February 2026

Q: What is present-centered therapy?

A: Present-centered therapy (PCT) is a manualized, non-trauma-focused psychotherapy for adults with posttraumatic stress disorder (PTSD). PCT can be conducted in an individual or group format and includes nonspecific therapeutic components such as the establishment of a positive therapeutic relationship, normalization of symptoms, validation of experiences, greater insight into PTSD symptoms, and an increased sense of mastery of dealing with problems (Shea, 2021; Vogel et al., 2021). PCT does not explicitly include trauma exposure, cognitive restructuring, or behavioral activation. Therefore, it may be an attractive alternative to trauma-focused psychotherapy for those who do not wish to participate in trauma-based exposure therapies (Rosner et al., 2024; Vogel et al., 2021).

Q: What is the treatment model underlying PCT for PTSD?

A: PCT was developed to serve as a "control" condition when comparing the therapeutic effectiveness of evidence-based treatments for PTSD. PCT was designed to include non-specific factors that are present in most forms of psychotherapy without the active components that are thought to lead to improvement or remission of psychological symptoms (Shea, 2021). PCT is based on a model of empathic listening, psychoeducation, and problem-solving skills (Vogel et al., 2021). The primary goals of PCT are for patients to enhance interpersonal connections, gain insight into the ways their current behaviors are influenced by PTSD symptoms, and explore more effective ways of problem-solving (Belsher et al., 2019). Through practice, patients develop a greater sense of mastery over their environment and learn to apply more effective solutions to daily stressors thereby improving their psychosocial functioning and decreasing symptoms (Vogel et al., 2021).

Q: Is PCT recommended as a treatment for PTSD?

A: Yes. The *2023 VA/DOD Clinical Practice Guideline (CPG) for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder* suggests PCT for patients diagnosed with PTSD, with a "Weak For" strength of recommendation.

The VA/DOD CPGs were jointly developed by the Department of Veterans Affairs and the Department of Defense to inform best clinical practices. They 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 authoritative reviews recommend PCT as a treatment for PTSD?

A: No. *Other recognized organizations publish CPGs or conduct systematic reviews and evidence syntheses on psychological health topics using similar grading systems as the VA/DoD CPGs. These include the American Psychological Association (APA) and United Kingdom's National Institute for Health and Care Excellence (NICE). Additionally, Cochrane is an international network that conducts high-quality reviews of healthcare interventions.*

- APA: A 2025 systematic review update of psychosocial and pharmacological treatments for adults with PTSD states there is insufficient evidence to recommend for or against PCT for PTSD over no intervention or treatment as usual (APA, 2025).
- NICE: An updated 2025 review of the 2018 NICE PTSD Guidelines indicates PCT was not recommended as an intervention for adults with PTSD. The guidelines state there may be benefits of non-trauma-focused interventions, but that any such interventions should not be regarded as an alternative to trauma-focused, first-line treatment (NICE, 2025).
- Cochrane: A 2019 systematic review of PCT for PTSD in adults included 12 studies with 1,837 participants comparing PCT to either a wait-list/minimal attention control group (three studies) or to trauma-focused cognitive-behavioral therapy (TF-CBT; 11 studies; Belsher et al., 2019). Moderate quality evidence indicated that PCT was more effective than control conditions for reducing PTSD symptom severity. In a comparison of PCT with TF-CBT, low quality evidence did not support PCT as a non-inferior treatment for PTSD symptom severity at post-treatment, though treatment effect differences may have attenuated over time. Dropout was lower for PCT than TF-CBT.

Q: What conclusions can be drawn about the use of PCT as a treatment for PTSD?

A: The 2023 VA/DOD PTSD CPG suggests PCT for patients diagnosed with PTSD, with a "Weak For" strength of recommendation. A 2019 Cochrane systematic review found that PCT may not be as effective as TF-CBT in reducing post-treatment PTSD severity (Belsher et al., 2019). However, the review also found that PCT had lower dropout rates compared to TF-CBT, and the differential effects of PCT versus TF-CBT may have attenuated over time. These findings are in line with the CPG recommendation that PCT should be considered as a treatment for certain patients. Clinicians should consider several factors when choosing an evidence-based treatment with their patient. Treatment decisions should incorporate clinical judgment and expertise, patient characteristics and treatment history, and patient preferences that might influence treatment engagement and retention.

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