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Quick reference guide

Post-traumatic stress disorder (PTSD)

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

Clinical Guideline 26

Developed by the National Collaborating Centre for Mental Health

Ordering information

Copies of this quick reference guide can be obtained from the NICE website at www.nice.org.uk/CG026quickrefguide or from the NHS Response Line by telephoning 0870 1555 455 and quoting reference number N0848.

Information for the public on the guideline ('Post-traumatic stress disorder (PTSD): the treatment of PTSD in adults and children') is also available from the NICE website at www.nice.org.uk/CG026publicinfo or from the NHS Response Line (quote reference number N0849 for a version in English and N0850 for a version in English and Welsh).

This guidance is written in the following context

This guidance represents the view of the Institute, which was arrived at after careful consideration of the evidence available. Health professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of health professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer.

National Institute for Clinical Excellence

MidCity Place
71 High Holborn
London
WC1V 6NA

www.nice.org.uk

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Patient-centred care

Treatment and care should take into account patients' individual needs and preferences. Good communication is essential, supported by evidence-based information, to allow patients to reach informed decisions about their care. Carers and relatives should have the chance to be involved in discussions unless the patient considers it inappropriate.

Grading of the recommendations

This quick reference guide summarises the recommendations in the NICE clinical guideline 'Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care'. The recommendations are based on the best available evidence and are graded **A**, **B**, **C** or good practice point (**GPP**) depending on the type of evidence they are based on. For more information on the grading system, see the NICE guideline (www.nice.org.uk/CG026NICEguideline).

Key priorities for implementation

The following recommendations have been identified as priorities for implementation.

Initial response to trauma

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

Trauma-focused psychological treatment

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

Children and young people

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

Drug treatments for adults

- Drug treatments for PTSD should not be used as a routine first-line treatment for adults (in general use or by specialist mental health professionals) in preference to a trauma-focused psychological therapy.
- Drug treatments (paroxetine or mirtazapine for general use, and amitriptyline or phenelzine for initiation only by mental health specialists) should be considered for the treatment of PTSD in adults who express a preference not to engage in trauma-focused psychological treatment¹.

Screening for PTSD

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

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

Post-traumatic stress disorder (PTSD)

PTSD can develop in people of any age following a stressful event or situation of an exceptionally threatening or catastrophic nature. PTSD does not usually develop following generally upsetting situations such as divorce, loss of job, or failing an exam.

Effective treatment of PTSD can only take place if the disorder is recognised. In some cases, for example following a major disaster, specific arrangements to screen people at risk may be considered.

Up to 30% of people experiencing a traumatic event may develop PTSD

For the vast majority of people with PTSD, opportunities for recognition and identification come as part of routine healthcare interventions, such as treatment following an assault or accident, or when domestic violence or childhood sexual abuse is disclosed.

Remember that PTSD can also develop in children following a traumatic event

Symptoms often develop immediately after the traumatic event but the onset of symptoms may be delayed in some people (less than 15%). PTSD is treatable even when problems present many years after the traumatic event.

Identification of PTSD in children presents particular problems, but is improved if children are asked directly about their experiences.

People with PTSD may not present for treatment for months or years after onset of symptoms

Assessment can present significant challenges as many people avoid talking about their problems.

Recognition

Recognition in primary care and general hospital settings

Symptoms typically associated with PTSD are as follows:

- **re-experiencing** – flashbacks, nightmares, repetitive and distressing intrusive images or sensory impressions; in children, these symptoms may include: re-enacting the experience, repetitive play or frightening dreams without recognisable content
- **avoidance** – avoiding people, situations or circumstances resembling or associated with the event
- **hyperarousal** – hypervigilance for threat, exaggerated startle response, sleep problems, irritability and difficulty concentrating
- **emotional numbing** – lack of ability to experience feelings, feeling detached from other people, giving up previously significant activities, amnesia for significant parts of the event
- **depression**
- **drug or alcohol misuse**
- **anger**
- **unexplained physical symptoms (resulting in repeated attendance).**

If it is not immediately clear that symptoms relate to a specific traumatic event:

- ask patients if they have experienced a traumatic event and give examples (such as assault, rape, road traffic accidents, childhood sexual abuse and traumatic childbirth) **GPP**
- consider asking adults specifically about re-experiencing (including flashbacks and nightmares) or hyperarousal (including exaggerated startle response or sleep disturbance). **GPP**

Specific recognition issues for children and young people


- Do not rely solely on information from the parent/guardian in any assessment for PTSD – ask the child or young person separately and directly about PTSD symptoms. **GPP**
- Consider asking children and/or their parents/guardians about sleep disturbance or significant changes in sleeping patterns. **C**

Children in emergency departments


- Inform the parents/guardians that PTSD may develop in children who have been involved in traumatic events. **GPP**
- Briefly describe the possible symptoms to the parents/guardians (e.g. sleep disturbance, nightmares, difficulty concentrating and irritability). **GPP**
- Suggest to parents/guardians they contact the child's GP if the symptoms persist beyond 1 month. **GPP**

Screening





Screening after a major disaster

- Those coordinating the disaster plan should consider using a brief screening instrument for PTSD 1 month after the event for individuals at high risk of developing PTSD following a major disaster. 

Screening refugees and asylum seekers

- Those managing refugee programmes should consider using a brief screening instrument for PTSD for:
 - programme refugees (people who are brought to the UK from a conflict zone through a programme organised by an agency such as the United Nations High Commission for Refugees) and
 - asylum seekers at high risk of developing PTSD.This should be part of the initial refugee healthcare assessment and of any comprehensive physical and mental health screen. 

Assessment and coordination of care

- GPs should take responsibility for initial assessment and coordination of care of PTSD sufferers in primary care and determine the need for emergency medical or psychiatric assessment. 
- Ensure that assessment is comprehensive and includes a risk assessment and assessment of physical, psychological and social needs, and is conducted by a competent individual. 
- Give PTSD sufferers sufficient information about effective treatments and take into account their preference for treatment. 
- If management is shared between primary and secondary care, establish a written agreement outlining the responsibilities for monitoring individuals. Where appropriate, use the Care Programme Approach (CPA) and share with the sufferer, their family and carers. 

Support to families and carers

- Consider and, when appropriate, assess the impact of the traumatic event on all family members and consider providing appropriate support. **GPP**
- With the consent of the PTSD sufferer where appropriate, inform their family about common reactions to traumatic events, the symptoms of PTSD, and its course and treatment. **GPP**
- Inform families and carers about self-help and support groups and encourage them to participate. **GPP**
- Effectively coordinate the treatment of all family members if more than one family member has PTSD. **GPP**

Practical and social support

- Provide practical advice to enable people with PTSD to access appropriate information and services for the range of emotional responses that may develop. **GPP**
- Identify the need for social support and advocate for the meeting of this need. **GPP**
- Consider offering help and advice on how continuing threats related to the traumatic event may be alleviated or removed. **GPP**

Language and culture

- Familiarise yourself with the cultural and ethnic backgrounds of PTSD sufferers. **GPP**
- Consider using interpreters and bicultural therapists if language or cultural differences present challenges for trauma-focused psychological interventions. **GPP**
- 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. **GPP**

Care across all conditions

- When developing and agreeing a treatment plan, ensure individuals receive information about common reactions to traumatic events, the symptoms of PTSD, and its course and treatment. **GPP**
- Do not withhold or delay treatment because of court proceedings or applications for compensation. **C**
- Respond appropriately if a PTSD sufferer is anxious about and may avoid treatment (e.g. by following up those who miss scheduled appointments). **C**
- Keep technical language to a minimum and treat patients with respect, trust and understanding. **GPP**
- Only consider providing trauma-focused psychological treatment when the patient considers it safe to proceed. **GPP**
- Ensure that treatment is delivered by competent individuals who have received appropriate training. **C**

Comorbidities

Depression

- Consider treating the PTSD first unless the depression is so severe that it makes psychological treatment very difficult, in which case treat the depression first. ©

High risk of suicide or at risk of harming others

- Concentrate first on the management of this risk in PTSD sufferers. ©

Drug or alcohol problem

- Treat any significant drug or alcohol problem before treating the PTSD. ©

Personality disorder

- For PTSD sufferers with personality disorder, consider extending the duration of trauma-focused psychological interventions. ©

Death of a close friend or relative

- For patients who have lost a close friend or relative due to an unnatural or sudden death, assess for PTSD and traumatic grief and consider treating the PTSD first (without avoiding discussion of the grief). ©

Treatment of PTSD

Early interventions

Watchful waiting

- Consider watchful waiting when symptoms are mild and have been present for less than 4 weeks after the trauma. **C**
- Arrange a follow-up contact within 1 month. **C**

Immediate psychological interventions for all

- Be aware of the psychological impact of traumatic events in the immediate post-incident care of survivors and offer practical, social and emotional support. **GPP**
- For individuals who have experienced a traumatic event, **do not** routinely offer brief, single-session interventions (debriefing) that focus on the traumatic incident to that individual alone. **A**

Interventions where symptoms are present within 3 months of a trauma

- Offer trauma-focused CBT (usually on an individual outpatient basis) to people:
 - with severe post-traumatic symptoms or with severe PTSD within 1 month after the event **B**
 - who present with PTSD within 3 months of the event. **A**
- Consider offering 8–12 sessions of trauma-focused CBT (or fewer sessions – about 5 – if the treatment starts in the first month after the event). When the trauma is discussed, longer treatment sessions (90 minutes) are usually necessary. **B**
- Ensure that psychological treatment is regular and continuous (usually at least once a week) and is delivered by the same person. **B**
- Consider the following drug treatment for sleep disturbance:
 - hypnotic medication for short-term use
 - a suitable antidepressant for longer-term use, introduced at an early stage to reduce later risk of dependence. **C**
- Do not routinely offer non-trauma-focused interventions (such as relaxation or non-directive therapy) that do not address traumatic memories. **B**

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

- Offer trauma-focused psychological treatment (trauma-focused CBT or EMDR) to all patients, usually on an individual outpatient basis. **A**
- Consider offering 8–12 sessions of trauma-focused psychological treatment when the PTSD results from a single event. When the trauma is discussed, longer treatment sessions (90 minutes) are usually necessary. **B**
- Ensure that trauma-focused psychological treatment is:
 - offered regardless of the time elapsed since the trauma **B**
 - regular and continuous (usually at least once a week) **B**
 - delivered by the same person. **B**
- Consider extending trauma-focused psychological treatment beyond 12 sessions and integrating it into an overall care plan if several problems need to be addressed, particularly:
 - after multiple traumatic events
 - after traumatic bereavement
 - where chronic disability results from the trauma
 - when significant comorbid disorders or social problems are present. **C**
- If the individual finds it difficult to disclose details of the trauma(s), consider devoting several sessions to establishing a trusting therapeutic relationship and emotional stabilisation before addressing the trauma. **C**
- Do not routinely offer non-trauma-focused interventions (such as relaxation or non-directive therapy) that do not address traumatic memories. **B**
- For PTSD sufferers with no or limited improvement after a specific trauma-focused psychological treatment, consider:
 - an alternative form of trauma-focused psychological treatment
 - pharmacological treatment in addition to trauma-focused psychological treatment. **C**
- If PTSD sufferers request other forms of psychological treatment (e.g. supportive therapy, non-directive therapy, hypnotherapy, psychodynamic therapy or systemic psychotherapy), inform them that there is no convincing evidence for a clinically important effect. **GPP**

Drug treatments

- Do not offer drugs as routine first-line treatment for adult PTSD sufferers (for general use or by specialist mental health professionals) in preference to trauma-focused psychological therapy. **A**
- Consider paroxetine or mirtazapine (for general use) and amitriptyline or phenelzine (under specialist mental health care supervision) in adult PTSD sufferers²:
 - if the individual prefers not to engage in a trauma-focused psychological treatment **B**
 - if the individual cannot start psychological treatment because of serious threat of further trauma **C**
 - if the individual has gained little or no benefit from a course of trauma-focused psychological treatment **C**
 - as an adjunct to psychological treatment where there is significant comorbid depression or severe hyperarousal that significantly affects the individual's ability to benefit from psychological treatment. **C**
- For sleep disturbance, consider:
 - hypnotic medication for short-term use
 - a suitable antidepressant for longer-term use, introduced at an early stage to reduce later risk of dependence. **C**
- When an adult PTSD sufferer responds to drug treatment, continue the treatment for at least 12 months before gradual withdrawal. **C**
- When an adult PTSD sufferer does not respond to drug treatment, consider increasing the dose within approved limits. If further drug treatment is considered, it should generally be with a different class of antidepressant or involve the use of adjunctive olanzapine. **C**

Starting drug treatments

- Inform all adult PTSD sufferers who are prescribed antidepressants of potential side effects and discontinuation/ withdrawal symptoms (particularly with paroxetine) at the time that treatment is initiated. **C**

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

- See adult PTSD sufferers who are at increased risk of suicide, and all PTSD sufferers aged 18–29, after 1 week of starting antidepressants and frequently thereafter until the risk is not considered significant. **GPP**
- Seek out signs of akathisia, suicidal ideation and increased anxiety and agitation, particularly in the initial stages of SSRI treatment. Advise adult PTSD sufferers of the risk of these symptoms and to seek help promptly if these are distressing. **GPP**
- Review the use of the drug if the PTSD sufferer develops marked and/or prolonged akathisia. **GPP**
- See adult PTSD sufferers who are not considered to be at increased risk of suicide after 2 weeks of starting antidepressants and thereafter on an appropriate and regular basis (e.g. every 2–4 weeks in the first 3 months, and at greater intervals thereafter if response is good). **GPP**

Discontinuation/withdrawal symptoms

- Gradually reduce the dose of antidepressants over a 4-week period (some people may require longer periods). **C**
- If discontinuation/withdrawal symptoms are mild, reassure the PTSD sufferer and arrange for monitoring. **C**
- If symptoms are severe, consider re-introducing the original antidepressant (or another with a longer half-life from the same class) and reduce gradually while monitoring symptoms. **C**

Chronic disease management

- Consider chronic disease management models for people with chronic PTSD who have not benefited from a number of courses of evidence-based treatment. **C**

Children and young people

Interventions in the first month after a trauma

- Offer trauma-focused CBT to older children with severe post-traumatic symptoms or with severe PTSD in the first month after the event. **B**

Interventions more than 3 months after a trauma

- Offer children and young people a course of trauma-focused CBT adapted as needed to suit their age, circumstances and level of development. (This should also be offered to those who have experienced sexual abuse.) **B**
- For chronic PTSD in children and young people resulting from a single event, consider offering 8–12 sessions of trauma-focused psychological treatment. When the trauma is discussed, longer treatment sessions (90 minutes) are usually necessary. **C**
- Psychological treatment should be regular and continuous (usually at least once a week) and delivered by the same person. **C**
- Do not routinely prescribe drug treatments for children and young people with PTSD. **C**
- Involve families in the treatment of children and young people where appropriate, but remember that treatment consisting of parental involvement alone is unlikely to be of benefit for PTSD symptoms. **C**
- Inform parents (and where appropriate, children and young people) that apart from trauma-focused psychological interventions, there is no good evidence for the efficacy of other forms of treatment such as play therapy, art therapy or family therapy. **C**

Disaster planning

- Ensure disaster plans contain provision for a fully coordinated psychosocial response. **GPP**
- Ensure that the psychosocial aspect of the plan contains:
 - provision for immediate practical help
 - means to support the role of the affected communities in caring for those involved in the disaster
 - provision of specialist mental health, evidence-based assessment and treatment services. **GPP**
- Ensure that all healthcare workers involved in a disaster plan have clear roles and responsibilities agreed in advance. **GPP**

Implementation

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

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

This guideline should be used in conjunction with the National Service Framework for Mental Health, which is available from www.dh.gov.uk

Further information

Distribution

This quick reference guide to the Institute's guideline on post-traumatic stress disorder contains the key priorities for implementation, summaries of the guidance, and notes on implementation. The distribution list for this quick reference guide is available from www.nice.org.uk/CG026distributionlist.

NICE guideline

The NICE guideline, 'Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care', is available from the NICE website (www.nice.org.uk/CG026NICEguideline).

The NICE guideline contains the following sections: Key priorities for implementation; 1 Guidance; 2 Notes on the scope of the guidance; 3 Implementation in the NHS; 4 Research recommendations; 5 Other versions of this guideline; 6 Related NICE guidance; 7 Review date. It also gives details of the grading scheme for the evidence and recommendations, the Guideline Development Group and the Guideline Review Panel, and technical detail on the criteria for audit.

Full guideline

The full guideline includes the evidence on which the recommendations are based, in addition to the information in the NICE guideline. It is published by the National Collaborating Centre for Mental Health. It is available from www.rcpsych.ac.uk, www.nice.org.uk/CG026fullguideline and the website of the National Library for Health (www.nlh.nhs.uk).

Information for the public

NICE has produced a version of this guidance for people with PTSD, their advocates and carers, and the public. The information is available, in

English and Welsh, from the NICE website (www.nice.org.uk/CG026publicinfo).

Printed versions are also available – see inside front cover for ordering information.

Related guidance

For information about NICE guidance that has been issued or is in development, see the website (www.nice.org.uk).

- Anxiety: management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. NICE Clinical Guideline No. 22 (December 2004). Available from www.nice.org.uk/CG022
- Depression: management of depression in primary and secondary care. NICE Clinical Guideline No. 23 (December 2004). Available from www.nice.org.uk/CG023
- Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care. NICE Clinical Guideline No. 16 (July 2004). Available from www.nice.org.uk/CG016
- Depression in children: identification and management of depression in children and young people in primary care and specialist services. NICE Clinical Guideline. (Publication expected August 2005.)

Review date

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