

American Psychological Association (APA)
Clinical Practice Guideline Development Panel for PTSD

December 14-15, 2014

APA Headquarters
 Washington, DC

Meeting Summary

Attending (*Meeting conducted electronically via GoToMeeting. APA staff and some panel members participate from APA Headquarters (Washington, DC). Other panel members participate from their local areas.)

Guideline Development Panel members: Christine Courtois (Chair), Laura Brown, Thomas Mellman, and Priscilla Schulz (Not attending: and Matthew Friedman)

By phone: Joan Cook, John Fairbank, Joseph Gone, Russell Jones, Annette La Greca, John Roberts, Jeffrey Sonis

Advisory Steering Committee liaison: Thomas Sexton

APA staff: Shannon Beattie, Lynn Bufka, Alissa Forman-Alberti (intern), Raquel Halfond, Howard Kurtzman, and C. Vaile Wright

Day One (Dec. 14)

Panel members were welcomed and APA staff provided an overview of the agenda.

The panel members spent about 20 minutes working on the harms and burdens section of the following decision tables:

- Cognitive Processing Therapy (#1)
- Cognitive Therapy (#2)
- Exposure (#5)
- Cognitive Behavioral Therapy Mixed (#6)
- EMDR (#7)
- Narrative Exposure (#9)

While the panel members completed these decision tables at their previous two-day meeting in September, they decided to expand the ratings for harms and burdens from two to four categories.

As the panel worked through the harms and burdens section, they decided to add a category on withdrawal, which would include two different components:

- 1) Overall dropout in the active component
- 2) Differential attrition between active and comparator

The panel then spent between one to two hours completing each of the following decision tables:

- Comparative Effectiveness (CE) of Exposure vs. Exposure plus Cognitive Restructuring
- CE of CBT Mixed vs. Relaxation
- CE of Seeking Safety vs. Active Controls
- Fluoxetine

As the panel worked through Fluoxetine, the question of whether or not there's been consistency in the way the harms and burdens section has been interpreted across all decision tables was raised. The panel debated about using the rating of "slightly" vs. "clearly" for the harms and burdens section of Fluoxetine. It was argued that Fluoxetine is a unique set of findings relevant to what's been looked at before in terms of there being multiple studies with fairly consistent information. For medication classes, the improvement data are less robust for Fluoxetine. The panel discussed whether they're making ratings based on weighing critical outcomes in particular to secondary outcomes and if so, the evidence for the critical outcomes is quite lower than the evidence for the secondary outcomes. Up until this point, the process has been more about magnitude of treatment benefits, rather than certainty. Dr. Sonis said it should be noted in the comments section of the guideline document that there was a robust debate about the degree to which the panel members decided to weight the magnitude of the effect for the primary outcomes vs. secondary outcomes. In the case of Fluoxetine, the magnitude of benefits for the primary outcome was smaller than the magnitude for many of the secondary outcomes, which was large. This posed the dilemma of whether Fluoxetine should be categorized under "clearly" or "slightly".

Several panel members expressed interest in looking at an additional psychopharmacological treatment, Prazosin, since the most comprehensive study on this particular treatment was published several months before this meeting, and therefore, not included in the AHRQ report. With new data emerging, some panel members said they do not want to miss treatments important to the target audience of the guideline. Other panel members declared concern about reviewing a treatment that had not been included in the systematic review and not adhering to a clear and neutral standard by which treatments are judged. Dr. Cook suggested addressing this issue in the discussion section of the guideline. Given that there are a scarce number of relevant studies for many of these types of treatments, it's possible that one new study might completely change the panel's ratings on a particular treatment. If the panel decides to include Prazosin, Dr. Sonis recommended that they look at any new data available since the AHRQ report for all the treatments rated for the guideline. However, this could extend the project by 1-2 years. The panel decided that they will complete what they already set out to do, and then depending on the timeline, make decisions about what additional work should be done.

The panel discussed including in the preamble to the guidelines notation regarding comparative effectiveness related to clinical relevance not directly derived from empirical evidence. Suggestion made to include a review of the methodology and descriptions of methodology/procedures in the evidence used in addition to how the conclusions differ/converge with alternative guidelines. Suggest addressing how these recommendations map out to other established guidelines/recommendations.

The IOM staff should take a major role in writing core methodological components, purpose/goals and findings. Panel should be brought in throughout and should take on the lead role of common factors and diversity, deficiencies and gaps in the literature. Introduction should include: What do we know? What do we not know? What can we know? Recommendations are key contributions of the panel as are

justification for review and method of process. Implementation consideration (including barriers) cannot be written until after other items but much of this information can be drawn from advisory steering committee. Anticipated draft of text loosely expected by June.

Heavier involvement on the part of the panel: based on our methodology, what can we say and not say? There are critical clinical questions that we want to address but do not have the specificity in the data for yet. Nuances of recommendations. What are the gaps? Descriptions of context re: diversity, relationship, common factors. Concern is expressed re: clinician buy-in. Must be willing to say that we cannot talk about (e.g.) brain spotting and somatic experiencing in context of the epistemology of psychological science. How do we navigate not closing down development of future treatments while still addressing the lack of current empirical support? For example, traction is gaining in support of dissociative amnesia as a mechanism of memory loss; changes in the DSM-5 have restimulated this conversation. Questions were raised regarding whether we will be addressing the network meta-analysis. Will be investigated and readdressed.

Concern is expressed regarding the consistency of the components of the decision table and the process. Suggestions made to take the (e.g.) benefits section for all treatments and farm out to each member of the panel. Results can then be collected, compared and mapped for consistency to ensure a parallel nature of the process.

Suggestion made to send a preliminary draft to council agenda for August. Does it go to council or CLT? Must go to the board in June to make council in August. Final version likely to go to council in August 2016. Must be submitted for public comment (including APA governance groups) 30 (?) or 60 (?) days. Key contacts w/in other organizations have already been identified to send the document to for public commentary. Council will want to see comments and panel response to comments. Do we need to have to have an initial item go to council before precipitating this? No amendments allowed on council floor. Steve Holland (chair of advisory steering committee) will be presenting to council in Feb. Chris invited to join.

Day Two (Dec. 15)

Topic #18: Comparative Effectiveness of: Exposure vs. Exposure plus Cognitive Restructuring. Outcomes: PTSD symptom reduction (critical outcome), loss of diagnosis, prevention or reduction of comorbid depression and prevention or reduction of comorbid anxiety. Quality of evidence graded as low. Upon review, evidence is graded as low due to “imprecision” which refers to a confidence interval that includes the null value. Should studies with point estimates near the null be categorized instead as “unable to rate?” One member votes “unable to rate” and 7 vote “no difference in effect.” A footnote is proposed: “this varies somewhat from previous decisions of the committee based on the comparison of two active treatments. The panel believe that in this case, the point estimate while not tiny was close enough to the null value and the confidence interval was tight enough that it was believed future studies would confirm no difference.”

Quantitative information & evidence about harms specifically in regard to specific serious adverse events is limited. It is not reported by treatment condition in studies. Other serious adverse events: unable to rate. Panel discussed approaching authors of studies at hand for additional data reported by treatment condition. Decision is made to not create this exception. Suggestion to refer to the upcoming National

Childhood Stress Network's series of basic principles about what's required by clinicians before they are trained on trauma specific interventions. Panel discusses need for efforts to encourage research. Suggests that publishers of research on trauma to include a web appendix of all elements of metaanalysis.

What do we want to say about applicability and do we want to keep in the info about cognitive capacity of individuals? Considering it can be done with individuals who are not literate, who have TBIs, etc., do we want to imply that the therapy may be limited to not include individuals with particular cognitive challenges? Proposal to include stmt. "shouldn't rule out the use of this for patients with cognitive inabilities in the absence of an in depth clinical evaluation."

Adapt vs. adopt phenomenon should be mentioned in cultural competence section. How to address what is the acceptable amount of adaptation for special populations? Some adaptations assist in retention but overall the data is too limited. Are we conflating messages to researchers and clinicians?

Disability functional impairment: limited data. Need additional studies. Evidence suggests a potential large effect but CI is not necessarily defensible b/c it is a spread of 25 points and includes the null.

Balance of benefits, harms and burdens favors CBT mixed over Relaxation. Patients' values and preferences: self-help groups rated lowest of treatment approaches. Deleted: patients vary in preferences depending upon types of symptoms. Variability (changed from small group's rating of high to panel's rating of unknown) and certainty (low). Workgroup gave conditional recommendation for use. Panel supports conditional recommendation. Although very few studies, greater dropouts were in CBT mix than in Relaxation group; however, this does not rise to the level of questioning the strength of the recommendation for CBT mix. Large magnitude of benefit to relaxation; however sample size is small and CI is wide. Summary statement should reflect the degree to which harms and benefits are balanced.

Are there substance-abuse related harms that should be considered (e.g. relapse)? Are there phase-ready symptoms that should be mentioned? How should treatments for both PTSD and substance use be described in terms of the primary and secondary foci? Adverse events leading to withdrawals: most of the study's adverse events are related to medical issues. Unable to rate or small harm burden of trmt. 1 relative to trmt. 2? Study at hand does not distinguish dropouts due to AE's leading to withdrawals. Therefore unable to rate.

Study-related adverse events are expected in a more active treatment condition when people are being told about the relationship between trauma symptoms and substance abuse. Might decrease substance use and would then expect more symptom aggravation.

Clinician input re: seeking safety: very positive but often used in group settings not focused on PTSD. Used widely at VAs in generic group settings despite data not existing to support it for PTSD. VA requires concurrent treatment, not sequential treatment. Variability in patient values and preferences: can we use data on seeking safety to answer question about preference for seeking safety over other treatments? Also, clinicians are not specifically treating symptoms of PTSD but instead making it possible for clients to engage in pretreatment that readies them for treatment for PTSD specific treatments. Based on the efficacy data, does this apply to assumptions about using the treatment for PTSD symptoms?

Generalizability. Consider adding that this may be a more symptomatic group due to the substance use. Also mention extensive nature (25+ sessions) of this treatment. Particularly useful in settings that involve

clients who are not ready to engage in trauma-focused therapy or in settings that are equipped for longer term therapy (this statement is based on clinician input but no evidence is highlighted to support this). Due to the length of the treatment or number of sessions involved, short term settings would not be appropriate for the entirety of treatment implementation.

Suggestion to maintain that this is a readiness approach to preparing clients for PTSD treatment. One panel member strongly resists due to lack of any randomized trial experiment. Another maintains clinical perspective that readiness should be a recommendation for PTSD treatment as Seeking Safety is not a trauma treatment. Concern expressed that “no recommendation” may be interpreted as “not recommended” with an assumption that evidence does not exist. A lot of data, however, exists. Discussion section (and not recommendation section) might include that multiple commissions on the panel recognize the benefits of utilizing this treatment but not for the direct treatment of PTSD. Should be included in the discussion of stages of change. Strong recommendation against use of Seeking Safety based on the evidence.

Comparative effectiveness reviews: active treatment comparisons (as opposed to active control comparisons). Venlafaxine ER vs. Sertraline. Unanimous panel votes.

Panel proposes: instead of a strong recommendation for use or against use (which is appropriate when discussing active controls), we should instead state a conditional recommendation for X compared to Y. Caution should also be used when comparing two treatments that have previously been rated by the panel as (e.g.) strongly recommended and not recommended. Proposal to modify the comparative effectiveness recommendation page format. Panel suggests including a middle category that indicates the panel has no preference for recommending one over the other. Will refer to Steve Holland for guidance. Panel also suggests two different recommendation pages (one modified for recommendations for comparative effectiveness) with concern for seeking safety. Should comparative effectiveness studies be done before inactive controls are conducted? For now, we should state that strong evidence exists for there to be no preference for one treatment compared to the other.

What to do with treatments or comparisons that do not have at least moderate quality evidence for at least one outcome (and therefore were not included in the tables)? Why would we include them now? Would they compromise the integrity of our work? Leaving them out would strengthen our ability to make contentions. Panel suggests creating a decision table for doing so. If we have done comparative effectiveness, efficacy data is necessary. Does not need to go the other direction (e.g. if we have efficacy data, don't need to do comparative effectiveness).

Plan of action:

- Modify recommendation page for comparative effectiveness. Make an effort to ensure that (part. w/ seeking safety) that information is translated to these.
- Decision tables sent to whole group. Specifically requesting feedback from panel members who have not been a part of the entire process.
- Add decision table on relaxation.
- Look at consistency across sections. E.g. how are benefits/burdens & harms/patient preferences & values rated?
- Look at summary of a list of recommendations (efficacy & comparative effectiveness).
- Make a master summary of decision tables.

- Document will circulated re: competencies for delivery of trauma-focused care.

Status of Decision Tables

By the end of the two-day meeting, the panel had completed decision tables on the efficacy of: Cognitive Processing Therapy (decision table #1), Cognitive Therapy (#2), Exposure (#5), CBT Mixed (#6), EMDR (#7), Narrative Exposure (#9), and Topiramate (#28). The decision table for Paroxetine (#34) was mostly completed but a question remained about the accuracy of a number reported by RTI for adverse events. The decision table on efficacy of Venlafaxine (#36) was also completed but only seven panel members were present for the vote, and so quorum was not met. Thus the tables on Paroxetine and Venlafaxine will need to be re-visited by the full panel.

Further, because the panel made a change on the second day of the meeting from a two-category to four-category listing of harms and burdens, some decision tables completed earlier will need to be re-visited. These tables include: Cognitive Processing Therapy (#1), Cognitive Therapy (#2), Exposure (#5), CBT Mixed (#6), EMDR (#7), and Narrative Exposure (#9).

Work on the following decision tables also needs to be completed: Comparative Effectiveness of: Exposure vs. Exposure plus Cognitive Restructuring (#18), CBT Mixed vs. Relaxation (#19), Seeking Safety vs. Active Controls (#22), Venlafaxine ER vs. Sertraline (#41); Efficacy of Fluoxetine (#33) and Sertraline (#35).

APA staff and the panel members discussed how to best move forward with completing the remaining decision tables. The panel decided to try completing decision tables electronically via 90-minute Skype or GoToMeeting conferences scheduled once every week or so if possible. Additionally, staff will try to schedule another in-person meeting.

Next Steps

- Panel will continue work to complete and review decision tables via technology and/or in-person meetings.
- Next conference call: January 26, 2015 at 1pm ET.