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A comparison of Narrative Exposure Therapy and Prolonged Exposure therapy for PTSD☆,☆☆

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HIGHLIGHTS

- There is evidence that PE and NET can be effective in alleviating PTSD symptoms.
- PE's status as a first line treatment for the populations studied seems warranted.
- Research on each treatment has focused on different populations and traumas.
- Future research should investigate each treatments effect on diverse populations.
- Knowledge of the impact of specific components might increase personalization of care.

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ABSTRACT

The purpose of this review was to compare and contrast Prolonged Exposure (PE) and Narrative Exposure Therapy (NET). We examined the treatment manuals to describe the theoretical foundation, treatment components, and procedures, including the type, manner, and focus of exposure techniques and recording methods used. We examined extant clinical trials to investigate the range of treatment formats reported, populations studied, and clinical outcome data. Our search resulted in 32 studies on PE and 15 studies on NET. Consistent with prior reviews of PTSD treatment, it is evident that PE has a solid evidence base and its current status as a first line treatment for the populations studied to this date is warranted. We argue that NET may have advantages in treating complex traumatization seen in asylum seekers and refugees, and for this population NET should be considered a recommended treatment. NET and PE have several commonalities, and it is recommended that studies of these treatments include a broader range of populations and trauma types to expand the current knowledge on the treatment of PTSD.

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1. Introduction

Since the diagnosis of posttraumatic stress disorder (PTSD) entered the Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1980 (DSM-III, APA, 1980), work has been underway to develop effective psychotherapies. Empirical research suggests that PTSD can be treated effectively using variants of cognitive behavioral therapy (CBT). These interventions are considered a first line treatment for PTSD (Cukor, Olden, Lee, & Difede, 2010; Institute of Medicine, 2008; NICE, 2005; Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Prolonged Exposure (PE) therapy is a specific exposure-based type of CBT for PTSD which has been under development since 1982 (Foa, Hembree, & Rothbaum, 2007). PE is the most studied psychotherapy for PTSD, and it is accepted as a gold standard (Cukor et al., 2010; Institute of Medicine, 2008). The goal of PE is to reduce PTSD symptom severity through safe confrontation with thoughts, memories, places, activities and people that have been avoided since a traumatic event occurred (Foa et al., 2007).

There are more than a dozen randomized controlled trials (RCTs) lending support to PE in reducing PTSD symptoms. In reviewing studies on PTSD, Powers et al. (2010) found that 86% of the clients who received PE had better outcomes than clients in control conditions. However, there were no significant differences between PE and the other psychotherapies for PTSD at either post-treatment or follow up.

Despite the demonstrated effectiveness of PE, 25–45% of individuals still meet diagnostic criteria for PTSD after treatment (Van Minnen, Arntz, & Keijsers, 2002). A significant minority of individuals do not complete a full course of therapy, and many cannot access treatment due to constraints on availability, lack of client resources, or other barriers. Moreover, much of the research supporting the efficacy of PE and other interventions has focused on clients in Western countries, often combat-veterans or victims of rape and sexual assault (Breslau, 2009; Foa, Gillihan, & Bryant, 2011; Foa, Keane, & Friedman, 2000).

Complex trauma is characterized by sustained exposure to repeated or multiple traumatic incidents, often of an interpersonal nature, occurring in circumstances where escape is impossible. Examples of complex trauma are sexual and physical abuse during childhood, being a child soldier, experiencing torture and genocide, or being a refugee. Experiencing this type of trauma is associated with higher rates of PTSD than other types of trauma (Courtois, 2008). Moreover, individuals who experience complex trauma often experience additional trauma-related symptoms characterized by increased difficulties in regulating emotions, problems in relational areas, and dissociation and somatization (Cloitre et al., 2011; Foa et al., 2000).

To date, the diagnostic systems including the DSM-IV and the International Classification of Diseases 10 (ICD-10) described a single trauma as a cause of subsequent posttraumatic symptoms (American Psychiatric Association, 1994; World Health Organization, 1992). The DSM-5 clarifies that PTSD can be the result of one or more traumatic events (American Psychiatric Association, 2013). Knowledge is relatively scarce on how PE and other traditional CBT programs work for individuals with complex trauma, although there are suggestions that individuals with complex trauma may not respond optimally to conventional treatments (Cloitre, 2009).

Although available research on psychotherapies for PTSD indicates that CBTs and exposure therapies are highly efficacious in reducing PTSD symptoms (McLean & Foa, 2011; NCCMH, 2005), it is unknown if these treatments are the best option for survivors of multiple or complex interpersonal traumatic events which are known to affect PTSD severity (Bradley, Greene, Russ, Dutra, & Westen, 2005). These treatments often focus on a single traumatic event, and it has been suggested that complex traumatization may require a different approach (Cloitre, 2009; Green et al., 2000).

There are some studies to date investigating PE and complex traumatization. Van Minnen et al. (2002) found that clients showed good outcomes from PE after having been exposed to sexual abuse and/or battering in childhood or adulthood, and McDonagh et al. (2005) found that for women who had PTSD from childhood sexual abuse, those who received PE and Cognitive Processing Therapy (CPT) were more likely to no longer meet PTSD criteria than those who received present-centered therapy (PCT). All active treatments (PE, CPT, and PCT) were superior to wait list in decreasing PTSD symptoms and