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Letter to the Editor

Response to 'Augmenting cognitive behavior therapy for post-traumatic stress disorder with emotion tolerance training'

With interest we read the article of Bryant *et al.* (2013), recently published in *Psychological Medicine*. Nevertheless, the interpretation of the data raised a number of questions and concerns, which we recognize as our obligation to share with the readers of this journal.

The study investigated the efficacy of providing civilian survivors suffering from post-traumatic stress disorder (PTSD) with training in emotion regulation skills prior to trauma-focused cognitive behavior therapy. Based on the study results of Cloitre *et al.* (2010), it was the assumption of the authors that emotion regulation skills training may be beneficial, not only for individuals suffering from complex PTSD (e.g. due to childhood sexual abuse), but also for those suffering from single-event PTSD (e.g. due to a car accident). Although this is an interesting hypothesis, it should be noted on the other hand that established treatments of single-event PTSD, like imaginary exposure or eye movement desensitization and reprocessing (EMDR), already have been found to be quite efficacious within a short time span (Bisson & Andrew, 2007; Ho & Lee, 2012; Watts *et al.* 2013; WHO, 2013). For example, Nijdam *et al.* (2012) found that after six sessions of EMDR 92% of the 70 patients no longer met the criteria for PTSD diagnosis.

In the Bryant *et al.* (2013) study patients received six sessions of imaginary and *in vivo* exposure, combined with cognitive restructuring, which was preceded by four sessions of either supportive counseling or emotion tolerance skills training. Immediately after treatment no differences were found between both groups with regard to PTSD symptoms, but it appeared that at 6 months follow-up the patients trained in emotion regulation skills fared significantly better than those in the supportive counseling condition. According to the authors these findings suggest that response to trauma-focused treatment may be enhanced by preparatory emotion regulation skills training.

We seriously doubt whether this conclusion is justified based on the data that the paper provides. The authors discuss their results in terms of success for the skills training. However, at post-treatment both groups did not differ. Differences only reached significance at 6 months follow-up. When carefully reading the methods section, we found that of the patients prepared with emotion regulation skills prior to the trauma-focused treatment part, 19% still fulfilled the diagnostic criteria of PTSD at post-treatment. At 6 months follow-up this percentage increased to 28%. Of the patients in the supportive counseling condition at post-treatment, 26% fulfilled the diagnostic criteria of PTSD. Remarkably, at 6 months follow-up this percentage grew to 50%. Accordingly, the significant difference between both conditions at follow-up (a relative difference of 22% in PTSD diagnoses) is not explained by an improvement in the patients who were trained in emotion regulation but, most probable, by a significantly greater relapse in the supportive counseling condition. In other words, the authors may have misinterpreted their data, because individuals who received supportive counseling prior to the trauma-focused treatment part responded less favorably than what is to be expected based on the literature of treatments without a skills training (Bisson & Andrew, 2007; Powers *et al.* 2010). This, to a lesser extent, also holds true for those who were trained in emotion regulation skills, and who also showed a slight relapse at follow-up, which is not in agreement with other PTSD outcome studies. For example, van der Kolk *et al.* (2007) found that 9% of patients maintained their PTSD diagnosis at 6 months follow-up. Also the drop-out of 42% is much higher than in most other trauma studies (e.g. 17% in Van der Kolk *et al.* 2007; Hembree *et al.* 2003). Thus, the authors included skills training in their treatment aimed at reducing attrition and increasing the number of treatment responders, but found a drop-out as well as a deterioration rate incomparable with most other studies without such training.

To date, there is no evidence to suggest that a procedure in which patients with PTSD are exposed to their traumatic memories involves unacceptable risks, nor is there any evidence that the use of emotion regulation skills is a prerequisite for a positive treatment outcome or high end-state functioning in this population (Van Minnen *et al.* 2012). Although interpreted and presented otherwise by the authors, the results of the study of Bryant *et al.* (2013) just add further support to this notion.

Declaration of Interest

None.

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