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Cognitive Therapy Gets Nod for PTSD Prevention

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MedPage Today Action Points

- Note that this study evaluated protective effects of therapies on the incidence of PTSD in patients who were survivors of traumatic events with symptoms of acute stress disorders and met PTSD symptom criteria.
- Point out that participants who received prolonged exposure or cognitive therapy had a significantly lower incidence of PTSD than those receiving placebo or SSRI.

Review

Survivors of traumatic events had a significantly reduced risk of developing post-traumatic stress disorder with prolonged exposure therapy or cognitive therapy but not with medication alone, investigators found.

Five months after the traumatic event, patients assigned to prolonged exposure or cognitive therapy had an 80% reduction in the odds for PTSD as compared with patients assigned to a waiting list, as reported online in *Archives of General Psychiatry*.

In contrast, those randomized to antidepressant therapy or placebo had a PTSD prevalence similar to that of patients on the waiting list.

At nine months, waiting-list patients treated by prolonged exposure therapy had the same PTSD prevalence as patients initially assigned to prolonged exposure.

"The results of our study show that there are significant and similar preventive effects of prolonged exposure and cognitive therapy," Arieh Y. Shalev, MD, of Hadassah University Hospital in Jerusalem, and co-authors wrote in conclusion.

"Delaying prolonged exposure did not affect the nine-month outcome. The [antidepressant] subgroup did not differ from the placebo subgroup or the waiting-list group at five months. However, the [antidepressant] group fared worse than all the other groups at nine months."

Patients with partial PTSD had similar outcomes with or without treatment, they added.

Clinical studies, systematic reviews, and meta-analyses have all shown that exposure-based cognitive behavioral therapy is effective in preventing PTSD. But results of some studies have suggested the efficacy of the interventions is limited to patients who meet diagnostic criteria for acute stress disorder or PTSD, the authors wrote by way of background.

The efficacy of cognitive therapy and medication for PTSD prevention has not been established, and the influence of timing of early interventions and the long-term effects of refusing care has not been examined in controlled studies, the authors

continued.

In an effort to clarify the unresolved issues, the investigators conducted a study to compare early and delayed interventions in adult survivors of traumatic events. Participants were identified and screened by telephone interview, and those with signs and symptoms suggestive of PTSD were referred for clinical evaluation.

Individuals who had qualifying symptoms by clinical assessment were eligible to participate in the study.

The investigators randomized patients to four groups: trauma-focused exposure therapy, cognitive therapy, a comparison of the antidepressant escitalopram (Lexapro) and placebo, or a waiting list for prolonged exposure.

Randomized therapy continued for 12 weeks, at which point waiting-list patients who met diagnostic criteria for PTSD could undergo a 12-week course of exposure therapy.

Patients who agreed to participate in the study were informed of the types of interventions and could decline as many as two before randomization.

Study participants underwent a second comprehensive clinical assessment at five months.

Qualifying participants in the waiting-list group underwent the same 12-week course of prolonged exposure as the patients who were randomized to immediate prolonged-exposure therapy.

Randomized therapy began approximately one month after the traumatic event.

Primary outcomes were the proportion of patients in each group who met diagnostic criteria for PTSD at five and nine months.

The randomization process resulted in 63 patients assigned to immediate prolonged exposure, 40 to cognitive therapy, 46 to the double-blind comparison of escitalopram and placebo, and 93 to the waiting list.

At five months, the rates of PTSD were:

- 58.2% in the waiting-list group
- 21.4% with immediate prolonged exposure
- 18.2% with cognitive therapy
- 61.9% with escitalopram
- 55.6% with placebo

The prolonged-exposure and cognitive-therapy groups had significantly lower rates of PTSD than the other three groups ($P < 0.001$) but did not differ from each other. The medication, placebo, and waiting-list groups also did not differ significantly with respect to the proportion of patients with PTSD.

The nine-month results showed PTSD rates of 21.2% with immediate prolonged exposure, 22.8% with cognitive therapy, and 22.9% with delayed prolonged exposure. The escitalopram and placebo groups had PTSD rates of 42.1% and 47.1%, respectively.

The study population included 54 participants with partial PTSD, defined as meeting two of three symptom criteria for PTSD. Their results were evaluated separately and showed no evidence of benefit from any of the interventions, consistent with results of previous studies.

"To our knowledge, this is the first comparative study of early and delayed cognitive behavioral interventions for PTSD," the authors wrote in the discussion of their findings. "Our finding suggests that delaying the intervention does not increase the risk of chronic PTSD."

"Thus, a delayed intervention is an acceptable option when early clinical interventions cannot be provided," they added.

The escitalopram and placebo groups had the highest rates of patient refusal, resulting in small group sizes, the authors noted. The findings for those two groups require further study, but are consistent with results of previous evaluations of pharmacologic interventions.

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Shalev disclosed a relationship with Lundbeck Pharmaceuticals.

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