PTSD

A summary of the evidence for psychological therapies

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Overview

The National Institute of Clinical Excellence (NICE) has recommended that some psychological therapies, namely trauma focussed CBT and exposure therapy are provided for those suffering from long term PTSD (2005). This guideline is supported by evidence from a range of systematic reviews of randomised controlled trials (see tables below). Furthermore similar guidance has been issued from countries such as Australia (Forbes et al, 2007). There is considerable evidence available regarding the use of psychological therapies for PTSD. Due to the volume of evidence, the main focus of this bulletin is on systematic reviews in relation to PTSD for adults (as these summarise the best available evidence). However individual trials which have directly compared counselling interventions with other therapies are listed separately.

Overall these studies show that a wide range of psychological therapies are effective in treating PTSD in a range of contexts. The weight of the evidence is in favour of trauma focussed CBT. One meta-analysis suggested that there was equivalent effects for a range of psychological therapies (Benish et al, 2008), however more recently (Ehlers et al,2010) argues that (1) the selection procedure of the available evidence used in Benish et al.'s (2008)meta-analysis introduces bias, and (2) the analysis and conclusions fail to take into account the need to demonstrate that treatments for PTSD are more effective than natural recovery. Ehlers et al (2010) recommend further research into the active mechanisms of therapeutic change, including treatment elements commonly considered to be non-specific, a suggestion echoed by a number of systematic reviews noted below.

The evidence from studies included in this overview has been summarised in the form of evidence tables, which give a brief overview of each review (based on the abstracts), most of the reviews included are systematic reviews published since 2000. This evidence suggests that

- Trauma focussed CBT and EMDR are effective for treating adults with PTSD. These two modalities appear equally effective but it is unknown what the eye movement component of EMDR contributes
- There is no evidence that debriefing is effective in preventing PTSD
- There is insufficient evidence to determine whether combining psychological therapies with pharmacological therapies improves effectiveness
- Non trauma focussed treatments reduce symptoms of PTSD but not as significantly as trauma focussed ones
- Individual studies suggest that counselling is as effective as other therapies over the longer term, but more people drop out of treatment. In some cases the effect sizes are not as significant as those treated with CBT.
- More research is needed for specific populations and contexts

Reference

Ehlers, A., J. Bisson, et al. (2010). "Do all psychological treatments really work the same in posttraumatic stress disorder?*." Clinical Psychology Review 30(2): 269-276.

Guidelines

Details	Therapy	Overview	Findings/Conclusions
Forbes, D., M. Creamer, et al. (2007). "Australian guidelines for the treatment of adults with acute stress disorder and post-traumatic stress disorder." Aust N Z J Psychiatry 41(8): 637-48.	Mixed	Development of National Guidelines for Posttraumatic Mental Health based on systematic review of the evidence and applied to Australian context.	Key recommendations indicate the use of trauma-focused psychological therapy (cognitive behavioural therapy or eye movement desensitization and reprocessing in addition to in vivo exposure) as the most effective treatment for ASD and PTSD. Where medication is required for the treatment of PTSD in adults, selective serotonin re-uptake inhibitor antidepressants should be the first choice. Medication should not be used in preference to trauma-focused psychological therapy. In the immediate aftermath of trauma, practitioners should adopt a position of watchful waiting and provide psychological first aid. Structured interventions such as psychological debriefing, with a focus on recounting the traumatic event and ventilation of feelings, should not be offered on a routine basis.
Hudson, P. (2011). "Review of Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies." British Journal of Guidance & Counselling 39(2): 194-195.	Mixed	Reviews of the book Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies. Foa et al (eds) which is developed under the auspices of the Post-Traumatic Stress Disorder (PTSD) Treatment Guidelines Task Force of the International Society for Traumatic Stress Studies (ISTSS).	Presents findings of 'leading authorities' in the field who present evaluations of the range of treatments for PTSD to provide a best practice reference for mental health clinicians who are caring for any trauma population.
NICE (2005). Post-traumatic stress disorder: the management of PTSD in adults and children in	Mixed	Evidence-based clinical guideline commissioned by the UK's National	Recommends trauma focussed CBT or EMDR for those suffering from long term PTSD. Debriefing after traumatic

primary and secondary care http://www.nice.org.uk/nicemedia/live/10966/29771/29771.pdf		Institute for Clinical Excellence presents guidance on the management of post-traumatic stress disorder (PTSD) in primary and secondary care.	events is not recommended.
Weine, S., Y. Danieli, et al. (2002). "Guidelines for international training in mental health and psychosocial interventions for trauma exposed populations in clinical and community settings." Psychiatry 65(2): 156-64.	Mixed	Task Force on International Trauma Training of the International Society for Traumatic Stress Studies. To develop consensus-based guidelines for training in mental health and psychosocial interventions for trauma-exposed populations in the international arena.	The Task Force engaged in a 1-year dialogue on the practice of international training, drawing upon field experience, literature review, and consultation with key informants. The generated guidelines addresses four dimensions: (1) values, (2) contextual challenges in societies during or after conflicts, (3) core curricular elements, and (4) monitoring and evaluation. The guidelines can improve international training.

Reviews of psychological therapies

Systematic reviews of psychological therapies	Therapy	Overview	Findings/Conclusions
Adshead, G. (2000). "Psychological therapies for post-traumatic stress disorder." British Journal of Psychiatry 177: 144-148.	Mixed	Reviews the published evidence about the effectiveness of psychological treatments for posttraumatic stress disorder (PTSD) and discusses the psychopathological mechanisms involved in PTSD.	Suggests that persistent fear or shame reactions are key aspects of PTSD. Systematic reviews suggest that psychotherapeutic treatments are effective in the therapy of reactions based on fear but there is less systematic evidence for the efficacy of interventions for symptoms based on shame. (AA)
Benish, S. G., Z. E. Imel, et al. (2008). "The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: a meta-analysis of direct comparisons." Clin Psychol Rev 28(5): 746-58.	Mixed	Meta-analysis to controlled for potential confounds in previous PTSD meta-analyses by including only bona fide psychotherapies, avoiding categorization of psychotherapy treatments, and using direct comparison studies only.	Primary analysis revealed that effect sizes were homogenously distributed around zero for measures of PTSD symptomology, and for all measures of psychological functioning, indicating that there were no differences between psychotherapies. Additionally, the upper bound of the true effect size between PTSD psychotherapies was quite small. The results suggest that despite strong evidence of psychotherapy efficaciousness vis-a-vis no treatment or common factor controls, bona fide psychotherapies produce equivalent benefits for patients with PTSD.

Bisson, J. and M. Andrew (2007) Psychological treatment of post-traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD003388.pub3		Systematic review of randomised controlled trials of all psychological treatments following the guidelines of The Cochrane Collaboration.	Thirty-three studies were included in the review. 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. Psychological treatments can reduce symptoms of post traumatic stress disorder (PTSD). Trauma focused treatments are more effective than non-trauma focused treatments.
Bradley, R., J. Greene, et al. (2005). "A multidimensional meta-analysis of psychotherapy for PTSD." Am J Psychiatry 162(2): 214-27.		Multidimensional meta-analysis of studies published between 1980 and 2003 on Psychotherapy for PTSD.	The majority of patients treated with psychotherapy for PTSD in randomized trials recover or improve, rendering these approaches some of the most effective psychosocial treatments devised to date. Several caveats, however, are important in applying these findings to patients treated in the community. Exclusion criteria and failure to address polysymptomatic presentations render generalizability to the population of PTSD patients indeterminate. The majority of patients posttreatment continue to have substantial residual symptoms, and follow-up data beyond very brief intervals have been largely absent.

Cloitre, M. (2009). "Effective psychotherapies for posttraumatic stress disorder: a review and critique." CNS Spectr 14(1 Suppl 1): 32-43.	Mixed	Reviews and critiques the psychotherapy literature for the treatment of posttraumatic stress disorder (PTSD) and systematically presents data on sample size, rates of completion and effect sizes.	Suggests substantial progress has been made in the use of cognitive behavioral therapies and eye movement desensitization and reprocessing for the resolution of PTSD. Further advances are needed in the treatment of populations with complex and chronic forms of PTSD such as those found in childhood abuse populations, refugee populations, and those experiencing chronic mental illness. The need to address comorbid emotional, social, and physical health consequences of trauma, to implement treatments in community-based settings, and to incorporate larger systems of care into study designs is noted.
Hetrick Sarah, E., R. Purcell, et al. (2010) Combined pharmacotherapy and psychological therapies for post traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD007316.pub2	Psychological therapies combined with pharmacological therapies	To assess whether the combination of psychological therapy and pharmacotherapy provides a more efficacious treatment for PTSD than either of these interventions delivered separately.	Both psychological therapy and pharmacotherapy have been used to treat PTSD and guidelines suggest that a combination of both may mean people recover from PTSD more effectively. Four trials including 124 participants were included in this review. One of these trials (n =24) was on children and adolescents. The trials all used SSRIs and prolonged exposure or a cognitive behavioural intervention. Only two trials reported on total PTSD symptoms but the data could not be combined. In this review, there are too few studies to be able to draw conclusions about whether a combination of psychological therapy and pharmacotherapy result in better outcomes for patients than either of these treatments alone.
Ponniah, K. and S. D. Hollon (2009). "Empirically supported psychological treatments for adult acute stress disorder and posttraumatic stress disorder: a review." Depress Anxiety 26(12): 1086-109.		Review of randomized controlled trials to give an update on which psychological treatments are empirically supported for	Fifty-seven studies were included. Trauma-focused CBT and to a lesser extent EMDR (due to fewer studies having been conducted and many having had a mixed trauma sample) are the psychological treatments of choice for PTSD, but further research of these and other therapies with different

		ASD and PTSD	populations is needed.
Seidler, G. H. and F. E. Wagner (2006). "Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: A meta-analytic study." Psychological Medicine: A Journal of Research in Psychiatry and the Allied Sciences 36(11): 1515-1522.	EMDR CBT	Systematic review to determine whether there is any evidence to show that EMDR is superior to CBT or vice versa.	Eight publications were included which directly compared EMDR and CBT, seven of these studies were investigated meta-analytically. The superiority of one treatment over the other could not be demonstrated and Trauma-focused CBT and EMDR tend to be equally efficacious. What remains unclear is the contribution of the eye movement component in EMDR to treatment outcome.

Early interventions and prevention

Early interventions and prevention	Therapy	Overview	Findings/Conclusions
Agorastos, A., C. R. Marmar, et al. (2011). "Immediate and early behavioral interventions for the prevention of acute and posttraumatic stress disorder." Curr Opin Psychiatry 24(6): 526-32.	Early behavioural interventions	Reviews the current evidence regarding immediate (within hours) and early (within days and weeks) psychological and behavioral interventions to prevent posttraumatic stress symptoms.	There is no empirical (RCT) evidence to support any immediate intervention within hours after the traumatic event to prevent posttraumatic stress symptoms. With regard to early interventions in the first days or weeks after trauma, literature is also sparse, but supports brief cognitive behavioral interventions as a first choice. There is an urgent need for RCTs to examine if behavioral interventions immediately following a traumatic event might be able to reduce the burden of acute and posttraumatic stress symptoms.
Ehlers, A. and D. M. Clark (2003). "Early psychological interventions for adult survivors of trauma: A review." Biological Psychiatry 53(9): 817-826.	CBT	Reviews trials of early cognitive behavior therapy (CBT) after trauma.	CBT was more effective than supportive counseling in preventing chronicity of PTSD symptoms; however, in most available studies it remained unclear whether supportive counseling facilitated or retarded recovery, compared with no intervention. A brief CBT program given in the first month of trauma was not superior to repeated assessment; however, a course of CBT of up to 16 sessions given at 1-4 months after trauma was superior to self-help, repeated assessment, and no intervention.
Kornor, H., D. Winje, et al. (2008). "Early trauma-focused cognitive-behavioural therapy to prevent chronic post-traumatic stress disorder and related symptoms: a systematic review and meta-	Trauma focussed CBT	To provide an evaluation of the effectiveness of early TFCBT on the prevention of PTSD in high risk populations.	Seven articles reporting the results of five RCTs were included. All compared TFCBT to supportive counselling (SC). The study population was patients with acute stress disorder (ASD) in four trials, and with a PTSD diagnosis disregarding the duration criterion in the fifth trial. Anxiety and depression scores were generally lower in the TFCBT groups than in the SC groups. CONCLUSION: There is evidence for the effectiveness of TFCBT compared to SC in preventing chronic PTSD in patients with an initial ASD diagnosis. As

analysis." BMC Psychiatry 8: 81.			this evidence originates from one research team replications are necessary to assess generalisability. The evidence about the effectiveness of TFCBT in traumatised populations without an ASD diagnosis is insufficient.
Roberts Neil, P., J. Kitchiner Neil, et al. (2009) Multiple session early psychological interventions for the prevention of post-traumatic stress disorder. Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD006869.pub2	Multiple session early intervention	To examine the efficacy of multiple session early psychological interventions commenced within three months of a traumatic event aimed at preventing PTSD	Evaluated the results of 11 studies that tested a diverse range of psychological interventions aimed at preventing PTSD. The results did not find any evidence to support the use of an intervention offered to everyone. There was some evidence that multiple session interventions may result in worse outcome than no intervention for some individuals.
Roberts Neil, P., J. Kitchiner Neil, et al. (2010) Early psychological interventions to treat acute traumatic stress symptoms. Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD007944.pub2	Early intervention	To perform a systematic review of randomised controlled trials of all psychological treatments and interventions commenced within three months of a traumatic event aimed at treating acute traumatic stress reactions.	This review evaluated the results of 15 studies that tested a diverse range of psychological interventions aimed at treating acute traumatic stress problems. There was evidence to support the use of trauma focused cognitive behavioural therapy with such individuals, although there were a number of potential biases in identified studies which means the results should be treated with some caution. Further research is required to evaluate longer terms effects of TF-CBT, to explore potential benefits of other forms of intervention and to identify the most effective ways of providing psychological help in the early stages after a traumatic event.

Specific contexts or populations

	Therapy	Overview	Findings/Conclusions
Older Adults			
Bottche, M., P. Kuwert, et al. (2012). "Posttraumatic stress disorder in older adults: an overview of characteristics and treatment approaches." Int J Geriatr Psychiatry 27(3): 230-9. :	Mixed	To summarize available data on the prevalence and symptoms of late-life PTSD and to review the current treatment approaches for older adults.	The course and severity of PTSD symptoms in older adults depend on the time the trauma occurred (early versus late life). Research on treatment approaches has produced promising results, indicating that disorder-specific interventions (i.e., trauma confrontation and cognitive restructuring) can be effectively combined with an age-specific narrative life-review approach however given the limited empirical evidence, caution is warranted in generalizing the reported findings.
Terrorism			
Foa, E. B., S. P. Cahill, et al. (2005). "Social, psychological, and psychiatric interventions following terrorist attacks: recommendations for practice and research." Neuropsychopharmacology 30(10): 1806-17.	Interventions following terrorism	To review knowledge about (1) reactions following terrorist attacks (2) the practical experiences accumulated in recent years in countries (eg, Israel) that have had to cope with the threat of bioterrorism and the reality of terrorism, and (3) interventions for acute and chronic stress reactions following other types of traumatic events	Found several treatments efficacious in treating individuals for acute and chronic post-traumatic stress disorder (PTSD) related to other traumatic events that will likely be efficacious in treating PTSD related to terrorist attacks. However, there were significant gaps in our knowledge about how to prepare populations and individuals for the possibility of a terrorist attack and what interventions to apply in the immediate aftermath of such an attack.

Childbirth			
Lapp, L. K., C. Agbokou, et al. (2010). "Management of post traumatic stress disorder after childbirth: a review." J Psychosom Obstet.	Interventions on PTSD after childbirth	To describe the studies that examine the effects of Interventions on PTSD after childbirth	Nine studies were retrieved. Seven studies that examined debriefing or counselling were identified; six randomised controlled trials and one pilot study. Also found were one case report describing the effects of cognitive behavioural therapy (CBT) on two women, and one pilot study of eye movement desensitisation and reprocessing (EMDR). Overall, there is limited evidence concerning the management of women with PTSD after childbirth. The results agree with the findings from the non-childbirth related literature: debriefing and counselling are inconclusively effective while CBT and EMDR may improve PTSD status but require investigation in controlled trials before conclusions could be drawn.
Refugees			
Palic, S. and A. Elklit (2011). "Psychosocial treatment of posttraumatic stress disorder in adult refugees: A systematic review of prospective treatment outcome studies and a critique." Journal of Affective Disorders 131(1-3): 8-23.	Mixed	Systematic review of effective treatments for traumatized refugees	Twenty-five studies were reviewed. The majority were treatment studies of different forms of cognitive-behavioral therapy (CBT). The rest were reports of outcomes of alternative treatments and a small group of studies of multidisciplinary treatments. Very large effect sizes were obtained in some of the CBT studies, indicating a broad suitability of CBT in the treatment of core symptoms of PTSD in adult refugees. There are few studies of treatments alternative to CBT and they are less methodologically rigorous than the CBT studies. (AA)
Sexual abuse			
Peleikis, D. E. and A. A. Dahl (2005) A systematic review of empirical studies of psychotherapy with women who were sexually abused	Mixed	Systematic review of psychotherapies with women exposed to childhood sexual	Fifteen studies examined short-term group (≤20 sessions) psychotherapies. All studies examined treatment effectiveness, and they mostly had a low quality of design. For posttreatment gains, mean total effect size was .63 in controlled studies. Effect sizes for noncontrolled studies were somewhat

as children (Structured abstract). Psychotherapy Research 304-315		abuse (CSA).	higher. Minimal changes from posttreatment to follow-up were observed. Multicenter studies with better design are needed, but the theoretical underpinnings for specific therapies in women with CSA should first be reexamined.
Taylor, J. E. and S. T. Harvey (2009) Effects of psychotherapy with people who have been sexually assaulted: a meta-analysis Aggression and Violent Behavior 273-285	Mixed	Systematic review of psychotherapeutic interventions following sexual assault	This review assessed the effects of psychotherapeutic interventions following sexual assault and concluded that they were beneficial for victims of sexual assault up to one year following treatment. Due to the type of analysis, the conclusion should be treated with some caution as the generalisability of the findings to specific psychotherapeutic interventions and specific sexually assaulted populations was unclear.
Torture			
Regel, S. and P. Berliner (2007). "Current perspectives on assessment and therapy with survivors of torture: The use of a cognitive behavioural approach." European Journal of Psychotherapy and Counselling 9(3): 289-299.	Mixed	To review and critique the current literature on therapy with refugees and survivors of torture	Uses case examples to illustrate the use of CBT as an effective treatment intervention for this group.

Therapeutic modalities

CBT			
Mendes, D. D., M. F. Mello, et al. (2008). "A systematic review on the effectiveness of cognitive behavioral therapy for posttraumatic stress disorder." International Journal of Psychiatry in Medicine 38(3): 241-259.	CBT	Systematic review of CBT	23 clinical trials included in the review comprised 1,923 patients: 898 in the treatment group and 1,025 in the control group. CBT had better remission rates than EMDR or supportive therapies. CBT was comparable to Exposure Therapy (ET), and cognitive therapy (CT) in terms of efficacy and compliance. Concludes that specific therapies, such as CBT, exposure therapy and cognitive therapy are equally effective, and more effective than supportive techniques in the treatment of PTSD. (AA)
Debriefing			
Rose, S., J. Bisson, et al. (2003). "A systematic review of single-session psychological interventions ('debriefing') following trauma." Psychother Psychosom 72(4): 176-84. Rose Suzanna, C., J. Bisson, et al. (2002) Psychological debriefing for preventing post traumatic stress disorder (PTSD). Cochrane Database of Systematic Reviews DOI: 10.1002/14651858.CD000560		Systematic review of the evidence for the effectiveness of one-off early interventions within 1 month of a traumatic event.	This review concerns the efficacy of single session psychological "debriefing" in reducing psychological distress and preventing the development of post traumatic stress disorder (PTSD) after traumatic events. Psychological debriefing is either equivalent to, or worse than, control or educational interventions in preventing or reducing the severity of PTSD, depression, anxiety and general psychological morbidity. There is some suggestion that it may increase the risk of PTSD and depression. The routine use of single session debriefing given to non selected trauma victims is not supported. No evidence has been found that this procedure is effective.

Stapleton, A. B., J. Lating, et al. (2006). "Effects of medical crisis intervention on anxiety, depression, and posttraumatic stress symptoms: a meta-analysis." Psychiatr Q 77(3): 231-8.	Individual crisis intervention	Meta analysis of individual crisis intervention	A meta-analysis of 11 studies (N=2124) investigating the impact of individual crisis intervention with medical patients yielded a significant, overall moderate effect size, d=0.44. Specific moderating factors, such as single versus multiple sessions, single versus multiple components of intervention, and level of interventionists' training, were also analyzed. In sum, the results support highly trained interventionists continuing to provide multi-session interventions in order to mitigate posttraumatic symptomatology following traumatic events.
van Emmerik, A. A., J. H. Kamphuis, et al. (2002). "Single session debriefing after psychological trauma: a meta-analysis." Lancet 360(9335): 766-71.	Single session debriefing	Meta analysis of Single session debriefing after psychological trauma	Non-CISD interventions and no intervention improved symptoms of post-traumatic stress disorder, but CISD did not improve symptoms. CISD did not improve natural recovery from other trauma-related disorders . CISD and non-CISD interventions do not improve natural recovery from psychological trauma.
Exposure Therapy			
Powers, M. B., J. M. Halpern, et al. (2010). "A meta-analytic review of prolonged exposure for posttraumatic stress disorder." Clin Psychol Rev 30(6): 635-41.	Exposure therapy	Meta analysis	Thirteen studies with a total sample size of 675 participants met the final inclusion criteria. There was no significant difference between PE and other active treatments (CPT, EMDR, CT, and SIT). The average PE-treated patient fared better than 86% of patients in control conditions at post-treatment on PTSD measures. PE is a highly effective treatment for PTSD, resulting in substantial treatment gains that are maintained over time.
Robjant, K. and M. Fazel (2010). "The emerging evidence for Narrative Exposure Therapy: a review." Clin Psychol Rev 30(8): 1030-9.	Narrative exposure therapy	Review of all the currently available literature investigates the effectiveness of NET in treatment trials.	Emerging evidence suggests that NET is an effective treatment for PTSD in individuals who have been traumatised by conflict and organised violence, even in settings that remain volatile and insecure.

Counselling studies

Cottraux, J., I. Note, et al. (2008). "Randomized controlled comparison of cognitive behavior therapy with Rogerian supportive therapy in chronic post-traumatic stress disorder: a 2-year follow-up." Psychother Psychosom 77(2): 101-10.	Counselling and CBT	To compare cognitive behavior therapy (CBT) with Rogerian therapy in post-traumatic stress disorder.	Sixty outpatients with DSM-IV chronic post-traumatic stress disorder were randomized into two groups for 16 weekly individual sessions of CBT or Rogerian supportive therapy (ST) at two centers. CBT retained significantly more patients in treatment than ST, but its effects were equivalent to those of ST in the completers. CBT was better in the dimensional intent-to-treat analysis at post-test.
Foa, E. B., L. A. Zoellner, et al. (2006). "An evaluation of three brief programs for facilitating recovery after assault." J Trauma Stress 19(1): 29-43.	CBT Assessment condition Supportive counselling	To compare three programmes for recovery after assault	Ninety female recent assault survivors who met symptom criteria for posttraumatic stress disorder (PTSD) were randomized to one of three interventions: Brief Cognitive Behavioral Intervention, which focused on processing the traumatic event (B-CBT); assessment condition (AC); or supportive counseling (SC). Across all interventions, participants reported decreases in PTSD symptoms, depression, and anxiety over time. Although outcomes were better for CBT in the shorter term, at the last available follow-up (on average, 9-months postassault), all three interventions were generally similar in outcome. These findings suggest that a trauma-focused intervention aimed at those with severe PTSD symptoms after an assault can accelerate recovery.
Holmes, A., G. Hodgins, et al. (2007). "Trial of interpersonal counselling after major physical trauma." Aust N Z J Psychiatry 41(11): 926-33.	Interpersonal counselling	To determine if interpersonal counselling (IPC) was effective in reducing psychological morbidity after major physical trauma	Fifty-eight patients completed the study. Only half the patients randomized to IPC completed the therapy. At 6 months the level of depressive, anxiety and post-traumatic symptoms and the prevalence of psychiatric disorder did not differ significantly between the intervention and treatment-as-usual groups. Subjects with a past history of major depression who received IPC had significantly higher levels of depressive symptoms at 6 months. CONCLUSION: IPC was not effective as a universal intervention to reduce psychiatric morbidity

			after major physical trauma and may increase morbidity in vulnerable individuals. Patient dropout is likely to be a major problem in universal multi-session preventative interventions.
Jackson, C. T., G. Allen, et al. (2006). "Clients' satisfaction with Project Liberty counseling services." Psychiatr Serv 57(9): 1316-9.	Counselling following terrorist attack	To assess satisfaction with counselling services offered through Project Liberty after the September 11, 2001, attacks on the World Trade Center.	Suggest that, from the viewpoint of recipients, Project Liberty counselors were largely successful in providing accessible, acceptable, and useful services after the World Trade Center disaster. Such evaluations can be conducted in a cost-effective manner and integrated with evidence-based practice to ultimately ensure that recipients of counseling receive the most efficient and effective interventions.
Neuner, F., M. Schauer, et al. (2004). "A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an african refugee settlement." J Consult Clin Psychol 72(4): 579-87.	Narrative exposure therapy Supportive counselling Psychoeducation	Randomised controlled trial in Sudanese refugees suffering from PTSD	One year after treatment, only 29% of the NET participants but 79% of the SC group and 80% of the PE group still fulfilled PTSD criteria. These results indicate that NET is a promising approach for the treatment of PTSD for refugees living in unsafe conditions.

Notes

This bulletin is based on searches of PubMed, Psychinfo and NHS Evidence from 2000 onwards. Searches were conducted in April 2012 and updated in December 2012. Items have been selectively included with a main focus on systematic reviews of psychological therapies. Where abstracts have been amended from the Psychinfo database, they are marked AA. The overview has been written using the abstracts of the articles and no attempt has been made to critically appraise the full text.

This bulletin has been created by Brettle Innovations Ltd on behalf of the British Association of Counselling and Psychotherapy (BACP).