Accelerated Resolution Therapy for Posttraumatic Stress Disorder

Psychological Health Center of Excellence Psych Health Evidence Briefs August 2019

Q. What is accelerated resolution therapy?

A. Accelerated resolution therapy (ART) is an emerging psychotherapy that can be completed in a short time period (one to five 60-minute sessions over a two-week period) and does not require repeated exposure to traumatic events or homework/skills practice (Finnegan et al., 2016). ART includes the use of three components of trauma-focused therapy: imaginal exposure, cognitive restructuring, and rapid eye movements (Kip et al., 2014) to enhance visualization techniques used to target the way individuals process distressing memories and images in order to prevent them from eliciting strong, negative reactions (Finnegan et al., 2016).

Q. What is the proposed treatment model underlying ART?

A. Like other trauma-focused therapies, ART aims to promote extinction learning in order to lessen the distress of trauma-related thoughts (Kip et al., 2014; Yehuda et al., 2015). ART aims to modify traumatic memories, reducing their intensity and intrusiveness, in order to reduce the distressing emotions, thoughts, sensations, and images that characterize posttraumatic stress disorder (PTSD; Kip et al., 2014). Modification of traumatic memories is hypothesized to be aided by the use of cognitive restructuring to rescript traumatic events and the use of eye movements that reduce the physiological reactions that occur during imaginal exposure (Kip et al., 2014).

Q. Is ART recommended in the Military Health System (MHS)?

A. **No.** The *2017 VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* does not include ART in their recommendation for trauma-focused psychotherapies, stating that "there are other psychotherapies that meet the definition of trauma-focused treatment for which there is currently insufficient evidence to recommend for or against their use. Future research is needed to explore the efficacy of novel, emerging treatments."

The MHS relies on the Department of Veterans Affairs (VA)/Department of Defense (DoD) clinical practice guidelines (CPGs) to inform best clinical practices. The CPGs are developed under the purview of clinical experts and are derived through a transparent and systematic approach that includes, but is not limited to, systematic reviews of the literature on a given topic and development of recommendations using a graded system that takes into account the overall quality of the evidence and the magnitude of the net benefit of the recommendation. A further description of this process and CPGs on specific topics can be found on the VA clinical practice guidelines website.

Q. Do other guidelines and evidence reviews recommend ART for PTSD?

A. **No.** Other authoritative reviews have not substantiated the use of ART for treating PTSD.

Several other recognized organizations conduct systematic reviews and evidence syntheses on psychological health topics using similar grading systems as the VA/DoD CPGs. These include the Agency for Healthcare Research and Quality (AHRQ) Systematic Review Repository, and the Cochrane Database of Systematic Reviews.

- AHRQ: No reviews were found on ART as treatment for PTSD.
- Cochrane: No reviews were found on ART as a treatment for PTSD.

Q. Is there any recent research on ART as a treatment for PTSD?

A. A July 2019 literature search identified one randomized controlled trial (RCT) of ART tested on military veterans with post-traumatic stress symptoms indicated by a self-report questionnaire. Two to five sessions of ART were compared to an attention control (AC) group that consisted of two one-

hour sessions with a personal trainer or career coach (the interventions were not intended to be equal in duration) on post-treatment outcomes (Kip et al., 2013). ART demonstrated superior self-report outcomes post-treatment relative to the AC group. Since participants in the AC group were able to cross over to receive ART after their two sessions, longer-term outcomes between treatments could not be compared. Among participants who started ART and completed a 3-month post-treatment session (n = 38), 80 percent experienced a continued reduction of at least 10 points on the self-report PTSD measure.

Another RCT is in progress to examine the effectiveness of cognitive processing therapy compared to ART and a waitlist control (NCT03384706).

Q. What conclusions can be drawn about the use of ART as a treatment for PTSD in the MHS?

A. The research base for ART is emerging. However, the limitations of the available evidence do not allow strong conclusions to be made from the existing research that could inform clinical practice guidelines or policy decisions within the MHS. One RCT has been published to date on participants with post-traumatic stress symptoms. ART was not compared to an active PTSD treatment, limiting the conclusions that can be made about the efficacy of ART for PTSD compared to other front-line treatments currently recommended by the VA/DoD CPG. Thus, the current state of the evidence base is not mature enough to recommend ART as a front-line treatment for PTSD in the MHS.

References

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Released August 2019 by the Psychological Health Center of Excellence
301-295-7681 | health.mil/PHCoE