In veterans with PTSD, mindfulness-based group therapy reduced symptom severity

Polusny MA, Erbes CR, Thuras P, et al. ***Mindfulness-based stress reduction for posttraumatic stress disorder among veterans: a randomized clinical trial.*** *JAMA. 2015;314:456-65.*

Clinical impact ratings: GM ★★★★★★☆ MH ★★★★★★☆

Question

In veterans with posttraumatic stress disorder (PTSD), what is the efficacy of mindfulness-based, stress-reduction group therapy compared with present-centered group therapy?

Methods

Design: Randomized controlled trial. Clinicaltrials.gov NCT01548742.

Allocation: {Concealed}*.†

Blinding: Blinded† (outcome assessors, {investigators, and statistician}*).

Follow-up period: 17 weeks.

Setting: Minneapolis Veterans Affairs Medical Center.

Patients: 116 veterans (mean age 59 y, 84% men) who had current full PTSD (according to the *Diagnostic and Statistical Manual of Mental Disorders, 4th edition*) or subthreshold PTSD, who agreed not to receive other psychotherapy during the study and, if applicable, had a stable psychoactive medication regimen for ≥ 2 months.

Intervention: Mindfulness-based, stress-reduction group therapy comprising 9 sessions (8 weekly 2.5-h group sessions plus a full-day retreat) focused on teaching patients to attend to the present moment in a nonjudgmental, accepting manner, adopting kindness and curiosity (n = 58), or present-centered group therapy comprising 9 weekly 1.5-h group sessions focused on current life problems (n = 58).

Outcomes: Primary outcome was change in PTSD symptom severity. Secondary outcomes included depression symptoms, quality of life (QOL), and loss of PTSD diagnosis.

Patient follow-up: 90% (intention-to-treat analysis).

Mindfulness-based, stress-reduction group therapy vs present-centered group therapy in veterans with posttraumatic stress disorder (PTSD)‡

Outcomes	Change in mean score§		At 17 wk
	Mindfulness	Present-centered	Mean difference (95% CI)‖
PTSD Checklist¶	−9.2	−2.8	6.4 (3.3 to 9.5)
PHQ-9**	−2.2	−0.8	1.3 (−0.1 to 2.8)
WHOQOL-BREF††	4.6	−0.6	5.2 (1.7 to 8.7)
Event rates			
Loss of PTSD diagnosis	53%	47%	6.0% (−14 to 26)
Clinically significant improvement in PTSD symptom severity‡‡	49%	28%	21% (2 to 40)

‡PHQ = Patient Health Questionnaire; WHOQOL-BREF = World Health Organization Quality of Life-Brief; other abbreviations defined in Glossary.

§Calculated by subtracting mean at baseline from the mean at 17 wk.

‖Between-treatment difference in improvement from baseline.

¶Score range 17 to 85; higher scores = more severe symptoms; minimal clinically important difference (MCID) = reduction of ≥ 10 points.

***Score range 0 to 27; higher scores = greater depressive symptoms; MCID = reduction of ≥ 5 points.*

††Score range 0 to 130; higher scores = greater quality of life.

‡‡Reduction ≥ 10 points on the PTSD Checklist.

Main results

Mindfulness-based, stress-reduction group therapy reduced PTSD symptom severity and improved QOL more than present-centered group therapy (Table). Groups did not differ for change in depression symptoms or loss of PTSD diagnosis (Table).

Conclusion

In veterans with posttraumatic stress disorder, mindfulness-based, stress-reduction group therapy reduced symptom severity more than present-centered group therapy.

**Information provided by author.*

†See Glossary.

Source of funding: US Department of Veterans Affairs.

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Commentary

The trial by Polusny and colleagues assessed an appealing mindfulness training intervention in a population that is difficult to treat. Mindfulness training influences life skills relevant to work, functioning, and relationships, as shown by the improvement in the QOL scores. It also provides a form of self-administered cognitive–behavioral therapy that can have lasting effects over a lifetime, although this needs further study.

On the other hand, the intervention did not resolve PTSD symptoms. Although there was a small improvement in PTSD Checklist scores, this finding could have been affected by confounding. Groups differed in PTSD scores at baseline, and true blinding is difficult with such behavioral interventions. Also, 75% of patients served in Vietnam; chronicity of PTSD in this group may explain the lack of responsiveness to the intervention.

The study had a small sample size, lacked a true control (e.g., placebo or usual care), and the intervention duration was short. These factors make it difficult to discount mindfulness therapy for patients with PTSD. The ability to master the skill of mindfulness in just 9 sessions and then translate it into self-management of agitated symptoms may be unrealistic. Such a skill probably requires more sessions and more time to inculcate in practice. Further study is needed in patients with more recent symptom onset, with a more intensive intervention to enable mastery of the skills, a longer follow-up, and measurement of a broader range of important functional outcomes.

Therapy for PTSD continues to be a major challenge. Although some effective treatments are available, their effects tend to be modest (1). Given the burden of this illness and its relative recalcitrance to treatment, the need for primary prevention is the best strategy for managing the societal burden of PTSD. We have a responsibility to try to influence those who are making the choices that lead to exposure to war and other traumas. In the meantime, mindfulness training may be a useful process for helping people cope with PTSD.

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Reference

1. **Steenkamp MM, Litz BT, Hoge CW, Marmar CR.** Psychotherapy for military-related PTSD: a review of randomized clinical trials. JAMA. 2015;314:489-500.

