



Post-traumatic stress disorder

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

All problems (adverse events) related to a medicine or medical device used for treatment or in a procedure should be reported to the Medicines and Healthcare products Regulatory Agency using the [Yellow Card Scheme](#).

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should [assess and reduce the environmental impact of implementing NICE recommendations](#) wherever possible.

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This guideline replaces CG26.

This guideline is the basis of QS53.

Overview

This guideline covers recognising, assessing and treating post-traumatic stress disorder (PTSD) in children, young people and adults. It aims to improve quality of life by reducing symptoms of PTSD such as anxiety, sleep problems and difficulties with concentration. Recommendations also aim to raise awareness of the condition and improve coordination of care.

Who is it for?

- Healthcare professionals
- Other professionals who work with people at risk of or who have PTSD, including in criminal justice and education services and non-government organisations
- Commissioners and providers, including directors of public health, NHS trust managers and managers in clinical commissioning groups
- People at risk of or who have PTSD (including complex PTSD), their families and carers, and the public

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in [NICE's information on making decisions about your care](#).

Recommendations in this guideline relate to everyone who is at risk of or has post-traumatic stress disorder (PTSD). The guideline has looked at inequalities relating to gender, sexual orientation, gender reassignment, age, homelessness, refugees and asylum seekers, illegal immigrants, undocumented workers, people with neurodevelopmental disorders, people with coexisting conditions, and people who are critically ill.

[Making decisions using NICE guidelines](#) explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

Health and care professionals should follow our general guidelines for people delivering care:

- [babies, children and young people's experience of healthcare](#)
- [decision making and mental capacity](#)
- [medicines adherence](#)
- [medicines associated with dependence or withdrawal symptoms: safe prescribing and withdrawal management for adults](#)
- [medicines optimisation](#)
- [multimorbidity](#)
- [service user experience in adult mental health](#)
- [shared decision making](#)
- [supporting adult carers](#)
- [transition between inpatient mental health settings and community or care home](#)

settings

- transition from children's to adults' services.

1.1 Recognition of post-traumatic stress disorder

1.1.1 Be aware that people with post-traumatic stress disorder (PTSD), including complex PTSD, may present with a range of symptoms associated with functional impairment, including:

- re-experiencing
- avoidance
- hyperarousal (including hypervigilance, anger and irritability)
- negative alterations in mood and thinking
- emotional numbing
- dissociation
- emotional dysregulation
- interpersonal difficulties or problems in relationships
- negative self-perception (including feeling diminished, defeated or worthless). **[2005, amended 2018]**

1.1.2 Be aware of traumatic events associated with the development of PTSD. These could be experiencing or witnessing single, repeated or multiple events and could include, for example:

- serious accidents
- physical and sexual assault
- abuse, including childhood or domestic abuse

- work-related exposure to trauma, including remote exposure
 - trauma related to serious health problems or childbirth experiences (for example, intensive care admission or neonatal death)
 - war and conflict
 - torture. **[2005, amended 2018]**
- 1.1.3 When assessing for PTSD, ask people specific questions about re-experiencing, avoidance, hyperarousal, dissociation, negative alterations in mood and thinking, and associated functional impairment. **[2005, amended 2018]**
- 1.1.4 When assessing for PTSD, ask people with symptoms in recommendation 1.1.1 if they have experienced 1 or more traumatic events (which may have occurred many months or years before). Give specific examples of traumatic events as listed in recommendation 1.1.2. **[2005, amended 2018]**
- 1.1.5 For people with unexplained physical symptoms who repeatedly attend health services, think about asking whether they have experienced 1 or more traumatic events and provide specific examples of traumatic events (see recommendation 1.1.2). **[2005, amended 2018]**

Specific recognition issues for children

- 1.1.6 When a child who has been involved in a traumatic event is treated in an emergency department, emergency staff should explain to their parents or carers about the normal responses to trauma and the possibility of PTSD developing. Briefly describe the possible symptoms (for example, nightmares, repetitive trauma-related play, intrusive thoughts, avoiding things related to the event, increased behavioural difficulties, problems concentrating, hypervigilance, and difficulties sleeping), and suggest they contact their GP if the symptoms persist beyond 1 month. **[2005, amended 2018]**

Screening of people involved in a major disaster, refugees and asylum seekers

- 1.1.7 For people at high risk of developing PTSD after a major disaster, those responsible for coordinating the [disaster plan](#) should think about the routine use of a validated, brief screening instrument for PTSD at 1 month after the disaster. **[2005, amended 2018]**
- 1.1.8 For refugees and asylum seekers at high risk of PTSD, think about the routine use of a validated, brief screening instrument for PTSD as part of any comprehensive physical and mental health screen. **[2005, amended 2018]**

1.2 Assessment and coordination of care

- 1.2.1 For people with [clinically important symptoms](#) of PTSD presenting in primary care, GPs should take responsibility for assessment and initial coordination of care. This includes determining the need for emergency physical or mental health assessment. **[2005, amended 2018]**
- 1.2.2 Assessment of people with PTSD should be comprehensive, including an assessment of physical, psychological and social needs and a risk assessment. **[2005, amended 2018]**
- 1.2.3 Where management is shared between primary and secondary care, healthcare professionals should agree who is responsible for monitoring people with PTSD. Put this agreement in writing (if appropriate, using the Care Programme Approach) and involve the person and, if appropriate, their family or carers. **[2005, amended 2018]**

Supporting transitions between services

- 1.2.4 Provide additional support:
- to children and young people with PTSD who are within the care system when they are transitioning between services or settings

- during admission and discharge to people with PTSD who are admitted to hospital because of other mental or physical health problems.

Follow [NICE's guidelines on transition from children's to adults' services for young people using health or social care services, common mental health problems: identification and pathways to care and transition between inpatient mental health settings and community or care home settings](#).

[2018]

- 1.2.5 During transitions between services for people with PTSD who need ongoing care, the referring team should not discharge the person before a care plan has been agreed in the new service. **[2018]**

For a short explanation of why the committee made the 2018 recommendations and how they might affect practice, see the [rationale and impact section on supporting transitions between services](#).

Full details of the evidence and the committee's discussion are in [evidence review J: care pathways for adults, children and young people with PTSD](#).

1.3 Access to care

- 1.3.1 Promote access to services for people with PTSD by:

- reassuring them that PTSD is a treatable condition
- providing care that places a positive emphasis on the range of interventions offered and their likely benefits
- ensuring that methods of access to services take into account the needs of specific populations of people with PTSD, including migrants and asylum seekers, people who are homeless or not registered with a GP, looked-after children and young people, and preschool-aged children
- minimising the need to move between different services or providers
- providing multiple points of access to the service, including self-referral

- establishing clear links to other care pathways, including for physical healthcare needs
- offering flexible modes of delivery, such as care in non-clinical settings such as schools or offices
- offering a choice of therapist that takes into account the person's trauma experience – for example they might prefer a specific gender of therapist
- assessing the need for further treatment or support for people who have not benefited fully from treatment or have relapsed. **[2018]**

1.3.2 Do not delay or withhold treatment for PTSD solely because of court proceedings or applications for compensation. Discuss with the person the implications of the timing of any treatment to help them make an informed decision about if and when to proceed, in line with [Crown Prosecution Service guidance on pre-trial therapy](#). **[2018]**

For a short explanation of why the committee made the 2018 recommendations and how they might affect practice, see the [rationale and impact section on access to care](#).

Full details of the evidence and the committee's discussion are in [evidence review J: care pathways for adults, children and young people with PTSD](#). Other supporting evidence and discussion is in [evidence review H: principles of care](#), and [evidence review I: organisation and delivery of care for people with PTSD](#).

1.4 Principles of care

Peer support

1.4.1 Tell people about and help them access peer support groups if they want to and could benefit. Peer support groups should:

- be facilitated by people with mental health training and supervision

- be delivered in a way that reduces the risk of exacerbating symptoms
- provide information and help to access services. **[2018]**

Maintaining safe environments

- 1.4.2 Be aware of the risk of continued exposure to trauma-inducing environments. Avoid exposing people to triggers that could worsen their symptoms or stop them from engaging with treatment, for example, assessing or treating people in noisy or restricted environments, placing them in a noisy inpatient ward, or restraining them. **[2018]**

Involving and supporting families and carers

- 1.4.3 When providing information and support to family members and carers of people with PTSD, think about covering:
- the treatment and management of trauma-related psychological and behavioural problems, including the person's possible risk to themselves and others
 - how they can support the person to access treatment, including what to do if they do not engage with, or drop out of treatment. **[2018]**
- 1.4.4 Think about the impact of the traumatic event on other family members because more than one family member might have PTSD. Consider further assessment, support and intervention for any family member suspected to have PTSD. **[2018]**
- 1.4.5 For members of the same family who have PTSD after experiencing the same traumatic event, think about what aspects of treatment might be usefully provided together (such as psychoeducation), alongside individual treatments. **[2018]**

For a short explanation of why the committee made the 2018 recommendations and how they might affect practice, see the [rationale and impact section on principles of care](#).

Full details of the evidence and the committee's discussion are in [evidence review H: principles of care](#). Other supporting evidence and discussion is in [evidence review G: psychological and psychosocial interventions for family members](#) and [evidence review J: care pathways for adults, children and young people with PTSD](#).

1.5 Language and culture

- 1.5.1 Pay particular attention to identifying people with PTSD in working or living environments where there may be cultural challenges to recognising the psychological consequences of trauma (see [recommendations on avoiding stigma and promoting social inclusion in the NICE guideline on service user experience in adult mental health](#)). **[2005, amended 2018]**

1.6 Management of PTSD in children, young people and adults

Planning treatment and supporting engagement

- 1.6.1 When discussing treatment options with people with PTSD (and their family members or carers as appropriate), take into account any social or personal factors that may have a role in the development or maintenance of the disorder, such as childhood maltreatment and multiple traumatic experiences. **[2018]**
- 1.6.2 Be aware that people with PTSD may be apprehensive, anxious, or ashamed. They may avoid treatment, believe that PTSD is untreatable, or have difficulty developing trust. Engagement strategies could include following up when people miss appointments and allowing flexibility in service attendance policies. **[2018]**
- 1.6.3 For people with PTSD whose assessment identifies a significant risk of harm to

themselves or others, establish a risk management and safety plan (involving family members and carers if appropriate) as part of initial treatment planning. **[2018]**

For a short explanation of why the committee made the 2018 recommendations and how they might affect practice, see the [rationale and impact section on planning treatment and supporting engagement](#).

Full details of the evidence and the committee's discussion are in [evidence review H: principles of care](#) and [evidence review J: care pathways for adults, children and young people with PTSD](#).

Active monitoring

- 1.6.4 Consider [active monitoring](#) for people with subthreshold symptoms of PTSD within 1 month of a traumatic event. Arrange follow-up contact to take place within 1 month. **[2018]**

For a short explanation of why the committee made the 2018 recommendation and how it might affect practice, see the [rationale and impact section on active monitoring](#).

Full details of the evidence and the committee's discussion are in [evidence review A: psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in children](#) and [evidence review C: psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in adults](#).

Psychologically-focused debriefing

- 1.6.5 Do not offer psychologically-focused debriefing for the prevention or treatment of PTSD. **[2018]**

For a short explanation of why the committee made the 2018 recommendation and how it might affect practice, see the [rationale and impact section on psychologically-focused debriefing](#).

Full details of the evidence and the committee's discussion are in:

- [evidence review A: psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in children](#)
- [evidence review B: psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in children](#)
- [evidence review C: psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in adults](#)
- [evidence review D: psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults](#).

Psychological interventions for the prevention and treatment of PTSD in children and young people

Prevention for children and young people

- 1.6.6 Consider active monitoring or individual trauma-focused cognitive behavioural therapy (CBT) within 1 month of a traumatic event for children and young people aged under 18 years with a diagnosis of [acute stress disorder](#) or [clinically important symptoms](#) of PTSD. **[2018]**
- 1.6.7 Consider a group trauma-focused CBT intervention for children and young people aged 7 to 17 years if there has been an event within the last month leading to large-scale shared trauma. **[2018]**
- 1.6.8 Group trauma-focused CBT interventions for children and young people who have been exposed to large-scale shared trauma within the last month should:
- be based on a validated manual

- typically be provided over 5 to 15 sessions
- be delivered by trained [practitioners](#) with ongoing supervision
- include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning
- involve elaboration and processing of the trauma memories
- involve restructuring trauma-related meanings for the individual
- provide help to overcome avoidance. **[2018]**

For a short explanation of why the committee made the 2018 recommendations and how they might affect practice, see the [rationale and impact section on psychological interventions for the prevention of PTSD in children and young people](#).

Full details of the evidence and the committee's discussion are in [evidence review A: psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in children](#).

Treatment for children and young people

- 1.6.9 Consider an individual trauma-focused CBT intervention for children aged 5 to 6 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event. **[2018]**
- 1.6.10 Consider an individual trauma-focused CBT intervention for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented between 1 and 3 months after a traumatic event. **[2018]**
- 1.6.11 Offer an individual trauma-focused CBT intervention to children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event. **[2018]**

1.6.12 Individual trauma-focused CBT interventions for children and young people should:

- be based on a validated manual
- typically be provided over 6 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas
- be delivered by trained practitioners with ongoing supervision
- be adapted to the child or young person's age and development
- involve parents or carers as appropriate
- include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning
- involve elaboration and processing of the trauma memories
- involve processing trauma-related emotions, including shame, guilt, loss and anger
- involve restructuring trauma-related meanings for the individual
- provide help to overcome avoidance
- prepare them for the end of treatment
- include planning booster sessions if needed, particularly in relation to significant dates (for example trauma anniversaries). **[2018]**

1.6.13 Consider eye movement desensitisation and reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event only if they do not respond to or engage with trauma-focused CBT. **[2018]**

For a short explanation of why the committee made the 2018 recommendations and how they might affect practice, see the [rationale and impact section on psychological interventions for the treatment of PTSD in children and young people](#).

Full details of the evidence and the committee's discussion are in [evidence review B: psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in children](#).

Drug treatments for children and young people

- 1.6.14 Do not offer drug treatments for the prevention or treatment of PTSD in children and young people aged under 18 years. **[2018]**

For a short explanation of why the committee made the 2018 recommendation and how it might affect practice, see the [rationale and impact section on drug treatments for children and young people](#).

Full details of the evidence and the committee's discussion are in [evidence review E: pharmacological interventions for the prevention or treatment of PTSD in children](#).

Psychological interventions for the prevention and treatment of PTSD in adults

Prevention for adults

- 1.6.15 Offer an individual trauma-focused CBT intervention to adults who have acute stress disorder or clinically important symptoms of PTSD and have been exposed to 1 or more traumatic events within the last month. These interventions include:
- cognitive processing therapy
 - cognitive therapy for PTSD
 - narrative exposure therapy

- prolonged exposure therapy. [2018]

For a short explanation of why the committee made the 2018 recommendation and how it might affect practice, see the [rationale and impact section on psychological interventions to prevent PTSD in adults](#).

Full details of the evidence and the committee's discussion are in [evidence review C: psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in adults](#).

Treatment for adults

1.6.16 Offer an individual trauma-focused CBT intervention to adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event. These interventions include:

- cognitive processing therapy
- cognitive therapy for PTSD
- narrative exposure therapy
- prolonged exposure therapy. [2018]

1.6.17 Trauma-focused CBT interventions for adults should:

- be based on a validated manual
- typically be provided over 8 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas
- be delivered by trained practitioners with ongoing supervision
- include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning
- involve elaboration and processing of the trauma memories
- involve processing trauma-related emotions, including shame, guilt, loss and

anger

- involve restructuring trauma-related meanings for the individual
- provide help to overcome avoidance
- have a focus on re-establishing adaptive functioning, for example work and social relationships
- prepare them for the end of treatment
- include planning booster sessions if needed, particularly in relation to significant dates (for example trauma anniversaries). **[2018]**

1.6.18 Consider EMDR for adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented between 1 and 3 months after a non-combat-related trauma if the person has a preference for EMDR. **[2018]**

1.6.19 Offer EMDR to adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a non-combat-related trauma. **[2018]**

1.6.20 EMDR for adults should:

- be based on a validated manual
- typically be provided over 8 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas
- be delivered by trained practitioners with ongoing supervision
- be delivered in a phased manner and include psychoeducation about reactions to trauma; managing distressing memories and situations; identifying and treating target memories (often visual images); and promoting alternative positive beliefs about the self
- use repeated in-session bilateral stimulation (normally with eye movements but use other methods, including taps and tones, if preferred or more appropriate, such as for people who are visually impaired) for specific target memories until the memories are no longer distressing

- include the teaching of self-calming techniques and techniques for managing flashbacks, for use within and between sessions. **[2018]**
- 1.6.21 Consider supported trauma-focused computerised CBT for adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event if they prefer it to face-to-face trauma-focused CBT or EMDR as long as:
- they do not have severe PTSD symptoms, in particular dissociative symptoms **and**
 - they are not at risk of harm to themselves or others. **[2018]**
- 1.6.22 Supported trauma-focused computerised CBT interventions for adults should:
- be based on a validated programme
 - typically be provided over 8 to 10 sessions
 - involve elaboration and processing of the trauma memories; processing trauma-related emotions; restructuring trauma-related meanings for the individual; helping to overcome avoidance; and re-establishing adaptive functioning (for example, work and social relationships)
 - include guidance and support from a trained practitioner to encourage people to complete the intervention, give feedback on homework assignments and review progress and outcomes. **[2018]**
- 1.6.23 Consider CBT interventions targeted at specific symptoms such as sleep disturbance or anger, for adults with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event only if the person:
- is unable or unwilling to engage in a trauma-focused intervention **or**
 - has residual symptoms after a trauma-focused intervention. **[2018]**

For a short explanation of why the committee made the 2018 recommendations and how they might affect practice, see the [rationale and impact section on psychological interventions to treat PTSD in adults](#).

Full details of the evidence and the committee's discussion are in [evidence review D: psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults](#).

Drug treatments for adults

1.6.24 Do not offer drug treatments, including benzodiazepines, to prevent PTSD in adults. **[2018]**

1.6.25 Consider venlafaxine or a selective serotonin reuptake inhibitor (SSRI), such as sertraline, for adults with a diagnosis of PTSD if the person has a preference for drug treatment. Review this treatment regularly. **[2018]**

In December 2018, this was an off-label use for venlafaxine. See [NICE's information on prescribing medicines](#).

In December 2018, only sertraline and paroxetine had a UK marketing authorisation for this indication. See [NICE's information on prescribing medicines](#).

1.6.26 Consider antipsychotics such as risperidone in addition to psychological therapies to manage symptoms for adults with a diagnosis of PTSD if:

- they have disabling symptoms and behaviours, for example severe hyperarousal or psychotic symptoms **and**
- their symptoms have not responded to other drug or psychological treatments.

Antipsychotic treatment should be started and reviewed regularly by a specialist (see [recommendations on how to use antipsychotic medication in NICE's guideline on psychosis and schizophrenia in adults](#)). **[2018]**

In December 2018, this was an off-label use of risperidone. See [NICE's information on prescribing medicines](#).

For a short explanation of why the committee made the 2018 recommendations and how they might affect practice, see the [rationale and impact section on drug treatments in adults](#).

Full details of the evidence and the committee's discussion are in [evidence review F: pharmacological interventions for the treatment of PTSD in adults](#).

1.7 Care for people with PTSD and complex needs

1.7.1 For people presenting with PTSD and depression:

- usually treat the PTSD first because the depression will often improve with successful PTSD treatment
- treat the depression first if it is severe enough to make psychological treatment of the PTSD difficult, or there is a risk of the person harming themselves or others. **[2018]**

1.7.2 Do not exclude people with PTSD from treatment based solely on comorbid drug or alcohol misuse. **[2018]**

1.7.3 For people with additional needs, including those with [complex PTSD](#):

- build in extra time to develop trust with the person, by increasing the duration or the number of therapy sessions according to the person's needs
- take into account the safety and stability of the person's personal circumstances (for example their housing situation) and how this might affect engagement with and success of treatment
- help the person manage any issues that might be a barrier to engaging with trauma-focused therapies, such as substance misuse, dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception

- work with the person to plan any ongoing support they will need after the end of treatment, for example to manage any residual PTSD symptoms or comorbidities. **[2018]**

For a short explanation of why the committee made the 2018 recommendations and how they might affect practice, see the [rationale and impact section on care for people with PTSD and complex needs](#).

Full details of the evidence and the committee's discussion are in [evidence review D: psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults](#) and [evidence review J: care pathways for adults, children and young people with PTSD](#).

1.8 Disaster planning

- 1.8.1 Ensure that [disaster plans](#) provide a fully coordinated psychosocial response to the disaster. A disaster plan should include:
- immediate practical help
 - support for the affected communities in caring for those involved in the disaster
 - access to specialist mental health, evidence-based assessment and treatment services
 - clear roles and responsibilities for all professionals involved. **[2005]**

Terms used in this guideline

Active monitoring

Also known as watchful waiting. This means regularly monitoring a person who has some symptoms but who is not currently having clinical intervention for the condition.

Acute stress disorder

Acute stress disorder is a DSM-5 diagnosis that applies in the first month after a traumatic event. It requires the presence of 9 or more symptoms from any of the 5 categories of intrusion, negative mood, dissociation, avoidance and arousal. These can be starting or worsening after the traumatic event.

Clinically important symptoms

People with clinically important symptoms of PTSD refer to those who are assessed as having PTSD on a validated scale, as indicated by baseline scores above clinical threshold, but who do not necessarily have a diagnosis of PTSD. They are typically referred to in studies that have not used a clinical interview to arrive at a formal diagnosis of PTSD and instead have only used self-report measures of PTSD symptoms.

Combat-related trauma

Combat-related trauma refers to traumatic incidents associated with military combat. In many cases, the sorts of traumas that military personnel encounter are not particularly distinct from those encountered by civilians. However, they might include having to contend with challenging situations to which there is no correct answer, which may lead to shame or guilt (known as moral injuries).

Complex PTSD

Complex PTSD develops in a subset of people with PTSD. It is a diagnosis in the ICD-11, which defines it as arising after exposure to an event or series of events of an extremely threatening or horrific nature, most commonly prolonged or repetitive events from which escape is difficult or impossible (for example, torture, slavery, genocide campaigns, prolonged domestic violence, repeated childhood sexual or physical abuse). The disorder is characterised by the core symptoms of PTSD; that is, all diagnostic requirements for PTSD are met. In addition, complex PTSD is characterised by:

- severe and pervasive problems in affect regulation
- persistent beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event
- persistent difficulties in sustaining relationships and in feeling close to others.

DSM-5 does not include a diagnosis of complex PTSD. It covers the complexity of presentation through a wider range of core PTSD symptoms (such as 'negative mood and cognitions') and the potential specifier of a 'dissociative subtype'.

Disaster plan

A plan setting out the overall framework for starting, managing, coordinating and controlling staff and other resources to reduce, control or respond to an emergency.

Practitioner

A person with mental health training, particularly in PTSD, who also has training and competence in delivering interventions for PTSD.

Recommendations for research

As part of the 2018 update, the guideline committee removed the 2005 recommendations for research and replaced them with the recommendations for research below.

Key recommendations for research

1 Stepped care for post-traumatic stress disorder

What is the clinical and cost effectiveness of stepped care for post-traumatic stress disorder (PTSD)?

For an explanation of why the committee made this recommendation for research, see [appendix L of evidence review I: organisation and delivery of care for people with PTSD](#).

2 Sequencing and further line treatment

What is the clinical and cost effectiveness of sequencing and further line treatment in PTSD?

For an explanation of why the committee made this recommendation for research, see [appendix L of evidence review D: psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults](#).

3 Trauma-informed approaches

What is the clinical and cost effectiveness of trauma-informed care or trauma-informed approaches?

For an explanation of why the committee made this recommendation for research, see [appendix L of evidence review I: organisation and delivery of care for people with PTSD](#).

4 Personalisation and risk markers

What prognostic and prescriptive factors are important in determining the choice of PTSD treatment?

For an explanation of why the committee made this recommendation for research, see [appendix L of evidence review D: psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults](#).

5 Complex PTSD

What is the clinical and cost effectiveness of interventions to deliver stabilisation and reintegration for people with [complex PTSD](#)?

For an explanation of why the committee made this recommendation for research, see [appendix L of evidence review D: psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults](#).

Other recommendations for research

6 Emotional freedom techniques

What is the clinical and cost effectiveness of emotional freedom techniques (EFT) for the treatment of PTSD in adults?

For an explanation of why the committee made this recommendation for research, see [appendix L of evidence review D: psychological, psychosocial and other non-pharmacological interventions for the treatment of PTSD in adults](#).

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Supporting transitions between services

[Recommendations 1.2.4 to 1.2.5](#)

Why the committee made the recommendations

There was not enough good evidence about access to care, developing care pathways and coordinating care, so the committee drew on sources from other mental health disorders describing pathways and systems that support access and engagement with care. Based on this information they used a formal consensus method to make recommendations on good practice.

They noted that overall coordination and continuity of care could be achieved by having a key professional to oversee the whole period of care – they agreed that this was already covered by the [recommendations on GPs taking responsibility and management shared between primary and secondary care in the section on assessment and coordination of care](#). The committee also identified certain groups that might need extra support during care transitions.

How the recommendations might affect practice

These recommendations will help to improve the way in which care is provided and improve consistency between services. Any resource impact should be offset by time savings and efficiency benefits from improved care coordination and continuity.

[Return to recommendations](#)

Access to care

[Recommendations 1.3.1 and 1.3.2](#)

Why the committee made the recommendations

In the absence of good evidence the committee used formal consensus to recommend some key strategies for promoting access to care. Based on their clinical experience the committee agreed that a common barrier to accessing care can be the person's belief that PTSD is untreatable. The committee agreed it was important to present a more hopeful and optimistic picture of the treatment of PTSD.

They also discussed evidence on delivering care more flexibly. Qualitative evidence showed that some people with PTSD prefer to have their treatment away from a clinical environment. There was also clinical evidence that some types of remote care (for example, computerised trauma-focused cognitive behavioural therapy [CBT] and video consultation) can be as successful as face-to-face interventions. Based on this, the committee agreed that delivering care in more flexible ways, including by making it available in non-clinical locations like schools or offices, would improve access.

How the recommendations might affect practice

These recommendations will help to improve consistency in the way services are provided. Any resource impact should be offset by time savings and efficiency benefits from improved uptake and engagement. Currently video consultation is not available everywhere so this recommendation could have a moderate impact on resources. However, it is expected to save resources in the future, in particular in remote areas where therapists need to travel further to deliver trauma-focused CBT in person.

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Principles of care

[Recommendations 1.4.1 to 1.4.5](#)

Why the committee made the recommendations

Peer support

Recommendation 1.4.1

The evidence for peer support groups was limited but included some compelling reports from people with PTSD that sharing experiences with other people who had also experienced a traumatic event was beneficial, and this was reported for different types of traumatic experience. Findings suggested that peer support could also help people overcome their doubts and fears about having treatment by telling them about available help and support and encouraging them to engage with services.

Maintaining safe environments

Recommendation 1.4.2

The committee discussed the importance of maintaining safe environments for people with PTSD. Based on their clinical experience, they agreed that a number of environmental triggers could worsen people's symptoms or stop them from engaging in treatment. Practitioners assessing and treating people with PTSD – including those providing treatment for other mental or physical health conditions – should be aware of the need to minimise this risk.

Supporting families and carers

Recommendations 1.4.3 and 1.4.4

Qualitative evidence suggested that a common reason for not seeking help for PTSD is a lack of awareness about interventions and services. The committee agreed that information and support provided to family and carers could act as a facilitator for accessing services for both the carer and the person with PTSD.

The committee discussed the potential for more than one family member to have PTSD. They considered it important to raise awareness about this risk so that people are offered support promptly.

Involving family members in treatment

Recommendation 1.4.5

There was evidence that involving families and carers in treatment provided extra support for the person while also giving the family or carer a greater understanding of PTSD. However, family or carer involvement was not universally reported as positive, with some people not liking the feeling of being talked about in their absence.

Limited evidence showed that involving families and carers in treatment had benefits for improving carer mental health and reducing parenting difficulties. However, the evidence was too uncertain to support any recommendations for specific interventions to support family members and carers.

How the recommendations might affect practice

These recommendations are good practice points that will help to improve consistency of care. Any minor resource impact should be offset by time savings and efficiency benefits from improved uptake and engagement.

Peer support groups are not routinely offered everywhere but they are in fairly widespread use. The committee noted that facilitating access to these groups should not involve major resource implications. Any costs would be offset by potential savings associated with promoting earlier access to support that will help to prevent people from developing more severe problems.

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Planning treatment and supporting engagement

Recommendations 1.6.1 to 1.6.3

Why the committee made the recommendations

The committee agreed it was important to use a holistic approach when planning treatment, for example by thinking about every aspect of a person's life that could be contributing to their continuing PTSD symptoms.

The committee agreed that any strategies for promoting engagement need to be based on an understanding that people with PTSD are often highly anxious about having treatment and frequently avoid it. This was supported by evidence that common reasons for not seeking help include worry about engaging with a therapist, fear of exacerbating symptoms and stigmatisation. People may also have difficult emotions, such as shame, linked to the trauma, which can stop them from engaging with treatment. The committee agreed that healthcare professionals need to understand these reasons so that they don't misinterpret why someone is not engaging and they know the best ways to help them – including by contacting them if they don't come for an arranged appointment.

How the recommendations might affect practice

These recommendations are good practice points that will help to improve consistency of practice. Any minor resource impact should be offset by potential time savings and efficiency benefits from improved uptake and engagement.

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Active monitoring

[Recommendation 1.6.4](#)

Why the committee made the recommendation

There was no consistent evidence for effective interventions to prevent PTSD in people with subthreshold PTSD symptoms within 1 month of a traumatic event. The committee drew on their clinical experience and discussed how some people do not develop PTSD symptoms after a trauma even with no, or limited, interventions. Conversely, some people develop chronic symptoms if intervention is not provided early. Based on consensus, the committee agreed that [active monitoring](#) within the first month after the trauma could help professionals to judge whether people with less severe symptoms would need further intervention.

How the recommendation might affect practice

Any changes to practice should be minimal because active monitoring (known as watchful waiting in the 2005 version of this guideline) is already part of recommended practice.

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Psychologically-focused debriefing

[Recommendation 1.6.5](#)

Why the committee made the recommendation

Evidence on psychologically-focused debriefing, either individually or in groups, showed no benefit for children or adults, and some suggestion of worse outcomes than having no treatment. The committee agreed that psychologically-focused debriefing should not be offered. Providing an ineffective intervention can be regarded as harmful because it means that people are being denied access to another intervention with greater evidence of benefits.

How the recommendation might affect practice

Psychologically-focused debriefing was not part of previously recommended practice so there should be no impact on practice.

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Psychological interventions for the prevention of PTSD in children and young people

[Recommendations 1.6.6 to 1.6.8](#)

Why the committee made the recommendations

There was no evidence for individual trauma-focused CBT for children and young people within the first month of trauma. Despite the lack of direct evidence, the committee decided to make a recommendation for this intervention in light of the strong evidence for its efficacy for children who have experienced trauma more than 1 month ago, and the evidence for benefits in adults within 1 month of trauma. There can be a lot of natural recovery in the early weeks and it can be difficult to gauge a child or young person's readiness for intervention within 1 month of trauma. Based on consensus, the committee

agreed that individual trauma-focused CBT and active monitoring could both be considered as options within 1 month of trauma for children and young people with clinically important PTSD symptoms or acute stress disorder, and that this decision was best left to clinical judgement.

There was evidence that trauma-focused CBT group interventions were effective for improving PTSD symptoms and other important outcomes for children and young people who had been exposed to ongoing trauma, for example from living in a war zone. The committee agreed that these findings could also apply to other types of large-scale shared traumas. There were some gaps and uncertainties in the evidence, for example in how long the benefits might last and whether they were specific to that intervention or could be explained by other general factors such as receiving attention from a therapist. Based on this evidence and the additional considerations, the committee recommended the intervention should be considered as a possible option. The cognitive and language demands of trauma-focused group CBT mean that it would not be suitable for children under 7 so the committee used an age range that reflected the age of children in the included studies.

Although specific group trauma-focused CBT interventions use the same broad approach, the committee was concerned that psychological interventions are not always delivered in a consistent way, so they agreed to specify the structure and content.

How the recommendations might affect practice

There is currently variation in care for children and young people with acute stress disorder or clinically important symptoms of PTSD within 1 month of a traumatic event. Recommending active monitoring or individual trauma-focused CBT as options to consider should improve consistency in practice and help to reduce the use of more resource-intensive interventions for which the effectiveness is unknown.

There is currently no guidance on interventions for children exposed to large-scale shared trauma, and current practice has involved providing a range of different interventions. Without a clear steer on what works best there has been variability in access to interventions, the type of interventions offered and the extent to which they have been evidence-based. The recommendation for group trauma-focused CBT will lead to more consistency in practice and improve clinical outcomes for children who might otherwise need more costly management for PTSD later in the care pathway.

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Psychological interventions for the treatment of PTSD in children and young people

[Recommendations 1.6.9 to 1.6.13](#)

Why the committee made the recommendations

The evidence showed that trauma-focused CBT is effective in improving PTSD symptoms and other important outcomes, and that improvements last for at least a year. Benefits were seen for different specific trauma-focused interventions and different types of trauma. Trauma-focused CBT is more effective, as well as more cost effective, when it is provided individually than in a group so the committee agreed it should be delivered individually.

Most of the evidence for trauma-focused CBT came from children aged over 7 years. There was some evidence from 5 and 6 year olds so the committee agreed it could be an option for them, but could not be recommended with the same certainty.

There was no evidence for treatment with trauma-focused CBT between 1 and 3 months after a traumatic event compared with a non-active control, so the committee could not recommend it with the same certainty as for more than 3 months after trauma. However, by extrapolating from the broad evidence base for benefits more than 3 months after trauma and drawing on members' own clinical experience, the committee agreed that trauma-focused CBT could be an option during this period.

Although specific trauma-focused CBT interventions use the same broad approach, the committee was concerned that psychological interventions are not always delivered in a consistent way, so they agreed to specify the structure and content. This recommendation was informed by the evidence and modified by the committee's expert advice. For example, a typical number of sessions was recommended based on the evidence, but the committee agreed that more might be needed, including for those who have experienced multiple traumas.

There was limited evidence for eye movement desensitisation and reprocessing (EMDR) suggesting possible benefits on PTSD symptoms in children older than 7 years. However,

EMDR was found to be less clinically effective and cost effective than all individual trauma-focused CBT interventions. On this basis, the committee decided it should be considered only if children do not respond to or engage with trauma-focused CBT.

How the recommendations might affect practice

Offering trauma-focused CBT more than 3 months after a traumatic event is in line with previously recommended practice and the committee was not aware of wide variation in practice. Considering trauma-focused CBT between 1 and 3 months after a traumatic event and recommending EMDR as an option are both new. They are only recommended as options to consider, which should limit their impact on practice, as should the fact that EMDR should only be considered for children who do not respond to or engage with trauma-focused CBT.

NICE's previous guideline made recommendations for children with PTSD, whereas current recommendations are also relevant to children and young people with clinically important symptoms of PTSD. The structure, content and time of the assessment, as well as the benefits from treatment, are broadly the same for both populations and it was the committee's view that there should not be a significant impact on practice.

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Drug treatments for children and young people

[Recommendation 1.6.14](#)

Why the committee made the recommendation

There was very little evidence on the use of drug treatments to prevent or treat PTSD in children and young people. This limited evidence showed no significant benefits so the committee agreed drug treatment should not be offered.

How the recommendation might affect practice

This recommendation is in line with previously recommended practice so there should be no impact on practice.

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Psychological interventions for the prevention of PTSD in adults

[Recommendation 1.6.15](#)

Why the committee made the recommendation

Evidence showed that individual trauma-focused CBT interventions were effective for improving PTSD symptoms in adults who had experienced a traumatic event within the last month. They also reduced the number of adults who met the criteria to be diagnosed with PTSD after 1 month. There was also limited evidence from outside the UK that trauma-focused CBT is cost effective in adults at risk of PTSD.

There was evidence for a number of specific interventions within the trauma-focused CBT class, and the committee agreed it would be helpful to give some examples of named therapies that fall under this term.

The evidence of benefits was restricted to adults with clinically important symptoms or acute stress disorder, so the committee only recommended the intervention for these groups and not for people with less significant symptoms.

How the recommendation might affect practice

The recommendation is in line with previous recommended practice so there should not be a major change in practice.

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Psychological interventions for the treatment of PTSD in adults

[Recommendations 1.6.16 to 1.6.23](#)

Why the committee made the recommendations

Trauma-focused CBT

Recommendations 1.6.16 and 1.6.17

There was extensive evidence that trauma-focused CBT interventions improve PTSD symptoms as well as other important outcomes, and that these improvements can be maintained up to a year later. Benefits were seen across a wide range of types of trauma, including both single and multiple incident traumas. There was evidence for a number of specific interventions within the trauma-focused CBT class, and the committee agreed it would be helpful to give some examples of named therapies that fall under this term.

Most of the evidence for trauma-focused CBT interventions came from adults who had been exposed to 1 or more traumatic events more than 3 months ago, although there was limited evidence showing benefits between 1 and 3 months after trauma. The committee discussed this limited evidence alongside the broader evidence base that showed benefits within the first month and more than 3 months after trauma. They thought it was unlikely that effects would be different in this 2-month time period, so recommended trauma-focused CBT for adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 1 month after a traumatic event.

There was good evidence that offering up to 12 sessions of individual trauma-focused CBT was clinically and cost effective. Group trauma-focused CBT was not seen to be clinically or cost effective based on the guideline network meta-analysis and economic analysis, although the evidence was limited. Based on the standard number of sessions outlined in most validated treatment manuals and the most common number of sessions in the evidence base, the committee recommended providing 8 to 12 sessions. However, based on their clinical experience, they recommended offering more sessions if needed, including for people who have experienced multiple traumas.

Using both the evidence and their clinical experience, the committee outlined the structure and content of individual trauma-focused CBT interventions to make sure they are delivered in a consistent way because they were concerned that this may not happen in practice.

Psychoeducation was found to be highly clinically and cost effective in comparisons with psychological interventions according to the guideline network meta-analysis and

economic analysis, but its evidence base was very limited and uncertain. The committee agreed that the evidence could not support a recommendation for psychoeducation on its own but it should be delivered as part of individual trauma-focused CBT.

Eye movement desensitisation and reprocessing

Recommendations 1.6.18 to 1.6.20

Less evidence was found on EMDR than on trauma-focused CBT, but the committee agreed that what was available justified recommending EMDR. Although studies that compared EMDR directly with trauma-focused CBT did not show significant differences, there was a trend towards EMDR. This trend in favour of EMDR was also present in the cost effectiveness results. The evidence suggested EMDR was not effective in people with military combat-related trauma, and this was in marked contrast to all other included trauma types for which benefits were observed. On this basis, the committee restricted their recommendation to non-combat-related trauma.

Most of the evidence for EMDR came from adults who had been exposed to 1 or more traumatic events more than 3 months ago, although there was limited evidence showing benefits between 1 and 3 months after trauma. Based on this limited evidence and by extrapolating from the stronger evidence for EMDR more than 3 months after trauma, the committee recommended considering EMDR between 1 and 3 months after a non-combat-related trauma. This recommendation was made with less certainty than treatment after 3 months because of the very limited direct evidence (a single study) and because limited evidence suggested non-statistically significant benefits of EMDR within 1 month of trauma.

Although EMDR interventions use the same broad approach, the committee was concerned that psychological interventions are not always delivered in a consistent way, so they agreed a specific structure and content based on the interventions in the evidence and modified by their expert opinion.

Supported trauma-focused computerised CBT

Recommendations 1.6.21 and 1.6.22

There was evidence that both supported and unsupported self-help, and computerised trauma-focused CBT in particular, were beneficial in terms of self-rated PTSD symptoms

and other important outcomes. These benefits were maintained up to a year later. Both interventions were cost effective compared with other psychological interventions. The evidence was limited for some of the outcomes that were looked at, and it was unclear whether self-help was effective across different types of trauma. Although both supported and unsupported self-help were found to be effective, the former was more clinically and cost effective because the greater effect sizes were sufficient to offset the higher costs.

Taking the evidence for efficacy together with the gaps in the evidence, the committee agreed that supported computerised trauma-focused CBT should be considered as an option for adults with PTSD who prefer this to face-to-face trauma-focused CBT or EMDR. The committee was concerned that a lower intensity intervention might not be clinically appropriate for all adults with PTSD, so this recommendation was limited to those who do not have severe PTSD symptoms (in particular dissociative symptoms) and are not at risk of harm to themselves or others.

A number of computerised trauma-focused CBT interventions are available, and the committee felt it was important to specify their structure and content to make sure a minimum standard was set.

CBT interventions for specific symptoms

Recommendation 1.6.23

There was some evidence that non-trauma-focused CBT is beneficial when targeted at specific symptoms such as sleep disturbance or anger, and also leads to improvements in PTSD symptoms, but it was not clear how long these benefits would be maintained. Non-trauma-focused CBT was less cost effective than individual trauma-focused CBT, EMDR and self-help, but more cost effective than other interventions such as present-centred therapy, group trauma-focused CBT, combined individual trauma-focused CBT and SSRIs, counselling and no treatment. The committee agreed the potential benefits of non-trauma-focused CBT were important, but that symptom-specific interventions should not be seen as an alternative to a trauma-focused first-line treatment. Instead, they could be an option when people are not ready to directly confront memories of the trauma and could promote uptake and engagement with a trauma-focused intervention. They could also be used to target residual symptoms after a trauma-focused intervention.

How the recommendations might affect practice

NICE's previous guideline made recommendations for adults with PTSD, whereas current recommendations are also relevant to adults with clinically important symptoms of PTSD. The structure, content and time of the assessment, as well as the benefits from treatment, are broadly the same for both populations and it was the committee's view that there should not be a significant impact on practice.

Both trauma-focused CBT and EMDR were already recommended and the committee did not think there was wide variation in practice. The new recommendation for non-trauma-focused CBT interventions targeted at specific symptoms represents a bigger change because previous recommendations stated that non-trauma-focused interventions should not be routinely offered to people with chronic PTSD. The impact on resources is difficult to predict because it is recommended only as an option to consider, but it might bring potential savings by improving uptake and engagement with trauma-focused therapies that should reduce missed appointments and early drop-out.

The recommendation for supported computerised trauma-focused CBT is also thought to represent a bigger change. Self-help-based interventions were not previously part of recommended practice and the committee was not aware of such interventions being in widespread use. The cost of supported computerised trauma-focused CBT includes, in addition to a therapist's time, the cost of the digital mental health programmes and computers needed for delivery. If such an intervention is delivered in a public place (like a library), or the person's home, there is no equipment cost. If the computer is used in a clinical practice setting, it can be shared by many people having computerised therapy, minimising the equipment cost. It could therefore lead to cost savings if part of routine practice is shifted from the more resource-intensive individual trauma-focused CBT and EMDR to the less resource-intensive supported computerised trauma-focused CBT.

The committee acknowledged that there would be a cost associated with providing extra trauma-focused therapy sessions if they are needed (for example, for people who have experienced multiple traumas). Previous recommended practice was to consider more than 12 sessions for people after multiple incident trauma, or who have chronic disability or significant coexisting conditions or social problems. However, in clinical practice the provision of additional sessions is variable.

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Drug treatments in adults

Recommendations 1.6.24 to 1.6.26

Why the committee made the recommendations

Prevention

Recommendation 1.6.24

There was no consistent evidence that any drug treatments are effective in preventing PTSD. Given the limited evidence of benefits and the potential harms, including side effects, the committee agreed that drug treatments should not be offered to prevent PTSD in adults. The committee specifically referred to benzodiazepines because of the lack of benefit in the evidence, concerns about harm and their clinical experience of these drugs being prescribed in practice.

Treatment

Recommendations 1.6.25 and 1.6.26

There was evidence that SSRIs and venlafaxine are effective in treating PTSD. There was a large number of studies for SSRIs but the sizes of the effects were smaller than for venlafaxine. The committee decided that either an SSRI or venlafaxine could be considered if a person prefers to have drug treatment, but they should not be offered as first-line treatment for PTSD. This is based partly on the lack of follow-up data for SSRIs and venlafaxine, and because evidence showed that SSRIs are less effective than any of the psychological interventions recommended. Economic modelling also showed SSRIs are less cost effective than EMDR, brief individual trauma-focused CBT or self-help with support.

There was no evidence for significant differential efficacy of specific SSRIs (sertraline, fluoxetine and paroxetine), so the committee agreed to allow prescribers to decide which SSRI to use. However, they included sertraline as an example because it is 1 of 2 drugs licensed in the UK for this indication and the other drug, paroxetine, is more likely to be associated with discontinuation symptoms.

The committee agreed that it was important to review antidepressant treatment regularly

to manage any side effects and to review clinical progress and outcomes.

There was some evidence that antipsychotics, either alone or in addition to routine medications, are effective in treating PTSD symptoms. However, it was more limited than the evidence supporting SSRIs and the psychological interventions (for example, the evidence for other important outcomes was limited and there were no follow-up data). The committee agreed that antipsychotics should not be seen as an alternative to a trauma-focused psychological intervention as first-line treatment for PTSD and should only be considered as an adjunct to psychological therapy. However, they might be beneficial for symptom management for adults with a diagnosis of PTSD if their symptoms have not responded to other drug or psychological treatments and they have disabling symptoms and behaviours that makes it difficult for them to engage with psychological treatment. Given the different side effect profiles, the committee agreed to leave the choice of antipsychotic to clinical judgement. Risperidone was included as an example because the evidence for risperidone included more participants.

The committee discussed concerns about the tolerability of antipsychotic drugs and agreed they should only be prescribed in a specialist setting, or after consultation with a specialist.

How the recommendations might affect practice

The committee was concerned that drug treatment within the first month of trauma may be reasonably common in clinical practice. The [do not offer drug treatments recommendation in the section on drug treatments for adults](#) will therefore help to reduce the use of non-evidence-based interventions and improve consistency of practice. These recommendations represent a small change in practice because the previous guideline recommended drug treatment as an option only for adults who could not start a psychological therapy, did not want to start trauma-focused psychological therapy or who had gained little or no benefit from it.

In the UK, only paroxetine and sertraline are licensed for the treatment of PTSD so the recommendations involve off-licence use. Offering antipsychotics only in a specialist setting or after consultation with a specialist is expected to reduce variation in the way antipsychotics are used in current practice. Regular review of drug treatment is essential but might not be happening currently, so this should also improve consistency.

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Care for people with post-traumatic stress disorder and complex needs

Recommendations 1.7.1 to 1.7.3

Why the committee made the recommendations

There was a lack of evidence on care for people with PTSD and complex needs, including people with coexisting conditions such as depression or substance misuse, so the committee used a formal consensus method to agree some overarching principles.

The evidence was limited on interventions for people who have complex PTSD, but it suggested that trauma-focused therapies could also benefit this group. Based on their clinical experience, the committee recommended modifications that may be needed to trauma-focused therapies to facilitate engagement for those with complex PTSD or other additional needs.

How the recommendations might affect practice

The committee acknowledged that there would be a cost associated with increasing the duration or the number of therapy sessions, if this is necessary for people with PTSD and additional needs. Previous recommended practice was to consider more than 12 sessions for people after multiple incident trauma, or who have chronic disability or significant coexisting conditions or social problems. However, in clinical practice the provision of additional sessions is variable.

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Context

Post-traumatic stress disorder (PTSD) develops after a stressful event or situation of an exceptionally threatening or catastrophic nature. It is a disorder that can affect people of any age. Around 25–30% of people experiencing a traumatic event go on to develop PTSD.

PTSD can present with a range of symptoms. In adults the most common of these are vivid, distressing memories of the event or flashbacks, known as intrusive symptoms. Another prominent symptom is avoidance of trauma-related reminders or general social contact. People with PTSD often try to push memories of the event out of their mind and avoid thinking or talking about it in detail. On the other hand, people may also reflect excessively on questions that prevent them from coming to terms with the event – for example, why it happened to them, how it could have been prevented, or how they could take revenge. People with PTSD often have nightmares related to the trauma that affect their sleep.

Symptoms of PTSD often develop immediately after the traumatic event but in some people (fewer than 15%) onset is delayed. People may not present for treatment for months or years despite experiencing considerable distress. PTSD is a treatable disorder, even for people who present many years later, but assessment can be challenging because many people avoid talking about their problems even when presenting with associated complaints.

Children, particularly those aged under 8 years, may not complain directly of PTSD symptoms such as re-experiencing or avoidance. Instead, symptoms may take the form of re-enacting the experience, repetitive play or frightening dreams with no recognisable content.

It is common for people with PTSD to have other problems such as depression. If people have had repeated or multiple traumas, or have other significant mental health problems, their presentation of PTSD may be complex and adjustments may be needed to the way in which treatment is delivered.

Effective treatment of PTSD can only take place if the disorder is recognised. Opportunities for recognition usually come during routine healthcare, for example during physical treatment after an assault or an accident, or when a person discloses domestic violence or a history of childhood sexual abuse. Many people attending for medical

services in hospital have experienced traumatic events, particularly in emergency departments, and orthopaedic and plastic surgery clinics. Up to 30% of children who attend an emergency department for a traumatic injury go on to develop PTSD. Identifying PTSD in children presents particular problems, but is improved by asking children directly about their experiences.

This guideline updates NICE's 2005 guidance on PTSD. It covers children, young people and adults (aged 18 years and over) who are at risk of PTSD or have a diagnosis of PTSD, and their families and carers. It also covers people with comorbid conditions including drug and alcohol misuse and common mental health conditions.

The guideline covers all NHS and social care-commissioned services that provide care for people with PTSD.

Finding more information and committee details

To find NICE guidance on related topics, including guidance in development, see the [NICE topic pages on anxiety and mental health, behavioural and neurodevelopmental conditions](#).

For full details of the evidence and the guideline committee's discussions, see the [evidence reviews](#). You can also find information about [how the guideline was developed](#), including [details of the committee](#).

NICE has produced [tools and resources to help you put this guideline into practice](#). For general help and advice on putting our guidelines into practice, see [resources to help you put NICE guidance into practice](#).

Update information

December 2018: We have reviewed the evidence and made new recommendations on the prevention, treatment and care of people with post-traumatic stress disorder (PTSD). These recommendations are marked **[2018]**.

We have also made some changes without an evidence review. These recommendations are marked **[2005, amended 2018]**.

- For clarity recommendation 1.1.1 has been split to separate awareness of symptoms from assessment.

Functional impairment has been added and symptoms updated compared with 2005 in light of new classification systems.

Reference to complex PTSD and the additional symptoms of complex PTSD (interpersonal difficulties or problems in relationships, negative self-perception, and emotional dysregulation) have been included after the publication of ICD-11 and the new diagnostic classification of complex PTSD.

Substance misuse has been removed as although this is a commonly coexisting condition it is not a core symptom of PTSD like all other bullet points in this recommendation.

- Recommendation 1.1.2 has been broadened to all settings so 'primary care' has been removed.

Examples of types of traumatic events have been extended and clarified.

Traumatic childbirth has been broadened to include serious health problems and childbirth experiences.

- In recommendation 1.1.3, symptoms have been updated in line with recommendation 1.1.1.
- Recommendation 1.1.4 has been broadened to all settings so 'primary care' has been removed.

'Traumatic experience' has been amended to '1 or more traumatic events' because of the possibility of multiple/repeated trauma.

- Recommendation 1.1.5 has been broadened to all care settings. To reduce repetition, examples of traumatic events have been replaced by a cross reference to recommendation 1.1.2.
- In recommendation 1.1.7, symptoms have been updated compared with 2005 in light of new classification systems. The normal responses to trauma has been added based on the opinion of the committee that it is helpful to 'normalise' the presence of some symptoms in the first few weeks as they can manifest but diminish as part of 'natural' recovery.
- The committee added that the screening instrument should be validated to recommendation 1.1.8.
- Programme refugees has been changed to 'refugees' and 'validated' added to recommendation 1.1.9 for clarification.
- Recommendation 1.2.1 has been updated to reflect that, before assessment, people with clinically important symptoms of PTSD will not have a diagnosis so it is not meaningful to talk about people with PTSD in this recommendation.
- Competence has been removed from recommendation 1.2.2 as this is a general expectation of the NHS and is not specific to PTSD or to assessment.
- In recommendation 1.2.3, 'Share it with' has been replaced by 'involve' to reflect that the person (and family if appropriate) would have a more active role in this process.
- A cross reference to NICE guidance published since 2005 has been added to recommendation 1.5.1 to provide further detail.

Recommendations marked [2005] last had an evidence review in 2005. In some cases minor changes have been made to the wording to bring the language and style up to date, without changing the meaning.

Minor changes since publication

August 2024: We have simplified the guideline by removing recommendations on general principles of care that are covered in other NICE guidelines (for example, the [NICE guideline on service user experience in adult mental health](#)).

This is a presentational change only, and no changes to practice are intended.

December 2022: We replaced the links in recommendation 1.3.2 with a link to new Crown Prosecution Service guidance on pre-trial therapy.

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