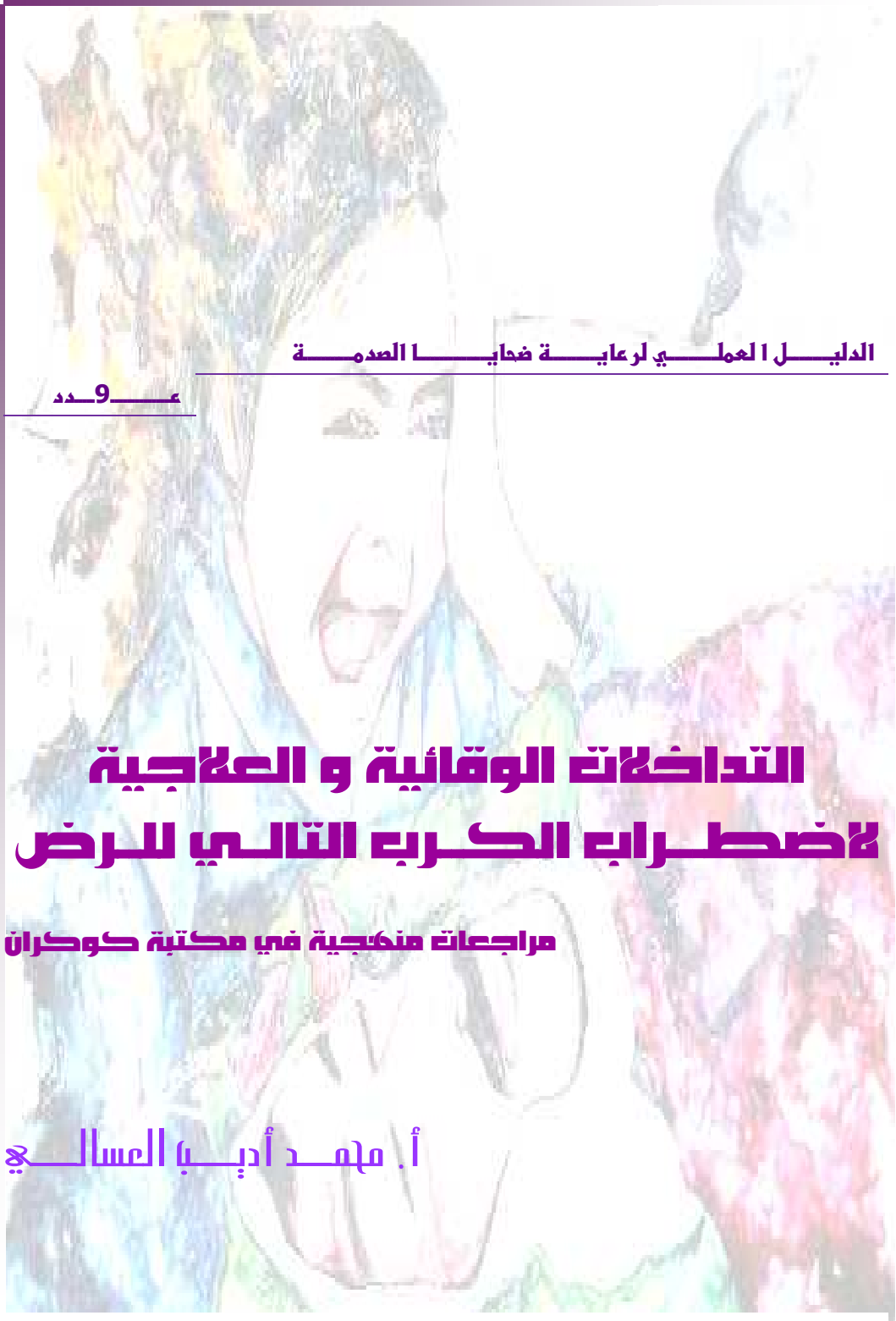
الدليل العملي لرعاية ضحايا الصدمة النفسية

نحو تيسير خدمات الرعاية النفسية لضحايا الصدمة



الدليل العملي لرعاية ضحايا الصدمة

عدد 9

التداخلات الوقائية و العلاجية لاضطراب الكرب التالي للرض

مراجعات منهجية في مكتبة كوكران

أ. محمد أديب العسالي

عدد 9 - 2012

إصدارات شبكة العلوم النفسية العربية

مراجعـــــــــــات منهجيـــــــــــة فـــي مكتبـــــــــــة كوكـــــــــران
للتداخـــــلات الوقائيـــــة والعلاجيـــــة لاضطـــــراب الكـــــرب التالـــــي للـــــرض

أ.د. محمـــــد أديـــــب العسالـــــي -رئيـــس البـــورد السـوري للطـب النفســي و رئيـــس المركـــز الطبـــي النفســي، دمشـق
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يشهد وطننا العربي تغيرات غير مسبوقة أخذ بعضها – مع الأسف – منحى عنيفاً اختلفت أسبابه وشدة عنفه من بلد عربي لآخر، ولكن آثاره النفسية لا تختلف ويتأثر بها المواطن العادي بنفس الطريقة التي يتأثر بها طرفا الصراع العنيف. لقد شاهدت العديد من المصابين برض نفسي خلال الأشهر الأخيرة، كما سمعت وقرأت وتلقيت أسئلةً عن الكثير من الحالات. من العواقب الهامة للرض النفسي (أو الكرب stress)، الحالة المعروفة باسم "اضطراب الكرب التالي للرض post-traumatic stress disorder (PTSD) " وقد ارتأيت أنه من المناسب تخصيص زاوية مراجعات كوكران في هذا العدد للمداخلات العلاجية الهادفة إلى تدبير هذا الاضطراب أو إلى الوقاية منه.

يحدث اضطراب الكرب التالي للرض عقب التعرض لحدث راض نفسياً بشكل يهدد بالموت أو بأذى جسيم، سواءً أكان ذلك التهديد حقيقياً أم متوقعاً، وسواء أكان المعرض للخطر هو الشخص نفسه أم أحبته أو غيرهم ممن يعتبرهم مهمين في حياته، فقد يصاب به أي شخص – حتى الأطفال – عقب معاناة أو مشاهدة حدث راض مثل الكوارث الطبيعية أو الحروب أو التعذيب أو الاغتصاب أو حوادث السير، وقد تبدأ أعراض الاضطراب عند البعض فور التعرض للحدث الراض، بينما تبدأ عند غيرهم بعد أشهر أو سنوات.

تتطور الأعراض عادةً خلال شهر إلى ثلاثة أشهر من الحادث، حيث يعاني المصاب من تكرر عيش الحدث الراض وكأنه يحدث مجدداً بكل رعبه (ومضات flashbacks) أومن صور مقحمة ومزعجة أو كوابيس تتعلق بالحدث الراض، وتثار ارتكاسات فيزيولوجية قلقية أو انزعاج شديد عند التعرض لأشخاص أو لظروف تذكر بالحدث فيحاول المصاب تجنب مثل هذه المثيرات. كما تشاهد عند الكثيرين أعراض فرط التنبه مثل فرط الحذر والهيوجية والذهول وصعوبة التركيز وصعوبة النوم، ويصف البعض إحساساً بأنهم معزولون عن الآخرين وبأن مشاعرهم جامدة مع فقد الاهتمام بنشاطات كانوا يعتبرونها هامة، وتترافق بعض الحالات بالاكتئاب والقلق والهلع، وقد يحاول البعض معالجة أنفسهم بتعاطي الكحول أو المهدئات فتضاف إلى مشاكلهم مشكلة الإدمان.

يعاني معظم المتعرضين لحوادث كارثية من أعراض اضطراب الكرب التالي للرض بدرجات وشدات مختلفة، ويتحسن معظمهم خلال سنة أو سنوات بدون علاج أو بالاعتماد على دعم الأهل والأصدقاء، ولكن قد تستمر الأعراض المزعجة عند حوالي ثلثهم لسنوات عديدة بعد الحادث الراض.

تحتوي مكتبة كوكران على مراجعات منهجية لأفضل البراهين المتعلقة بتداخلات تهدف إلى الوقاية والعلاج المبكر لاضطراب الكرب التالي للرض ومنها:

1. التداخلات النفسية المبكرة لمعالجة أعراض الكرب الرضي الحاد
2. التفريغ النفسي للوقاية من اضطراب الكرب التالي للرض
3. التداخل النفسي المبكر متعدد الجلسات للوقاية من اضطراب الكرب التالي للرض
4. العلاج النفسي لاضطراب الكرب التالي للرض
5. التداخلات النفسية للوقاية من الاضطرابات النفسية عند عناصر حفظ النظام
6. العلاج الدوائي لاضطراب الكرب التالي للرض
7. مشاركة العلاج الدوائي مع العلاج النفسي في اضطراب الكرب التالي للرض
8. الرياضة والألعاب في اضطراب الكرب التالي للرض

نورد فيما يلي ملخصات لمراجعات كوكران هذه، والتي تبين توفر براهين على فعالية التداخلات السلوكية الاستعرافية الفردية المركزة على الرض على المدى القصير. أما المداخلات النفسية المقدمة لكل البشر المعرضين لحادث راض فغير فعالة في الوقاية من اضطراب الكرب التالي للرض، كما لا تتوفر براهين داعمة لفعالية جلسة تفريغ نفسي مفردة في العلاج أو الوقاية من اضطراب الكرب التالي للرض، مما يوجب التوقف عن التفريغ القسري لضحايا الرض النفسي. كذلك يجب عدم استخدام التداخلات نفسية عديدة الجلسات لضحايا الحوادث الراضة (ولكن هذه المراجعة لم تشتمل على العلاج الجماعي).

أما بالنسبة للعلاج فهناك براهين على فعالية بعض العلاجات النفسية مثل: العلاج السلوكي الاستعرافي المركز على الرض والمتضمن العلاج بالتعريض سواءً أكان فردياً أم جماعياً، وإزالة تحسس وإعادة برمجة حركات العين، وتدبير الكرب. كما تتوفر براهين ضعيفة على فعالية التداخلات النفسية للوقاية من الاضطرابات النفسية عند عناصر حفظ النظام. وبينما تتوفر براهين على فعالية مضادات الاكتئاب المثبطة لقبط السيروتونين في العلاج الدوائي لاضطراب الكرب التالي للرض، فإنه لاتتوفر براهين كافية لتأكيد أو لنفي فعالية مشاركة العلاج الدوائي مع العلاج النفسي مقارنة بأي منهما منفردا. وكما هي الحال بالنسبة لمعظم "التداخلات البديلة" فإنه لم يتم تنفيذ تجارب معشاة على فعالية الرياضة والألعاب في تدبير اضطراب الكرب التالي للرض.

▪ Psychological debriefing for preventing post-traumatic stress disorder (PTSD)

Rose SC, Bisson J, Churchill R, Wessely S. Cochrane Database of Systematic Reviews 2002, Issue 2. Art. No.: CD000560. DOI: 10.1002/14651858.CD000560.

Background: Over approximately the last fifteen years, early psychological interventions, such as psychological 'debriefing', have been increasingly used following psychological trauma. Whilst this intervention has become popular and its use has spread to several settings, empirical evidence for its efficacy is noticeably lacking. This is the third update of a review of single session psychological "debriefing", first having been undertaken in 1997.

Objectives: To assess the effectiveness of brief psychological debriefing for the management of psychological distress after trauma, and the prevention of post traumatic stress disorder.

Search strategy: Electronic searching of MEDLINE, EMBASE, PsychLit, PILOTS, Biosis, Pascal, Occ.Safety and Health,SOCIOFILE, CINAHL, PSYCINFO, PSYNDEX, SIGLE, LILACS, CCTR, CINAHL, NRR, Hand search of Journal of Traumatic Stress. Contact with leading researchers.

Selection criteria: The focus of RCTs was on persons recently (one month or less) exposed to a traumatic event. The intervention consisted of a single session only, and involved some form of emotional processing/ventilation, by encouraging recollection/reworking of the traumatic event, accompanied by normalisation of emotional reaction to the event.

Data collection and analysis: 15 trials fulfilled the inclusion criteria. Methodological quality was variable, but the majority of trials scored poorly. Data from 6 trials could not be included the meta-analyses. These trials are summarised in the text.

Main results: Single session individual debriefing did not prevent the onset of post-traumatic stress disorder (PTSD) nor reduce psychological distress, compared to control. At one year, one trial reported a significantly increased risk of PTSD in those receiving debriefing (OR 2.51 (95% CI 1.24 to 5.09). Those receiving the intervention reported no reduction in PTSD severity at 1-4 months (SMD 0.11 (95%CI 0.10 to 0.32)), 6-13 months (SMD 0.26 (95%CI 0.01 to 0.50)), or 3 years (SMD 0.17 (95%CI -0.34 to 0.67)). There was also no evidence that debriefing reduced general psychological morbidity, depression or anxiety, or that it was superior to an educational intervention.

Authors' conclusions: There is no evidence that single session individual psychological debriefing is a useful treatment for the prevention of post-traumatic stress disorder after traumatic incidents. Compulsory debriefing of victims of trauma should cease. A more appropriate response could involve a 'screen and treat' model (NICE 2005).

▪ Early psychological interventions to treat acute traumatic stress symptoms

Roberts NP, Kitchiner NJ, Kenardy J, Bisson JI. Cochrane Database of Systematic Reviews 2010, Issue 3. Art. No.: CD007944. DOI: 10.1002/14651858.CD007944.pub2.

Background: The amelioration of psychological distress following traumatic events is a major concern. Systematic reviews suggest that interventions targeted at all of those exposed to such events are not effective at preventing post traumatic stress disorder (PTSD). Recently other forms of intervention have been developed with the aim of treating acute traumatic stress problems.

Objectives: To perform a systematic review of randomised controlled trials of all psychological treatments and interventions commenced within three months of a traumatic event aimed at treating acute traumatic stress reactions. The review followed the guidelines of the Cochrane Collaboration.

Search strategy: Systematic searches were performed of of CCDAN Registers up to August 2008. Editions of key journals were searched by hand over a period of two years; personal communication was undertaken with key experts in the field; online discussion fora were searched.

Selection criteria: Randomised controlled trials of any psychological intervention or treatment designed to reduce acute traumatic stress symptoms, with the exception of single session interventions.

Data collection and analysis: Data were entered and analysed for summary effects using Review Manager 5.0 software. Standardised mean differences were calculated for continuous variable outcome data. Relative risks were calculated for dichotomous outcome data. When statistical heterogeneity was present a random effects model was applied.

Main results: Fifteen studies (two with long term follow-up studies) were identified examining a range of interventions.

In terms of main findings, twelve studies evaluated brief trauma focused cognitive behavioural interventions (TF-CBT). TF-CBT was more effective than a waiting list intervention (6 studies, 471 participants; SMD -0.64, 95% CI -1.06, -0.23) and supportive counselling (4 studies, 198 participants; SMD -0.67, 95% CI -1.12, -0.23). Effects against supportive counselling were still present at 6 month follow-up (4 studies, 170 participants; SMD -0.64, 95% CI -1.02, -0.25). There was no evidence of the effectiveness of a structured writing intervention when compared against minimal intervention (2 studies, 149 participants; SMD -0.15, 95% CI -0.48, 0.17).

Authors' conclusions: There was evidence that individual TF-CBT was effective for individuals with acute traumatic stress symptoms compared to both waiting list and supportive counselling interventions. The quality of trials included was variable and sample sizes were often small. There was considerable clinical heterogeneity in the included studies and unexplained statistical heterogeneity observed in some comparisons. This suggests the need for caution in interpreting the results of this review. Additional high quality trials with longer follow up periods are required to further test TF-CBT and other forms of psychological intervention.

▪ Psychological treatment of post-traumatic stress disorder (PTSD)

Bisson J, Andrew M. Cochrane Database of Systematic Reviews 2007, Issue 3. Art. No.: CD003388. DOI: 10.1002/14651858.CD003388.pub3.

Background: Psychological interventions are widely used in the treatment of post-traumatic stress disorder (PTSD).

Objectives: To perform a systematic review of randomised controlled trials of all psychological treatments following the guidelines of The Cochrane Collaboration.

Search strategy: Systematic searches of computerised databases, hand search of the Journal of Traumatic Stress, searches of reference lists, known websites and discussion fora, and personal communication with key workers.

Selection criteria: Types of studies - Any randomised controlled trial of a psychological treatment.

Types of participants - Adults suffering from traumatic stress symptoms for three months or more.

Types of interventions - Trauma-focused cognitive behavioural therapy/exposure therapy (TFCBT); stress management (SM); other therapies (supportive therapy, non-directive counselling, psychodynamic therapy and hypnotherapy); group cognitive behavioural therapy (group CBT); eye movement desensitisation and reprocessing (EMDR).

Types of outcomes - Severity of clinician rated traumatic stress symptoms. Secondary measures included self-reported traumatic stress symptoms, depressive symptoms, anxiety symptoms, adverse effects and dropouts.

Data collection and analysis

Data were entered using Review Manager software. Quality assessments were performed. Data were analysed for summary effects using Review Manager 4.2.

Main results: Thirty-three studies were included in the review. With regards to reduction of clinician assessed PTSD symptoms measured immediately after treatment TFCBT did significantly better than waitlist/usual care (standardised mean difference (SMD) = -1.40; 95% CI, -1.89 to -0.91; 14 studies; n = 649). There was no significant difference between TFCBT and SM (SMD = -0.27; 95% CI, -0.71 to 0.16; 6 studies; n = 239). TFCBT did significantly better than other therapies (SMD = -0.81; 95% CI, -1.19 to -0.42; 3 studies; n = 120). Stress management did significantly better than waitlist/usual care (SMD = -1.14; 95% CI, -1.62 to -0.67; 3 studies; n = 86) and than other therapies (SMD = -1.22; 95% CI, -2.09 to -0.35; 1 study; n = 25). There was no significant difference between other therapies and waitlist/usual care control (SMD = -0.43; 95% CI, -0.90 to 0.04; 2 studies; n = 72). Group TFCBT was significantly better than waitlist/usual care (SMD = -0.72; 95% CI, -1.14 to -0.31). EMDR did significantly better than waitlist/usual care (SMD = -1.51; 95% CI, -1.87 to -1.15; 5 studies; n = 162). There was no significant difference between EMDR and TFCBT (SMD = 0.02; 95% CI, -0.28 to 0.31; 6 studies; n = 187). There was no significant difference between EMDR and SM (SMD = -0.35; 95% CI, -0.90 to 0.19; 2 studies; n = 53). EMDR did significantly better than other therapies (self-report) (SMD = -0.84; 95% CI, -1.21 to -0.47; 2 studies; n = 124).

▪ Multiple session early psychological interventions for the prevention of post-traumatic stress disorder

Roberts NP, Kitchiner NJ, Kenardy J, Bisson JI. Cochrane Database of Systematic Reviews 2009, Issue 3. Art. No.: CD006869. DOI: 10.1002/14651858.CD006869.pub2.

Background: The prevention of long-term psychological distress following traumatic events is a major concern. Systematic reviews have suggested that individual Psychological Debriefing is not an effective intervention at preventing post traumatic stress disorder (PTSD). Recently other forms of intervention have been developed with the aim of preventing PTSD.

Objectives: To examine the efficacy of multiple session early psychological interventions commenced within three months of a traumatic event aimed at preventing PTSD. Single session individual/group psychological interventions were excluded.

Search strategy: Computerised databases were searched systematically, the most recent search was conducted in August 2008. The Journal of Traumatic Stress and the Journal of Consulting and Clinical Psychology were handsearched for the last two years. Personal communication was undertaken with key experts in the field.

Selection criteria: Randomised controlled trials of any multiple session early psychological intervention or treatment (two or more sessions) designed to prevent symptoms of PTSD.

Data collection and analysis: Data were entered using Review Manager software. The methodological quality of included studies was assessed individually by two review authors. Data were analysed for summary effects using Review Manager 4.2. Mean difference was used for meta-analysis of continuous outcomes and relative risk for dichotomous outcomes.

Main results: Eleven studies with a total of 941 participants were found to have evaluated brief psychological interventions aimed at preventing PTSD in individuals exposed to a specific traumatic event, examining a heterogeneous range of interventions. Eight studies were entered into meta-analysis. There was no observable difference between treatment and control conditions on primary outcome measures for these interventions at initial outcome (k=5, n=479; RR 0.84; 95% CI 0.60 to 1.17). There was a trend for increased self-report of PTSD symptoms at 3 to 6 month follow-up in those who received an intervention (k=4, n=292; SMD 0.23; 95% CI 0.00 to 0.46). Two studies compared a memory structuring intervention against supportive listening. There was no evidence supporting the efficacy of this intervention.

Authors' conclusions: The results suggest that no psychological intervention can be recommended for routine use following traumatic events and that multiple session interventions, like single session interventions, may have an adverse effect on some individuals. The clear practice implication of this is that, at present, multiple session interventions aimed at all individuals exposed to traumatic events should not be used. Further, better designed studies that explore new approaches to early intervention are now required.

studies compared a psychosocial intervention to a control group. Only one primary prevention trial reported data for the primary outcomes and, although this study found a significant difference in depression in favour of the intervention at endpoint, this difference was no longer evident at 18 months. No studies of primary prevention comparing different interventions and reporting primary outcomes of interest were identified.

The methodological quality of the included studies was summarised. No study met our full quality criteria and one was regarded as low-quality. The remainder could not be rated because of incomplete data in the published reports and inadequate responses from the trialists.

Authors' conclusions: There is evidence only from individual small and low quality trials with minimal data suggesting that police officers benefit from psychosocial interventions, in terms of physical symptoms and psychological symptoms such as anxiety, depression, sleep problems, cynicism, anger, PTSD, marital problems and distress. No data on adverse effects were available. Meta-analyses of the available data were not possible. Further well-designed trials of psychosocial interventions are required. Research is needed on organization-based interventions to enhance psychological health among police officers.

▪ Pharmacotherapy for post-traumatic stress disorder (PTSD)

Stein DJ, Ipser JC, Seedat S. Cochrane Database of Systematic Reviews 2006, Issue 1. Art. No.: CD002795. DOI: 10.1002/14651858.CD002795.pub2.

Background: Post traumatic stress disorder (PTSD) is a prevalent and disabling disorder. Evidence that PTSD is characterised by specific psychobiological dysfunctions has contributed to a growing interest in the use of medication in its treatment.

Objectives: To assess the effects of medication for post traumatic stress disorder.

Search strategy: We searched the Cochrane Depression, Anxiety and Neurosis Group specialised register (CCDANCTR-Studies) on 18 August 2005, the Cochrane Central Register of Controlled Trials (CENTRAL) (The Cochrane Library issue 4, 2004), MEDLINE (January 1966 to December 2004), PsycINFO (1966 to 2004), and the National PTSD Center Pilots database. Reference lists of retrieved articles were searched for additional studies.

Selection criteria: All randomised controlled trials (RCTs) of pharmacotherapy for PTSD.

Data collection and analysis: Two raters independently assessed RCTs for inclusion in the review, collated trial data, and assessed trial quality. Investigators were contacted to obtain missing data. Summary statistics were stratified by medication class, and by medication agent for the selective serotonin reuptake inhibitors (SSRIs). Dichotomous and continuous measures were calculated using a random effects model, heterogeneity was assessed, and subgroup/sensitivity analyses were undertaken.

Authors' conclusions: There was evidence individual TFCBT, EMDR, stress management and group TFCBT are effective in the treatment of PTSD. Other non-trauma focused psychological treatments did not reduce PTSD symptoms as significantly. There was some evidence that individual TFCBT and EMDR are superior to stress management in the treatment of PTSD at between 2 and 5 months following treatment, and also that TFCBT, EMDR and stress management were more effective than other therapies. There was insufficient evidence to determine whether psychological treatment is harmful. There was some evidence of greater drop-out in active treatment groups. The considerable unexplained heterogeneity observed in these comparisons, and the potential impact of publication bias on these data, suggest the need for caution in interpreting the results of this review.

▪ Psychosocial interventions for prevention of psychological disorders in law enforcement officers

Peñalba V, McGuire H, Leite JR. Cochrane Database of Systematic Reviews 2008, Issue 3. Art. No.: CD005601. DOI: 10.1002/14651858.CD005601.pub2.

Background: Psychosocial interventions are widely used for the prevention of psychological disorders in law enforcement officers.

Objectives: To assess the effectiveness and comparative effectiveness of psychosocial interventions for the prevention of psychological disorders in law enforcement officers.

Search strategy: CCDANCTR-References was searched on 12/5/2008, electronic databases were searched, reference lists of review articles and included studies were checked, a specialist journal was handsearched, specialist books were checked and we contacted experts and trialists.

Selection criteria: Randomised and quasi randomised controlled trials were eligible. The types of participants were people employed directly in law enforcement, including police officers and military police, regardless of gender, age and country of origin, and whether or not they had experienced some psychological trauma. All types of psychosocial intervention were eligible. The relevant outcome measures were psychological symptoms, adverse events and acceptability of interventions.

Data collection and analysis: Data was entered into Review Manager 4.2 for analysis, but this review was converted to RevMan 5.0 for publication. Quality assessments were performed. Two authors independently selected studies, extracted data and assessed the quality of studies. Summary effects were to be calculated using RevMan but no meta-analyses were possible. For individual studies, dichotomous outcome data are presented using relative risk, and continuous outcome data are presented using the weighted mean difference. These results are given with their 95% confidence intervals (CI).

Main results: Ten studies were included in the review but only five reported data that could be used. Three of the ten studies were related to exercise-based psychological interventions. Seven were related to psychological interventions. No meta-analyses were possible due to diversity of participants, interventions and outcomes. Two studies compared a psychosocial intervention versus another intervention. Three

Data collection and analysis: Two or three review authors independently selected trials, assessed their 'risk of bias' and extracted trial and outcome data. We used a fixed-effect model for meta-analysis. The relative risk was used to summarise dichotomous outcomes and the mean difference and standardised mean difference were used to summarise continuous measures.

Main results: Four trials were eligible for inclusion, one of these trials (n =24) was on children and adolescents. All used an SSRI and prolonged exposure or a cognitive behavioural intervention. Two trials compared combination treatment with pharmacological treatment and two compared combination treatment with psychological treatment. Only two trials reported a total PTSD symptom score and these data could not be combined. There was no strong evidence to show if there were differences between the group receiving combined interventions compared to the group receiving psychological therapy (mean difference 2.44, 95% CI -2.87, 7.35 one study, n=65) or pharmacotherapy (mean difference -4.70, 95% CI -10.84 to 1.44; one study, n = 25). Trialists reported no significant differences between combination and single intervention groups in the other two studies. There were very little data reported for other outcomes, and in no case were significant differences reported.

Authors' conclusions: There is not enough evidence available to support or refute the effectiveness of combined psychological therapy and pharmacotherapy compared to either of these interventions alone. Further large randomised controlled trials are urgently required.

▪ Sports and games for post-traumatic stress disorder (PTSD)

Lawrence S, De Silva M, Henley R. Cochrane Database of Systematic Reviews 2010, Issue 1. Art. No.: CD007171. DOI: 10.1002/14651858.CD007171.pub2.

Background: Traumatic experiences evoke emotions such as fear, anxiety and distress and may encourage avoidance of similar situations in the future. For a proportion of those exposed to a traumatic event, this emotional reaction becomes uncontrollable and can develop into Post Traumatic Stress Disorder (PTSD) (Breslau 2001). Most of those diagnosed with PTSD fully recover while a small proportion develop a chronic PTSD a year after the event (First 2004). Sports and games may be able to alleviate symptoms of PTSD.

Objectives

Primary objective:

1. To assess the effectiveness of sports, and games in alleviating and/or diminishing the symptoms of PTSD when compared to usual care or other interventions.

Secondary objective:

2. To assess the effectiveness of different types of sports and games in alleviating and/or diminishing symptoms of PTSD.

Search strategy: The Cochrane Collaboration Depression, Anxiety and Neurosis Controlled Trials Registers (CCDAN-CTR) were searched up to June 2008.

Main results: 35 short-term (14 weeks or less) RCTs were included in the analysis (4597 participants). Symptom severity for 17 trials was significantly reduced in the medication groups, relative to placebo (weighted mean difference -5.76, 95% confidence intervals (CI) -8.16 to -3.36, number of participants (N) = 2507). Similarly, summary statistics for responder status from 13 trials demonstrated overall superiority of a variety of medication agents to placebo (relative risk 1.49, 95% CI 1.28 to 1.73, number needed to treat = 4.85, 95% CI 3.85 to 6.25, N = 1272). Medication and placebo response occurred in 59.1% (N = 644) and 38.5% (628) of patients, respectively. Of the medication classes, evidence of treatment efficacy was most convincing for the SSRIs.

Medication was superior to placebo in reducing the severity of PTSD symptom clusters, comorbid depression and disability. Medication was also less well tolerated than placebo. A narrative review of 3 maintenance trials suggested that long term medication may be required in treating PTSD.

Authors' conclusions: Medication treatments can be effective in treating PTSD, acting to reduce its core symptoms, as well as associated depression and disability. The findings of this review support the status of SSRIs as first line agents in the pharmacotherapy of PTSD, as well as their value in long-term treatment. However, there remain important gaps in the evidence base, and a continued need for more effective agents in the management of PTSD.

▪ Combined pharmacotherapy and psychological therapies for post-traumatic stress disorder (PTSD)

Hetrick SE, Purcell R, Garner B, Parslow R. Cochrane Database of Systematic Reviews 2010, Issue 7. Art. No.: CD007316. DOI: 10.1002/14651858.CD007316.pub2.

Background: PTSD is an anxiety disorder related to exposure to a severe psychological trauma. Symptoms include re-experiencing the event, avoidance and arousal as well as distress and impairment resulting from these symptoms.

Guidelines suggest a combination of both psychological therapy and pharmacotherapy may enhance treatment response, especially in those with more severe PTSD or in those who have not responded to either intervention alone.

Objectives: To assess whether the combination of psychological therapy and pharmacotherapy provides a more efficacious treatment for PTSD than either of these interventions delivered separately.

Search strategy: Searches were conducted on the trial registers kept by the CCDAN group (CCDANCTR-Studies and CCDANCTR-References) to June 2010. The reference sections of included studies and several conference abstracts were also scanned.

Selection criteria: Patients of any age or gender, with chronic or recent onset PTSD arising from any type of event relevant to the diagnostic criteria were included. A combination of any psychological therapy and pharmacotherapy was included and compared to wait list, placebo, standard treatment or either intervention alone. The primary outcome was change in total PTSD symptom severity. Other outcomes included changes in functioning, depression and anxiety symptoms, suicide attempts, substance use, withdrawal and cost.

a group. Psychological interventions such as music therapy, art therapy and play therapy and behavioural therapy were excluded.

Data collection and analysis: Two reviewers (SL and MD) separately checked the titles and abstracts of the search results to determine which studies met the pre-determined inclusion criteria. A flow chart was used to guide the selection process. No studies met the inclusion criteria.

Main results: The search strategy identified five papers but none of the studies met inclusion criteria.

Authors' conclusions: No studies met the inclusion criteria. More research is therefore required before a fair assessment can be made of the effectiveness of sports and games in alleviating symptoms of PTSD

The following databases were searched up to June 2008: the Cochrane Central registry of Controlled Trials; MEDLINE; EMBASE; CINAHL; PsycINFO. Reference lists of relevant papers were searched and experts in the field were contacted to determine if other studies were available.

Selection criteria: To be included, participants had to be diagnosed with PTSD using criteria outlined in the Diagnostic and Statistical Manual for Mental Disorders (DSM IV) and/or ICD criteria. Randomised controlled trials (RCTs) that considered one or more well-specified sports or games for alleviating and/or diminishing symptoms of PTSD were included.

Sports, and games were defined as any organized physical activity done alone or with a group and non-physical activities such as computer games and card games done alone or with

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