1. PTSD (post-traumatic stress disorder) - read all about it
Post-traumatic stress disorder (PTSD) describes a range of symptoms people may get following a traumatic event or situation.
You can access the NHS Choices section on PTSD here.

What are the symptoms of post-traumatic stress disorder?
Post-Traumatic Stress Disorder (PTSD) is a form of anxiety disorder. It happens after an extreme stressful event, e.g. a serious threat to the person's life or where a loved one is caught up in a catastrophic event such as a plane crash. The person then re-lives the event over and over again through dreams, feelings and thoughts. PTSD may actually be quite common but often go unnoticed e.g. nearly one in ten people may have some PTSD at some time in their lives. Severe trauma or unpleasant events can actually produce long-lasting changes in brain structure.

Does anything else have the same symptoms as PTSD?
Because everyone is unique, everyone's symptoms are different. So, it's not always clear what the right diagnosis is. Here is a list of some other possible causes for the symptoms of PTSD. This is not meant to be a textbook list, just some ideas. Sometimes it doesn't matter anyway as the symptoms need to be treated anyway, no matter what causes them. They include:

- Acute stress, but not if it has lasted longer than a month
- (Borderline) Personality Disorder - many people with a BPD have a history of PTSD
- GAD or Generalised Anxiety Disorder
- Panic disorder

Just to confuse matters further, sometimes people have more than one illness (sometimes called "co-morbidity"). For example, if 1 in 10 people get depressed and 1 in 10 people get anxiety, then just by chance 1 in 10 of the depressed people get anxiety as well. However, if you're depressed, you're more likely to be anxious. Co-morbidity means what else the person is more likely to have at the same time. This can make diagnosis more difficult.

- Depression – often caused by the PTSD symptoms in up to 1 in 2 people (Rytwinski, 2013)
- Substance misuse e.g. drug dependence or addiction (usually as a result of the PTSD)
- GAD or Generalised Anxiety Disorder
- Bipolar mood disorder
- ADHD (Attention Deficit Hyperactivity Disorder)
- Social anxiety – which is five times more likely if you have PTSD
- Obsessive Compulsive Disorder (OCD) (Assunção, 2012)

What causes PTSD?
Anyone can get PTSD but here are some "risk factors" that make it more likely. This is not a complete list but some of the main ones include (roughly in order of importance, most important first):

- A major event – most often rape, plus also combat exposure or war, childhood abuse, sudden death of a loved one, physical attack or being threatened by

weapons. Better known, although less common, are accidents, fire, disaster and torture. It is more likely if the major event is prolonged, repeated, intentional (e.g. torture), abusive or involves children, and involves a threat to life
- Further life stress after the main event
- Childhood adversity e.g. sexual abuse as a child, separation from parents, unstable family
- Having had a trauma before the main event
- Family history of anxiety and substance misuse
- Lower education or being poorer
- Being female – probably about 8% men and 20% women get PTSD. It is also more likely in black or Hispanic people
- Genetics – there may be a genetic susceptibility as it is more common in identical twins
- Having another mental health problem e.g. depression or anxiety
- Having insomnia e.g. less than 6 hours of sleep per night before the trauma increases the risk of then getting PTSD (Gehrman, 2013)
- Having a stroke – 1 in 4 stroke survivors get PTSD (Edmondson, 2013)

Serotonin is a chemical messenger in the brain that in some parts of the brain seems to control many things, including thoughts, obsessions, mood etc. The only medicines that seem to help PTSD are those that boost serotonin, so it seems low serotonin could be a major cause of the symptoms.

What are the risks of having PTSD?
Here are some of the risks of having PTSD:

- Twice risk of heart disease (Vaccarino, 2013)
- Higher chance of suicidal ideation – PTSD can make a mess of your quality of life and the risk of wanting to harm yourself doubles(Nepon 2010), although adequate treatment (e.g. Cognitive Processing Therapy or CPT) and prolonged exposure (PE) therapy much reduces this risk (Gradus, 2013)
- Substance misuse – starting to take illicit drugs or drinking excess alcohol (to help forget) is a risk of having PTSD
- Chronic depression may develop if your PTSD symptoms are not effectively treated early enough
- Risky, impulsive behaviour
- Road accidents. Accidents are more likely with PTSD as your concentration may be affected
- PTSD can be a trigger to an eating disorder, especially anorexia nervosa (Reyes 2011)
- Getting heart disease and high blood pressure is twice as likely (Vaccarino, 2012)
- Getting dementia later in life (double the risk in men) (Günak et al, 2020)
- Self-harm is a bigger risk with PTSD
- More likely to get diabetes, probably from stress (Lukaschek, 2013).

What will happen to my PTSD?
We can only guess at what will or will not happen because the following things can have an influence and these are all different for everyone.

- Your age
- Whether you have done well in the past with a treatment
- How bad the symptoms are
- How long you have had the symptoms for
- Any other illnesses you may have at the same time
- The support your family is able to offer and your home-life
- Any job and any stress at work
- Genes – your family history and what genes you might have inherited are often important
- What the words "well", "better", "the same" or "worse" mean to you
- What your expectations are – what you expect to be able to do when you are "well"?
- How a treatment works for you, what side effects you have and how they affect your life
- How well you follow your doctor's or therapist's advice and instructions.
- Your chances of becoming well again are much lower if you don't take the medicines prescribed for you regularly and reliably, or you don't put what you learn from "talking therapies" into practice. You must do your homework!
- With medicines, the dose you actually take, how often you take it and when you take it are all important
- If you have high blood pressure and are taking a calcium channel blocker (such as nifedipine, nicardipine, amlodipine, and felodipine) you are less likely to get PTSD after a trauma (Gradus et al, 2023).

What we can't do is use this to tell an individual person what might happen. Many other things will make the prognosis better or worse. So, read on...

What will affect the chances of my PTSD improving?

"Prognosis" is the word used for the likely outcome of any condition. There are several things that will help or not help your prognosis or symptoms and the chances of them improving. You should try to make the most or build on the good prognosis factors, and try to work on or minimise the poor prognosis factors. That will give you the best chance of doing well. You are also likely to do better if you accept the treatment being offered to you.

Factors which may lead to a good outcome (prognosis) (Royal College of Psychiatrists).

These are things that give someone a better chance of doing well. Build on these as much as you can.

- Taking any medicine you choose exactly as your doctor prescribes it. If you take your medicines they will help you to get the most out of talking therapies and will help you to sleep
- Taking part in any psychological or talking therapy such cognitive behavioural therapy (CBT) that may be offered to you
- Learning to trust those trying to help you
- Not stopping taking your medicines without first discussing it with your doctor, nurse or key worker

- Not talking about any medicine side-effects that is causing you trouble. Instead tell your doctor, nurse or key worker as there may be an alternative treatment you can have or an effective way of dealing with the side-effects
- Trying to keep life as normal as possible and get back to your usual routine as quickly as possible
- Going back to work
- Having good social support and talking about what has happened to you with someone you trust (and not keeping it bottled up)
- Eating and exercise regularly
- Going back to where the traumatic event happened
- Spending time with family and friends
- Expecting to get better
- Keeping the rest of your life as low stress as possible.

Factors which can make PTSD worse or which may lead to a poor outcome (prognosis) (RCPsych; Koren 1999; Karamustafalioglu 2006)
These are things that are more likely to give you a worse chance of doing well. Try to reduce these as much as possible.

- Being younger when you suffered the trauma
- The worse the trauma the harder it is to get over it
- The trauma being caused by a parent or caregiver
- The trauma going on for a long time
- Mild traumatic brain injury (Bryant, 2015)
- Not seeking or getting effective treatment early
- Not sticking to the chosen treatment, especially if it has worked
- Some studies show men do worse than women and some that women do worse then men (e.g. Bryant, 2015)
- Being isolated
- Staying in contact with the abuser and/or the threats to your safety
- If the symptoms came on very quickly you may not do as well as people who became unwell gradually
- Having another mental health problem e.g. anxiety or depression may make it take longer to get better
- Suffering from a mental health problem before the traumatic event happened – you may take longer to get better
- Other people not letting you talk about it, avoiding you, being angry with you, thinking you are weak or blaming you
- Being exposed to continual stress and uncertainty (Bryant, 2015)
- Being very stressed e.g. personal problems, financial problems, social issues, any legal actions
- Having "Post-trauma debriefing" – this was thought to be a good idea at the time but can actually make the symptoms worse
- Fear of the trauma occurring again
- Behaviours such as avoidance, not talking about it, safety behaviour, denial, depression, rumination (mulling about the event(s) over and over), especially early on
- Symptoms getting worse over the first 3 months

- Having bad PTSD symptoms immediately after the event
- Having new traumatic events
- Having to be treated in hospital in an intensive care unit (Bryant, 2015).

What might happen if I don't have any treatment for my PTSD?
Here at C&M we have researched this extensively but don't feel a lot wiser. There are of course many studies to show what works and what doesn't and, believe me, we've looked at hundreds.
However, everyone is an individual. Specific symptoms are unique to that person. Your personal circumstances will also be unique. Some books give an idea of what used to happen years ago but of course the world has changed since modern treatments such as medicines and "talking therapies" first became available. It is important to remember that not all books agree with each other about what might happen if you do nothing.
To do nothing is a personal choice unless you are a danger to yourself or others when your symptoms are at their worst. However, you need to know the risks and benefits of having no treatment.
All medicines have side-effects but not everyone will suffer all of the possible side-effects of the medicines they take.

The up-side of no treatment is no side-effects or adverse from medicines or therapy

The down-sides of no treatment are:
- Having worse symptoms that last longer and not being able to enjoy your life to the full (Perkonigg 2005)
- You will be more likely to have new traumatic events (Perkonigg 2005)
- You will be more likely to have 'avoidance symptoms' than people who take medicines or have other forms of help (Perkonigg 2005)
- You may also have more physical symptoms and are more likely to suffer from other anxiety problems (Perkonigg 2005)
- Without treatment you may be more likely to take too much alcohol or other drugs to "self medicate" for your symptoms or to help control your emotions (Royal College of Psychiatry)
- You may be more likely to feel so bad you want to kill yourself
- You may also be more likely to take risks and act in haste.

About one third to a half of people with PTSD seem to get over the trauma without any treatment, usually within the first year. This seems more likely in females than males (Karamustafalioglu 2006). In another study, after eighteen months, about 1 in 5 (20%) had recovered completely, another 1 in 5 (20%) said they were much better, I in 25 (4%) were worse but just over 1 in 2 (56%) were no better. (De Vries 2001).
We've put this research about what happens to PTSD symptoms if not treated into a table, which may (or may not) help:

Type of trauma:	Earthquake (Karamusta-falioglu 2006).	Earthquake (Karamusta-falioglu 2006).	Road accident	US army Cambodian veterans	Earthquake (Karamusta-falioglu 2006).	Variety of trauma in younger adults

				(De Vries 2001)		(Perkonigg 2005)
Time after the event(s):	3 months	6-10 months	12 months	18 months	18 months	4 years
How many people feel recovered	2 in 3 (70%)	73% (3 in 4)	2 in 3 (68%)	1 in 5 (19%)	89% (8 in 9)	1 in 2 (52%)
How many people feel better				1 in 5 (20%)		
How many people feel unchanged	30% (1 in 3)	27% (1 in 4)	1 in 3 (32%)	1 in 2 (57%)	11% (1 in 9)	1 in 2 (48%)
How many people feel worse				1 in 25 (4%)		

2. PTSD - the options

This website is dedicated to trying to help people get the best from medicines so, for the most part, we'll focus on medicines. We'll mention some of the other options, but not in great detail.

Our aim is to try to help people who are taking medicines (or should be) to get the right medicine, the best dose and take it regularly for as long as is right. Any medicines should usually be part of your overall treatment, although some people are quite happy just to stick with drugs or talking treatments. If your medicines are right, then everything else can fall into place. If the medicines are wrong, then they may make the symptoms worse, self-help and help from others will not work as well.

The list here includes most of the main options but does not say what works and doesn't. Many may be used in combination. Most herbal and alternative therapies have not really been tested in the same rigorous way that medicines have.
For PTSD, there are a number of alternatives, depending on what you would prefer, what might suit you best and how much distress the symptoms are causing you, when and how often.

Main alternatives for PTSD - self-help

Self-help includes:

- Watchful waiting – if the symptoms are mild and less than 4 weeks has gone since the trauma
- Taking any medicines regularly and reliably
- Eating healthily and taking exercise ("exercise to energise") or being active, and having regular sleep patterns
- Do: keep life as normal as possible; get back to your usual routine; talk about it to people you trust; try relaxation exercises; and (if you work) go back to work;

drive carefully as your concentration may be worse; and finally expect it to improve
- Do **not** beat yourself up about it (this is quite natural, PTSD is not a sign of weakness); don't bottle it up; don't expect memories to go away quickly; don't expect too much of yourself; don't drink more alcohol, smoke more; don't miss meals; don't take holidays on your own; don't go back to the place it happened.
- The Royal College of Psychiatrists has a good advice leaflet with some dos and don'ts
- Speaking to your GP and local mental health team about your symptoms and treatment can also make sure you have the right support. Try and keep to your appointment times if you are able to.

A number of other treatments have been tried but not shown to work. Whilst they might help a person, they should only be tried in extreme cases, as they may do more harm than good. Post-Trauma Debriefing has actually been shown to be harmful, probably by reinforcing the memories the brain was trying to forget.

Main alternatives for PTSD - help from others

Help from others includes a range of therapies (US Guidelines reviewed by Schnurr 2024):

- Trauma-focused psychological treatment may be useful if the symptoms are severe and it is less than 4 weeks since the event
- Prolonged exposure, cognitive processing therapy, and eye movement desensitisation and reprocessing psychotherapy (EMDR) may be helpful for adults who have had PTSD symptoms for several months. There are 15 studies to 2010 that show that brief Trauma Focused-Cognitive Behavioural Therapy (TF-CBT) is better than supportive counseling and better than sitting on a waiting list (Roberts 2010). Mindfulness-Based Stretching and Deep Breathing Exercise may also help (Kim, 2013). Other variations include Trauma-focused cognitive behavioural therapy (TF-CBT), group TF-CBT, and stress management (SM). Some of these can be delivered through secure video teleconferencing if known to work via video or when other options are unavailable
- Counselling, to listen to your concerns
- Alternative therapies such as aromatherapy, hypnosis, hypnotherapy, acupuncture, homeopathy (click for a review of the 25 studies in mental health by Davidson 2011) (treating like with like) can be used with (but not instead of) conventional treatments. Acupuncture is used extensively in many countries and may help anxiety, stress and insomnia. The evidence for these treatments is not very good and not tested in PTSD. All of these can be used in conjunction with other therapies. If they work then that is fine and we wouldn't knock them. Click here for a balanced review of complementary and alternative therapies from the Royal College of Psychiatrists (e.g. Ginkgo, Sage, vitamins, other herbals etc, and some useful links).

Main alternatives for PTSD - medicines

Medicines are not usually a first-line treatment but can be very helpful in combination with cognitive behavioural therapy (CBT). Medicines boosting serotonin seem to be

the most effective. The biggest review, of 35 studies, shows that medicines can be effective for reducing the core symptoms and depression and disability (Stein 2006). Prazosin may help nightmares, sometimes enough to let psychological therapies to work.

If you are prescribed a medicine, then there may be many reasons why that one has been chosen. These might include:

- Side effects (which ones are important to you)
- Local policies or agreements (such as what your GP surgery uses or agreements in your area)
- National policies (e.g. NICE, SIGN – see last question)
- Familiarity (it may be better for prescribers to use medicines they are familiar with)
- Relative costs for similar medicines (if two medicines are very similar, why waste money on the more expensive one?)
- Personal preference (either yours or your prescriber)
- How bad your symptoms are
- Any medicine you might have done well with in the past (as it's more likely to work again).

The main medicine treatment options are listed below. They are divided into "Main medicines" and "Others".

For convenience, the "Main medicines" are those medicines that are officially "approved" to treat the condition or symptoms and which are listed in the British National Formulary (BNF). To be listed in the BNF there needs to be good evidence that the medicine works and that the manufacturers have applied for a license (a long and costly exercise). "Others" are those medicines where there is some evidence that they help, but either not enough for a license or that no license has been applied for. These should usually only be used where other standard treatments have failed.

Main medicines

BNF Listed:

- Serotonin boosters (SSRIs) (such as sertraline up to 200mg a day, and paroxetine up to 50mg a day) - a review of 66 major trials (RCTs) showed SSRIs improved PTSD symptoms and are the first line medicines based on moderate certainty evidence (Williams et al, 2022).

Others:

- Other serotonin boosters (SSRIs) may help e.g. fluoxetine, mirtazapine and venlafaxine. Citalopram and escitalopram have been used but there isn't much evidence they work
- Prazosin – especially for nightmares and sleep problems (Byers 2010). It is used widely in USA but it isn't quite as well-known in Europe, but is growing in popularity. Doxazosin is an alternative.
- Trazodone (generally only prescribed by mental health specialists for PTSD). There's not much evidence as such but some specialists speak highly of it
- Amitriptyline (generally only prescribed by mental health specialists for PTSD)
- Phenelzine (generally only prescribed by mental health specialists for PTSD)

- Antipsychotics (such as olanzapine and risperidone), in addition to other medications in difficult-to-treat symptoms. Several experts have suggested not taking quetiapine, even just for sleep
- Sometimes help with getting to sleep (medicines such as zolpidem, zopiclone or benzodiazepines like temazepam) have been used but these really must only be for **short-term** use (up to a couple of weeks), where sleep is a really major problem and where sedative antidepressants such as mirtazapine or trazodone have not worked. The trouble is that once you start relying on sleeping tablets with PTSD it can be very difficult to stop and several experts have suggested not taking benzodiazepines, even just for sleep .

It can be very difficult to decrease the symptoms of PTSD. Doses of SSRIs such as sertraline and paroxetine will generally need to be increased to the top end of the dose range for 6 to 12 months to get the full effect.
The US CPG recommends **against** use of benzodiazepines, cannabis, or cannabis-derived products (reviewed by Schnurr 2024)

Is there an easy way to compare the main medicines for post traumatic stress disorder?
Download a handy summary chart (PDF format) comparing the main medicines for PTSD e.g. names, how they work, doses, how long they take to work, some side effects, how long to take and how to stop.

How long will the medicine take to work for PTSD?
Before going onto another medicine, it is worth trying to get the best out of the first one. There is a risk that switching medicines too quickly means you don't get the best out of the first medicine. Then perhaps you start to search for the "magic bullet", wanting the drugs to work quicker and having less patience. There are of course no "magic bullets". It is perhaps unfair to expect symptoms to go over a few days. The symptoms are more likely to go gradually over a few weeks or months. If side effects are the main problem with a medicine, talk about this with your prescriber to see if there is any way to manage them better e.g. changing times, splitting the dose or manage side effects. See the side effects list for your medicine where there are some ideas. It is always worth having a chat with your GP or mental health team to see if they can suggest something to help with your side effects.
The best thing to do is set out your aims for success of any treatment in advance and be realistic. If you decide to stop, then that's your decision, but make sure you consider the chances of becoming unwell again (and consequences of that to yourself and the people close to you).
PTSD (like OCD) can be slow to respond to medicines but medicines can often help (or at least help reduce the symptoms) if given enough time. Research from 2021 suggests that there seem to be three separate groups of people with PTSD who do well with paroxetine or sertraline:

1. Fast responders (starting in a week).
2. People who had low symptom severity.
3. People who had high symptom severity.

People whose trauma was longer ago may be more likely to do well on an SSRI e.g. up to 10-15 years before. If the trauma was more than 5-15 years ago you were more likely to be in the "fast responder" group above (Nøhr, 2021).
These are unusual findings as they are at odds with previous research that you need to get to the full therapeutic dose (usually much higher than the antidepressant doses) and then stick with it for around 3 months for the full effect to build up. If things improve it is almost certainly the medicine working because there is almost no response to the placebo part of medicine trials. If the medicine hasn't worked after three months of the full dose, then it probably won't work so that's the time for a change.

If the medicine is working for post traumantic stress disorder, how long will I need to keep taking it?
If you have improved, you should probably go on for at least 12 months before thinking about stopping slowly. If you stop earlier than this there is a high risk of the symptoms coming back to their previous level. It seems that about 1 in 4 people relapse or get their symptoms back within 6 months of stopping medicines but only 1 in 20 (5%) get them back if staying on a medicine that worked for you. You can go on longer than a year. Whatever you do, stop any medicines slowly.

How many medicines should I be taking for my symptoms of post traumatic stress disorder?
There are no easy answers to this and it is a very individual choice. Generally one medicine should always be the aim but combinations (often called "polypharmacy") sometimes help. It is rarely of any use to combine drugs with similar ways of working. Below are some of the combinations that are used with the reasons. This is not a complete list but you might want to talk to your prescriber about any combinations not on this list you may be prescribed.
Generally only one antidepressant e.g. an SSRI, should be taken but you should make sure you are taking the highest dose you can cope with. Sometimes, antipsychotics and/or sedating antidepressants can help as well.

Main medicine	Second medicine	Reason
A serotonin booster (e.g. citalopram, escitalopram, fluvoxamine, paroxetine, sertraline, trazodone)	Antipsychotic (e.g. risperidone, olanzapine)	Symptoms not getting any better
A serotonin booster (e.g. citalopram, escitalopram, fluvoxamine, paroxetine, sertraline, trazodone)	Sedating medicines e.g. trazodone, mirtazapine	If sleep is a major problem

3. PTSD - decision making
In mental health there is rarely a clear best choice. No treatments are universally effective, and all have different risks so most choices involve a trade-off between the effects and side effects of the many treatments. We still don't know why particular treatments work for some people but not others and only partly in others. So, there has to be a bit of guesswork but the more you know the better the guess is likely to be.

Shared decision making:

The aim of shared decision making is to come up with a plan that is agreeable to both parties, likely to be effective (i.e. there is evidence that it will work) and practical. In most cases some shared decision-making in mental health should be possible. In fact, treatments may actually be more effective if you're involved with the decisions (see Drake et al, 2009).

Healthcare professionals should know about:

- The problems
- The possible treatments
- What has worked for other people like yourself
- The potential benefits and risks of each of them for you.

You will know about your own:

- Values
- Goals
- Support and preferences.

You can really only make shared decisions when both you and your healthcare professional know enough about the options and are up-to-date. To help this is the main reason behind putting together this website and making it freely available.

Appointments:

- A big problem is forgetting what questions to ask and finding it difficult to express yourself so write your questions down in advance
- Read up as much as you feel comfortable with in advance. Then your time with a clinician can be discussing the risks and benefits for you rather than general education.
- Prepare before your next meeting and be clear about your options
- Take someone with you if you want

All this takes time and the health services may not always be set up for this with standard appointment times, so best to be prepared by reading what you can first. A few doctors may not be quite ready for shared decision making. Some may have concerns about whether you are well enough safe decision making and of their legal responsibility to care for you.

General information:

- You need to make a decision, even if it is to do nothing ("watchful waiting") at the moment (unless you are under a MHA section)
- You have the opportunity to find out about the treatments so, even if you then let someone else make a decision, at least you know nothing is being hidden from you
- Ask your doctor and other healthcare professional for advice – they should have more knowledge about the options
- Don't be misled by reports you may see in the newspapers as they almost always don't give the full story
- Don't rule anything in or out just on principle
- Your decisions can change with time, based on e.g. symptoms, experience, severity, and the outcome of other treatments

- It is best not to make big decisions when you are very unwell.
- Remember: The main thing that matters is to help you to get on with your life and not to suffer the symptoms.

Should I be worried about taking medicines for post-traumatic stress disorder? Are talking therapies better?
You should think carefully about taking any chemical that affects your body, including your brain. Even too much caffeine found in tea and coffee can affect your thinking.
For PTSD, some specific types of CBT (see above) are probably the most effective, but medicines may be useful and helpful. From an analysis of 15 studies, it seems that early and individual TFCBT may be effective but that non-trauma focused treatments probably don't help (CDSR 2010). While we know that some medicines and some Talking Therapies both help, we don't yet know if having both is better than either by themselves (CDSR 2010)
For an appeal for everyone to have a sense of balance about medicines and talking therapies please click here for our take on it.

Are there any guidelines I can look at for post-traumatic stress disorder?
If you want to read up a bit more on the best treatments, there are many guidelines that you can look at. Probably the most important of these for England and Wales are those produced by NICE (the National Institute for Health and Clinical Excellence). NICE is an independent body that is asked to produce advice about preventing and treating illnesses and promoting good health. Scotland has a similar group called SIGN.
Each set of NICE Guidelines is usually written by an independent and carefully chosen group of specialists and experts (including service users and carers). They review the available evidence and base their guidelines on this.

There are two main types of NICE guidance:
- Technology appraisals. These look at an "intervention" (i.e. a medicine, a surgical operation etc) and decide if they think the evidence is good enough to make this intervention a standard and/or if it is cost-effective compared to other treatments
- Clinical guidelines. These look at a particular condition (e.g. hypertension, lung cancer, depression, Parkinson's disease, bipolar disorder etc) and give guidelines covering medicines, talking treatments, support from other professionals and other services.

There are other types of guidance e.g. Public health guidance, Social care guidelines, quality standards and so on.

The concept of NICE guidance is well-intentioned and to give sound guidance. It has to be added that the mental health guidance can sometimes be controversial and their conclusions are not always accepted by everyone. They are, however, only 'guidance', so are not rigid rules as to what should happen. They are 'guidelines' not 'tramlines'.
When NICE issues a guideline, it produces a series, and all of these are available on the

NICE website. These include:

- Full guideline (very long and detailed, often several hundred pages, for anorak healthcare professionals only)
- Official guideline (usually 10-30 pages, the summary version for healthcare professionals)
- Information for the public (user-friendly summary for service users, carers and the general public).

These should then be reviewed, usually about 4-5 years, or sooner if more information becomes available.

As a general rule, you should start with treatments recommended by NICE as these are the treatments with most evidence that they work. However, if these do not help you, it may be useful to try other treatments.

- NICE (click here for the PTSD guidelines). There is also a guideline for Common mental health disorders, Identification and pathways to care, and this includes PTSD. NICE has an Evidence Update for PTSD from December 2013.
- Scottish Intercollegiate Guidelines Network (SIGN) although they don't have one for PTSD at the moment
- Harvard South Shore Psychopharmacology Algorithms Project,with a good review of the medicines.
- The SIGN (Scottish Intercollegiate Guidelines Network) Perinatal Guidelines cover people suffering a mental health problem during pregnancy or for the year afterwards (issued in December 2023).

There are plenty of other guidelines and so-called "consensus statements" (where a group of experts and specialists pool their ideas, based on their own experiences as well as what the published papers say, rather than just what the published studies say). These will have been produced for healthcare professionals by such bodies as BAP (British Association for Psychopharmacology).

Where can I find out more information about post-traumatic stress disorder?
Use the resources below to find out more information about post traumatic stress disorder. Please note that this is not an exhaustive list. We welcome your feedback on resources that you think should be listed here.

- Mental Health Ireland has a great links page on this extensive site
- The British Association for Psychopharmacology has a BAP public area, which has loads of interesting articles, some mentioning PTSD
- Co-Dependents Anonymous - a UK fellowship of men and women whose common purpose is to develop healthy relationships. The only requirement for member is a desire for healthy and loving relationships
- The Big White Wall is a 16+ safe, anonymous web-based service for people experiencing emotional or psychological distress provided entirely online. Professionally staffed 24/7 it offers a wide range of services for improving mental wellbeing including tests, peer support, individual and group therapies, articles, tips and creative self expression. Simply click on the link to learn more, or to join for £2 a week.