



RESEARCH ARTICLE

THE EFFECTIVENESS OF INTERPERSONAL PSYCHOTHERAPY FOR POSTTRAUMATIC STRESS DISORDER (PTSD)

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Abstract

Background: Interventions are required that give a lecture depression and post-traumatic stress disorder (PTSD) indications and social wellbeing. The Psychotherapies aimed at Chronic PTSD randomized experimental establish that three fourteen -week psychotherapies severely furthered patients with chronic posttraumatic stress disorder (PTSD). Earlier investigation has described constant follow-up assistances for prolonged exposure (PE) and relaxation therapy (RT), but few comparable data exist for interpersonal psychotherapy (IPT).

Mode: The associated Interpersonal Psychotherapy-Trauma (IPT-T), an IPT adaptation for this residents and background, to Clinic Psychotherapy (CP). CP clinicians were free to implement the psychotherapy of choice. Women with a major depressive episode (MDE) and history of sexual abuse before eighteen were randomly assigned to IPT-T or CP. Outcomes were MDE remission, improved depression (Beck Depression Inventory, Hamilton Depression Rating Scale) and PTSD symptoms (Modified PTSD Symptom Scale), and developed social health (e.g., UCLA Loneliness Scale). Weighted generalized estimating equations were used to examine outcomes at eight (primary) and twenty (secondary) months post-randomization. Acute responders, defined a priori as $\geq 30\%$ improved from baseline, were reconsidered after three-month no-treatment follow-up by independent evaluators using the Clinician-Administered PTSD Scale (CAPS).

Conclusion: Evidence-based psychotherapies like IPT-T are desired in CMHCs, where several of the maximum exposed patients obtain treatment. By means of a good conclusion for depression, IPT-T's superior developments in social wellbeing and PTSD symptoms are source for hopefulness. IPT-T should be appraised in dissemination trials. These are the first methodical statistics on follow-up responder position and perseverance of acute treatment assistances in patients acceptance separate IPT for prolonged PTSD. Patients usually maintained gains across treatments, mutably maximum in RT. Study boundaries embrace minor sample size and momentary follow-up interval. PTSD examination should service response and decrease standards.

Introduction:-

This resource purposes to summarisepresent research associated to post-traumatic stress disorder (PTSD) to give counsellors and psychotherapists an overview of currently available and empirically based treatment recommendations and information about best practice for the treatment of PTSD. This covers meta-analyses and clinical trials. The studies included in this resource have been identified through a literature search in PsychINFO, the Cochrane library and in reference lists of significant articles and other guidelines. Epidemiological studies have shown that a sexual abuse history significantly increases riskof adult major depression and that more severe forms of abuse increase the odds more thanthreefold. One prospective study reported higher rates of treatment seeking amongwomen with documented sexual abuse compared with women in the general population. In mental health settings, estimates of reported childhood sexual abuse range from 35%to 75%. Depression and childhood sexual abuse co-occurred among approximately 25%of treatment-seeking women in a CMHC. Women who have been sexually abused aremore likely to experience difficulties maintaining stable intimate relationships, poor communication with intimate partners, and relationship dissatisfaction. They are at increased risk of adult sexual assault and intimate partner violence and intergenerational transmission of sexual abuse. Psychotherapeutic interventions, to be effective, must respond to these interpersonal patterns and challenges and accommodate resulting disruptions to treatment engagement. The aim of this randomized controlled trial was to examine whether interpersonal psychotherapy would produce greater mental health gains than usual care for women with major depression and sexual abuse histories who were seeking treatment at a CMHC.⁷ In a previous uncontrolled pilot study, we found that interpersonal psychotherapy was well suited to the concerns of depressed women with sexual abuse histories and well received by staff therapists. Interpersonal psychotherapy has demonstrated efficacy in improving severe and recurrent depression, shown promise for treating PTSD, and improved clinical outcomes among women with low income and from racial-ethnic minority groups. Here, we report on the effectiveness of interpersonal psychotherapy compared with usual care individual psychotherapy, delivered by staff therapists serving a primarily low-income, racially and ethnically diverse, urban patient population. To maximize representativeness and the application of findings to public-sector mental health care, we included women prescribed psychotropic medications before study entry as well as those with comorbid conditions, such as PTSD and borderline personality disorder, and current severe stressors, such as intimate partner violence. The primary hypothesis was that interpersonal psychotherapy would lead to lower levels of depressive symptoms than usual care at 36 weeks postrandomization. Secondary hypotheses were that interpersonal psychotherapy would lead to greater reductions in PTSD symptoms and shame and better social and mental health–related functioning.^{1,20}

Types of posttraumatic responses

The classification of a traumatic occurrence has transformeded time and the criteria have been relaxed since first listed in the DSM-III (McNally, 2003). There has been controversy about the exact definition and interpretation of the term ‘traumatic event’ (Elhai, Kashdan, &Frueh, 2005). It can sometimes be used incorrectly by health professionals to refer to stressful life events or problematic situations. However, this term refers diagnostically to psychologically overwhelming or traumatic experiences and events that include an element of serious physical threat. Therefore, events such as divorce or loss of job would not be considered as potentially traumatic events. In the DSM-IV-TR (APA, 2000), the list of potentially traumatic events include combat, sexual and physical assault, childhood sexual abuse, robbery, kidnapping, terrorist attacks, torture, disasters, severe accidents, life threatening illnesses, or witnessing death or serious injury by violent assault, accidents, war or disaster. Not every individual who experiences a potentially traumatic event reacts with psychological injury or trauma. A traumatic event refers to an event that has resulted in psychological injury or distress. Briere and Scott (2006) have provided a slightly wider definition of traumatic event in their book about principles of trauma therapy.^{11,13}

Diagnostic Criteria for PTSD and ASD

PTSD is a mental illness that selected people mature after anremarkably threatening or distressing event or series of events. Some individuals respond with psychological symptoms in the first days or weeks after a traumatic event but feel better after this initial period and do not develop PTSD. For a minority of individuals, however, the symptoms persist and develop into PTSD. The term PTSD is relatively new and this disorder was only introduced to the DSM-III in 1980 (APA, 1980). However, a number of other disorders or symptoms can develop after exposure to a traumatic event, disorders such as depression, generalized anxiety, panic, or phobias (Briere& Scott, 2006).¹⁷

PTSD is classified in the DSM-IV as an anxiety disorder that can develop after exposure to a traumatic event (APA, 1994). The diagnosis of PTSD is used if symptoms persist for more than one month. An acute stress disorder (ASD) is diagnosed if symptoms after exposure to a trauma last for a minimum of 2 days and a maximum of 4 weeks and occur within four weeks of the traumatic event. Chronic PTSD should be diagnosed if symptoms persist for three months or longer. It has been suggested that ASD is a good predictor for the development of PTSD (McNally, Bryant, & Ehlers, 2003).^{1,12,15}

However, a large proportion of individuals with PTSD do not initially have ASD. PTSD symptoms are clustered in three different categories:

1. Recurrent re-experiencing of the traumatic event in the form of flashbacks, nightmares or intrusive thoughts.
2. Avoidance of trauma-related stimuli and numbing; and persistent hyperarousal.

A high percentage of clients who suffer from PTSD also suffer from comorbid conditions. The Australian National Comorbidity study (Creamer, Burgess, & McFarlane, 2001) indicated that 88% of the people with PTSD had at least one other disorder. The most common comorbid disorders were alcohol abuse (52%) and depression (48%). Therefore, clients with PTSD often present with a variety of symptoms.¹⁶

Complex Trauma and Desnos Forms Of PTSD

There is no category in the current DSM-IV-TR that allows for diagnosing complex forms of PTSD in survivors of prolonged, repeated trauma, or which enables us to differentiate complex forms of PTSD from PTSD after single traumatic events. Complex forms of PTSD are suggested to be related to extended child abuse, torture, captivity as a prisoner of war or in a concentration camp, and chronic spouse abuse (Briere & Scott, 2006).^{17,18}

Herman (1992) has suggested the existence of 'complex PTSD' for which the term disorder of extreme stress not otherwise specified (DESNOS) is currently used. DESNOS is differentiated from PTSD by more diffuse and complex symptoms including somatic and dissociative problems, difficulties with relatedness or identity, and a vulnerability to self-harm or re-victimisation (Herman, 1992; van der Kolk, Roth, Pelcovitz, Sunday, & Spinazzola, 2005). Van der Kolk et al. (2005) demonstrated that prolonged trauma, which occurred at an early age or was of an interpersonal nature resulted in symptoms which differed from PTSD symptoms, such as problems with regulation of affect and impulses, memory or attention, self-perception, interpersonal relationships, somatisation and systems of meaning. It is not clear yet if 'complex PTSD' is an independent disorder and a new diagnostic category, or if it just describes associated features of PTSD (Briere & Scott, 2006).^{1,5,9}

A further disorder, shown to be associated with severe and extended childhood trauma or neglect, is borderline personality disorder (Herman, Perry, & van der Kolk, 1989; Ogata et al., 1990) and these symptoms are suggested to be relatively similar to those of 'complex PTSD' (Briere & Scott, 2006).

Prevalence of PTSD

Several representative studies (Frans, Rimmo, Aberg, & Fredrikson, 2005; Hapke, Schumann, Rumpf, John, & Meyer, 2006; Perkonig, Kessler, Storz, & Wittchen, 2000; Peters, Issakidis, Slade, & Andrews, 2006; Resnick, Kilpatrick, Dansky, Saunders, & Best, 1993) have reported prevalence rates for PTSD. The Australian National Survey of Mental Health and Well-Being with 10,641 participants found that 1.2% of males and 1.4% of females reported PTSD 12 months prior to assessment, if assessed using the DSM-IV criteria (Peters, Issakidis, Slade, & Andrews, 2006). However, ICD-10 PTSD diagnoses were found in 2.3% of the males and 4.2% of the females. Results of this study suggested that gender differences in PTSD depend on the classification system used.

In the study by Perkonig et al. (2000), it has been found that physical attacks (7.5%), serious accidents (5.4%), witnessing traumatic events happen to another person (3.6%), and sexual abuse as a child (2%) were the traumatic events most frequently reported. Significantly more women than men reported that they had experienced child sexual abuse and rape. The events with the highest probabilities for PTSD to develop for women were rape (44%), child sexual abuse (31%), and experiencing actual sudden death or threat of sudden death of close associates (27%).

For men, it was not possible to calculate the conditional probabilities of traumatic events due to a low base rate of PTSD. Furthermore, the comorbidity rate was high with 88% of clients suffering from PTSD reporting at least one other diagnosis and 78% reporting two or more additional diagnoses (Perkonig et al., 2000). Frans et al. (2005) have found that the type of trauma did not explain gender differences, but the distress experienced did contribute to

the explanation of the gender differences. Sexual and physical assault, robbery and multiple trauma experience were the most significant PTSD risk factors.⁵

Authors	Country of study	No of participant ± N	Prevalence of PTSD	Lifetime exposure to trauma	Comments
Peters, Issakidis, Slade, & Andrews (2006)	Australia	10,641	12 months prior to assessment: 1.2% of males and 1.4% of females reported PTSD	—	Higher PTSD prevalence in females than in males.
Resnick, Kilpatrick, Dansky, Saunders, & Best (1993)	U. S.A.	4,008 women	Lifetime prevalence 12.3%	Reported by 69%	
Perkonigg, Kessler, Storz, & Wittchen (2000)	Germany	3,021 aged 14-24 years	Lifetime prevalence 1.3%	25% of the men and 18% of the women	Higher prevalence of exposure to trauma in males, but higher prevalence of PTSD in females than in males.
Hapke, Schumann, Rumpf, John, & Meyer (2006)	Germany	4,075	Lifetime prevalence 1.4%	20%, no gender difference	Risk of developing PTSD after a traumatic event was 6.9%. Risk higher in women than in men.
Frans, Rimmö, Åberg, & Fredrikson (2005)	Sweden	1,824	Lifetime prevalence 5.6%	85% of men and 77% of women	Women reported suffering from PTSD twice as often as men, in spite of greater reported trauma exposure by men.

Certain types of trauma such as rape, child sexual abuse and other personal assaults, are more often experienced by women and have shown to be related to a higher risk to develop PTSD than other traumatic events (Creamer et al., 2001; Gavranidou&Rosner, 2003). Only a minority of people who are exposed to trauma develop PTSD. Most people exposed to trauma recover from the initial post-trauma reactions (Flouri, 2005) and show resilience (Bonanno, 2004). Bonanno (2004) suggested that hardiness, self enhancement, repressive coping and positive emotion were related to resilience. Perkonigg et al. (2000) found that the onset of PTSD was rarely reported to be before the age of eleven. In another study, exposure to interpersonal violence before the age of 14 led to higher prevalence of PTSD or DESNOS than exposure to trauma later in life (van der Kolk et al., 2005).⁷

Causes and Risk Factors Of Post-Traumatic Stress Disorder

The investigation of risk factors is important for the understanding of the PTSD and its development (McNally, 2003). A meta-analysis of 77 studies about risk factors for PTSD reported that factors during or after trauma (such as trauma severity, lack of social support, and additional life stressors) had a slightly stronger influence than pre-trauma factors (Brewin, Andrews, & Valentine, 2000). Pre-trauma factors were not found to be powerful predictors of PTSD. Altogether, fourteen different risk factors were identified: gender, younger age, low socio-economic status, lack of education, lack of intelligence, race, psychiatric history, childhood abuse, previous trauma, general childhood adversity, family psychiatric history, trauma severity, lack of social support, and life stresses. In some meta-analyses gender, age at trauma, and race accounted for only a small proportion of the variance. At this stage it is not completely clear which pre-trauma factors play a role in the development of PTSD, given different traumatic

events and methodological differences between studies. A prospective study (Shalev, Peri, Canetti, & Schreiber, 1996) indicated that dissociative experiences during a traumatic event were strongly associated with the development of PTSD six months later. Similar results have been found in a meta-analysis of 68 studies (Ozer, Best, Lipsey, & Weiss, 2003).^{8,9}

Dissociative experiences during or immediately after the traumatic event were the strongest predictor of PTSD out of the seven predictors which all yielded significant effect sizes: prior trauma; prior psychological adjustment; family history of psychopathology; perceived life threat during the trauma; post-trauma social support; peri-traumatic emotional responses; and peri-traumatic dissociation. Briere and Scott (2006) suggested that high levels of peri-traumatic distress might be related to pre-existing problems in stress tolerance or affect regulation, prior trauma exposure, and a tendency to view life events as not controllable. McNally et al. (2003) suggested that negative appraisal of the peri-traumatic dissociation, rather than peri-traumatic dissociation itself, might predict the development of PTSD.^{12,18}

In a further study the development of PTSD was related to gender as well as the number and type of trauma (Perkonig et al., 2000). Several authors have found rape or sexual abuse to be significant predictors of an increased risk to develop PTSD after a traumatic event (Hapke et al., 2006; Perkonig et al., 2000). Van der Kolk et al. (2005) demonstrated that trauma exposure at an early age, interpersonal trauma and prolonged trauma were associated with more complex posttraumatic psychopathology. Further risk factors were pre-existing anxiety disorders and somatoform disorders. In contrast to Perkonig et al. (2000), van der Kolk et al. (2005) did not find women to be at higher risk to develop PTSD.

They suggested that the gender differences in PTSD related to the fact that women experienced more traumatic events (e.g. sexual violence) and were more likely to have pre-existing anxiety disorders. However, Stein, Walker, and Forde (2000) demonstrated that women were at higher risk of developing PTSD than men, even when sexual trauma was excluded. Nemeroff et al. (2006) reported in their review article that women have about twice the risk to develop PTSD, even when they experienced the same trauma as men. There is a lack of research and of explanatory models about the gender differences in PTSD (Gavranidou & Rosner, 2003; Stein et al., 2000). Our understanding of the influence of risk factors in the development of PTSD is still at an early stage.

Healing Intermediations

There is substantial empirical support for the effectiveness of psychotherapeutic interventions for the treatment of PTSD (Schnyder, 2005). One meta-analysis (Bradley et al., 2005), with 26 studies in which different psychotherapeutic treatments were included (N = 1535), found that most of the clients completed treatment (79%) and that 67% of the completers no longer met criteria for PTSD. In a further meta-analysis which included 17 studies with behavioural, cognitive, and psychodynamic treatments (N = 690), psychotherapeutic treatment was found to be effective and, at the end of therapy, symptomatology significantly decreased ($d = .52$) (Sherman, 1998). Treatment of PTSD is challenging for the therapist because it involves containing and dealing with severe distress. Therefore, it is important to have highly developed relational and supportive skills, as well as knowledge about appropriate and effective treatment methods. A positive therapeutic relationship and the client's expectations towards the treatment were found to be positively associated with treatment outcome (Australian Centre for Posttraumatic Mental Health, 2007b). Some studies reported the influence of pre-treatment factors on treatment outcome (Australian Centre for Posttraumatic Mental Health, 2007b; Tarrier, Sommerfield, Pilgrim, & Faragher, 2000; van Minnen, Arntz, & Keijser, 2002). It was found that inconsistent attendance of therapy sessions was the best predictor of therapy outcome (Tarrier et al., 2000). Furthermore duration of therapy, gender, and suicide risk were significant predictors of treatment outcome. Another study showed that it was difficult to predict treatment outcome from pre-treatment factors such as trauma characteristics, personality or demographic variables and that these factors were not related to treatment outcome or dropout rate (van Minnen et al., 2002). Depression was not related to the outcome of treatment (Tarrier et al., 2000; van Minnen et al., 2002). There is a variety of psychotherapeutic treatments for PTSD (Schottenbauer, Arnkoff, Glass, Gray, & Hafter, 2006; Sherman, 1998). Three different types of psychotherapeutic approaches have been reported to be used most frequently: trauma-focused cognitive-behavioural therapy (TFCBT); eye movement desensitization and reprocessing (EMDR); and psychodynamic psychotherapy (Friedman, 2006). Other therapies used for the treatment of PTSD are supportive counselling/therapy, narrative exposure therapy (NET), hypnotherapy, and psychological debriefing (Australian Centre for Posttraumatic Mental Health, 2007b). In over 30 randomized controlled studies the effectiveness of psychological treatments for PTSD has been investigated (Australian Centre for Posttraumatic Mental Health,

2007b; Bisson et al., 2007). In the following section, empirical evidence for several widely used treatment approaches for PTSD is reported.^{8,16,19}

Trauma-Focused Cognitive-Behavioural Therapy (TFCBT)

TFCBT was the most studied treatment approach for PTSD (Roberts et al., 2008; Solomon & Johnson, 2002; Foa & Meadows, 1997; Friedman, 2006). The effectiveness of this approach for PTSD was reported in several reviews and meta-analyses (APA, 2004; Australian Centre for Posttraumatic Mental Health, 2007b; Livanou, 2001; NICE, 2005; Schnyder, 2005). TFCBT has been shown to be more effective than awaiting list or than usual care (Australian Centre for Posttraumatic Mental Health, 2007b; Bisson & Andrew, 2007; Bisson et al., 2007; NICE, 2005).^{3,5}

Cognitive-behavioural interventions for the treatment of PTSD include exposure, cognitive restructuring, anxiety management, relaxation techniques and a combination of these interventions. Exposure is used for re-experiencing and reactivating the trauma memory in order to stimulate the development of new, corrective information. There is strong evidence for the efficacy of exposure for the treatment of PTSD and its inclusion into trauma treatment has been recommended (Rothbaum, Meadows, Resick, & Foy, 2000). Scott and Stradling (2006) described a cognitive contextual treatment approach, and included case examples and transcripts of sessions in their book *Counselling for Post-traumatic Stress Disorders* to guide therapists in their work with trauma victims.^{8,9}

Study	Title	Approaches	No. of Studies	No. of Patients N	Outcome
Benish, Imel & Wampold (2008)	The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder (PTSD): A meta-analysis of direct comparisons.	Different bona fide psychotherapies	15	958	There was no evidence for outcome differences between bona fide psychotherapies in the treatment of PTSD.
Bisson & Andrew (2007)	Psychological treatment of post-traumatic stress disorder (PTSD)	TFCBT, group TFCBT, EMDR, SM, waiting list/ usual care, other therapies	33	-	TFCBT, EMDR, SM, and group TFCBT were effective in the treatment of PTSD. TFCBT, EMDR and SM were more effective than other therapies. There was some evidence that individual TFCBT and EMDR are superior to SM at 2 and 5 months following treatment.
Bisson et al. (2007)	Psychological treatments for chronic post-traumatic stress disorder (PTSD)	TFCBT, EMDR, stress management, group CBT, other therapies	38	-	Treatments were more effective than waiting list or usual care. Inconclusive evidence regarding other therapies. TFCBT and EMDR were equally effective and both treatments were superior to stress management and other therapies. Stress management was superior to other therapies.
Bradley et al. (2005)	A multidimensional meta-analysis of psychotherapy for PTSD.	Exposure based therapies, CBT other than exposure, CBT with exposure, EMDR, other, control condition waiting list	26	1535	67% of completers no longer met criteria for PTSD after treatment. Comparable effectiveness across CBT treatments with or without exposure, and between CBT and EMDR were found.
Chemtob et al. (2000)	Eye movement desensitization and reprocessing (EMDR)	EMDR vs. waiting list, standard care, muscle relaxation	8	-	EMDR was more effective than waiting list, routine-care, and active-treatment controls. EMDR treatments yielded large effect sizes.
Davidson & Parker (2001)	Eye movement desensitization and reprocessing (EMDR): A meta-analysis.	EMDR vs. no treatment, therapies not using exposure, therapies with exposure	34	-	EMDR was more effective than no treatment and treatments without exposure but equally as effective as treatments with exposure techniques.
Everly, Boyle, & Lating (1999)	The effectiveness of psychological debriefing with vicarious trauma: A meta-analysis.	Psychological debriefing	10	698	Beneficial outcome after psychological debriefing ($d = 0.54$).

Eye Movement Desensitisation and Reprocessing (EMDR)

EMDR was developed by Shapiro in 1987 as a treatment for traumatic memories (Shapiro, 1989, 1995). During EMDR the client performs rhythmic eye movements while concentrating on a traumatic memory. The eye movements are part of the structured, multistage treatment. Desensitisation and reprocessing through eye movement is a critical stage of the treatment in which the client is asked to hold a traumatic image, negative cognition, and bodily sensations in mind whilst tracking the moving fingers of the therapist. A detailed description of EMDR can be found in the EMDR treatment manual (Shapiro, 1995). EMDR was shown to be more effective than no treatment and more effective than treatments not using exposure in a meta-analysis with 34 studies (Davidson & Parker, 2001). Chemtob, Tolin, van der Kolk, and Pitman (2000) reviewed eight studies and found EMDR to be more effective than a waiting list, routine-care, and active-treatment controls. They reported that EMDR generally yielded

large effect sizes. In the NICE guidelines (2005) EMDR was described as more effective than a waiting list at reducing the severity of PTSD symptoms. There are differing opinions about how EMDR works and what the underlying mechanisms are. It has been argued by some researchers (Seidler & Wagner, 2006) that EMDR might be understood as an exposure or imaginal flooding technique. Others (Lee, Taylor, & Drummond, 2006) have suggested that EMDR and exposure are two different processes and that with EMDR treatment, trauma is processed in a more detached manner. Davidson and Parker (2001) concluded in their study that eye movements might even be unnecessary for a positive outcome. EMDR was found to be equally effective as other exposure treatments (Bisson et al., 2007; Davidson & Parker, 2001; Seidler & Wagner, 2006; van Etten & Taylor, 1998). In their meta-analysis of 7 studies (N = 209), Seidler and Wagner (2006) showed that EMDR was equally effective as TFCBT. In a further meta-analysis (Shepherd, Stein, & Milne, 2000), in which 16 studies were included, EMDR was found to be superior to relaxation training (three studies) and delayed treatment (three studies) and similarly. Effective as exposure therapies (two studies). Van Etten and Taylor (1998) showed that EMDR was equally effective as behaviour therapy. Bisson and Andrew (2007) have also found in their meta-analysis that EMDR was significantly better than a waiting list or than usual care, and was better than other therapies (except TFCBT and stress management). EMDR was equally effective as TFCBT and stress management. In a meta-analysis in which only comparison studies were included (Benish, Imel, & Wampold, 2008), no differences between several bona fide psychotherapies for the treatment of PTSD were found.⁹

Psychodynamic Psychotherapy

The goal of psychodynamic treatment is the integration of the traumatic experience by gaining insight into the conscious and unconscious meaning of the symptoms. Techniques used in psychodynamic therapy for PTSD varied greatly with regard to how various concepts are applied (e.g. defense mechanisms, transference, countertransference, the therapeutic relationship etc.). Horowitz (1999) has described psychodynamic psychotherapy for PTSD and a sequence of a time-limited treatment strategies, however, there is a lack of meta-analyses or randomized clinical trials relating to psychodynamic psychotherapy. Therefore only limited evidence about its effectiveness for PTSD is available (Australian Centre for Posttraumatic Mental Health, 2007b; Friedman, 2006; Schnyder, 2005). Brom, Kleber, and Defares (1989) conducted a study with 112 individuals suffering from PTSD and compared three brief psychotherapies: trauma desensitization; hypnotherapy; and psychodynamic psychotherapy. Symptoms were more significantly reduced in all three treatment groups than in the waiting list control group and differences between the three therapeutic approaches were small. The psychodynamic psychotherapy approach involved a higher number of sessions but showed the least improvement in relation to intrusion symptoms at the end of therapy. However, there was an improvement between the end of therapy and a 3-month follow-up in the psychodynamic group and, therefore, the overall outcome was comparable to the other two treatment groups at the 3-month follow-up. Most of the research literature relating to the psychodynamic psychotherapy approach for PTSD was presented as case studies (Kudler, Blank, & Krupnick, 2000; Shalev, Bonne, & Eth, 1996). In the APA guideline (2004) it has been suggested that psychodynamic psychotherapy might be helpful for ameliorating developmental, interpersonal or intrapersonal problems relating to PTSD, which can be difficult to treat.¹⁰

Critical incident stress debriefing (CSID)

Psychological debriefing was widely used in crisis intervention. It was designed to reduce initial distress and to prevent the development of psychopathology or PTSD (Bisson, McFarlane, & Rose, 2000; Flouri, 2005; Rose, Bisson, Churchill, & Wessely, 2002). One of the first forms of psychological debriefing was critical incident stress debriefing (CISD) as first described by Mitchell (1983). This intervention was provided shortly after a traumatic event and was used with survivors of trauma, emergency care workers, and providers of psychological care (Bisson et al., 2000). It aimed to provide psychosocial support and an opportunity for those affected to express their feelings and thoughts about the trauma. The approach also included psycho-education about coping, reactions after trauma or stress, and its management. However, results relating to CSID were contradictory and there was a controversy over its effectiveness (Gist & Devilly, 2002; McNally et al., 2003). Earlier meta-analyses (e.g., Everly, Boyle, & Lating, 1999) suggested that psychological debriefing resulted in positive outcomes with a medium effect size ($d = 0.54$), but a more recent meta-analysis by van Emmerik, Kamphuis, Hulsbosch, & Emmelkamp (2002) reported that a single session of debriefing, offered within one month after trauma, did not improve symptoms. In a further meta-analysis, Rose et al. (2002) found that debriefing did not prevent the onset of PTSD, nor reduce psychological distress compared to controls. The authors concluded that there was no evidence that psychological debriefing was effective in preventing PTSD.¹⁸

Evaluation among psychotherapeutic methods

A number of meta-analyses have found no differences in outcomes between different psychotherapeutic approaches, concluding that the efficacy of different psychotherapeutic approaches was comparable (Benish et al., 2008; Bradley et al., 2005; Seidler & Wagner, 2006). These results suggest that common factors which are significant to all treatment approaches might be responsible for similar outcomes between different therapeutic approaches. Other studies found differences between different psychotherapeutic approaches (Bisson & Andrew, 2007; Mendes, Feijo Mello, Bentura, De Medeiros Passarela, & De Jesus Mari, 2008; van Etten & Taylor, 1998), and yet others reported that the results were inconclusive, or that there was limited evidence available (Australian Centre for Posttraumatic Mental Health, 2007b). These contradictory results could be due, in part, to different methodological conditions. For example, some authors (Benish et al., 2008) included only 'bona fide' psychotherapies and did not have a category "other therapies" (e.g. a mixture of therapeutic approaches or combined approaches). Other authors (Mendes et al., 2008) however combined different therapeutic approaches with relaxation and psycho-education into one category. A further reason why some psychotherapeutic approaches have been found to be less effective could also be related to a lack of empirical data. Several authors (Bisson et al., 2007; Van Etten and Taylor, 1998) suggested in their meta-analyses that, although some psychotherapeutic approaches, such as dynamic therapy and hypnotherapy, were considered less effective than others, the results were often based on single trials. There was not much research about the efficacy of psychodynamic and humanistic/experiential psychotherapy available (Bradley et al., 2005; Foa & Meadows, 1997) and therefore their ability to draw conclusions about the effectiveness of these approaches was limited.^{3,5,7,9}

Pharmacology of PTSD

Pharmacological interventions have been used to reduce PTSD symptoms, based on the concept that some individuals are vulnerable to extreme stress (Charney, 2004). It has been suggested that psychobiological abnormalities might be associated with PTSD and that certain drugs might be effective as treatment, by normalizing these psychobiological abnormalities (Friedman, Davidson, Mellman, & Southwick, 2000). The efficacy of pharmacological treatment of PTSD has been investigated in several meta-analyses (Stein, Ipser, & Seedat, 2006; van Etten & Taylor, 1998) and reviews (Shalev, Bonne, et al., 1996). In one study (van Etten & Taylor, 1998), psychotherapeutic approaches were found to be more effective and to result in lower drop-out rates than drug therapies (14% versus 32%). The most effective drug therapies were treatments with selective serotonin reuptake inhibitors (SSRIs) and carbamazepine. Friedman et al. (2000) reported on the effectiveness of pharmacotherapy for PTSD and concluded that dramatic responses to medication were the exception, and that monoamine oxidase inhibitors (MAOIs) and SSRIs were more successful than other drugs. Stein et al. (2006) concluded in their Cochrane review of pharmacotherapy for PTSD that if different medication classes were compared, evidence about the long-term efficacy of SSRIs was the most convincing. In the APA guideline (2004) SSRIs have also been reported to decrease PTSD symptoms and to show some therapeutic benefit in clients with PTSD. Shalev, Bonne et al. (1996) concluded in their review that pharmacotherapy was rarely sufficient for the treatment of PTSD. The NICE guideline (2005) for the treatment of PTSD and the Australian Guidelines for the Treatment of Adults with ASD and PTSD (2007) both recommended the use of psychotherapeutic approaches over pharmacological treatments. In summary, pharmacotherapy should not be used as a first line treatment for PTSD. If medication is chosen as a treatment, SSRI antidepressants should be considered.

Authors/Organisation	Title
American Psychiatric Association (2004)	<i>Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder.</i>
Australian Centre for Posttraumatic Mental Health (2007)	<i>Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder: Practitioner Guide.</i>
Australian Centre for Posttraumatic Mental Health (2007)	<i>Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder.</i>
National Institute for Clinical Excellence (NICE) (2005)	<i>Clinical Guideline 26. Post-traumatic Stress Disorder (PTSD): the Management of PTSD in Adults and Children in Primary and Secondary Care.</i>

Conclusion:-

Some general principles for effective trauma-focused treatment have been summarized below from different guidelines and reviews (APA, 2004; Australian Centre for Posttraumatic Mental Health, 2007b; Briere & Scott, 2006; Friedmann, 2006; NICE, 2005). Basic treatment principles include: a safe therapeutic environment; stability (e.g. stable living conditions, emotional stability); the maintenance of a positive and consistent therapeutic relationship; and a therapy that is tailored to the client and considers the client's social status, cultural background and gender (Briere & Scott, 2006). Psychoeducation is also recommended as an important part of trauma therapy (Briere & Scott, 2006). An initial step in treatment is the assessment and establishment of a safe physical and psychological environment (e.g. assessment of risk for suicide) and basic care (APA, 2004). Friedman (2006) suggested that working with clients suffering from PTSD might evoke distress or intense emotions in the health professional.⁶

Self-care in the form of regular supervision, developing a supportive work environment, engaging in activities such as exercise or hobbies, and making time for personal life and relationships can be important to prevent secondary traumatization. The importance of self-care in the form of a balanced and healthy lifestyle, appropriate emotional boundaries with clients, regular supervision and professional development has also been reported in the Australian Guidelines for the Treatment of Adults with ASD and PTSD (2007). The main treatment goals are: reducing the severity of PTSD symptoms; treating comorbid disorders; improving the client's overall functioning; regaining of a sense of safety and trust; and preventing relapse (APA, 2004). For the planning of treatment and the formulation of treatment goals it has been recommended that besides a thorough assessment before and throughout treatment, comorbidities should be considered and the development of a positive and robust therapeutic relationship should be a central aim. The NICE guideline (2005) recommends that the impact of the traumatic event on all family members be considered.

The counsellor or psychotherapist should also keep in mind that adequate practical and social support might be significant factors for the client's recovery. The counsellor or psychotherapist should also know about the cultural background of the client. If a client suffers from PTSD and depression, PTSD should be given priority, as the depression will often improve through the PTSD treatment. However, if the client suffers from severe depression, alcohol or drug dependency, these comorbidities should be treated first (NICE, 2005). If the client does not respond to treatment, it is important to review and evaluate factors that may contribute to nonresponse such as the relevance of the treatment goals, problems in the therapeutic relationship, psychosocial difficulties interfering with the treatment, or comorbid disorders (APA, 2004).

For the treatment of PTSD, trauma-focused psychotherapeutic interventions should be offered to the client (Australian Centre for Posttraumatic Mental Health, 2007a). Trauma-focused treatments have two key elements: the memory of the traumatic experience is confronted in a safe environment; and exposure to situations, people or places that the client has previously avoided is gradually increased. A strong, safe therapeutic relationship that is tailored to the client is essential and is related to therapeutic outcomes.

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