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## POST-TRAUMATIC STRESS DISORDER Factsheet

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### What are psychological therapies?

Treatment guidelines typically recommend psychological treatments as first-line treatment for PTSD. Cognitive behavioural therapy (CBT) is one of the most common psychological treatments. It challenges distorted, negative thinking patterns associated with the trauma to help people develop more adaptive cognitions and behaviours, and to rethink assumptions and reactions to the event. Exposure therapies aim to desensitise people to trauma-related memories and to help people overcome symptoms by exposing them to specific or non-specific cues or memories related to the trauma. Eye movement desensitisation and reprocessing (EMDR) may also be effective. EMDR involves the patient focussing on a disturbing image, memory, emotion, or cognition associated with the trauma while the therapist initiates rapid voluntary eye movements. This is based on the observation that the intensity of traumatic memories can be reduced through eye movements, although how this occurs remain unclear. Other common therapies include narrative therapy, which can help people reconstruct a consistent narrative about the trauma, and supportive therapy, which involves giving support, listening, and helping.

### What is the evidence for psychological therapies for PTSD?

Moderate to low quality evidence found large improvements in PTSD symptoms by last follow-up after treatment, but not at the end of treatment, with any psychological and combined psychological plus medication treatments compared to medications alone. These improvements can be seen for up to 20 months, and were largest in military samples and in samples exposed to childhood abuse.

There were large improvements in PTSD symptoms, depression, and anxiety for up to four weeks post-treatment with psychological therapies in adults exposed to humanitarian crises in low and middle-income countries. There were smaller, but significant improvements for up to 6 months. There were improvements in children in these settings, particularly in children aged 15-18 years, in non-displaced children, and in children living in smaller households (<6 members). Functioning, hope, coping, and social support also improved. There were no significant improvements in depression and anxiety post-treatment and at follow up (≥6 weeks) in children in these settings.

Moderate quality evidence found CBT with or without a trauma focus, EMDR, prolonged exposure, cognitive processing therapy, narrative exposure therapy, cognitive therapy, present-centred therapy, and virtual reality therapy all showed greater improvements in PTSD symptoms than waitlist or treatment as usual. Moderate to low quality evidence found CBT with a trauma focus was more effective for PTSD symptoms than present-centred therapy, supportive counselling, relaxation training, dialogical exposure therapy, and interpersonal therapy.

**For more information see the technical table**

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*Medical research is the cornerstone of efforts to advance the health and wellbeing of families and the community. Our dedicated scientists are focussed on transforming their research into significant and practical benefits for all patients.*

*While we hope you find this information useful, it is always important to discuss any questions about PTSD and its treatment with your doctor or other health care provider.*