Assessment of PTSD can, however, present significant challenges as many people avoid talking about their problems even when presenting with associated complaints.

1.3 Recognition of PTSD

Effective treatment of PTSD can only take place if the disorder is recognised. In some cases, for example following a major disaster, specific arrangements to screen people at risk may be considered. For the vast majority of people with PTSD, opportunities for recognition and identification come as part of routine healthcare interventions, for example, following an assault or an accident for which physical treatment is required, or when a person discloses domestic violence or a history of childhood sexual abuse. Identification of PTSD in children presents particular problems, but is improved if children are asked directly about their experiences.

1.3.1 Recognition in primary care

PTSD can present with a range of symptoms, which in adults are most commonly in the form of very vivid, distressing memories of the event or flashbacks (otherwise known as intrusive or re-experiencing symptoms). However, at times, the most prominent symptoms may be avoidance of trauma-related situations or general social contacts. It is important when recognising and identifying PTSD to ask specific questions in a sensitive manner about both the symptoms and traumatic experiences. A number of problems such as depression are often comorbid with PTSD. Often these problems will improve with the treatment of the PTSD, but where this does not happen or the comorbid disorder impedes the effective treatment of the PTSD it may be appropriate to consider providing specific treatment for that disorder.

1.3.1.1 PTSD may present with a range of symptoms (including re-experiencing, avoidance, hyperarousal, depression, emotional numbing, drug or alcohol misuse and anger) and therefore when assessing for PTSD, members of the primary care team should ask in a sensitive manner whether or not patients with such symptoms have suffered a traumatic experience (which may have occurred many months or years before) and give specific examples of

traumatic events (for example, assaults, rape, road traffic accidents, childhood sexual abuse and traumatic childbirth).

- 1.3.1.2 General practitioners and other members of the primary care team should be aware of traumas associated with the development of PTSD. These include single events such as assaults or road traffic accidents, and domestic violence or childhood sexual abuse.
- 1.3.1.3 For patients with unexplained physical symptoms who are repeated attendees to primary care, members of the primary care team should consider asking whether or not they have experienced a traumatic event and provide specific examples of traumatic events (for example, assaults, rape, road traffic accidents and childhood sexual abuse and traumatic childbirth).
- 1.3.1.4 When seeking to identify PTSD, members of the primary care team should consider asking adults specific questions about re-experiencing (including flashbacks and nightmares) or hyperarousal (including an exaggerated startle response or sleep disturbance). For children, particularly younger children, consideration should be given to asking the child and/or the parents about sleep disturbance or significant changes in sleeping patterns.

1.3.2 Recognition in general hospital settings

Many people attending for medical services in a general hospital setting may have experienced traumatic events. This may be particularly so in emergency departments, and orthopaedic and plastic surgery clinics. For some people with PTSD, this may be the main point of contact with the healthcare system and the opportunity that this presents for the recognition and identification of PTSD should be taken.

- 1.3.2.1 PTSD may present with a range of symptoms (including re-experiencing, avoidance, hyperarousal, depression, emotional numbing and anger) and therefore when assessing for PTSD, members of secondary care medical teams should ask in a sensitive manner whether or not patients with such symptoms have suffered a traumatic experience and give specific examples of traumatic events (for example, assaults, rape, road traffic accidents, childhood sexual abuse and traumatic childbirth).

1.3.3 Screening of individuals involved in a major disaster, programme refugees and asylum seekers

Many individuals involved in a major disaster will suffer both short- and long-term consequences of their involvement. Although the development of single-session debriefing is not recommended, screening of all individuals should be considered by the authorities responsible for developing the local disaster plan. Similarly, the vast majority of programme refugees (people who are brought to the UK from a conflict zone through a programme organised by an agency such as the United Nations High Commission of Refugees) will have experienced major trauma and may benefit from a screening programme.

1.3.3.1 For individuals at high risk of developing PTSD following a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD at 1 month after the disaster.

1.3.3.2 For programme refugees and asylum seekers at high risk of developing PTSD consideration should be given (by those responsible for management of the refugee programme) to the routine use of a brief screening instrument for PTSD as part of the initial refugee healthcare assessment. This should be a part of any comprehensive physical and mental health screen.

1.3.4 Specific recognition issues for children

Children, particularly those aged under 8 years, may not complain directly of PTSD symptoms, such as re-experiencing or avoidance. Instead children may complain of sleeping problems. It is therefore vital that all opportunities for identifying PTSD in children should be taken. Questioning the children as well as parents or guardians will also improve the recognition of PTSD. PTSD is common (up to 30%) in children following attendance at emergency departments for a traumatic injury. Emergency department staff should inform parents or guardians of the risk of their child developing PTSD following emergency attendance for a traumatic injury and advise them on what action to take if symptoms develop.

1.3.4.1 When assessing a child or young person for PTSD, healthcare professionals should ensure that they separately and directly question the child or young person about the presence of PTSD symptoms. They should not rely solely on information from the parent or guardian in any assessment.

- 1.3.4.2 When a child who has been involved in a traumatic event is treated in an emergency department, emergency staff should inform the parents or guardians of the possibility of the development of PTSD, briefly describe the possible symptoms (for example, sleep disturbance, nightmares, difficulty concentrating and irritability) and suggest that they contact their GP if the symptoms persist beyond 1 month.

1.4 Assessment and coordination of care

- 1.4.1 For PTSD sufferers presenting in primary care, GPs should take responsibility for the initial assessment and the initial coordination of care. This includes the determination of the need for emergency medical or psychiatric assessment.
- 1.4.2 Assessment of PTSD sufferers should be conducted by competent individuals and be comprehensive, including physical, psychological and social needs and a risk assessment.
- 1.4.3 Patient preference should be an important determinant of the choice among effective treatments. PTSD sufferers should be given sufficient information about the nature of these treatments to make an informed choice.
- 1.4.4 Where management is shared between primary and secondary care, there should be clear agreement among individual healthcare professionals about the responsibility for monitoring patients with PTSD. This agreement should be in writing (where appropriate, using the Care Programme Approach [CPA]) and should be shared with the patient and, where appropriate, their family and carers.

1.5 Support for families and carers

Families and carers have a central role in supporting people with PTSD. However, depending on the nature of the trauma and its consequences, many families may also need support for themselves. Healthcare professionals should be aware of the impact of PTSD on the whole family.

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- 1.5.1 In all cases of PTSD, healthcare professionals should consider the impact of the traumatic event on all family members and, when appropriate, assess this impact and consider providing appropriate support.
 - 1.5.2 Healthcare professionals should ensure, where appropriate and with the consent of the PTSD sufferer where necessary, that the families of PTSD sufferers are fully informed about common reactions to traumatic events, including the symptoms of PTSD and its course and treatment.
 - 1.5.3 In addition to the provision of information, families and carers should be informed of self-help groups and support groups and encouraged to participate in such groups where they exist.
 - 1.5.4 When a family is affected by a traumatic event, more than one family member may suffer from PTSD. If this is the case, healthcare professionals should ensure that the treatment of all family members is effectively coordinated.

1.6 Practical support and social factors

Practical and social support can play an important part in facilitating a person's recovery from PTSD, particularly immediately after the trauma. Healthcare professionals should be aware of this and advocate for such support when people present with PTSD.

- 1.6.1 Healthcare professionals should identify the need for appropriate information about the range of emotional responses that may develop and provide practical advice on how to access appropriate services for these problems. They should also identify the need for social support and advocate for the meeting of this need.
- 1.6.2 Healthcare professionals should consider offering help or advice to PTSD sufferers or relevant others on how continuing threats related to the traumatic event may be alleviated or removed.

1.7 Language and culture

People with PTSD treated in the NHS come from diverse cultural and ethnic backgrounds and some have no or limited English, but all should be offered the opportunity to benefit from psychological interventions. This can be achieved by the use of interpreters and bicultural therapists. In all cases, healthcare professionals must familiarise themselves with the cultural background of the sufferer.

- 1.7.1 Where a PTSD sufferer has a different cultural or ethnic background from that of the healthcare professionals who are providing care, the healthcare professionals should familiarise themselves with the cultural background of the PTSD sufferer.
- 1.7.2 Where differences of language or culture exist between healthcare professionals and PTSD sufferers, this should not be an obstacle to the provision of effective trauma-focused psychological interventions.
- 1.7.3 Where language or culture differences present challenges to the use of trauma-focused psychological interventions in PTSD, healthcare professionals should consider the use of interpreters and bicultural therapists.
- 1.7.4 Healthcare professionals should pay particular attention to the identification of individuals with PTSD where the culture of the working or living environment is resistant to recognition of the psychological consequences of trauma.

1.8 Care for all people with PTSD

PTSD responds to a variety of effective treatments. All treatment should be supported by appropriate information to sufferers about the likely course of such treatment. A number of factors, which are described below, may modify the nature, timing and course of treatment.

1.8.1 Care across all conditions

- 1.8.1.1 When developing and agreeing a treatment plan with a PTSD sufferer, healthcare professionals should ensure that sufferers receive information

about common reactions to traumatic events, including the symptoms of PTSD and its course and treatment.

- 1.8.1.2 Healthcare professionals should not delay or withhold treatment for PTSD because of court proceedings or applications for compensation.
- 1.8.1.3 Healthcare professionals should be aware that many PTSD sufferers are anxious about and can avoid engaging in treatment. Healthcare professionals should also recognise the challenges that this presents and respond appropriately, for example, by following up PTSD sufferers who miss scheduled appointments.
- 1.8.1.4 Healthcare professionals should treat PTSD sufferers with respect, trust and understanding, and keep technical language to a minimum.
- 1.8.1.5 Healthcare professionals should normally only consider providing trauma-focused psychological treatment when the sufferer considers it safe to proceed.
- 1.8.1.6 Treatment should be delivered by competent individuals who have received appropriate training. These individuals should receive appropriate supervision.

1.8.2 Comorbidities

- 1.8.2.1 When a patient presents with PTSD and depression, healthcare professionals should consider treating the PTSD first, as the depression will often improve with successful treatment of the PTSD.
- 1.8.2.2 For PTSD sufferers whose assessment identifies a high risk of suicide or harm to others, healthcare professionals should first concentrate on management of this risk.
- 1.8.2.3 For PTSD sufferers who are so severely depressed that this makes initial psychological treatment of PTSD very difficult (for example, as evidenced by extreme lack of energy and concentration, inactivity, or high suicide risk), healthcare professionals should treat the depression first.

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- 1.8.2.4 For PTSD sufferers with drug or alcohol dependence or in whom alcohol or drug use may significantly interfere with effective treatment, healthcare professionals should treat the drug or alcohol problem first.
- 1.8.2.5 When offering trauma-focused psychological interventions to PTSD sufferers with comorbid personality disorder, healthcare professionals should consider extending the duration of treatment.
- 1.8.2.6 People who have lost a close friend or relative due to an unnatural or sudden death should be assessed for PTSD and traumatic grief. In most cases, healthcare professionals should treat the PTSD first without avoiding discussion of the grief.

1.9 *The treatment of PTSD*

1.9.1 Early interventions

A number of sufferers with PTSD may recover with no or limited interventions. However, without effective treatment, many people may develop chronic problems over many years. The severity of the initial traumatic response is a reasonable indicator of the need for early intervention, and treatment should not be withheld in such circumstances.

Watchful waiting

- 1.9.1.1 Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by individual sufferers, should be considered by healthcare professionals. A follow-up contact should be arranged within 1 month.

Immediate psychological interventions for all

As described in this guideline, practical support delivered in an empathetic manner is important in promoting recovery for PTSD, but it is unlikely that a single session of a psychological intervention will be helpful.

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- 1.9.1.2 All health and social care workers should be aware of the psychological impact of traumatic incidents in their immediate post-incident care of survivors and offer practical, social and emotional support to those involved.
- 1.9.1.3 For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident should **not** be routine practice when delivering services.

PTSD where symptoms are present within 3 months of a trauma

Brief psychological interventions (5 sessions) may be effective if treatment starts within the first month after the traumatic event. Beyond the first month, the duration of treatment is similar to that for chronic PTSD.

- 1.9.1.4 Trauma-focused cognitive behavioural therapy should be offered to those with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis.
- 1.9.1.5 Trauma-focused cognitive behavioural therapy should be offered to people who present with PTSD within 3 months of a traumatic event.
- 1.9.1.6 The duration of trauma-focused cognitive behavioural therapy should normally be 8–12 sessions, but if the treatment starts in the first month after the event, fewer sessions (about 5) may be sufficient. When the trauma is discussed in the treatment session, longer sessions (for example, 90 minutes) are usually necessary. Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person.
- 1.9.1.7 Drug treatment may be considered in the acute phase of PTSD for the management of sleep disturbance. In this case, hypnotic medication may be appropriate for short-term use but, if longer-term drug treatment is required, consideration should also be given to the use of suitable antidepressants at an early stage in order to reduce the later risk of dependence.

1.9.1.8 Non-trauma-focused interventions such as relaxation or non-directive therapy, that do not address traumatic memories, should not routinely be offered to people who present with PTSD symptoms within 3 months of a traumatic event.

1.9.2 PTSD where symptoms have been present for more than 3 months after a trauma

Most patients presenting with PTSD have had the problem for many months, if not years. The interventions outlined below are effective in treating such individuals and duration of the disorder does not itself seem an impediment to benefiting from effective treatment provided by competent healthcare professionals.

Psychological interventions

1.9.2.1 All PTSD sufferers should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing). These treatments should normally be provided on an individual outpatient basis.

1.9.2.2 Trauma-focused psychological treatment should be offered to PTSD sufferers regardless of the time that has elapsed since the trauma.

1.9.2.3 The duration of trauma-focused psychological treatment should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person.

1.9.2.4 Healthcare professionals should consider extending the duration of treatment beyond 12 sessions if several problems need to be addressed in the treatment of PTSD sufferers, particularly after multiple traumatic events, traumatic bereavement, or where chronic disability resulting from the trauma, significant comorbid disorders or social problems are present. Trauma-focused treatment needs to be integrated into an overall plan of care.

- 1.9.2.5 For some PTSD sufferers, it may initially be very difficult and overwhelming to disclose details of their traumatic events. In these cases, healthcare professionals should consider devoting several sessions to establishing a trusting therapeutic relationship and emotional stabilisation before addressing the traumatic event.
- 1.9.2.6 Non-trauma-focused interventions such as relaxation or non-directive therapy, which do not address traumatic memories, should not routinely be offered to people who present with chronic PTSD.
- 1.9.2.7 For PTSD sufferers who have no or only limited improvement with a specific trauma-focused psychological treatment, healthcare professionals should consider the following options:
- an alternative form of trauma-focused psychological treatment
 - the augmentation of trauma-focused psychological treatment with a course of pharmacological treatment.
- 1.9.2.8 When PTSD sufferers request other forms of psychological treatment (for example, supportive therapy/non-directive therapy, hypnotherapy, psychodynamic therapy or systemic psychotherapy), they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments on PTSD.

1.9.3 Drug treatment

The evidence base for drug treatments in PTSD is very limited. There is evidence of clinically significant benefits for mirtazapine, amitriptyline and phenelzine. (Dietary guidance is required with phenelzine.) For paroxetine there were statistically but not clinically significant benefits on the main outcome variables. Nevertheless this drug has also been included in the list of recommended drugs. This is the only drug in the list of recommendations with a current UK product licence for PTSD.

- 1.9.3.1 Drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy.

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- 1.9.3.2 Drug treatments (paroxetine or mirtazapine for general use, and amitriptyline or phenelzine for initiation only by mental health specialists) should be considered for the treatment of PTSD in adults where a sufferer expresses a preference not to engage in a trauma-focused psychological treatment.
- 1.9.3.3 Drug treatments (paroxetine or mirtazapine for general use and amitriptyline or phenelzine for initiation only by mental health specialists) should be offered to adult PTSD sufferers who cannot start a psychological therapy because of serious ongoing threat of further trauma (for example, where there is ongoing domestic violence).
- 1.9.3.4 Drug treatments (paroxetine or mirtazapine for general use and amitriptyline or phenelzine for initiation only by mental health specialists) should be considered for adult PTSD sufferers who have gained little or no benefit from a course of trauma-focused psychological treatment.
- 1.9.3.5 Where sleep is a major problem for an adult PTSD sufferer, hypnotic medication may be appropriate for short-term use but, if longer-term drug treatment is required, consideration should also be given to the use of suitable antidepressants at an early stage in order to reduce the later risk of dependence.
- 1.9.3.6 Drug treatments (paroxetine or mirtazapine for general use and amitriptyline or phenelzine for initiation only by mental health specialists) for PTSD should be considered as an adjunct to psychological treatment in adults where there is significant comorbid depression or severe hyperarousal that significantly impacts on a sufferer's ability to benefit from psychological treatment^[2].
- 1.9.3.7 When an adult sufferer with PTSD has not responded to a drug treatment, consideration should be given to increasing the dose within approved limits. If further drug treatment is considered, this should generally be with a different class of antidepressant or involve the use of adjunctive olanzapine.
- 1.9.3.8 When an adult sufferer with PTSD has responded to drug treatment, it should be continued for at least 12 months before gradual withdrawal.

General recommendations regarding drug treatment

- 1.9.3.9 All PTSD sufferers who are prescribed antidepressants should be informed, at the time that treatment is initiated, of potential side effects and discontinuation/withdrawal symptoms (particularly with paroxetine).
- 1.9.3.10 Adult PTSD sufferers started on antidepressants who are considered to present an increased suicide risk and all patients aged between 18 and 29 years (because of the potential increased risk of suicidal thoughts associated with the use of antidepressants in this age group) should normally be seen after 1 week and frequently thereafter until the risk is no longer considered significant.
- 1.9.3.11 Particularly in the initial stages of SSRI treatment, practitioners should actively seek out signs of akathisia, suicidal ideation, and increased anxiety and agitation. They should also advise PTSD sufferers of the risk of these symptoms in the early stages of treatment and advise them to seek help promptly if these are at all distressing.
- 1.9.3.12 If a PTSD sufferer develops marked and/or prolonged akathisia while taking an antidepressant, the use of the drug should be reviewed.
- 1.9.3.13 Adult PTSD sufferers started on antidepressants who are not considered to be at increased risk of suicide should normally be seen after 2 weeks and thereafter on an appropriate and regular basis, for example, at intervals of 2–4 weeks in the first 3 months and at greater intervals thereafter, if response is good.

Recommendations regarding discontinuation/withdrawal symptoms

- 1.9.3.14 Discontinuation/withdrawal symptoms are usually mild and self-limiting but occasionally can be severe. Prescribers should normally gradually reduce the doses of antidepressants over a 4-week period, although some people may require longer periods.

1.9.3.15 If discontinuation/ withdrawal symptoms are mild, practitioners should reassure the PTSD sufferer and arrange for monitoring. If symptoms are severe, the practitioner should consider reintroducing the original antidepressant (or another with a longer half-life from the same class) and reduce gradually while monitoring symptoms.

1.9.4 Chronic disease management

1.9.4.1 Chronic disease management models should be considered for the management of people with chronic PTSD who have not benefited from a number of courses of evidence-based treatment.

1.9.5 Children

It is particularly difficult to identify PTSD in children (see [section 1.3.4](#)). The treatments for children with PTSD are less developed but emerging evidence provides an indication for effective interventions.

Early intervention

1.9.5.1 Trauma-focused cognitive behavioural therapy should be offered to older children with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.

PTSD where symptoms have been present for more than 3 months after a trauma

1.9.5.2 Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused cognitive behavioural therapy adapted appropriately to suit their age, circumstances and level of development.

1.9.5.3 The duration of trauma-focused psychological treatment for children and young people with chronic PTSD should normally be 8–12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are usually necessary (for example, 90 minutes). Treatment should be regular and continuous (usually at least once a week) and should be delivered by the same person.

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- 1.9.5.4 Drug treatments should not be routinely prescribed for children and young people with PTSD.
- 1.9.5.5 Where appropriate, families should be involved in the treatment of PTSD in children and young people. However, treatment programmes for PTSD in children and young people that consist of parental involvement alone are unlikely to be of any benefit for PTSD symptoms.
- 1.9.5.6 When considering treatments for PTSD, parents and, where appropriate, children and young people should be informed that, apart from trauma-focused psychological interventions, there is at present no good evidence for the efficacy of widely-used forms of treatment of PTSD such as play therapy, art therapy or family therapy.

1.10 Disaster planning

Both health and social services have a role in organising the appropriate social and psychological support for those affected by disaster.

- 1.10.1 Disaster plans should include provision for a fully coordinated psychosocial response to the disaster. Those responsible for developing the psychosocial aspect of a disaster plan should ensure it contains the following: provision for immediate practical help, means to support the affected communities in caring for those involved in the disaster, and the provision of specialist mental health, evidence-based assessment and treatment services. All healthcare workers involved in a disaster plan should have clear roles and responsibilities, which should be agreed in advance.

^[2] Paroxetine is the only drug listed with a current UK product licence for PTSD at the date of publication (March 2005).

2 Notes on the scope of the guidance

All NICE guidelines are developed in accordance with a scope document that defines what the guideline will and will not cover. The scope of this guideline was established at the start of the development of this guideline, following a period of consultation.

This guideline is relevant to PTSD sufferers, to their carers, and to all healthcare professionals involved in the help, treatment and care of PTSD sufferers. These include the following.

- Professional groups who share in the treatment and care of people with a diagnosis of PTSD, including psychiatrists, clinical psychologists, mental health nurses, community psychiatric nurses, social workers, practice nurses, secondary care medical staff and paramedical staff, occupational therapists, pharmacists, paediatricians, other physicians, general medical practitioners and family/other therapists.
- Professionals in other health and non-health sectors who may have direct contact with or are involved in the provision of health and other public services for those diagnosed with PTSD. These may include prison doctors, the police and professionals who work in the criminal justice and education sectors.
- Those with responsibility for planning services for people with a diagnosis of PTSD and their carers, including directors of public health, NHS trust managers and managers in primary care trusts.

The guidance does not specifically address treatments that are not normally available on the NHS.

3 Implementation in the NHS

3.1 In general

Local health communities should review their existing practice in the treatment and management of PTSD against this guideline. The review should consider the resources required to implement the recommendations set out in [Section 1](#), the people and processes involved and the timeline over which full implementation is envisaged. It is in the interests of PTSD sufferers that the implementation timeline is as rapid as possible.

Relevant local clinical guidelines, care pathways and protocols should be reviewed in the light of this guidance and revised accordingly.

This guideline should be used in conjunction with the [National Service Framework for Mental Health](#).

3.2 Audit

Suggested audit criteria are listed in the [NICE guideline](#). These can be used as the basis for local clinical audit, at the discretion of those in practice.

4 Research recommendations

The following research recommendations have been identified for this NICE guideline.

1. Guided self-help

A randomised controlled trial, using newly developed guided self-help (GSH) materials based on trauma-focused psychological interventions, should be conducted to assess the efficacy and cost effectiveness of guided self-help compared with trauma-focused psychological interventions for mild and moderate PTSD.

2. Children and young people

Randomised controlled trials for children of all ages should be conducted to assess the efficacy and cost effectiveness of trauma-focused psychological treatments (specifically CBT and EMDR). These trials should identify the relative efficacy of different trauma-focused psychological interventions and provide information on the differential effects, if any, arising from the age of the children or the nature of the trauma experienced.

3. Trauma-focused psychological interventions in adults

Adequately powered effectiveness trials of trauma-focused psychological interventions for the treatment of PTSD (TF-CBT and EMDR) should be conducted. They should provide evidence on the comparative effectiveness and cost effectiveness of these interventions and consider the format of treatment (type and duration) and the specific populations who may benefit.

4. Screening programme

An appropriately designed longitudinal study should be conducted to determine if a simple screening instrument, which is acceptable to those receiving it, can identify individuals who develop PTSD after traumatic events and can be used as part of a screening programme to ensure individuals with PTSD receive effective interventions.

5. Trauma-focused psychological treatment versus pharmacological treatment

Adequately powered, appropriately designed trials should be conducted to determine if trauma-focused psychological treatments are superior in terms of efficacy and cost effectiveness to pharmacological treatments in the treatment of PTSD and whether they are efficacious and cost effective in combination.

5 Other versions of this guideline

5.1 Full guideline

The National Institute for Clinical Excellence commissioned the development of this guidance from [the National Collaborating Centre for Mental Health](#). The Centre established a Guideline Development Group, which reviewed the evidence and developed the recommendations. The full guideline, [post-traumatic stress disorder \(PTSD\): the management of PTSD in primary and secondary care](#), is published by the National Collaborating Centre for Mental Health.

The members of the Guideline Development Group are listed in [Appendix B](#). Information about the independent Guideline Review Panel is given in [Appendix C](#).

There is more information about [how NICE clinical guidelines are developed](#) on the NICE website. A booklet, 'How NICE clinical guidelines are developed: an overview for stakeholders, the public and the NHS' is [available](#).

5.2 NICE pathway

The recommendations from this guideline have been incorporated into a [NICE pathway](#).

5.3 Information for the public

NICE has produced [information for the public](#) explaining this guideline.

We encourage NHS and third sector, including voluntary organisations, to use text from this information in their own materials about post-traumatic stress disorder.

6 Related NICE guidance

Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE Clinical Guideline No. 22 (December 2004). [Replaced by [NICE clinical guideline 113](#)]

Depression: management of depression in primary and secondary care. NICE Clinical Guideline No. 23 (December 2004). [Replaced by [NICE clinical guideline 90](#)]

Self-harm: The short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. [NICE Clinical Guideline No. 16](#) (July 2004).

7 Review date

The process of reviewing the evidence is expected to begin 4 years after the date of issue of this guideline. Reviewing may begin earlier than 4 years if significant evidence that affects the guideline recommendations is identified sooner. The updated guideline will be available within 2 years of the start of the review process.

Appendix A: Grading scheme

The recommendations in this guideline were graded according to the quality of the evidence they were based on. The gradings are available in the [full guideline](#) and are not shown in this web version.

Appendix B: The Guideline Development Group

Dr Jonathan Bisson (Co-Chair, Guideline Development Group)

Clinical Senior Lecturer in Psychiatry, Cardiff University

Professor Anke Ehlers (Co-Chair, Guideline Development Group)

Professor of Experimental Psychopathology, Institute of Psychiatry, King's College London

Mr Stephen Pilling (Guideline Facilitator)

Co-Director, The National Collaborating Centre for Mental Health

Director, Centre for Outcomes, Research and Effectiveness, University College, London

Consultant Clinical Psychologist Camden and Islington Mental Health and Social Care Trust

Mrs Pamela Dix

PTSD Sufferer Representative

Mr Andrew Murphy

PTSD Sufferer Representative

Mrs S Janet Johnston, MBE

Clinical Director, Ashford Counselling Service

Retired Senior Social Worker, Kent County Council

Founder of the Dover Counselling Centre

Professor David Richards

Professor of Mental Health, University of York

Dr Stuart Turner

Consultant Psychiatrist, Capio Nightingale Hospital

Chair of Trustees, Refugee Therapy Centre and Trustee, Redress

Honorary Senior Lecturer, Royal Free and University College Medical School, London

Professor William Yule

Professor of Applied Child Psychology, Institute of Psychiatry, King's College London

Mr Christopher Jones

Health Economist, The National Collaborating Centre for Mental Health

Ms Rebecca King

Project Manager, The National Collaborating Centre for Mental Health

Ms Rosa Matthews

Systematic Reviewer, The National Collaborating Centre for Mental Health

Ms Peggy Nuttall

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Mr Cesar De Oliveira

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Dr Clare Taylor

Editor, The National Collaborating Centre for Mental Health

Ms Lois Thomas

Research Assistant, The National Collaborating Centre for Mental Health

Ms Heather Wilder

Information Scientist, The National Collaborating Centre for Mental Health

Appendix C: The Guideline Review Panel

The Guideline Review Panel is an independent panel that oversees the development of the guideline and takes responsibility for monitoring its quality. The Panel includes experts on guideline methodology, healthcare professionals and people with experience of the issues affecting patients and carers. The members of the Guideline Review Panel were as follows.

Member	Area of expertise/ experience
Dr Chaand Nagpaul GP, Stanmore	Clinical practice
Mr John Seddon Patient Representative	Patient and carer issues
Professor Kenneth Wilson Professor of Psychiatry of Old Age and Honorary Consultant Psychiatrist, Cheshire and Wirral Partnership NHS Trust	Methodology
Professor Shirley Reynolds Professor of Clinical Psychology, School of Medicine, Health Policy and Practice, University of East Anglia, Norwich	Clinical practice
Dr Roger Paxton R&D Director, Newcastle, North Tyneside and Northumberland Mental Health NHS Trust	Implementation
Dr Paul Rowlands Consultant Psychiatrist, Derbyshire Mental Health Services Mental Health Care Trust	Clinical practice
Dr Catriona McMahon Medical Head, Specialist Care, Astra Zeneca	Industry representative

Appendix D: Technical detail on the criteria for audit

Possible objectives for an audit

One or more audits could be carried out in different care settings to ensure that:

- individuals with PTSD are involved in their care
- treatment options, including psychological interventions, are

appropriately offered and provided for individuals with PTSD.

People who could be included in an audit

A single audit could include all individuals with PTSD. Alternatively, individual audits could be undertaken on specific groups of individuals such as:

- people with a specific type of PTSD (for example, to study early intervention)
- a sample of patients from particular populations in primary care.

Measures that could be used as a basis for an audit

Recommendation	Measured by	Exception	Definition of terms
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<p>1. Brief, single-session interventions (debriefing)</p> <p>For individuals who have experienced a traumatic event, the systematic provision to that individual alone of brief, single-session interventions (often referred to as debriefing) that focus on the traumatic incident, should not be routine practice when delivering services.</p>	<p>100% of individuals who have experienced a traumatic event should not be offered single-session interventions (often referred to as debriefing).</p>	<p>None</p>	<p>Operational policies of relevant organisations should contain copies of relevant protocols and implementation plans, which specify that single-session debriefing should not be routinely provided.</p>
<p>2. Watchful waiting</p> <p>Where symptoms are mild and have been present for less than 4 weeks after the trauma, watchful waiting, as a way of managing the difficulties presented by individual sufferers, should be considered by healthcare professionals. A follow-up contact should be arranged within 1 month.</p>	<p>100% of patients identified as suffering from PTSD who are not offered or who decline an active intervention should have arranged a follow-up contact within 4 weeks.</p>	<p>Individuals who are offered the follow-up but who, for personal or practical reasons, are not able to attend within 4 weeks.</p>	<p>The notes should indicate that the healthcare professional responsible has discussed the need for follow-up and an arrangement has been made for a contact to be made.</p>

<p>3. Trauma-focused psychological treatment</p> <p>Trauma-focused cognitive behavioural therapy should be offered to those with severe posttraumatic symptoms or with severe PTSD in the first month after the traumatic event. These treatments should normally be provided on an individual outpatient basis.</p> <p>All people with PTSD should be offered a course of trauma-focused psychological treatment (trauma-focused CBT or EMDR). These treatments should normally be provided on an individual outpatient basis.</p>	<p>100% of PTSD sufferers with symptoms present for more than 3 months should be considered for trauma-focused psychological treatment.</p>	<p>Those who request or have taken up the offer of another intervention.</p>	<p>The notes should indicate that the patient was informed of the possibility of trauma-focused CBT.</p> <p>The notes should record if the patient completes a full course of treatment.</p>
<p>4. Trauma-focused cognitive behavioural therapy for older children with PTSD</p> <p>Trauma-focused cognitive behavioural therapy should be offered to older children with severe post-traumatic symptoms or with severe PTSD in the first month after the traumatic event.</p>	<p>100% of children and young people with severe post-traumatic symptoms seen within 1 month of the traumatic event should be considered for trauma-focused CBT.</p>	<p>Those who request or have taken up the offer of another intervention.</p>	<p>The notes should indicate that the patient was informed of the possibility of trauma-focused CBT.</p> <p>The notes should record if the patient completes a full course of treatment.</p>

<p>5. Trauma-focused cognitive behavioural therapy for chronic PTSD in children and young people</p> <p>Children and young people with PTSD, including those who have been sexually abused, should be offered a course of trauma-focused cognitive behavioural therapy adapted as needed to suit their age, circumstances and level of development.</p>	<p>100% of children and young people with PTSD should be offered a course for trauma-focused CBT.</p>	<p>Those who request or have taken up the offer of another intervention.</p>	<p>The notes should indicate that the patient was offered trauma-focused CBT.</p> <p>The notes should record if the patient completes a full course of treatment.</p>
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<p>6. Drug treatments for PTSD</p> <p>Drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy.</p>	<p>Drugs should not routinely be used in the treatment of PTSD. The option of trauma-focused psychological treatment should be considered.</p>	<p>Exceptions include:</p> <ul style="list-style-type: none"> a. patients who refuse psychological treatment b. patients who have not responded to psychological interventions c. patients who have significant sleep or related problems of hyperarousal d. patients where safety issues prevent the use of psychological interventions. 	<p>The notes should indicate for all patients in receipt of medication that they were considered for psychological interventions and the reason that this was not taken up – the exceptions set out in this audit apply.</p> <p>The notes should record if the patient completes a full course of treatment.</p>
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<p>7. Drug treatments for PTSD when a patient declines psychological interventions</p> <p>Drug treatments (paroxetine or mirtazapine for general use and amitriptyline or phenelzine for initiation only by mental health specialists) should be considered for the treatment of PTSD in adults who express a preference not to engage in a trauma-focused psychological treatment.</p>	<p>Drugs should be considered in the treatment of PTSD where a sufferer declines the offer of trauma-focused psychological treatment.</p>	<p>None</p>	<p>The notes should indicate for all patients who declined psychological interventions that the option of prescribing appropriate medication was considered. The reason that this was not taken up should be recorded in the notes, which should also record if the patient completes a full course of treatment.</p>
<p>8. Disaster screening</p> <p>For individuals at high risk of developing PTSD following a major disaster, consideration should be given (by those responsible for coordination of the disaster plan) to the routine use of a brief screening instrument for PTSD 1 month after the disaster.</p>	<p>100% of individuals who have been involved in a major disaster should be screened 1 month after the disaster.</p>	<p>Those who refuse to participate in the screening or who are not contactable despite reasonable efforts by those responsible for the screening.</p>	<p>Operational policies of relevant organisations should contain copies of relevant protocols and implementation plans that specify the requirement for screening. Where screening occurs, records should be reviewed to establish the numbers screened.</p>

Calculation of compliance

Compliance (%) with each measure described in the table above is calculated as follows.

Number of patients whose care is consistent with the criterion plus number of patients who meet any exception listed

/

Number of patients to whom the measure applies

× 100

Clinicians should review the findings of measurement, identify whether practice can be improved, agree on a plan to achieve any desired improvement and repeat the measurement of actual practice to confirm that the desired improvement is being achieved.

About this guideline

NICE clinical guidelines are recommendations about the treatment and care of people with specific diseases and conditions in the NHS in England and Wales.

The guideline was developed by the National Collaborating Centre for Mental Health. The Collaborating Centre worked with a group of healthcare professionals (including consultants, GPs and nurses), patients and carers, and technical staff, who reviewed the evidence and drafted the recommendations. The recommendations were finalised after public consultation.

The methods and processes for developing NICE clinical guidelines are described in [The guidelines manual](#).

We have produced [information for the public](#) explaining this guideline. Tools to help you put the guideline into practice and information about the evidence it is based on are also [available](#).

Changes after publication

March 2014: minor maintenance

November 2012: minor maintenance

March 2012: minor maintenance

Your responsibility

This guidance represents the view of NICE, which was arrived at after careful consideration of the evidence available. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have

regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way that would be inconsistent with compliance with those duties.

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