Overview of Psychotherapy for PTSD

Several clinical practice guidelines offer recommendations for the treatment of PTSD, for example see the newly revised VA/DoD PTSD Clinical Practice Guideline (2010). These guidelines come from different federal agencies, professional organizations, and countries (1-5). The Institute of Medicine (IOM) also published a report in 2007 evaluating the evidence on PTSD treatment (6). The guidelines unanimously recommend cognitive behavioral therapies as the most effective treatment for PTSD, and the majority of guidelines recommend Eye Movement Desensitization and Reprocessing (EMDR) as well.

Cognitive behavioral treatments typically include a number of components, including psychoeducation, anxiety management, exposure, and cognitive restructuring. Exposure and cognitive restructuring are thought to be the most effective components.

Exposure-based treatments

The greatest number of studies has been conducted on exposure-based treatments, which involve having survivors repeatedly re-experience their traumatic event. There is strong evidence for exposure therapy (7-12), and of the various approaches, Prolonged Exposure (PE) has received the most attention. PE (8) includes both imaginal exposure and in vivo exposure to safe situations that have been avoided because they elicit traumatic reminders.

In a multisite randomized controlled trial of PE in female Veterans and active-duty personnel with PTSD, those who received PE experienced greater reduction of PTSD symptoms relative to women who received present-centered therapy and were less likely to meet PTSD diagnostic criteria (13). Moreover, PE was more effective than the combination of PE plus stress inoculation training (SIT), SIT alone, or a waitlist control in female sexual assault survivors (10). In addition, PE alone and PE plus cognitive restructuring reduced PTSD and depression relative to a waitlist control in intention-to-treat and completer samples (11).

Cognitive approaches

Cognitive interventions also are widely supported in treatment guidelines (12, 15-17). Cognitive Processing Therapy (CPT; 18), one of the most well-researched cognitive approaches, has a primary focus on challenging and modifying maladaptive beliefs related to the trauma, but also includes a written exposure component.

Veterans with chronic military-related PTSD who received CPT showed better improvements in PTSD and comorbid symptoms than the waitlist control group (19). A dismantling study of CPT then examined the relative utility of the full protocol compared with its components: cognitive therapy alone and written exposure alone (20). Results indicated significant improvement in PTSD and depression for participants in all three treatments. However, the cognitive therapy alone
resulted in faster improvement than the written exposure alone, with the effects of the full protocol of CPT falling in-between (20). Both CPT and PE have shown great success in outcome research; thus, one logical research question involves whether one is more effective than the other. In a head-to-head comparison, CPT and PE were equally effective in treating PTSD and depression in female sexual assault survivors (7).

Ehlers and Clark have also developed a cognitive therapy for PTSD that involves three goals: modifying excessively negative appraisals, correcting autobiographical memory disturbances, and removing problematic behavioral and cognitive strategies (21). Elements unique to Ehlers and Clark's cognitive therapy include performing actions that are incompatible with the memory or engaging in behavioral experiments. Two randomized controlled trials have compared cognitive therapy to a waitlist, both with positive results (15, 16).

Adding components
Some investigators have added a novel component to an effective treatment in hopes of further optimizing outcomes (22-27). Three groups of investigators compared an enhanced treatment to a waitlist control group: Cloitre and colleagues (23) sequenced skills training in affect and interpersonal regulation before PE; Falsetti and colleagues (24) developed Multiple Channel Exposure Therapy, a combination of PE, CPT, and interoceptive exposure techniques for panic disorder; and Lindauer and colleagues (27) developed Brief Eclectic Therapy, a combination of psychodynamic and cognitive behavioral therapy. These studies showed that the combined treatments were effective, but not whether the additional components enhanced the standard treatments.

Glynn and colleagues (25) compared exposure therapy alone with exposure therapy followed by behavioral family therapy, and Arntz and colleagues (22) compared imaginal exposure alone with imaginal exposure plus imagery rescripting. In both studies, the combined treatment did not result in a greater reduction of PTSD severity, which suggests that the novel component was not necessary. However, statistical power may have been too low to compare the active treatments adequately.

EMDR
In addition to cognitive behavioral therapies, EMDR is recommended in most practice guidelines. Patients receiving EMDR engage in imaginal exposure to a trauma while simultaneously performing saccadic eye movements. There is good evidence that EMDR is more effective than waitlist and nonspecific comparison conditions (28-30). Further, two well-controlled studies compared EMDR to PE. One study found equivalent results (29) while the other found PE to be superior (30). Additional research has investigated the mechanism of action in EMDR, and there is growing evidence that the theorized eye movements are an unnecessary component (31), suggesting that perhaps the mechanism of action is exposure.

Other approaches
Other treatments in addition to cognitive behavioral therapy and EMDR may be effective; however, at this time we do not have enough evidence to confidently indicate that they are effective. For example, despite the appeal of group treatments, results of the few randomized controlled trials of group therapy have been mixed (32-36). In addition, psychodynamic therapy, hypnotherapy, and trauma desensitization were more effective than a waitlist control group in one trial (40). Rogerian
supportive therapy was less effective in treating symptoms of PTSD and anxiety than cognitive behavioral therapy in one study (41).

Acceptance and Commitment Therapy (ACT), which is considered a third wave behavioral therapy, focuses on reducing experiential avoidance and engagement with maladaptive thoughts and encourages clients to approach activities consistent with their personal values. Several case studies have documented support for ACT in the treatment of PTSD (37, 38). However, no trials of ACT for PTSD have been published to date. Finally, there is also interest in alternative medicine treatments. For example, acupuncture was as effective as group cognitive behavioral treatment, and both were more effective than the waitlist condition (39).

**Conclusion**

Overall, cognitive behavioral therapies such as Prolonged Exposure and Cognitive Processing Therapy, as well as Eye Movement Desensitization Reprocessing, are considered first-line treatments for PTSD and have strong evidence bases. Components of these treatments have been combined with other interventions, with no support for improved benefits over the standard treatments alone. Other interventions, such as group treatment, show promise; however, more research is needed before drawing firm conclusions about their effectiveness.

**References**


The National Center for PTSD does not provide direct clinical care or individual referrals. Please see: Where to Get Help for PTSD.

PTSD Information Voice Mail: (802) 296-6300
Contact Us: ncptsd@va.gov
Also see: VA Mental Health

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