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A large-scale meta-analysis of studies of psychological treatment approaches for adults with symptoms of post-traumatic stress disorder shows some perform better than waiting list/usual care

Therapies for chronic post-traumatic stress disorder

In this article...

- › Results of a review of psychological interventions to treat post-traumatic stress disorder
- › Recommendations for practice

Post-traumatic stress disorder (PTSD) is a widely recognised psychiatric condition that can occur following a traumatic event. Symptoms include nightmares and recurrent distressing thoughts of the event, avoidance and numbing of general responsiveness, and hyperarousal.

Psychological interventions are used but some appear more effective than others in treating clinician and self-assessed PTSD, depression and anxiety symptoms.

Review question

What is the efficacy of psychological intervention for the treatment of chronic PTSD?

Study characteristics

Bisson et al (2013) reviewed 70 randomised controlled trials of psychological treatments for PTSD, covering 4,761 participants. Sample sizes ranged from nine to 360. Participants were any adults (aged 18 or above) who showed traumatic stress symptoms for three months or more. No restrictions were applied on the severity of PTSD symptoms, type of traumatic event or presence of comorbidities.

Any psychological treatment designed to reduce symptoms of chronic PTSD was eligible for inclusion. Group and individual interventions were considered separately. Six types were considered:

- › Individual trauma-focused cognitive behavioural therapy (TFCBT) (49 studies);
- › Non-trauma-focused cognitive behavioural therapy (non-TFCBT) (eight studies);

- › Eye-movement desensitisation and reprocessing (EMDR) (16 studies);
- › Trauma-focused cognitive behavioural therapy group therapy (group TFCBT) (10 studies);
- › Non-trauma-focused cognitive behavioural group therapy (group non-TFCBT) (one study);
- › Other psychological treatments, including non-directive counselling, psychodynamic therapy and hypnotherapy (nine studies).

Waiting list/usual care (WL/UC) and symptom monitoring, repeated assessment, other minimal attention control group or an alternative psychological treatment were used as comparators.

The primary outcome measures were the severity of clinically rated traumatic stress symptoms using a standardised measure – for example, the Clinician Administered PTSD Symptom Scale – to measure the efficacy of psychological treatments in comparison with control conditions and other psychological treatments, and drop-out rates. The secondary outcome measures were: severity of self-reported stress; depressive and anxiety symptoms using validated measures; PTSD diagnosis after treatment; and adverse effects such as amplified PTSD symptoms.

Despite the number of studies in the review, methodological issues, small sample sizes, underpowered studies and limited follow-up data mean that overall the evidence for many comparisons in this review were of very low quality.

Summary of key evidence

There was good evidence that individual

TFCBT was better than WL/UC in reducing symptoms. There was evidence in five studies that individual TFCBT was superior to non-TFCBT in reducing PTSD symptoms at follow-up at one to four months, but little long-term data.

EMDR performed better than non-TFCBT for secondary outcomes around self-reported PTSD (immediately after treatment), depression and anxiety. Three treatments showed greater effectiveness than other treatments: individual TFCBT (10 studies), EMDR (two studies) and non-TFCBT (one study). Non-TFCBT in five studies was more effective than WL/UC across several secondary outcomes. In three studies other therapies were superior to WL/UC for the primary outcome and some secondary outcomes. Group TFCBT was also effective for the primary outcome in three studies and in most secondary outcomes.

There was no significant difference between individual TFCBT, EMDR and stress management immediately after treatment. The heterogeneity in the comparisons of the review, along with the potential impact of publication bias on the data, should prompt caution in interpreting the results.

Best practice recommendations

Health professionals should consider individual TFCBT, EMDR, individual non-TFCBT and group TFCBT to treat PTSD in adults. However, they should be mindful that there is insufficient evidence on their long-term effects.

Micah Peters is post-doctoral research fellow at the University of Adelaide and a member of the Cochrane Nursing Care Field

Reference

Bisson JI et al (2013) Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Database of Systematic Reviews* 2013, DOI: 10.1002/14651858.CD003388. tinyurl.com/CochranePTSD