Prolonged exposure and psychodynamic treatment for posttraumatic stress disorder

Wittmann, L; Halpern, J; Adams, C B; Orner, R J; Kudler, H
We welcome Gilboa-Schechtman et al.’s randomized controlled trial (RCT) comparing prolonged exposure (PE) and time-limited psychodynamic psychotherapy (TLDP). Despite the clarity and strengths of its findings, we wish to share the following concerns about research method and interpretations of results.

(1) Implementation of TLDP in the present study: “Therapists did not mention the traumatic event, and if the patient brought up details of the memory, they referred to the meaning of the event in the context of the central issue, without further encouragement to discuss the memory” (p. 1037). Clearly, the intent was to avoid exposure elements in a PE control condition but this delivers a therapy lacking a key element of psychodynamic treatment and which may actually be anti-therapeutic. Such avoidance by therapists may reinforce the patient’s avoidance directly by modelling and indirectly by implying that the therapist cannot tolerate the patient’s traumatic memories and their emotional impact. We are not convinced that this artificial form of TLDP can be considered a bona fide treatment for trauma survivors.

(2) Quantity of treatment received by both groups: Although treatment hours with patients are balanced between groups, only PE assigns daily homework including imaginal and in vivo exposure. This uncontrolled therapeutic dose difference was not considered by the authors’ discussion of outcome differences.

(3) Selection of outcome measures: PE aims specifically at reducing trauma-related symptoms while TLDP focuses on “changing entrenched patterns of inter- and intrapersonal relatedness […]. TLDP is based on the notion of a “central issue” and focuses on an unresolved conflict […], […] negative self-image, and on emotions associated with the conflict” (p. 1035). Unfortunately, the authors focus exclusively on outcomes associated with PE and fail to measure those outcomes which they, themselves, associate with TLDP.

(4) Discussion of results: Looking at the outcome variable depression severity score, the performed ANOVA indicates a superiority of PE over TLDP. However, controlling for baseline differences, subsequent ANCOVAS are not able to detect significant between group differences at any assessment time point. We cannot find mention of this latter finding in the discussion. Of core importance, at 17 months follow-up there were no significant between group differences with respect to PTSD severity yet the authors fail to focus on their own significant finding that a nontrauma-focused psychodynamic therapy was ultimately as effective as PE in reducing PTSD symptoms in an RCT. In failing to do so, they miss a vital opportunity to point out that the
different rate and range of outcomes which they have documented indicate that these two different psychotherapies are both effective but may operate via different processes.

Of note, as in Brom et al.’s RCT, patients in the psychodynamic arm made slower gains initially but caught up with exposure treatment at follow-up. This is in line with Shedler’s conclusion from his meta-analytic review that the “consistent trend toward larger effect sizes at follow-up suggests that psychodynamic therapy sets in motion psychological processes that lead to ongoing change, even after therapy has ended” (p. 101).

It is to be expected that future meta-analyses will cite this study as evidence that behavioral therapies are more effective for the treatment of PTSD than psychodynamic ones. We agree with the authors’ assessment that both treatments “were efficacious in decreasing posttraumatic distress and increasing functioning for adolescents with PTSD after single-event traumas” and wish to call attention to other lessons to be learned from this study including the importance of (1) comparing bona fide treatments; (2) a fair balance of therapeutic dose; (3) measuring outcomes appropriate to the therapy employed in order to understand its full impact on patient and pathology; and, (4) the need to better understand the processes by which different psychotherapies achieve their outcomes. Attention to these issues may help move us past the simpler question of “What works?” to approach the important clinical questions of “What works for whom?” and “How do we choose?”
References


