

Post-traumatic stress disorder overview

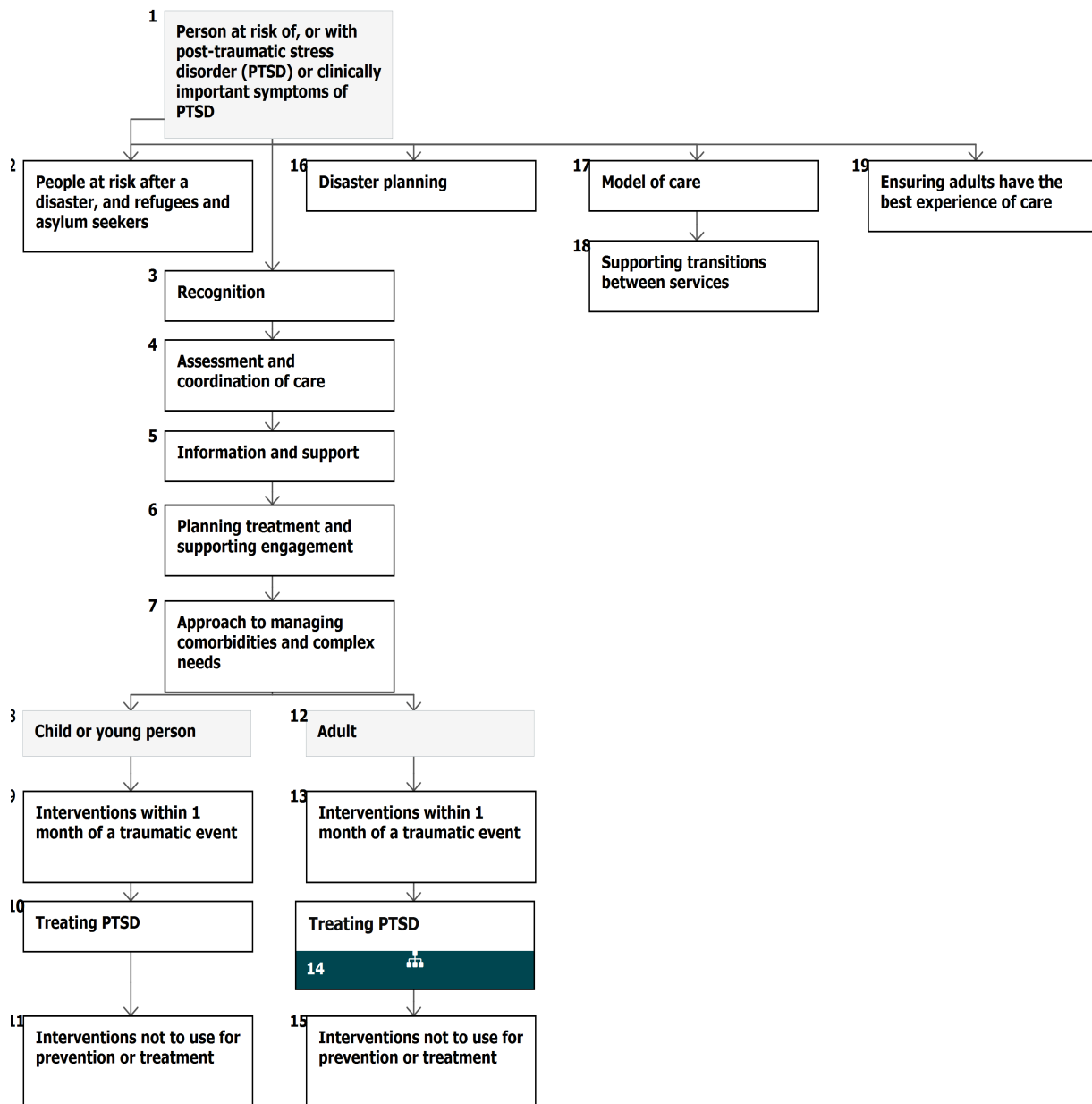
NICE Pathways bring together everything NICE says on a topic in an interactive flowchart. NICE Pathways are interactive and designed to be used online.

They are updated regularly as new NICE guidance is published. To view the latest version of this NICE Pathway see:

<http://pathways.nice.org.uk/pathways/post-traumatic-stress-disorder>

NICE Pathway last updated: 04 December 2018

This document contains a single flowchart and uses numbering to link the boxes to the associated recommendations.



1 Person at risk of, or with post-traumatic stress disorder (PTSD) or clinically important symptoms of PTSD

No additional information

2 People at risk after a disaster, and refugees and asylum seekers

Screening after a major disaster

For people at high risk of developing PTSD after a major disaster, those responsible for coordinating the disaster plan should think about the routine use of a validated, brief screening instrument for PTSD at 1 month after the disaster.

Screening refugees and asylum seekers

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.

3 Recognition

Be aware that people with PTSD, including complex PTSD [See page 16], may present with a range of symptoms associated with functional impairment, including:

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

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

- serious accidents
- physical and sexual assault
- abuse, including childhood or domestic abuse
- work-related exposure to trauma, including remote exposure
- trauma related to serious health problems or childbirth experiences (for example, intensive care admission or neonatal death)
- war and conflict
- torture.

When assessing for PTSD, ask people specific questions about re-experiencing, avoidance, hyperarousal, dissociation, negative alterations in mood and thinking, and associated functional impairment.

When assessing for PTSD, ask people with symptoms of PTSD 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 above.

For people with unexplained physical symptoms who repeatedly attend health services, think about asking whether they have experienced 1 or more traumatic events and provide specific examples of traumatic events (see above).

Specific recognition issues for children and young people

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.

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

4 Assessment and coordination of care

For people with clinically important symptoms of PTSD presenting in primary care, GPs should

take responsibility for assessment and initial coordination of care. This includes determining the need for emergency physical or mental health assessment.

Assessment of people with PTSD should be comprehensive, including an assessment of physical, psychological and social needs and a risk assessment.

Where management is shared between primary and secondary care, healthcare professionals should agree who is responsible for monitoring people with PTSD. Put this agreement in writing (if appropriate, using the CPA) and involve the person and, if appropriate, their family or carers.

5 Information and support

Provide information in both verbal and written format and in line with NICE's recommendations on [service user experience in adult mental health services](#) and [patient experience in adult NHS services](#).

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

- common reactions to traumatic events, including the symptoms of PTSD and its course
- assessment, treatment and support options
- where their care will take place.

See the NICE guideline to find out [why we made these recommendations and how they might affect practice](#).

NICE has written information for the public on [post-traumatic stress disorder](#).

Peer support groups

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

Peer support groups should:

- be facilitated by people with mental health training and supervision
- be delivered in a way that reduces the risk of exacerbating symptoms
- provide information and help to access services.

See the NICE guideline to find out [why we made this recommendation and how it might affect practice](#).

Maintaining safe environments

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

See the NICE guideline to find out [why we made this recommendation and how it might affect practice](#).

Supporting families and carers

Consider providing information and support to family members and carers of people with PTSD. This could cover:

- the treatment and management of trauma-related psychological and behavioural problems, including the person's possible risk to themselves and others
- discussing with family members and carers how they are being affected by the person's PTSD
- how they can support the person to access treatment, including what to do if they do not engage with, or drop out of treatment.

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.

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.

See the NICE guideline to find out [why we made these recommendations and how they might affect practice](#).

Involving families and carers

Involve family members and carers, if appropriate, in treatment for people with PTSD as a way to:

- inform and improve the care of the person with PTSD **and**
- identify and meet their own needs as carers.

For members of the same family who have PTSD after experiencing the same traumatic event, think about what aspects of treatment might be usefully provided together (such as

psychoeducation), alongside individual treatments.

See the NICE guideline to find out [why we made these recommendations and how they might affect practice](#).

Language and culture

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 NICE's recommendations on [avoiding stigma and promoting social inclusion in mental health services](#)).

Ensure that screening, assessment and interventions for PTSD are culturally and linguistically appropriate.

If 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 NICE's recommendations on [communication to enable adults to actively participate in NHS care](#).

6 Planning treatment and supporting engagement

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

- give them information about any proposed interventions, including:
 - their aim, content, duration and mode of delivery
 - the likelihood of improvement and recovery
 - what to expect during the intervention, including that symptoms can seem to get worse temporarily
 - that recovery is more likely if they stay engaged with treatment
- take into account the person's preferences, any previous treatment, associated functional impairment and coexisting conditions
- take into account any social or personal factors that may have a role in the development or maintenance of the disorder, such as childhood maltreatment and multiple traumatic experiences.

Be aware that people with PTSD may be apprehensive, anxious, or ashamed. They may avoid treatment, believe that PTSD is untreatable, or have difficulty developing trust. Engagement strategies could include following up when people miss appointments and allowing flexibility in

service attendance policies.

For people with PTSD whose assessment identifies a significant risk of harm to themselves or others, establish a risk management and safety plan (involving family members and carers if appropriate) as part of initial treatment planning.

Rationale and impact

See the NICE guideline to find out [why we made these recommendations and how they might affect practice](#).

7 Approach to managing comorbidities and complex needs

For people presenting with PTSD and depression:

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

Do not exclude people with PTSD from treatment based solely on comorbid drug or alcohol misuse.

For people with additional needs, including those with [complex PTSD](#) [See page 16]:

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

See what NICE says on [alcohol-use disorders](#), [depression](#), [drug misuse management in over 16s](#) and [self-harm](#).

For children or young people who also have, or may have, attachment difficulties, see what NICE says on [attachment difficulties in children and young people](#).

Rationale and impact

See the NICE guideline to find out [why we made these recommendations and how they might affect practice](#).

8 Child or young person

No additional information

9 Interventions within 1 month of a traumatic event

Child or young person with subthreshold symptoms of PTSD

Consider active monitoring for people with subthreshold symptoms of PTSD within 1 month of a traumatic event. Arrange follow-up contact to take place within 1 month.

See the NICE guideline to find out [why we made this recommendation and how it might affect practice](#).

Child or young person with a diagnosis of acute stress disorder or clinically important symptoms of PTSD

Consider active monitoring or individual trauma-focused 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.

See the NICE guideline to find out [why we made this recommendation and how it might affect practice](#).

Large-scale shared trauma for 7 to 17 year olds

Consider a group trauma-focused CBT intervention for children and young people aged 7 to 17 years if there has been an event within the last month leading to large-scale shared trauma.

Group trauma-focused CBT interventions for children and young people who have been exposed to large-scale shared trauma within the last month should:

- be based on a validated manual
- typically be provided over 5 to 15 sessions

- be delivered by trained practitioners with ongoing supervision
- include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning
- involve elaboration and processing of the trauma memories
- involve restructuring trauma-related meanings for the individual
- provide help to overcome avoidance.

See the NICE guideline to find out [why we made these recommendations and how they might affect practice](#).

10 Psychological interventions for treating PTSD in children and young people

Consider an individual trauma-focused CBT intervention for children aged 5 to 6 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 1 month after a traumatic event.

Consider an individual trauma-focused CBT intervention for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented between 1 and 3 months after a traumatic event.

Offer an individual trauma-focused CBT intervention to children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event.

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

- be based on a validated manual
- typically be provided over 6 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas
- be delivered by trained practitioners with ongoing supervision
- be adapted to the child or young person's age and development
- involve parents or carers as appropriate
- include psychoeducation about reactions to trauma, strategies for managing arousal and flashbacks, and safety planning
- involve elaboration and processing of the trauma memories
- involve processing trauma-related emotions, including shame, guilt, loss and anger
- involve restructuring trauma-related meanings for the individual

- provide help to overcome avoidance
- prepare them for the end of treatment
- include planning booster sessions if needed, particularly in relation to significant dates (for example trauma anniversaries).

Consider EMDR for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD who have presented more than 3 months after a traumatic event only if they do not respond to or engage with trauma-focused CBT.

Rationale and impact

See the NICE guideline to find out [why we made these recommendations and how they might affect practice](#).

11 Interventions not to use for children and young people

Psychologically-focused debriefing

Do not offer psychologically-focused debriefing for the prevention or treatment of PTSD.

See the NICE guideline to find out [why we made this recommendation and how it might affect practice](#).

Drug treatment

Do not offer drug treatments for the prevention or treatment of PTSD in children and young people aged under 18 years.

See the NICE guideline to find out [why we made this recommendation and how it might impact on practice](#).

12 Adult

No additional information

13 Interventions within 1 month of a traumatic event

Adult with subthreshold symptoms of PTSD

Consider active monitoring for people with subthreshold symptoms of PTSD within 1 month of a traumatic event. Arrange follow-up contact to take place within 1 month.

See the NICE guideline to find out [why we made this recommendation and how it might affect practice](#).

Adult with a diagnosis of acute stress disorder or clinically important symptoms of PTSD

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

- cognitive processing therapy
- cognitive therapy for PTSD
- narrative exposure therapy
- prolonged exposure therapy.

See the NICE guideline to find out [why we made this recommendation and how it might affect practice](#).

14 Treating PTSD

[See Post-traumatic stress disorder / Treating post-traumatic stress disorder in adults](#)

15 Interventions not to use for adults

Psychologically-focused debriefing

Do not offer psychologically-focused debriefing for the prevention or treatment of PTSD.

See the NICE guideline to find out [why we made this recommendation and how it might affect practice](#).

Drug treatment for preventing PTSD

Do not offer drug treatments, including benzodiazepines, to prevent PTSD in adults.

See the NICE guideline to find out [why we made this recommendation and how it might affect practice](#).

16 Disaster planning

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

- immediate practical help
- support for the affected communities in caring for those involved in the disaster
- access to specialist mental health, evidence-based assessment and treatment services
- clear roles and responsibilities for all professionals involved.

For more information on disaster planning, see [people at risk after a disaster, and refugees and asylum seekers](#) [See page 3].

17 Model of care

Promote access to services for people with PTSD by:

- reassuring them that PTSD is a treatable condition
- providing care that places a positive emphasis on the range of interventions offered and their likely benefits
- ensuring that methods of access to services take into account the needs of specific populations of people with PTSD, including migrants and asylum seekers, people who are homeless or not registered with a GP, looked-after children and young people, and preschool-aged children
- minimising the need to move between different services or providers
- providing multiple points of access to the service, including self-referral
- establishing clear links to other care pathways, including for physical healthcare needs
- offering flexible modes of delivery, such as text messages, email, telephone or video consultation, or care in non-clinical settings such as schools or offices
- offering a choice of therapist that takes into account the person's trauma experience – for example they might prefer a specific gender of therapist

- using proactive person-centred strategies to promote uptake and sustained engagement
- assessing the need for further treatment or support for people who have not benefited fully from treatment or have relapsed.

Do not delay or withhold treatment for PTSD solely because of court proceedings or applications for compensation. Discuss with the person the implications of the timing of any treatment to help them make an informed decision about if and when to proceed, in line with Crown Prosecution Service guidance ([Therapy: provision of therapy for child witnesses prior to a criminal trial](#) or [Therapy: provision of therapy for vulnerable or intimidated adult witnesses](#)).

Rationale and impact

See the NICE guideline to find out [why we made these recommendations and how they might affect practice](#).

18 Supporting transitions between services

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

- give the person information about the service they are moving to, including the setting and who will provide their care
- ensure there is effective sharing of information between all services involved
- involve the person and, if appropriate, their family or carers in meetings to plan the transition
- address any worries the person has, for example about changes to their routine or anxiety about meeting new people.

Provide additional support:

- to children and young people with PTSD who are within the care system when they are transitioning between services or settings
- during admission and discharge to people with PTSD who are admitted to hospital because of other mental or physical health problems.

Follow NICE's recommendations on [transition from children's to adults' services](#) and [transition between inpatient hospital settings and community or care home settings for adults with social care needs](#).

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

Rationale and impact

See the NICE guideline to find out [why we made these recommendations and how they might affect practice](#).

19 Experience of care

Use these recommendations with NICE's recommendations on

- [patient experience in adult NHS services](#)
- [service user experience in adult mental health services](#).

Complex PTSD

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

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

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

Glossary

Active monitoring

(also known as watchful waiting, this means regularly monitoring a person who has some symptoms but who is not currently having clinical intervention for the condition)

Acute stress disorder

(a DSM-5 diagnosis that applies in the first month after a traumatic event: it requires the presence of 9 or more symptoms from any of the 5 categories of intrusion, negative mood, dissociation, avoidance and arousal; these can be starting or worsening after the traumatic event)

ASD

acute stress disorder

CBT

cognitive behavioural therapy

clinically important symptoms of PTSD

(refers to people who are assessed as having PTSD on a validated scale, as indicated by baseline scores above clinical threshold, but who do not necessarily have a diagnosis of PTSD; they are typically referred to in studies that have not used a clinical interview to arrive at a formal diagnosis of PTSD and instead have only used self-report measures of PTSD symptoms)

Combat-related trauma

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

CPA

care programme approach

Disaster plan

(a plan setting out the overall framework for the initiation, management, coordination and control of staff and other resources to reduce, control or respond to an emergency)

Disaster plans

(plans setting out the overall framework for the initiation, management, coordination and control of staff and other resources to reduce, control or respond to an emergency)

EMDR

eye movement desensitisation and reprocessing

people with clinically important symptoms of PTSD

(refers to those who are assessed as having PTSD on a validated scale, as indicated by

baseline scores above clinical threshold, but who do not necessarily have a diagnosis of PTSD; they are typically referred to in studies that have not used a clinical interview to arrive at a formal diagnosis of PTSD and instead have only used self-report measures of PTSD symptoms)

PTSD

post-traumatic stress disorder

SSRI

selective serotonin re-uptake inhibitor

SSRIs

selective serotonin re-uptake inhibitors

Practitioners

(people with mental health training, particularly in PTSD, who also have training and competence in delivering interventions for PTSD)

Sources

Post-traumatic stress disorder (2018) NICE guideline NG116

Your responsibility

Guidelines

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

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

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

Technology appraisals

The recommendations in this interactive flowchart represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, health professionals are expected to take these recommendations fully into account, alongside the individual needs, preferences and values of their patients. The application of the recommendations in this interactive flowchart is at the discretion of health professionals and their individual patients and do not override the responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or their carer or guardian.

Commissioners and/or providers have a responsibility to provide the funding required to enable the recommendations to be applied when individual health professionals and their patients wish to use it, in accordance with the NHS Constitution. They should do so in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities.

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

Medical technologies guidance, diagnostics guidance and interventional procedures guidance

The recommendations in this interactive flowchart represent the view of NICE, arrived at after

careful consideration of the evidence available. When exercising their judgement, healthcare professionals are expected to take these recommendations fully into account. However, the interactive flowchart does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

Commissioners and/or providers have a responsibility to implement the recommendations, in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity, and foster good relations. Nothing in this interactive flowchart should be interpreted in a way that would be inconsistent with compliance with those duties.

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