

## Alternative Intensive Therapy for PTSD

An important emerging goal in mental health services is the development of patient-centered care. This includes providing patients with options regarding how their care is delivered and which treatments they should receive based on their needs and preferences. In this issue, Ehlers and colleagues (1) report on a randomized controlled trial that evaluates the acceptability and efficacy of a rapid, intensive cognitive therapy delivered over a 7-day period compared with its established version, which involves once weekly therapy over approximately 3 months. In addition, the study evaluates the efficacy of these two cognitive therapies against a credible alternative treatment of emotion-focused supportive therapy. The study has four treatment arms: a 7-day intensive version of cognitive therapy, standard cognitive therapy, emotion-focused supportive therapy, and a waiting list.

Three important findings are reported. First, cognitive therapy delivered intensively over little more than a week was as effective as cognitive therapy delivered over 3 months. Second, both intensive cognitive therapy and standard cognitive therapy were superior to emotion-focused supportive therapy. Third, emotion-focused supportive therapy was superior to the waiting list condition. The inclusion of the emotion-focused supportive therapy and waiting list conditions is of theoretical and practical importance. It is occasionally argued that waiting list should no longer be included in posttraumatic stress disorder (PTSD) trials because so many efficacious treatments for PTSD exist that the use of a waiting list is an expense with little scientific benefit or ethical justification. However, there is growing interest in evaluating the potential benefits of PTSD therapies that do not necessarily focus directly on traumatic memories or experiences, particularly for patients who refuse or who prefer not to engage in trauma-focused treatment. Thus, knowledge about the efficacy of emotion-focused supportive therapy relative to no therapy is important. The use of the waiting list condition allowed direct evaluation of the efficacy of emotion-focused supportive therapy while controlling for confounds such as the potential therapeutic effects of contact with a clinic and periodic assessments. The response rate in emotion-focused supportive therapy, defined as loss of PTSD diagnosis, was substantially superior to the waiting list response.

The intensive therapy did not differ from the standard therapy with regard to PTSD symptom reduction, as measured by within-group pre- to posttreatment effect sizes and as compared with emotion-focused supportive therapy at posttreatment. Participants in both the intensive and standard cognitive therapy received approximately 18 hours of therapy. However, intensive therapy participants completed these hours over a period of 5–7 working days. Treatment days were usually comprised of two sessions, one in the morning and one in the afternoon, each lasting from 90 minutes to 2 hours. Of note, treatment credibility and therapeutic alliance was as high in the intensive therapy as in the standard

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treatment. Intensive treatment of this kind has also been shown to be effective for panic disorder (2), suggesting the generalizability of this approach for some disorders, perhaps for individuals who have a phobia as a core component. The success of intensive cognitive therapy increases service options for patients with PTSD. Certain individuals, as a result of circumstances or by predisposition, may prefer a “total immersion” experience. Those individuals who have work or home responsibilities may find it easier to manage a brief period away from their day-to-day demands. Others may be in a state of “psychological readiness” and will be more motivated for and engaged in an intensive treatment. However, the ease of disseminating intensive forms of treatment remains to be seen. Challenges in the transition from a randomized controlled trial to community implementation need to be considered, and they include the cost of this approach to the community clinic as well as the willingness and availability of therapists to conduct intensive work.

Both intensive and standard cognitive therapies were superior to emotion-focused supportive therapy in reducing PTSD. Many variations of supportive therapy have been used in PTSD clinical trials (3–5). The investigators of this study formulated emotion-focused supportive therapy in a way that was distinct from cognitive therapy so that inferences regarding the underlying mechanisms of action might be considered. The cognitive therapies focused on identifying and modifying excessively negative appraisals of the trauma, identifying triggers of intrusive re-experiencing, and reducing the use of cognitive strategies and behaviors (e.g., safety seeking) that are believed to maintain PTSD. The supportive therapy was a patient-directed treatment that provided psychoeducation about the role of unprocessed emotions in PTSD, explored emotional reactions rather than cognitions, and provided interventions that clarified emotions as a means to problem solving. The results suggest that cognitive reappraisal is an important mechanism of action in recovery from PTSD and that attention to emotions in the absence of cognitive reappraisal produces less than optimal results.

Nevertheless, the effectiveness of emotion-focused supportive therapy relative to waiting list supports the potential benefit of exploring and building more patient-directed therapies that do not necessarily require sustained attention to trauma-related memories. While research to date suggests that PTSD recovery associated with these therapies is inferior to recovery with cognitive therapies or cognitive-behavioral therapies, studies have nevertheless consistently reported their benefits (3–5) and they may be an acceptable option or an engagement strategy for patients who would otherwise refuse treatment.

Dropout from intensive or standard cognitive therapy was extremely low (0% and 3%, respectively) and differs from a previous cognitive therapy trial by this group of investigators (6) and from the more common dropout rate seen in meta-analyses of PTSD treatment studies, which hovers around 20% (7). It may be that the innovative nature of the study engaged participants who were highly motivated for this type of treatment. No adverse effects were identified in any of the treatment conditions. Symptom deterioration at posttreatment was low in all of the active treatment conditions and significantly lower in the intensive and standard cognitive therapies than for waiting list. This result is important, as it indicates that delivering cognitive therapy in an intensive format did not increase symptoms. Some cautions about the generalizability of the therapy to more impaired populations should be noted. Participants' PTSD had to be related to discrete traumatic events in adulthood, and individuals with current substance abuse or borderline personality disorder were

excluded. Thus, the efficacy of intensive cognitive therapy for PTSD in individuals with certain types of comorbidities or PTSD related to chronic or repeated traumas, such as childhood sexual abuse or domestic violence, remains unknown.

This study tested an innovative approach for treating PTSD that, given the results, increases service delivery options for patients. The study also provides a model for conducting clinical trial research that contributes to patient-centered care.

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