**PTSD Prevalence in England and Co-Morbidity with Chronic Illnesses**

**Prevalence of PTSD in England’s General Population**

**National surveys** in England provide estimates of how common post-traumatic stress disorder (PTSD) is among adults. The **most recent data** and **historical trends** show a clear increase in prevalence over time:

* **2007 (APMS 2007):** Approximately **3.0%** of adults screened positive for *current* PTSD in the Adult Psychiatric Morbidity Survey (APMS) 2007. This was the first time PTSD prevalence was measured in an English national survey, using a Trauma Screening Questionnaire.
* **2014 (APMS 2014):** About **4.4%** of adults (roughly 1 in 23) screened positive for PTSD in the past month in the 2014 survey . (Notably, the 2014 survey used a more detailed PTSD Checklist (PCL) screen, so direct comparison with 2007 should be cautious.)
* **2023/24 (APMS 2023/24):** An estimated **5.7%** of adults (around 1 in 18) screened positive for PTSD symptoms in the latest 2023/24 survey . This indicates a further rise in PTSD prevalence in the general population over the last decade.

**Trend:** Overall, about *one in twenty* adults in England are estimated to have PTSD at a given time in the mid-2020s . This prevalence has **increased** from the mid-2000s to mid-2010s and again to the 2020s . For example, the rate rose from ~3% in 2007 to 4.4% in 2014, and then to 5.7% by 2023/24. The upward trend suggests a growing burden of PTSD in the population , although changes in diagnostic criteria and survey methods over time may partly affect comparisons. Importantly, **PTSD is not evenly distributed** across demographics. Surveys consistently find **higher rates among certain groups** – notably **young adults and women** – as well as among people facing socioeconomic adversity or physical ill-health. For instance, the 2023/24 data showed PTSD prevalence was **highest in women, younger adults, individuals with physical health limitations, and those under economic hardship (e.g. unemployed or in debt)**.

These patterns align with 2014 findings, where 16–24 year olds (especially young women) had the greatest likelihood of PTSD symptoms.

**Under-diagnosis:** There is evidence that a significant portion of PTSD in the community remains **unrecognized or untreated**. In 2014, while 4.4% screened positive, only **about 3.3%** of adults even believed they had ever had PTSD, and just **1.9%** had received a professional diagnosis . In fact, among those who screened positive for PTSD in the survey, only **one in eight (12.8%)** had been *formally diagnosed* by a health professional. This gap suggests many people suffering PTSD symptoms have not been identified by medical services.

**Implications:** The rising prevalence and diagnostic gap carry important implications. More people in England are experiencing clinically significant PTSD symptoms now than in previous decades, indicating a growing need for mental health support. Health authorities note that **widening inequalities** may be contributing – with young people, the socioeconomically disadvantaged, and those with chronic physical illnesses bearing a heavier PTSD and mental health burden. The literature emphasizes strengthening trauma-focused services and outreach. For example, experts argue the increase in PTSD **“highlights the urgent need to address”** unmet mental health needs and improve access to treatment, especially in high-risk groups . Improving early recognition (through screening in primary care or other settings) and ensuring adequate treatment provision (therapy, counseling, etc.) are seen as critical steps to mitigate the personal and societal impact of PTSD in England.

**PTSD Comorbidity with Chronic Illnesses (Fibromyalgia, ME/CFS, etc.)**

Research in the UK and other countries has shown that PTSD often **co-occurs with chronic physical illnesses**, and this comorbidity is especially notable for certain conditions like fibromyalgia and myalgic encephalomyelitis/chronic fatigue syndrome (ME/CFS). Key findings from **UK-based studies and surveys** include:

* **Fibromyalgia:** There is a striking overlap between fibromyalgia (a chronic pain syndrome) and PTSD. Multiple studies (including reviews by UK researchers) report that **a large proportion of fibromyalgia patients have co-morbid PTSD**. For example, one study of 395 fibromyalgia patients found **45.3% had diagnosable PTSD** – nearly half the sample . (Notably, in that study about two-thirds of those patients said their fibromyalgia developed *after* the onset of PTSD, suggesting a potential causal link.) Across the literature, estimates of PTSD prevalence in fibromyalgia populations range widely from roughly 20% up to over 50% in different samples , far above the ~4–6% base rate in the general population. This strong association has led clinicians to recommend routinely **screening fibromyalgia patients for PTSD** and past trauma , as unaddressed PTSD could be contributing to symptom severity. Conversely, individuals with PTSD have higher rates of chronic pain and fibromyalgia-like symptoms than those without PTSD , indicating a bidirectional relationship.
* **ME/CFS (Chronic Fatigue Syndrome):** Studies also document significant PTSD comorbidity in ME/CFS. **ME/CFS patients appear more prone to PTSD than other chronic illness groups**, according to some research. For instance, a survey of chronic illness sufferers (by a team including UK scientists) found **PTSD was more common in ME/CFS patients than in patients with other chronic illnesses** – even among those who had not experienced a single major external trauma. One 2012 study reported that a **lifetime diagnosis of CFS was strongly associated with having had PTSD** in one’s lifetime, as well as with current elevated trauma symptoms . This suggests that patients with ME/CFS have a much higher likelihood of significant past trauma or PTSD than the average person. Some researchers have even hypothesized that the **experience of ME/CFS itself can be traumatizing**, due to factors like severe illness stress and stigmatization. For example, patients in one study reported that **negative or dismissive healthcare encounters** and the stigma surrounding ME/CFS contributed to trauma – in a few cases leading to PTSD that was *attributed to the illness experience* rather than a single external event . Such findings highlight how living with a chronic, misunderstood condition can generate psychological trauma.
* **Other Chronic Physical Conditions:** The co-morbidity between PTSD and chronic illness is not limited to the above syndromes. Population data in England indicate that people suffering from **long-term medical conditions** (such as cancer, diabetes, heart disease, asthma, or hypertension) have *higher rates of PTSD and other mental health problems* compared to those without chronic conditions. In other words, having a serious ongoing physical illness increases the risk of developing PTSD (sometimes the trauma of a life-threatening illness or invasive treatments can trigger PTSD, or the stress of managing illness can exacerbate underlying vulnerabilities). For example, the Mental Health Foundation reports that *common chronic conditions are associated with elevated PTSD incidence* alongside depression and anxiety. This aligns with NHS survey observations that *“those with chronic physical illness”* represent a vulnerable group needing targeted mental health support.

**Implications:** High rates of PTSD co-occurring with chronic illnesses have important clinical implications. Research consistently shows that when PTSD and a chronic illness exist together, the **overall burden on the patient is greater**. Patients with both conditions tend to experience **worse outcomes** – for instance, **greater psychological distress, more severe physical symptoms, and lower functioning** – than those with the chronic illness alone. In UK veteran studies, individuals with chronic pain plus PTSD had significantly more impairment than those with pain but no PTSD , and similarly PTSD outcomes are poorer when chronic pain or fatigue is present. This means co-morbid PTSD can amplify the disability of diseases like fibromyalgia or CFS, creating a vicious cycle of pain/fatigue and traumatic stress symptoms reinforcing each other . Consequently, health experts advocate for **integrated, “trauma-informed” approaches** to managing chronic illnesses. This includes screening patients with chronic conditions for PTSD symptoms and trauma history, and providing appropriate psychological interventions (such as trauma-focused therapies) alongside standard medical treatment . Conversely, patients diagnosed with PTSD might benefit from monitoring and support for chronic pain or fatigue, since a substantial subset may develop stress-related physical syndromes. Addressing both the mental and physical aspects in tandem is seen as crucial. By treating PTSD in someone with a chronic illness, we may improve not only mental health but also their ability to cope with or recover from the physical condition. Overall, the literature suggests that recognizing PTSD co-morbidity and improving access to combined care (e.g. mental health services within chronic disease clinics) could significantly **improve patient outcomes** and quality of life in these populations.

**Sources:**

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* EMJ (Ada Enesco, 2025) – Summary of APMS 2023/24 findings , noting increased PTSD rates and high-risk groups.
* APMS 2014 – PTSD chapter (N. T. Fear et al.) – reporting 4.4% current PTSD and highlighting age/sex patterns and under-diagnosis in 2014.
* Mental Health Foundation, *“Long-term Conditions and Mental Health”* – UK statistics linking chronic physical conditions with higher PTSD/mental health risk .
* Littlejohn, G. (2021), *EMJ Rheumatology Review* – discussion of fibromyalgia as a stress-related disorder, noting **~45%** of fibromyalgia patients had PTSD in one cohort .
* MEpedia summary of research (Klimas & Fletcher; Dansie et al. 2012) – reports of elevated PTSD in ME/CFS patients and potential causes (medical trauma) .
* *BMJ Open* (2020) – **McGill et al.** review on chronic pain and PTSD in UK veterans, noting co-morbidity magnifies distress and functional impairment and citing high overlap rates of pain and PTSD in clinical populations.

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