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NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Guideline

Post-traumatic stress disorder

Draft for consultation, June 2018

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 with responsibility for planning services for people with PTSD and their families and carers, 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

This guideline will update NICE guideline CG26 (published March 2005).

We have reviewed the evidence on the prevention, treatment and care of people with PTSD. You are invited to comment on the new and updated recommendations. These are marked as **[2018]**.

You are also invited to comment on recommendations that NICE proposes to delete from the 2005 guideline.

We have not reviewed the evidence for the recommendations shaded in grey, and cannot accept comments on them. In some cases, we have made minor wording changes for clarification.

See [Update information](#) for a full explanation of what is being updated.

This version of the guideline contains:

- the draft recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the 2018 recommendations and how they might affect practice.
- the guideline context.

Information about how the guideline was developed is on the [guideline's page](#) on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest. Full details of the evidence and the committee's discussion on the 2018 recommendations are in the [evidence reviews](#). Evidence for the 2005 recommendations is in the [full version](#) of the 2005 guideline.

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1 Recommendations

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

Post-traumatic stress disorder (PTSD) is a disorder that can develop in response to specific traumatic events. Recommendations in this guideline relate to everyone who has PTSD. The guideline has looked at inequalities relating to gender, sexual orientation, gender reassignment, age, homelessness, refugees and asylum seekers, illegal immigrants, undocumented workers and failed asylum seekers, 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.

2 **1.1 Recognition of post-traumatic stress disorder**

3 1.1.1 Be aware that people with post-traumatic stress disorder (PTSD) may
4 present with a range of symptoms **associated with functional impairment**,
5 including:

- 6 • re-experiencing
- 7 • avoidance
- 8 • hyperarousal (**including anger and irritability**)
- 9 • **negative alterations in mood and thinking**
- 10 • emotional numbing
- 11 • substance misuse. **[2005, amended 2018]**

12 1.1.2 **Be aware** of traumatic events associated with the development of PTSD.
13 These could be **experiencing or witnessing single, repeated or multiple**
14 **events** and could include, for example:

- 1 • serious accidents
- 2 • physical and sexual assault
- 3 • abuse, including childhood or domestic abuse
- 4 • work-related exposure to trauma, including remote exposure
- 5 • traumatic childbirth
- 6 • war and conflict
- 7 • torture. [2005, amended 2018]

8 1.1.3 When assessing for PTSD, ask adults specific questions about
9 re-experiencing, avoidance, hyperarousal, negative alterations in mood
10 and thinking, and associated functional impairment. [2005, amended
11 2018]

12 1.1.4 When assessing for PTSD, ask people with symptoms in recommendation
13 1.1.1 if they have experienced 1 or more traumatic events (which may
14 have occurred many months or years before). Give specific examples of
15 traumatic events as listed in recommendation 1.1.2. [2005, amended
16 2018]

17 1.1.5 For people with unexplained physical symptoms who repeatedly attend
18 health services, think about asking whether they have experienced 1 or
19 more traumatic events and provide specific examples of traumatic events
20 (see recommendation 1.1.2). [2005, amended 2018]

21 Specific recognition issues for children

22 1.1.6 Do not rely solely on the parent or carer for information when it is
23 developmentally appropriate to directly and separately question a child or
24 young person about the presence of PTSD symptoms. [2005, amended
25 2018]

26 1.1.7 When a child who has been involved in a traumatic event is treated in an
27 emergency department, emergency staff should explain to their parents or
28 carers about the possibility of PTSD developing. Briefly describe the
29 possible symptoms (for example, nightmares, repetitive trauma-related
30 play, intrusive thoughts, avoiding things related to the events, increased

1 behavioural difficulties, problems concentrating, hypervigilance and
2 difficulties sleeping), and suggest they contact their GP if the symptoms
3 persist beyond 1 month. **[2005, amended 2018]**

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

5 1.1.8 For people at high risk of developing PTSD following a major disaster,
6 those responsible for coordinating the disaster plan should think about the
7 routine use of a validated, brief screening instrument for PTSD at 1 month
8 after the disaster. **[2005, amended 2018]**

9 1.1.9 For refugees and asylum seekers at high risk of PTSD, think about the
10 routine use of a validated, brief screening instrument for PTSD as part of
11 any comprehensive physical and mental health screen. **[2005, amended**
12 **2018]**

13 **1.2 Assessment and coordination of care**

14 1.2.1 For people with PTSD presenting in primary care, GPs should take
15 responsibility for initial assessment and coordination of care. This includes
16 determining the need for emergency physical or mental health
17 assessment. **[2005]**

18 1.2.2 Assessment of people with PTSD should be conducted by competent
19 individuals and be comprehensive, including an assessment of physical,
20 psychological and social needs and a risk assessment. **[2005, amended**
21 **2018]**

22 1.2.3 Where management is shared between primary and secondary care,
23 healthcare professionals should agree who is responsible for monitoring
24 people with PTSD. Put this agreement in writing (where appropriate, using
25 the Care Programme Approach) and share it with the person and, where
26 appropriate, their family or carers. **[2005]**

27 **Supporting transitions between services**

28 1.2.4 To support transitions when people with PTSD are moving between
29 services:

- 1 • give the person information about the service they are moving to,
2 including the setting and who will provide their care
- 3 • ensure there is effective sharing of information between all services
4 involved
- 5 • involve the person and, where appropriate, their family or carers in
6 meetings to plan the transition
- 7 • address any worries the person has, for example, about changes to
8 their routine or anxiety about meeting new people. **[2018]**

9 1.2.5 Provide additional support in line with NICE guidelines on [transition from](#)
10 [children's to adults' services](#) for young people using health or social care
11 services and [transition between inpatient mental health settings and](#)
12 [community or care home settings](#):

- 13 • to children and young people with PTSD who are within the care
14 system when they are transitioning between services or settings
- 15 • during admission and discharge to people with PTSD who are admitted
16 to hospital because of other mental or physical health problems. **[2018]**

17 1.2.6 During transitions between services for people with PTSD who need
18 ongoing care, the referring team should not discharge the person before
19 another team has accepted the referral. **[2018]**

To find out why the committee made the **[2018]** recommendations on supporting transitions between services and how they might affect practice, see [rationale and impact](#).

20 **1.3 Access to care**

21 1.3.1 Promote access to services for people with PTSD by:

- 22 • providing a care model that is clear about the range of interventions
23 and services offered and the people who may benefit, rather than
24 prioritising reasons why services cannot be accessed

- 1 • ensuring that methods of access to services take into account the
2 needs of specific populations of people with PTSD, including migrants
3 and asylum seekers
- 4 • minimising the need to move between different services or providers
- 5 • providing multiple points of access to the service
- 6 • establishing clear links to other care pathways, including for physical
7 healthcare needs
- 8 • offering flexible modes of delivery, such as using text messages, email,
9 telephone or video consultation, or care in non-clinical settings such as
10 schools or offices
- 11 • offering a choice of therapist that takes into account the person’s
12 trauma experience – for example, they might prefer a specific gender of
13 therapist
- 14 • using proactive person-centred strategies to promote uptake and
15 sustained engagement. **[2018]**
- 16 1.3.2 Do not delay or withhold treatment for PTSD because of court
17 proceedings or applications for compensation. Discuss with the person
18 the implications of the timing of any treatment to help them make an
19 informed decision about if and when to proceed. **[2018]**

To find out why the committee made the **[2018]** recommendations on access to care and how they might affect practice, see [rationale and impact](#).

20 **1.4 Principles of care**

21 **Supporting people with post-traumatic stress disorder**

- 22 1.4.1 Provide information in both oral and written format and in line with
23 recommendations in the NICE guidelines on [service user experience in](#)
24 [adult mental health](#) and [patient experience in adult NHS services](#). **[2018]**

- 25 1.4.2 Give information and support to people with PTSD (and their family
26 members or carers as appropriate) covering:

- 1 • common reactions to traumatic events, including the symptoms of
- 2 PTSD and its course
- 3 • assessment, treatment and support options to help the person make an
- 4 informed choice
- 5 • care pathways for PTSD
- 6 • where their care will take place. **[2018]**

7 **Peer support**

8 1.4.3 Provide access to peer support groups wherever possible. Peer support
9 groups should:

- 10 • be facilitated by people with training and supervision
- 11 • be delivered in a way that does not risk re-traumatisation
- 12 • provide information, and help to access services. **[2018]**

13 **Maintaining safe environments**

14 1.4.4 Be aware of the risk of continued exposure to trauma-inducing
15 environments or triggers for people with PTSD, and minimise exposure to
16 triggers that could risk exacerbating symptoms (for example, restraining
17 someone or placing them in a noisy inpatient ward). **[2018]**

18 **Involving and supporting families and carers**

19 1.4.5 Consider providing information and support to family members and carers
20 of people at risk of PTSD and people with PTSD. This could cover:

- 21 • the treatment and management of psychological and behavioural
- 22 problems related to PTSD, including the person's possible risk to
- 23 themselves and others
- 24 • discussing with carers how the person's PTSD symptoms are affecting
- 25 the carer themselves
- 26 • how they can support the person to access treatment, including what to
- 27 do if they don't engage with or drop out of treatment. **[2018]**

28 1.4.6 Involve family members and carers, where appropriate, in treatment for
29 people with PTSD as a way to:

- 1 • inform and improve the care of the person with PTSD **and**
2 • identify and meet their own needs as carers. **[2018]**
- 3 1.4.7 Consider providing practical and emotional support and advice to family
4 members and carers, for example, directing them to health or social
5 services or peer support groups. **[2018]**
- 6 1.4.8 Think about the impact of the traumatic event on other family members
7 because more than one family member might have PTSD. Consider
8 further assessment, support and intervention for any family member
9 suspected to have PTSD. **[2018]**

To find out why the committee made the **[2018]** recommendations on principles of care and how they might affect practice, see [rationale and impact](#).

10

11 **1.5 Language and culture**

- 12 1.5.1 Pay particular attention to identifying people with PTSD in working or
13 living environments where there may be cultural challenges to recognising
14 the psychological consequences of trauma (see recommendations on
15 [avoiding stigma and promoting social inclusion](#) in the NICE guideline on
16 [service user experience in adult mental health](#)). **[2005, amended 2018]**
- 17 1.5.2 **When offering interventions, ensure they are culturally and linguistically**
18 **appropriate for service users. [2005, amended 2018]**
- 19 1.5.3 Where language or culture differences present challenges to the use of
20 [psychological interventions](#) in PTSD, think about using interpreters or
21 offering a choice of therapists. **See recommendations on [communication](#)**
22 **in the NICE guideline on patient experience in adult NHS services. [2005,**
23 **amended 2018]**

1 **1.6** *Management of post-traumatic stress disorder in children,*
2 *young people and adults*

3 **Planning treatment and supporting engagement**

4 1.6.1 When discussing treatment options with people with PTSD (and their
5 family members or carers as appropriate):

- 6 • give them information about the aim, content, duration and mode of
7 delivery of any proposed interventions, including acceptability,
8 tolerability and any possible interactions with current interventions
- 9 • take into account any previous treatment, associated functional
10 impairment and any coexisting conditions
- 11 • take into account any social or personal factors that may have a role in
12 the development or maintenance of the disorder. **[2018]**

13 1.6.2 Be aware that people with PTSD may be apprehensive, anxious and may
14 avoid treatment or have difficulty developing trust. Engagement strategies
15 could include following up when people miss appointments. **[2018]**

To find out why the committee made the **[2018]** recommendations on planning treatment and supporting engagement and how they might affect practice, see [rationale and impact](#).

16 **Active monitoring**

17 1.6.3 Consider active monitoring for people within 1 month of a traumatic event
18 who do not have [clinically important symptoms](#) of PTSD or [acute stress](#)
19 [disorder](#). **[2018]**

To find out why the committee made the **[2018]** recommendation on active monitoring and how it might affect practice, see [rationale and impact](#).

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

3 ***Prevention for children and young people***

4 1.6.4 Consider active monitoring or individual trauma-focused cognitive
5 behavioural therapy (CBT) within 1 month of a traumatic event for children
6 and young people aged under 18 years with a diagnosis of [acute stress](#)
7 [disorder](#) or [clinically important symptoms](#) of PTSD. **[2018]**

8 1.6.5 Consider group trauma-focused CBT for children and young people aged
9 7 to 17 years if there has been an event within the last month leading to
10 large-scale shared trauma. **[2018]**

To find out why the committee made the **[2018]** recommendations on
psychological interventions for the prevention of PTSD in children and young
people and how they might affect practice, see [rationale and impact](#)

11 ***Treatment for children and young people***

12 1.6.6 Consider individual trauma-focused CBT for children aged under 7 years
13 with a diagnosis of PTSD or clinically important symptoms of PTSD more
14 than 1 month after a traumatic event. **[2018]**

15 1.6.7 Consider individual trauma-focused CBT for children aged 7 to 17 years
16 within 1 to 3 months of a traumatic event with a diagnosis of PTSD or
17 clinically important symptoms of PTSD. **[2018]**

18 1.6.8 Offer individual trauma-focused CBT to children and young people aged
19 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of
20 PTSD more than 3 months after a traumatic event. **[2018]**

21 1.6.9 Trauma-focused CBT for children and young people should:

- 22 • be based on a validated manual
- 23 • typically be provided over 6 to 12 sessions
- 24 • be adapted to the child or young person's age and development
- 25 • involve parents or carers as appropriate

- 1 • include psychoeducation about reactions to trauma, strategies for
2 managing arousal and safety planning
- 3 • involve elaboration and processing of the trauma memories
- 4 • involve restructuring trauma-related meanings for the individual
- 5 • provide help to overcome avoidance
- 6 • prepare them for the end of treatment
- 7 • include planning booster sessions if needed, particularly in relation to
8 significant dates (for example, trauma anniversaries). **[2018]**
- 9 1.6.10 Consider eye movement desensitisation and reprocessing (EMDR) for
10 children and young people aged 7 to 17 years with a diagnosis of PTSD
11 or clinically important symptoms of PTSD more than 3 months after a
12 traumatic event only if they do not respond to or engage with trauma-
13 focused CBT. **[2018]**

To find out why the committee made the **[2018]** recommendations on psychological interventions for the treatment of PTSD in children and young people, and how they might affect practice, see [rationale and impact](#).

14 **Drug treatments for children and young people**

- 15 1.6.11 Do not offer drug treatments for the prevention or treatment of PTSD in
16 children and young people aged under 18 years. **[2018]**

To find out why the committee made the **[2018]** recommendation on drug treatments for children and young people and how it might affect practice, see [rationale and impact](#).

17 **Psychological and psychosocial interventions for the prevention and** 18 **treatment of PTSD in adults**

19 ***Prevention in adults***

- 20 1.6.12 Offer individual trauma-focused CBT to adults who have acute stress
21 disorder or clinically important symptoms of PTSD and have been
22 exposed to 1 or more traumatic events within the last month. **[2018]**

To find out why the committee made the **[2018]** recommendation on psychological interventions to prevent PTSD in adults and how it might affect practice, see [rationale and impact](#).

1

2 ***Treatment in adults***

3 1.6.13 Offer individual trauma-focused CBT to adults with a diagnosis of PTSD or
4 clinically important symptoms of PTSD more than 1 month after a
5 traumatic event. **[2018]**

6 1.6.14 Trauma-focused CBT for adults should:

- 7 • be based on a validated manual
- 8 • typically be provided over 8 to 12 sessions
- 9 • include psychoeducation about reactions to trauma, strategies for
10 managing arousal and safety planning
- 11 • involve family members or carers as appropriate
- 12 • involve elaboration and processing of the trauma memories
- 13 • involve restructuring trauma-related meanings for the individual
- 14 • provide help to overcome avoidance
- 15 • have a focus on re-establishing a healthy lifestyle, for example, work
16 and social relationships
- 17 • prepare them for the end of treatment
- 18 • include planning booster sessions if needed, particularly in relation to
19 significant dates (for example, trauma anniversaries). **[2018]**

20 1.6.15 Offer eye movement desensitisation and reprocessing (EMDR) as an
21 option for non-combat-related trauma to adults with a diagnosis of PTSD
22 or clinically important symptoms of PTSD more than 3 months after a
23 traumatic event. **[2018]**

24 1.6.16 EMDR for adults should:

- 25 • be based on a validated manual

- 1 • typically be provided over 8 to 12 sessions but more if clinically
2 indicated, for example, where people have experienced multiple
3 traumas
- 4 • be delivered in a phased manner and include psychoeducation about
5 reactions to trauma; managing distressing memories and situations;
6 identifying and treating target memories (often visual images); and
7 promoting alternative positive beliefs about the self
- 8 • use repeated in-session bilateral stimulation (for example, eye
9 movements, taps or tones) for specific target memories until the
10 memories are no longer distressing
- 11 • use self-calming techniques in-session. **[2018]**
- 12 1.6.17 Consider supported trauma-focused computerised CBT for adults with a
13 diagnosis of PTSD or clinically important symptoms of PTSD more than
14 3 months after a traumatic event who do not want or have not been able
15 to engage in face-to-face, trauma-focused CBT or EMDR. **[2018]**
- 16 1.6.18 Consider symptom-specific CBT interventions (for symptoms such as
17 sleep disturbance or anger) for adults with a diagnosis of PTSD or
18 clinically important symptoms of PTSD more than 3 months after a
19 traumatic event who:
- 20 • are unable or unwilling to engage in a trauma-focused intervention that
21 specifically targets PTSD **or**
- 22 • have residual symptoms after a trauma-focused intervention. **[2018]**

To find out why the committee made the **[2018]** recommendations on psychological interventions to treat PTSD in adults and how they might affect practice, see [rationale and impact](#).

23 ***Psychologically-focused debriefing***

- 24 1.6.19 Do not offer psychologically-focused debriefing to adults for the prevention
25 or treatment of PTSD. **[2018]**

To find out why the committee made the **[2018]** recommendation on debriefing and how it might affect practice, see [rationale and impact](#).

1 **Drug treatments for adults**

2 1.6.20 Do not offer drug treatments, including benzodiazepines, to prevent PTSD
3 in adults. **[2018]**

4 1.6.21 Consider a selective serotonin reuptake inhibitor (SSRI) or venlafaxine¹
5 for adults with a diagnosis of PTSD if the person has a preference for drug
6 treatment. **[2018]**

7 1.6.22 Consider antipsychotics such as risperidone², quetiapine³ and olanzapine⁴
8 to manage symptoms for adults with a diagnosis of PTSD in a secondary
9 care setting. Ensure that regular reviews are carried out. **[2018]**

To find out why the committee made the **[2018]** recommendations on drug treatments for adults and how they might affect practice, see [rationale and impact](#).

10 **1.7 Care for people with post-traumatic stress disorder and** 11 **complex needs**

12 1.7.1 For people presenting with PTSD and depression:

- 13 • usually treat the PTSD first because the depression will often improve
14 with successful PTSD treatment

¹ At the time of publication June 2018, venlafaxine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.

² At the time of publication June 2018, risperidone did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.

³ At the time of publication June 2018, quetiapine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.

⁴ At the time of publication June 2018, olanzapine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.

- 1 • treat the depression first if it might make psychological treatment of the
2 PTSD difficult. **[2018]**
- 3 1.7.2 Do not exclude people with PTSD from treatment based on comorbid drug
4 or alcohol misuse. **[2018]**
- 5 1.7.3 For people with PTSD whose assessment identifies a high risk of suicide
6 or harm to others, establish a risk management plan as part of initial
7 treatment planning. **[2018]**
- 8 1.7.4 For people with additional needs, including those with [complex PTSD](#):
- 9 • help the person manage any symptoms, such as dissociation or
10 emotional dysregulation, that might be a barrier to engaging with
11 trauma-focused therapies
- 12 • ensure adequate time is included in treatment for the person to
13 establish trust
- 14 • take into account the safety and stability of the person’s personal
15 circumstances (for example, their housing situation), and how this
16 might impact on engagement with and success of treatment
- 17 • increase the number of trauma-focused therapy sessions according to
18 the person’s needs
- 19 • plan any ongoing support the person needs, for example, to start or
20 return to everyday activities and ongoing symptom management.
21 **[2018]**

To find out why the committee made the **[2018]** recommendations on care for people with PTSD and complex needs and how they might affect practice, see [rationale and impact](#).

22 **1.8 Disaster planning**

23 1.8.1 Ensure that disaster plans provide a fully coordinated psychosocial
24 response to the disaster. A disaster plan should include:

- 25 • immediate practical help

- 1 • support for the affected communities in caring for those involved in the
- 2 disaster
- 3 • access to specialist mental health, evidence-based assessment and
- 4 treatment services
- 5 • clear roles and responsibilities for all professionals involved. [2005]

6 ***Terms used in this guideline***

7 **Acute stress disorder**

8 Acute stress disorder is a DSM-5 diagnosis that applies in the first month after a
9 traumatic event. It requires the presence of 9 or more symptoms from any of the
10 5 categories of intrusion, negative mood, dissociation, avoidance and arousal. These
11 can be starting or worsening after the traumatic event.

12 **Clinically important symptoms**

13 Clinically important symptoms of PTSD refer to those with a diagnosis of PTSD
14 according to DSM, ICD or similar criteria or those with clinically significant PTSD
15 symptoms as indicated by baseline scores above clinical threshold on a validated
16 scale. These are typically referred to or seen in studies that have not used a clinical
17 interview to arrive at a formal diagnosis of PTSD and instead have only used self-
18 report measures of PTSD symptoms.

19 **Complex PTSD**

20 Complex PTSD arises in a subset of people who meet criteria for PTSD. It is a
21 diagnosis in the forthcoming ICD-11, which defines it as arising “after exposure to a
22 stressor event typically of an extreme or prolonged nature and from which escape is
23 difficult or impossible. The disorder is characterised by the core symptoms of PTSD
24 as well as the development of persistent and pervasive impairments in affective, self
25 and relational functioning, including difficulties in emotion regulation, beliefs about
26 oneself as diminished, defeated and worthless, and difficulties in sustaining
27 relationships”.

28 The traumatic events are typically interpersonal in nature; that is, they involve human
29 mistreatment. DSM-5 does not include a diagnosis of complex PTSD. It covers the
30 complexity of presentation through a wider range of core PTSD symptoms (such as

1 'negative mood and cognitions') and the potential specifier of a 'dissociative
2 subtype'.

3 **Disaster plan**

4 A plan setting out the overall framework for the initiation, management, coordination
5 and control of staff and other resources to reduce, control or respond to an
6 emergency.

7 **Recommendations for research**

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

10 ***Key recommendations for research***

11 **1 Stepped care for post-traumatic stress disorder**

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

14 To find out why the committee made the research recommendation on stepped care,
15 see appendix L of [evidence review I: organisation and delivery of care for people
16 with PTSD](#).

17 **2 Sequencing and further line treatment**

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

20 To find out why the committee made the research recommendation on sequencing
21 and further line treatment, see appendix L of [evidence review D: Psychological,
22 psychosocial and other non-pharmacological interventions for the treatment of PTSD
23 in adults](#).

24 **3 Trauma-informed approaches**

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

1 To find out why the committee made the research recommendation on trauma-
2 informed approaches, see appendix L of [evidence review I: organisation and delivery](#)
3 [of care for people with PTSD](#)

4 **4 Personalisation and risk markers**

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

7 To find out why the committee made the research recommendation on
8 personalisation and risk markers, see appendix L of [evidence review D:](#)
9 [Psychological, psychosocial and other non-pharmacological interventions for the](#)
10 [treatment of PTSD in adults](#).

11 **5 Complex PTSD**

12 What is the clinical and cost effectiveness of interventions to deliver stabilisation and
13 reintegration for people with complex PTSD?

14 To find out why the committee made the research recommendation on complex
15 PTSD, see appendix L of [evidence review D: Psychological, psychosocial and other](#)
16 [non-pharmacological interventions for the treatment of PTSD in adults](#).

17 **Rationale and impact**

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

21 ***Supporting transitions between services***

22 Recommendations [1.2.4 to 1.2.6](#)

23 **Why the committee made the recommendations**

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

1 The committee discussed strategies to improve care coordination and provide
2 smooth transitions of care for people with post-traumatic stress disorder (PTSD).
3 They agreed it was important to plan transitions in advance, involve families and
4 carers, make sure everyone involved in the person's care is aware of their role and
5 responsibility, and ensure that different services are communicating with each other,
6 as well as with the person with PTSD. They noted that overall coordination and
7 continuity of care could be achieved by having a key professional to oversee the
8 whole period of care (as covered by recommendations 1.2.1 and 1.2.3). The
9 committee also identified certain groups that might need extra support during care
10 transitions.

11 **How the recommendations might affect practice**

12 These recommendations will help to improve the way in which care is provided and
13 improve consistency between services. Any resource impact should be offset by time
14 savings and efficiency benefits from improved care coordination and continuity. Full
15 details of the evidence and the committee's discussion are in [evidence review J:
16 care pathways for adults, children and young people with PTSD](#).

17 [Return to recommendations](#)

18 **Access to care**

19 Recommendations [1.3.1 and 1.3.2](#)

20 **Why the committee made the recommendations**

21 In the absence of good evidence, the committee used formal consensus to
22 recommend some key strategies for promoting access to care.

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

1 The committee noted that the evidence on using a stepped care approach was
2 encouraging, but because only 1 study was identified, they decided to recommend it
3 as an area for further research (see [research recommendation 1](#)).

4 **How the recommendation might affect practice**

5 These recommendations will help to improve the way in which care is provided and
6 improve consistency between services. Currently video consultation is not available
7 everywhere so this recommendation could have a moderate impact on resources.
8 However, it is expected to save resources in the future, in particular in remote areas
9 where therapists need to travel further to deliver trauma-focused CBT in person.

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

14 [Return to recommendations](#)

15 ***Principles of care***

16 Recommendations [1.4.1 to 1.4.8](#)

17 **Why the committee made the recommendations**

18 ***Supporting people with PTSD (recommendations 1.4.1 and 1.4.2)***

19 Based on the evidence and their own clinical experience, the committee discussed
20 how people with PTSD are often apprehensive about making contact with services
21 and may not know what treatments and help are available. They agreed that this
22 underlined the need for good information and support, tailored to people's needs,
23 about interventions and services so that people know what care to expect and how it
24 will be provided (for example, where and by whom).

25 ***Peer support (recommendation 1.4.3)***

26 The evidence for peer support groups was limited but included some compelling
27 reports from people with PTSD that sharing experiences with other people who had
28 also experienced a traumatic event was beneficial, and this was reported for different
29 types of traumatic experience. Findings suggested that peer support could also help

1 people overcome their doubts and fears about having treatment by telling them
2 about available help and support, and encouraging them to engage with services.

3 ***Involving family members in treatment (recommendations 1.4.5 and 1.4.6)***

4 There was evidence that involving families and carers in treatment provided extra
5 support for the person while also giving the family or carer a greater understanding
6 of PTSD. However, family or carer involvement was not universally reported as
7 positive, with some people not liking the feeling of being talked about in their
8 absence, so the committee agreed this should be discussed with the person first.

9 Limited evidence showed that involving parents in the treatment of their child with
10 PTSD, and problem-solving and self-help (without support) interventions for parents
11 or partners had benefits on family and carer mental health. However, the evidence
12 was too uncertain to make recommendations for specific interventions to support
13 family members and carers. The committee recommended good practice points by
14 drawing on qualitative evidence and their own expert opinion.

15 **How the recommendations might affect practice**

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

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

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

28 [Return to recommendations](#)

1 ***Planning treatment and supporting engagement***

2 Recommendations [1.6.1 and 1.6.2](#)

3 **Why the committee made the recommendations**

4 The committee agreed it was important to use a holistic approach when planning
5 treatment with people who have PTSD, for example, by thinking about all the
6 different possible factors in their life that could be contributing to their continuing
7 symptoms and taking into account whether any treatments have worked in the past.
8 In the committee's opinion, these were important points of good practice, along with
9 providing information and support to help the person to make an informed choice
10 about treatments.

11 The committee agreed that any strategies for promoting engagement need to be
12 based on an understanding that people with PTSD are often highly anxious about
13 having treatment and frequently avoid it. This was supported by evidence that
14 common reasons for not seeking help include worry about engaging with a therapist,
15 fear of re-traumatisation and stigmatisation. The committee agreed that healthcare
16 professionals need to understand these reasons so that they don't misinterpret why
17 someone is not engaging and they know the best ways to help them – including by
18 contacting them if they don't come for an arranged appointment.

19 **How the recommendations might affect practice**

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

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

26 [Return to recommendations](#)

27 ***Active monitoring***

28 Recommendation [1.6.3](#)

1 **Why the committee made the recommendation**

2 There was no consistent evidence for effective interventions to prevent PTSD in
3 people with less significant PTSD symptoms within 1 month of a traumatic event.
4 The committee discussed how some people do not develop PTSD symptoms after a
5 trauma even with no, or limited, interventions. Conversely, some people develop
6 chronic symptoms if intervention is not provided early. Based on consensus, the
7 committee agreed that active monitoring within the first month after the trauma could
8 help professionals to judge whether people with less severe symptoms would need
9 further intervention.

10 **How the recommendation might affect practice**

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

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

18 [Return to recommendations](#)

19 ***Psychological interventions for the prevention of PTSD in children 20 and young people***

21 Recommendations [1.6.4 and 1.6.5](#)

22 **Why the committee made the recommendations**

23 ***Active monitoring or individual trauma-focused CBT (recommendation 1.6.4)***

24 Limited evidence showed that individual trauma-focused CBT (with carer
25 involvement) was superior to a psychoeducation and supportive intervention for
26 improving PTSD symptoms and anxiety symptoms in children and young people who
27 have been exposed to a range of (non-shared) traumatic events within the last
28 month. The committee considered this, together with the stronger evidence for the
29 efficacy of individual trauma-focused CBT for children who have experienced trauma

1 more than 1 month ago and the evidence for benefits in adults within 1 month of
2 trauma, and agreed that individual trauma-focused CBT should be an option for
3 children and young people with clinically important PTSD symptoms or acute stress
4 disorder within 1 month of a traumatic event.

5 The committee were mindful that even for children and young people with clinically
6 important PTSD symptoms or a diagnosis of acute stress disorder, there can be a lot
7 of natural recovery in the early weeks. They agreed that it can be difficult to gauge a
8 child or young person's readiness for intervention within 1 month of trauma. Based
9 on consensus, the committee agreed that active monitoring should be an option,
10 alongside individual trauma-focused CBT, within 1 month of trauma for children and
11 young people with clinically important PTSD symptoms or acute stress disorder, and
12 that this decision was best left to clinical judgement.

13 ***Group trauma-focused CBT (recommendation 1.6.5)***

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

25 ***Psychosocial interventions***

26 Limited evidence showed some benefit of a psychoeducational group for improving
27 PTSD symptoms in children exposed to ongoing trauma in the context of witnessing
28 war as a civilian. However, based on a comparison of the strength of evidence and
29 the size of effects for a psychoeducational group relative to the intervention
30 recommended (a trauma-focused CBT group), the committee did not judge it
31 appropriate to recommend a psychoeducational group for the early prevention of
32 PTSD in children who have been exposed to large-scale shared trauma.

1 **How the recommendations might affect practice**

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

9 For children and young people aged under 18 years with a diagnosis of acute stress
10 disorder or clinically important symptoms of PTSD within 1 month of a traumatic
11 event, there is currently variation in practice. Recommending active monitoring or
12 individual trauma-focused CBT as options to consider is expected to reduce this
13 variation in practice and redirect resources from interventions of higher resource
14 intensity and/or lesser known effectiveness to the less resource-intensive active
15 monitoring or to trauma-focused CBT, which is better supported by existing
16 evidence.

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

20 [Return to recommendations](#)

21 ***Psychological interventions for the treatment of PTSD in children 22 and young people***

23 Recommendations [1.6.6 to 1.6.10](#)

24 **Why the committee made the recommendations**

25 The evidence showed that trauma-focused CBT is effective in improving PTSD
26 symptoms and other important outcomes, and that improvements last for at least a
27 year. Benefits were seen for different specific trauma-focused interventions and
28 different types of trauma. Trauma-focused CBT is more effective, as well as more
29 cost effective, when it is provided individually than in a group so the committee
30 agreed it should be delivered individually (recommendation 1.6.8).

1 The evidence suggested that trauma-focused CBT was effective for children both
2 over and under 7 years. Most of the evidence came from older children, so the
3 committee could not recommend it with the same certainty for under 7s but agreed it
4 should be thought of as an option for them.

5 There was no evidence for early treatment (between 1 and 3 months of a traumatic
6 event) with trauma-focused CBT relative to a non-active control, so the committee
7 could not recommend it with the same certainty as for more than 3 months after
8 trauma. However, by extrapolating from the broad evidence base for benefits more
9 than 3 months after trauma and using their own clinical experience, they agreed that
10 trauma-focused CBT should be an option for treatment within this earlier time period
11 (recommendation 1.6.7).

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

15 There was limited evidence for eye movement desensitisation and reprocessing
16 (EMDR) suggesting possible benefits on PTSD symptoms in children aged over
17 7 years. Based on uncertainties in this evidence, the committee decided it should be
18 considered only if children do not respond to or engage with trauma-focused CBT,
19 an intervention that is supported by better evidence.

20 ***Other interventions***

21 Limited evidence showed that meditation and art therapy might have some benefit
22 on PTSD symptoms in children and young people. However, because there were too
23 many uncertainties in the evidence and there was much better evidence supporting
24 trauma-focused CBT, the committee did not make any recommendations. No
25 evidence was found on other non-pharmacological interventions, so the committee
26 did not make any recommendations.

27 **How the recommendations might affect practice**

28 The recommendations for trauma-focused CBT more than 3 months after a traumatic
29 event are in line with previously recommended practice and the committee were not
30 aware of wide variation in practice. Recommending trauma-focused CBT within 1 to

1 3 months after a traumatic event and also recommending EMDR as an option are
2 both new, but any impact on practice should be limited by the fact that these are
3 weaker ('consider') recommendations and that EMDR should only be considered for
4 children who do not respond to or engage with trauma-focused CBT.

5 Previous treatment recommendations were made for children with PTSD, whereas
6 current recommendations are relevant to children and young people with a diagnosis
7 of PTSD or with clinically important symptoms of PTSD. The committee noted that
8 the structure, content and time of the assessment, as well as the benefits from
9 treatment are broadly the same for both populations (that is, those diagnosed with
10 PTSD and those identified as having clinically important symptoms of PTSD), and
11 expressed the view that the population covered in the current treatment
12 recommendations does not represent a significant broadening of the population that
13 was covered by the previous guideline recommendations; indeed many children and
14 young people with clinically important symptoms of PTSD that are below the
15 diagnostic threshold for PTSD will eventually develop a diagnosis of PTSD.

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

19 [Return to recommendations](#)

20 ***Drug treatments for children and young people***

21 Recommendation [1.6.11](#)

22 **Why the committee made the recommendation**

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

26 **How the recommendation might affect practice**

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

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

3 [Return to recommendations](#)

4 ***Psychological interventions for the prevention of PTSD in adults***

5 Recommendation [1.6.12](#)

6 **Why the committee made the recommendation**

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

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

15 ***Other interventions***

16 There was only limited evidence on psychosocial and other non-pharmacological
17 interventions for adults within 1 month of a traumatic event – for example meditation,
18 mindfulness-based stress reduction (MBSR), acupuncture, yoga and massage – and
19 it was too uncertain to support any recommendations.

20 **How the recommendation might affect practice**

21 The recommendations are in line with previous recommended good practice, so
22 should not involve a major change in practice.

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

26 [Return to recommendations](#)

1 ***Psychological interventions for the treatment of PTSD in adults***

2 Recommendations [1.6.13 to 1.6.18](#)

3 **Why the committee made the recommendations**

4 ***Trauma-focused CBT (recommendations 1.6.13 and 1.6.14)***

5 There was extensive evidence that trauma-focused CBT improves PTSD symptoms
6 as well as other important outcomes, and that these improvements can be
7 maintained up to a year later. Benefits were seen across a wide range of specific
8 types of trauma-focused CBT intervention of varying durations, and for different
9 types of trauma. Trauma-focused CBT was effective both alone and in addition to
10 treatment as usual and/or medication.

11 There was good evidence that offering up to 12 sessions of individual trauma-
12 focused CBT was clinically and cost effective. Group trauma-focused CBT was not
13 seen to be clinically or cost effective based on the guideline network meta-analysis
14 and economic analysis, although the evidence was limited.

15 The committee used their experience to agree the structure and content of individual
16 trauma-focused CBT sessions to make sure these interventions are delivered in a
17 consistent way because they were concerned that this may not happen in practice.

18 Psychoeducation was found to be highly clinically and cost effective in comparisons
19 with psychological interventions according to the guideline network meta-analysis
20 and economic analysis, but its evidence base was very limited and uncertain. The
21 committee agreed that the evidence could not support a recommendation for
22 psychoeducation on its own but it should be delivered as part of individual trauma-
23 focused CBT.

24 ***Eye movement desensitisation and reprocessing (recommendations 1.6.15 and*** 25 ***1.6.16)***

26 Less evidence was found on EMDR than on trauma-focused CBT, but the committee
27 agreed that what was available justified recommending EMDR as an option.

28 Although studies that compared EMDR directly with trauma-focused CBT did not
29 show significant differences, there was a trend towards EMDR. This trend in favour

1 of EMDR was also present in the cost-effectiveness results. The evidence suggested
2 EMDR may be less effective in people with military combat-related trauma, so the
3 committee restricted their recommendation to non-combat-related trauma.

4 Although EMDR uses the same broad approach, the committee was concerned that
5 psychological interventions are not always delivered in a consistent way, so they
6 used their experience to agree a specific structure and content.

7 ***Supported trauma-focused computerised CBT (recommendation 1.6.17)***

8 There was evidence that both supported and unsupported self-help, and
9 computerised trauma-focused CBT in particular, were beneficial in terms of self-rated
10 PTSD symptoms and other important outcomes. These benefits were maintained up
11 to a year later. Both interventions were cost effective compared with psychological
12 interventions. The evidence was limited for some of the outcomes that were looked
13 at, and it was unclear whether self-help was effective across different types of
14 trauma. Although both supported and unsupported self-help were found to be
15 effective, the former was more clinically and cost effective. Taking the evidence for
16 efficacy, together with the gaps in the evidence, the committee agreed that
17 supported computerised trauma-focused CBT should be an option for adults with
18 PTSD who would find it difficult to engage in face-to-face, trauma-focused CBT or
19 EMDR.

20 ***Non-trauma-focused CBT interventions (recommendation 1.6.18)***

21 There was some evidence that non-trauma-focused CBT is beneficial when targeted
22 at associated symptoms such as sleep disturbance or anger, and also leads to
23 improvements in PTSD symptoms, but it was not clear how long these benefits
24 would be maintained. Non-trauma-focused CBT was less cost effective than
25 individual trauma-focused CBT, EMDR and self-help, but more cost effective than
26 other interventions such as interpersonal psychotherapy (IPT), present-centred
27 therapy, group trauma-focused CBT, combined individual trauma-focused CBT and
28 selective serotonin reuptake inhibitors (SSRIs), counselling and no treatment. The
29 committee agreed the potential benefits of non-trauma-focused CBT were important,
30 but that symptom-specific interventions should not be seen as an alternative to a
31 trauma-focused, first-line treatment. Instead, they could be an option when people

1 are not ready to directly confront memories of the trauma and could promote uptake
2 and engagement with a trauma-focused intervention that specifically targets PTSD.

3 ***Timing of interventions***

4 The evidence for providing treatment for PTSD between 1 and 3 months after a
5 traumatic event was limited across different interventions. Based on this limited
6 evidence and their own experience, the committee agreed that it was important to
7 focus treatment on the time period when they were most certain that people would
8 benefit – that is, more than 3 months after the trauma. One exception to this is for
9 trauma-focused CBT where the committee extrapolated from limited evidence
10 showing benefits between 1 and 3 months after trauma, and the broader evidence
11 base that showed benefits within the first month and more than 3 months after
12 trauma. It is unlikely that effects would be different in this 2-month time period, so the
13 committee recommended trauma-focused CBT for adults with a diagnosis of PTSD
14 or clinically important symptoms of PTSD more than 1 month after a traumatic event.

15 ***Other psychological interventions***

16 The committee agreed not to make recommendations about other psychological
17 interventions that were not well supported by the evidence. There was no evidence
18 that any of the other interventions would be more suitable in specific clinical
19 circumstances than the ones they had already recommended. The committee noted
20 that counselling was shown to be less cost effective than no treatment in the
21 guideline economic analysis.

22 **How the recommendations might affect practice**

23 Previous treatment recommendations were made for adults with PTSD, whereas
24 current recommendations are relevant to adults with a diagnosis of PTSD or with
25 clinically important symptoms of PTSD. The committee noted that the structure,
26 content and time of the assessment, as well as the benefits from treatment are
27 broadly the same for both populations and expressed the view that the population
28 covered in the current treatment recommendations does not represent a significant
29 broadening of the population that was covered by the previous guideline
30 recommendations, and indeed many individuals with clinically important symptoms of

1 PTSD that are below the diagnostic threshold for PTSD will eventually develop a
2 diagnosis of PTSD.

3 Both trauma-focused CBT and EMDR were recommended by the 2005 guideline,
4 and the committee did not think there was wide variation in practice. The new
5 recommendation for non-trauma-focused, symptom-specific CBT interventions
6 represents a bigger change in practice because the 2005 guideline recommended
7 that non-trauma-focused interventions should not be routinely offered to people with
8 chronic PTSD. The impact on resources is difficult to predict because it is
9 recommended only as an option to consider, but it might bring potential savings by
10 improving uptake and engagement with trauma-focused therapies that should reduce
11 missed appointments and early drop-out.

12 The recommendation for supported computerised trauma-focused CBT is also
13 thought to represent a bigger change in practice. There was no 2005
14 recommendation for self-help-based interventions and the committee were not aware
15 of such interventions being in widespread use in routine clinical practice. The cost of
16 supported computerised trauma-focused CBT includes, in addition to therapist's
17 time, the cost of the digital mental health programmes and equipment (computers)
18 needed for delivery. If the intervention is delivered in a public place, such as a
19 library, or the person's home, there is no equipment cost. If the computer is used in a
20 clinical practice setting, it can be shared by many people having computerised
21 therapy, minimising the equipment cost. It could therefore lead to cost savings if part
22 of routine practice is shifted from the more resource-intensive individual trauma-
23 focused CBT and EMDR to the less resource-intensive supported computerised
24 trauma-focused CBT.

25 The committee acknowledged that there would be a cost associated with providing
26 extra trauma-focused therapy sessions for people with complex PTSD if they are
27 necessary. Previous recommended practice was to consider more than 12 sessions
28 for people after multiple incident trauma, or who have a chronic disability, or
29 significant coexisting conditions or social problems. However, in clinical practice the
30 provision of additional sessions is variable.

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

4 [Return to recommendations](#)

5 ***Debriefing***

6 Recommendation [1.6.19](#)

7 **Why the committee made the recommendation**

8 Evidence on debriefing, either individually or in groups, showed no clinically
9 important benefit and potentially harmful effects, so the committee agreed it should
10 not be offered.

11 **How the recommendation might affect practice**

12 Debriefing was not part of previously recommended practice, so there should be no
13 impact on practice.

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

17 [Return to recommendations](#)

18 ***Drug treatments in adults***

19 Recommendations [1.6.20 to 1.6.22](#)

20 **Why the committee made the recommendations**

21 ***Prevention (recommendation 1.6.20)***

22 There was no consistent evidence that any drug treatments are effective in
23 preventing PTSD. Given the limited evidence of benefits and the potential harms,
24 including side effects, the committee agreed that drug treatments should not be
25 offered to prevent PTSD in adults. The committee specifically referred to
26 benzodiazepines because of the lack of benefit in the evidence, concerns about

1 harm and because they have clinical experience of these drugs being prescribed in
2 practice.

3 ***Treatment (recommendations 1.6.21 and 1.6.22)***

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

13 There was some evidence that antipsychotics, either alone or in addition to routine
14 medications, are effective in treating PTSD symptoms. However, it was more limited
15 than the evidence supporting SSRIs and the psychological interventions, particularly
16 trauma-focused CBT (for example, the evidence for other important outcomes was
17 limited and there was no follow-up data). The committee agreed that antipsychotics
18 should not be seen as an alternative to a trauma-focused psychological intervention
19 as first-line treatment for PTSD. However, they might be beneficial for symptom
20 management if a person has significant functional impairment that makes it difficult
21 for them to access or engage with psychological treatment.

22 The committee noted that some prescribers, including GPs, might not feel competent
23 to start or monitor antipsychotic medication, so they recommended managing
24 antipsychotic medication in a secondary care setting.

25 **How the recommendations might affect practice**

26 The committee were concerned that drug treatment within the first month of trauma
27 may be reasonably common in clinical practice. Recommendation 1.6.18 should
28 reduce the use of non-evidence-based interventions and improve consistency of
29 practice.

1 These recommendations represent a small change in practice because the 2005
2 guideline recommended drug treatment as an option only for adults who could not
3 start a psychological therapy, did not want to start trauma-focused psychological
4 therapy or who had gained little or no benefit from it.

5 In the UK, only paroxetine and sertraline are currently licensed for the treatment of
6 PTSD so the recommendations involve off-licence use. Offering antipsychotics only
7 in secondary care is expected to reduce variation in the way antipsychotics are used
8 in current practice. Regular review of drug treatment is essential but might not be
9 happening currently, so this should also improve consistency.

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

12 [Return to recommendations](#)

13 ***Care for people with post-traumatic stress disorder and complex*** 14 ***needs***

15 Recommendations [1.7.1. to 1.7.4](#)

16 **Why the committee made the recommendations**

17 There was a lack of evidence on care for people with PTSD and complex needs,
18 including people with coexisting conditions such as depression or substance misuse,
19 so the committee used a formal consensus method to agree some overarching
20 principles. They agreed that substance misuse should not be a barrier to people
21 accessing treatment for PTSD, so services should not exclude people on this basis.

22 The evidence was limited on interventions for people who have complex PTSD, but it
23 suggested that trauma-focused therapies could also benefit this group. Based on
24 their experience, the committee proposed ways of modifying interventions to address
25 the barriers people with complex PTSD might have to engaging in treatment, like
26 offering more sessions and avoiding an abrupt end to treatment by planning ongoing
27 support.

1 **How the recommendations might affect practice**

2 The committee acknowledged that there would be a cost associated with providing
3 extra trauma-focused therapy sessions for people with PTSD and complex needs if
4 they are necessary. Previous recommended practice was to consider more than
5 12 sessions for people after multiple incident trauma, or who have a chronic
6 disability, or significant coexisting conditions or social problems. However, in clinical
7 practice the provision of additional sessions is variable.

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

12 [Return to recommendations](#)

13 **Putting this guideline into practice**

14 **[This section will be completed after consultation]**

15 NICE has produced [tools and resources](#) **[link to tools and resources tab]** to help you
16 put this guideline into practice.

17 **[Optional paragraph if issues raised]** Some issues were highlighted that might need
18 specific thought when implementing the recommendations. These were raised during
19 the development of this guideline. They are:

- 20 • [add any issues specific to guideline here]
- 21 • [Use 'Bullet left 1 last' style for the final item in this list.]

22 Putting recommendations into practice can take time. How long may vary from
23 guideline to guideline, and depends on how much change in practice or services is
24 needed. Implementing change is most effective when aligned with local priorities.

25 Changes recommended for clinical practice that can be done quickly – like changes
26 in prescribing practice – should be shared quickly. This is because healthcare
27 professionals should use guidelines to guide their work – as is required by

1 professional regulating bodies such as the General Medical and Nursing and
2 Midwifery Councils.

3 Changes should be implemented as soon as possible, unless there is a good reason
4 for not doing so (for example, if it would be better value for money if a package of
5 recommendations were all implemented at once).

6 Different organisations may need different approaches to implementation, depending
7 on their size and function. Sometimes individual practitioners may be able to respond
8 to recommendations to improve their practice more quickly than large organisations.

9 Here are some pointers to help organisations put NICE guidelines into practice:

10 1. **Raise awareness** through routine communication channels, such as email or
11 newsletters, regular meetings, internal staff briefings and other communications with
12 all relevant partner organisations. Identify things staff can include in their own
13 practice straight away.

14 2. **Identify a lead** with an interest in the topic to champion the guideline and motivate
15 others to support its use and make service changes, and to find out any significant
16 issues locally.

17 3. **Carry out a baseline assessment** against the recommendations to find out
18 whether there are gaps in current service provision.

19 4. **Think about what data you need to measure improvement** and plan how you
20 will collect it. You may want to work with other health and social care organisations
21 and specialist groups to compare current practice with the recommendations. This
22 may also help identify local issues that will slow or prevent implementation.

23 5. **Develop an action plan**, with the steps needed to put the guideline into practice,
24 and make sure it is ready as soon as possible. Big, complex changes may take
25 longer to implement, but some may be quick and easy to do. An action plan will help
26 in both cases.

27 6. **For very big changes** include milestones and a business case, which will set out
28 additional costs, savings and possible areas for disinvestment. A small project group

1 could develop the action plan. The group might include the guideline champion, a
2 senior organisational sponsor, staff involved in the associated services, finance and
3 information professionals.

4 **7. Implement the action plan** with oversight from the lead and the project group.
5 Big projects may also need project management support.

6 **8. Review and monitor** how well the guideline is being implemented through the
7 project group. Share progress with those involved in making improvements, as well
8 as relevant boards and local partners.

9 NICE provides a comprehensive programme of support and resources to maximise
10 uptake and use of evidence and guidance. See our [into practice](#) pages for more
11 information.

12 Also see Leng G, Moore V, Abraham S, editors (2014) [Achieving high quality care –](#)
13 [practical experience from NICE](#). Chichester: Wiley.

14 **Context**

15 Post-traumatic stress disorder (PTSD) develops following a stressful event or
16 situation of an exceptionally threatening or catastrophic nature, which would be likely
17 to cause significant distress in almost anyone. It does not develop from upsetting
18 situations sometimes described as ‘traumatic’ in everyday language, for example,
19 divorce, losing a job or failing an exam. PTSD is a disorder that can affect people of
20 all ages. Around 25–30% of people experiencing a traumatic event go on to develop
21 PTSD.

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

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

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

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

15 Effective treatment of PTSD can only take place if the disorder is recognised.
16 Opportunities for recognition usually come during routine healthcare, for example,
17 during physical treatment after an assault or an accident, or when a person discloses
18 domestic violence or a history of childhood sexual abuse. Many people attending for
19 medical services in hospital have experienced traumatic events, particularly in
20 emergency departments, and orthopaedic and plastic surgery clinics. Up to 30% of
21 children develop PTSD after attending an emergency department for a traumatic
22 injury. Identifying PTSD in children presents particular problems, but is improved by
23 asking children directly about their experiences.

24 The aim of this guideline is to update and replace the previous NICE guideline on
25 PTSD (CG26) because new evidence that impacts on the recommendations was
26 identified during the surveillance review.

27 The guideline covers children, young people and adults (aged 18 years and over)
28 who are at risk of PTSD or have a diagnosis of PTSD, and their families and carers.
29 It also covers people with comorbid conditions including drug and alcohol misuse
30 and common mental health conditions.

1 The guideline covers all NHS and social care-commissioned services where care is
2 provided for people with PTSD.

3 **Finding more information and resources**

4 To find out what NICE has said on topics related to this guideline, see our web page
5 on [mental health and behavioural conditions](#).

6 **Update information**

7 **[For final version amend text to remove references to 'propose' 'draft' etc']**

8 **December 2018**

9 This guideline is an update of NICE guideline CG26 (published March 2005) and will
10 replace it.

11 We have reviewed the evidence on the prevention, treatment and care of people with
12 post-traumatic stress disorder (PTSD).

13 Recommendations are marked **[2018]** if the evidence has been reviewed.

14 ***Recommendations that have been deleted or changed***

15 We propose to delete some recommendations from the 2005 guideline. [Table 1](#) sets
16 out these recommendations and includes details of replacement recommendations.

17 If there is no replacement recommendation, an explanation for the proposed deletion
18 is given.

19 In recommendations shaded in grey and ending **[2005, amended 2018]**, we have
20 made changes that could affect the intent without reviewing the evidence. Yellow
21 shading is used to highlight these changes, and reasons for the changes are given in
22 [table 2](#).

23 In recommendations shaded in grey and ending **[2005]** we have not reviewed the
24 evidence. In some cases minor changes have been made – for example, to update
25 links, or bring the language and style up to date – without changing the intent of the
26 recommendation. Minor changes are listed in [table 3](#).

1 See also the [original NICE guideline and supporting documents](#).

2 **Table 1 Recommendations that have been deleted**

Recommendation in 2005 guideline	Comment
<p>Support for families and carers</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	<p>These recommendations have been deleted because the evidence has been reviewed for this guideline update.</p> <p>Replaced by:</p> <p>Involving and supporting families and carers</p> <p>1.4.5 Consider providing information and support to family members and carers of people at risk of PTSD and people with PTSD. This could cover:</p> <ul style="list-style-type: none"> • the treatment and management of psychological and behavioural problems related to PTSD, including the person's possible risk to themselves and others • discussing with carers how the person's PTSD symptoms are affecting the carer themselves • how they can support the person to access treatment, including what to do if they don't engage with or drop out of treatment. [2018] <p>1.4.6 Involve family members and carers, where appropriate, in treatment for people with PTSD as a way to:</p> <ul style="list-style-type: none"> • inform and improve the care of the person with PTSD and • identify and meet their own needs as carers. [2018] <p>1.4.7 Consider providing practical and emotional support and advice to family members and carers, for example directing them to health or social services or peer support groups. [2018]</p> <p>1.4.8 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]</p>

<p>Practical support and social factors</p> <p>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.</p> <p>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.</p> <p>1.8.1 Care across all conditions</p> <p>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.</p> <p>1.8.1.2 Healthcare professionals should not delay or withhold treatment for PTSD because of court proceedings or applications for compensation.</p> <p>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.</p> <p>1.8.1.4 Healthcare professionals should treat PTSD sufferers with respect, trust and understanding, and keep technical language to a minimum.</p> <p>1.8.1.5 Healthcare professionals should normally only consider providing trauma-focused psychological treatment when the sufferer considers it safe to proceed.</p> <p>1.8.1.6 Treatment should be delivered by competent individuals who have received appropriate training. These individuals should receive appropriate supervision.</p>	<p>These recommendations have been deleted because the evidence has been reviewed for this guideline update.</p> <p>Replaced by:</p> <p>Supporting people with post-traumatic stress disorder</p> <p>1.4.1 Provide information in both oral and written format and in line with recommendations in the NICE guidelines on service user experience in adult mental health and patient experience in adult NHS services. [2018]</p> <p>1.4.2 Give information and support to people with PTSD (and their family members or carers as appropriate) covering:</p> <ul style="list-style-type: none"> • common reactions to traumatic events, including the symptoms of PTSD and its course • assessment, treatment and support options to help the person make an informed choice • care pathways for PTSD • where their care will take place. [2018] <p>Peer support</p> <p>1.4.3 Provide access to peer support groups wherever possible. Peer support groups should:</p> <ul style="list-style-type: none"> • be facilitated by people with training and supervision • be delivered in a way that does not risk re-traumatisation • provide information, and help to access services. [2018] <p>Maintaining safe environments</p> <p>1.4.4 Be aware of the risk of continued exposure to trauma-inducing environments or triggers for people with PTSD and minimise exposure to triggers that could risk exacerbating symptoms (for example, restraining someone or placing them in a noisy inpatient ward). [2018]</p>
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<p>1.8.2 Comorbidities</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>1.9.4 Chronic disease management</p> <p>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.</p>	<p>These recommendations have been deleted because the evidence has been reviewed for this guideline update.</p> <p>Replaced by:</p> <p>Care for people with post-traumatic stress disorder and complex needs</p> <p>1.7.1 For people presenting with PTSD and depression:</p> <ul style="list-style-type: none"> usually treat the PTSD first because the depression will often improve with successful PTSD treatment treat the depression first if it might make psychological treatment of the PTSD difficult. [2018] <p>1.7.2 Do not exclude people with PTSD from treatment based on comorbid drug or alcohol misuse. [2018]</p> <p>1.7.3 For people with PTSD whose assessment identifies a high risk of suicide or harm to others, establish a risk management plan as part of initial treatment planning. [2018]</p> <p>1.7.4 For people with additional needs, including those with complex PTSD:</p> <ul style="list-style-type: none"> help the person manage any symptoms, such as dissociation or emotional dysregulation, that might be a barrier to engaging with trauma-focused therapies ensure adequate time is included in treatment for the person to establish trust take into account the safety and stability of the person's personal circumstances (for example their housing situation) and how this might impact on engagement with and success of treatment increase the number of trauma-focused therapy sessions according to the person's needs plan any ongoing support the person needs, for example to start or return to everyday activities and ongoing symptom management. [2018]
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<p>1.9.1 Early interventions</p> <p>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.</p> <p>Watchful waiting</p> <p>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.</p> <p>Immediate psychological interventions for all</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>PTSD where symptoms are present within 3 months of a trauma</p> <p>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.</p>	<p>These recommendations have been deleted because the evidence has been reviewed for this guideline update.</p> <p>Replaced by:</p> <p>Active monitoring</p> <p>1.6.3 Consider active monitoring for people within 1 month of a traumatic event who do not have clinically important symptoms of PTSD or acute stress disorder. [2018]</p> <p>Psychological interventions for the prevention and treatment of PTSD in children and young people</p> <p>Prevention for children and young people</p> <p>1.6.4 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]</p> <p>1.6.5 Consider group trauma-focused cognitive behavioural therapy (CBT) for children aged 7 and over if there has been an event within the last month leading to large-scale shared trauma. [2018]</p> <p>Treatment for children and young people</p> <p>1.6.6 Consider individual trauma-focused cognitive behavioural therapy (CBT) for children aged under 7 years with a diagnosis of PTSD or clinically important symptoms of PTSD more than 1 month after a traumatic event [2018].</p> <p>1.6.7 Consider individual trauma-focused CBT for children aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD within 1–3 months of a traumatic event. [2018]</p> <p>1.6.8 Offer individual trauma-focused CBT to children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event. [2018]</p>
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<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>1.9.2 PTSD where symptoms have been present for more than 3 months after a trauma</p> <p>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</p>	<p>1.6.9. Trauma-focused CBT for children and young people should:</p> <ul style="list-style-type: none"> • be based on a validated manual • typically be provided over 6 to 12 sessions • 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 safety planning • involve elaboration and processing of the trauma memories • 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] <p>1.6.10 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 more than 3 months after a traumatic event only if they do not respond to or engage with trauma-focused CBT. [2018]</p> <p>Psychological and psychosocial interventions for the prevention and treatment of PTSD in adults</p> <p><i>Prevention in adults</i></p> <p>1.6.12 Offer individual trauma-focused CBT to adults who have acute stress disorder or who have clinically important symptoms of PTSD and have been exposed to 1 or more traumatic events within the last month [2018]</p> <p><i>Treatment in adults</i></p> <p>1.6.13 Offer individual trauma-focused CBT to adults with a diagnosis of PTSD or clinically important symptoms of PTSD</p>
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<p>from effective treatment provided by competent healthcare professionals.</p> <p>Psychological interventions</p> <p>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.</p> <p>1.9.2.2 Trauma-focused psychological treatment should be offered to PTSD sufferers regardless of the time that has elapsed since the trauma.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	<p>more than 1 month after a traumatic event. [2018]</p> <p>1.6.14 Trauma-focused CBT for adults should:</p> <ul style="list-style-type: none"> • based on a validated manual • typically be provided over 8 to 12 sessions • include psychoeducation about reactions to trauma, strategies for managing arousal and safety planning • involve family members or carers as appropriate • involve elaboration and processing of the trauma memories • involve restructuring trauma-related meanings for the individual • provide help to overcome avoidance • have a focus on re-establishing a healthy lifestyle, 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] <p>1.6.15 Offer EMDR as an option for non-combat-related trauma to adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event. [2018]</p> <p>1.6.16 EMDR for adults should:</p> <ul style="list-style-type: none"> • be based on a validated manual • typically be provided over 8 to 12 sessions but more if clinically indicated, for example, where people have experienced multiple traumas • 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 use of bilateral stimulation (for example, eye movements, taps, or tones) for
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<p>to people who present with chronic PTSD.</p> <p>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:</p> <ul style="list-style-type: none"> • an alternative form of trauma-focused psychological treatment • the augmentation of trauma-focused psychological treatment with a course of pharmacological treatment. <p>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.</p> <p>1.9.5 Children</p> <p>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.</p> <p>Early intervention</p> <p>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.</p> <p>PTSD where symptoms have been present for more than 3 months after a trauma</p> <p>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.</p> <p>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</p>	<p>specific target memories until the memories are no longer distressing</p> <ul style="list-style-type: none"> • use self-calming techniques in-session [2018] <p>1.6.17 Consider supported trauma-focused computerised CBT for adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event who do not want or have not been able to engage in face-to-face trauma-focused CBT or EMDR. [2018]</p> <p>1.6.18 Consider symptom-specific CBT interventions (for symptoms such as sleep disturbance or anger) for adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event who:</p> <ul style="list-style-type: none"> • are unable or unwilling to engage in a trauma-focused intervention that specifically targets PTSD or • have residual symptoms after a trauma-focused intervention. [2018] <p>Debriefing</p> <p>1.6.19 Do not offer psychologically-focused debriefing to adults for the prevention or treatment of PTSD. [2018]</p>
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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.

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.

<p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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].</p> <p>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.</p>	<p>1.6.11 Do not offer drug treatments for the prevention or treatment of PTSD in children and young people. [2018]</p> <p>1.6.20 Do not offer drug treatments, including benzodiazepines, to prevent PTSD in adults. [2018]</p> <p>1.6.21 Consider a selective serotonin reuptake inhibitor (SSRI) or venlafaxine^a for adults with a diagnosis of PTSD if the person has a preference for drug treatment. [2018]</p> <p>1.6.22 Consider antipsychotics such as risperidone^b, quetiapine^c and olanzapine^d to manage symptoms for adults with a diagnosis of PTSD in a secondary care setting. Ensure that regular reviews are carried out. [2018]</p> <p>^a At the time of publication (June 2018), venlafaxine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.</p> <p>^b At the time of publication (June 2018), risperidone did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.</p> <p>^c At the time of publication (June 2018), quetiapine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.</p> <p>^d At the time of publication (June 2018), olanzapine did not have a UK marketing authorisation for this indication. The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.</p>
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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

<p>a 4-week period, although some people may require longer periods.</p> <p>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.</p>	
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2 **Table 2 Amended recommendation wording (change to intent) without an**
 3 **evidence review**

Recommendation in 2005 guideline	Recommendation in current guideline	Reason for change
<p>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).</p>	<p>1.1.1 Be aware that people with post-traumatic stress disorder (PTSD) may present with a range of symptoms associated with functional impairment, including:</p> <ul style="list-style-type: none"> • re-experiencing • avoidance • hyperarousal (including anger and irritability) • negative alterations in mood and thinking • emotional numbing • substance misuse. <p>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 1.1.2.</p>	<p>Recommendation has been reworded into active language. For clarity it has been split into 2 recommendations to separate symptoms awareness from assessment.</p> <p>Addition of functional impairment, changes to symptoms compared with 2005. Further clarification in light of new classification systems.</p> <p>Recommendation has been broadened to all settings so primary care has been removed from recommendation 1.1.4. 'Traumatic experience' has been amended to '1 or more traumatic events' because of the possibility of multiple/repeated trauma.</p>

<p>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.</p>	<p>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:</p> <ul style="list-style-type: none"> • serious accidents • physical and sexual assault • abuse, including childhood or domestic abuse • work-related exposure to trauma, including remote exposure • traumatic childbirth • war and conflict • torture 	<p>Recommendation has been broadened to all settings so primary care has been removed from recommendation.</p> <p>Examples of types of traumatic events have been extended and clarified to provide more information.</p>
<p>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).</p>	<p>1.1.5 For people with unexplained physical symptoms who repeatedly attend health services, think about asking whether they have experienced a traumatic event and provide specific examples of traumatic events (see recommendation 1.1.2)</p>	<p>Revised to aim at staff in all care settings.</p> <p>To reduce repetition, examples of traumatic events replaced with a cross-reference to 1.1.2.</p>
<p>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.</p>	<p>1.1.3 When assessing for PTSD, ask adults specific questions about re-experiencing, avoidance, hyperarousal, negative alterations in mood and thinking, and associated functional impairment</p>	<p>List of symptoms to ask about has been updated in line with changes to recommendation 1.1.1.</p> <p>Further clarification in light of new classification systems.</p>
<p>1.3.3.1 For individuals at high risk of developing PTSD following a major disaster,</p>	<p>1.1.8 For people at high risk of developing PTSD following a major disaster,</p>	<p>The committee clarified that the</p>

<p>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.</p>	<p>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.</p>	<p>screening instrument should be validated.</p>
<p>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.</p>	<p>1.1.9 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.</p>	<p>Programme refugees changed to 'refugees'. Further clarification was required in light of new terminology. Recommendation reworded to active and to aim at a broader audience.</p>
<p>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.</p>	<p>1.1.6 Do not rely solely on the parent or carer for information when it is developmentally appropriate to directly and separately question a child or young person about the presence of PTSD symptoms.</p>	<p>Recommendation reworded for simplification purposes and to emphasise when direct and separate questioning is appropriate.</p>
<p>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.</p>	<p>1.1.7 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 possibility of PTSD developing. Briefly describe the possible symptoms (for example, nightmares, repetitive trauma-related play, intrusive thoughts, avoiding things related to the events, increased behavioural difficulties, problems concentrating, hypervigilance, and difficulties sleeping) and</p>	<p>Changes to symptoms compared with 2005. Further clarification in light of new classification systems.</p>

	suggest they contact their GP if the symptoms persist beyond 1 month.	
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.	1.2.2 Assessment of people with PTSD should be conducted by competent individuals and be comprehensive, including an assessment of physical, psychological and social needs and a risk assessment.	Competence has been removed from the recommendation as this is a general expectation of the NHS and is not specific to PTSD or to assessment.
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.	1.5.2 When offering interventions ensure they are culturally and linguistically appropriate for service users. 1.5.3 Where language or culture differences present challenges to the use of psychological interventions in PTSD, think about using interpreters or offering a choice of therapists. See recommendations on communication in the NICE guideline on patient experience in adult NHS services	Recommendation has been broadened so applies to all interventions and wording simplified. A cross reference to NICE guidance published since 2005 has been added to provide further detail
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	1.5.1 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)	A cross reference to NICE guidance published since 2005 has been added to provide further detail.

1 **Table 3 Minor changes to recommendation wording (no change to intent)**

Recommendation numbers in current guideline	Comment
All recommendations except those labelled [2018]	Recommendations have been edited into the direct style (in line with current NICE style for recommendations in guidelines) where possible. Yellow highlighting has not been applied to these changes.
All recommendations except those labelled [2018]	'People suffering from PTSD' has been replaced by 'people with PTSD' throughout to reflect current NICE style.
1.2.1 For people with PTSD presenting in primary care, GPs should take responsibility for initial assessment and coordination of care. This includes determining the need for emergency physical or mental health assessment.	In the 2005 guideline (recommendation 1.4.1), 'medical and psychiatric' has been replaced by 'physical or mental health' to reflect updated NICE style and language used in practice.
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	Recommendation has been restructured to improve readability but no significant changes have been made that would affect the intent.

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3 **ISBN:**