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Psychological treatment of post-traumatic stress disorder (PTSD)

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Summary

Psychological treatments can reduce symptoms of post traumatic stress disorder (PTSD). Trauma focused treatments are more effective than non-trauma focused treatments.

This review concerns the efficacy of psychological treatment in the treatment of PTSD. There is evidence that individual trauma focused cognitive-behavioural therapy (TFCBT), eye movement desensitisation and reprocessing (EMDR), stress management and group TFCBT are effective in the treatment of PTSD. Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly. There is some evidence that individual TFCBT and EMDR are superior to stress management in the treatment of PTSD at between 2 and 5 months following treatment, and also that TFCBT, EMDR and stress management are more effective than other therapies. There is insufficient evidence to show whether or not psychological treatment is harmful. Trauma focused cognitive behavioural therapy or eye movement desensitisation and reprocessing should be considered in individuals with PTSD.

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Abstract

Background

Psychological interventions are widely used in the treatment of post-traumatic stress disorder (PTSD).

Objectives

To perform a systematic review of randomised controlled trials of all psychological treatments following the guidelines of The Cochrane Collaboration.

Search strategy

Systematic searches of computerised databases, hand search of the Journal of Traumatic Stress, searches of reference lists, known websites and discussion fora, and personal communication with key workers.

Selection criteria

Types of studies - Any randomised controlled trial of a psychological treatment.

Types of participants - Adults suffering from traumatic stress symptoms for three months or more.

Types of interventions - Trauma-focused cognitive behavioural therapy/exposure therapy (TFCBT); stress management (SM); other therapies (supportive therapy, non-directive counselling, psychodynamic therapy and hypnotherapy); group cognitive behavioural therapy (group CBT); eye movement desensitisation and reprocessing (EMDR).

Types of outcomes - Severity of clinician rated traumatic stress symptoms. Secondary measures included self-reported traumatic stress symptoms, depressive symptoms, anxiety symptoms, adverse effects and dropouts.

Data collection and analysis

Data were entered using Review Manager software. Quality assessments were performed. Data were analysed for summary effects using Review Manager 4.2.

Main results

Thirty-three studies were included in the review. With regards to reduction of clinician assessed PTSD symptoms measured immediately after treatment TFCBT did significantly better than waitlist/usual care (standardised mean difference (SMD) = -1.40; 95% CI, -1.89 to -0.91; 14 studies; n = 649). There was no significant difference between TFCBT and SM (SMD = -0.27; 95% CI, -0.71 to 0.16; 6 studies; n = 239). TFCBT did significantly better than other therapies (SMD = -0.81; 95% CI, -1.19 to -0.42; 3 studies; n = 120). Stress management did significantly better than waitlist/usual care (SMD = -1.14; 95% CI, -1.62 to -0.67; 3 studies; n = 86) and than other therapies (SMD = -1.22; 95% CI, -2.09 to -0.35; 1 study; n = 25). There was no significant difference between other therapies and waitlist/usual care control (SMD = -0.43; 95% CI, -0.90 to 0.04; 2 studies; n = 72). Group TFCBT was significantly better than waitlist/usual care (SMD = -0.72; 95% CI, -1.14 to -0.31). EMDR did significantly better than waitlist/usual care (SMD = -1.51; 95% CI, -1.87 to -1.15; 5 studies; n = 162). There was no significant difference between EMDR and TFCBT (SMD = 0.02; 95% CI, -0.28 to 0.31; 6 studies; n = 187). There was no significant difference between EMDR and SM (SMD = -0.35; 95% CI, -0.90 to 0.19; 2 studies; n = 53). EMDR did significantly better than other therapies (self-report) (SMD = -0.84; 95% CI, -1.21 to -0.47; 2 studies; n = 124).

Authors' conclusions

There was evidence individual TFCBT, EMDR, stress management and group TFCBT are effective in the treatment of PTSD. Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly. There was some evidence that individual TFCBT and EMDR are superior to stress management in the treatment of PTSD at between 2 and 5 months following treatment, and also that TFCBT, EMDR and stress management were more effective than other therapies. There was insufficient evidence to determine whether psychological treatment is harmful. There was some evidence of greater drop-out in active treatment groups. The considerable unexplained heterogeneity observed in these comparisons, and the potential impact of publication bias on these data, suggest the need for caution in interpreting the results of this review.

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