

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

September 12-13, 2014

APA Headquarters
 Washington, DC

Meeting Summary

Attending

Guideline Development Panel members: Christine Courtois (Chair), Joan Cook, John Fairbank, Joseph Gone, Russell Jones, Annette La Greca, Thomas Mellman, John Roberts, Priscilla Schulz, Jeffrey Sonis, and Sharon Wise (by phone). (Not attending: Laura Brown and Matthew Friedman)

Advisory Steering Committee liaison: Michelle Craske

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

Guest (by phone): Catherine Forneris (University of North Carolina School of Medicine)

Day One (Sept. 12)

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

The panel members spent the first day working together as a full group on the decision tables concerning the efficacy of psychological treatments. The panel agreed that it would begin by reviewing decision tables that were previously worked on by the entire panel at its July in-person meeting (July 13-14, 2014) but that still required additional information to be entered. Upon completing these, the panel agreed to review the decision tables that had only been worked on by small groups at the July meeting. It was determined that every decision table would be reviewed twice in the process.

A panel member expressed concern that information in the evidence profile for narrative exposure therapy might be misleading. Specifically, the panel member questioned the listing in the evidence profile of hospitalizations due to suicidal ideation as adverse events related to narrative exposure therapy, noting that these events occurred prior to treatment (though after randomization) and thus the events were not necessarily due to the treatment.

The panel recalled a previous discussion on one of its conference calls regarding the intention to treat principle. The panel had voted to adopt this principle, given its strong theoretical rationale and despite the fact that inclusion of post-randomization, pre-treatment events are controversial and pose a challenge. Following the intention to treat principle, the panel decided to include the adverse events list in the evidence profile for narrative exposure therapy; however, it also decided to add a note in the decision table indicating that these events occurred post-randomization and pretreatment. The panel agreed it was

important to follow what was listed in the AHRQ report and the intention to treat principle but noted that concerns could be addressed in the discussion section of the guideline document.

Staff shared with the panel written materials it had put together on harms and burdens of the interventions covered in the evidence profiles. The materials provided additional information about dropout rates, adverse events/symptom worsening, and the burdens of each treatment.

The panel had a phone conversation with Dr. Catherine Forneris, one of the co-authors of the AHRQ report (“Psychological and Pharmacological Treatments for Adults With Posttraumatic Stress Disorder (PTSD)”). Dr. Forneris reviewed the classification scheme for psychological treatments that was used to organize studies in the AHRQ report. The classification scheme was based on underlying theoretical orientations of treatments, but received some criticism from reviewers (particularly proponents of particular interventions). She and the panel noted that there is no standard scheme or approach that can satisfy all researchers and clinicians. Dr. Forneris recommended that the panel provide a clear, evidence-based rationale for its classification choices but also to be prepared for criticism of various types.

The panel discussed the fact that it has only weak evidence regarding patient values and preferences and agreed that it needed to compose a statement for the guideline document on this point. Typically in guideline development, the greater variability in patient values and preferences, or greater uncertainty about patient values and preferences, the more likely a conditional guideline recommendation is warranted.

Day Two (Sept. 13)

Panel members spent the second day completing work on the decision tables for psychological treatments and then began working on the decision tables for pharmacological treatments.

In the course of its work, the panel decided to expand the two-category listing in decision tables of “Serious harms” and “Burdens” to the four-category listing of “Adverse events leading to withdrawals,” “Other serious adverse events,” “Other adverse events,” and “Burdens.” The purpose of this change was to enable the panel to better understand and document harms and burdens as part of its process of producing and justifying guideline recommendations.

The panel also decided to list the quality ratings of evidence for benefits and for harms separately, in addition to listing an overall global rating of such evidence. In particular, for interventions for which lack of information about harms would lead to a lower global rating, this approach will provide clearer information to users of the guideline document about the source of the lower quality rating. It was noted that it is more common in studies of psychological than pharmacological treatments for little or no information about harms to be provided. [This approach was subsequently approved by the APA Advisory Steering Committee.]

Some concerns were raised by a panel member about the classification of adverse events in the AHRQ report, particularly for studies of pharmacological treatments. The member noted that events that are classified as adverse in original studies are not necessarily classified as adverse in the report, due to the report using different classification rules. The panel agreed that an inquiry about this should be made to the authors of the report (who are primarily at RTI International). Based on the response, some changes in the already completed decision tables may be needed.

It was also suggested that it would be helpful to have additional information for each scale used in the evidence profiles on what constitutes a clinically meaningful difference. Concern was expressed that the current method of using ranges to estimate clinically meaningful difference may be hard to defend.

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.
- Staff will determine which technology (e.g., GoToMeeting, Skype) to use for future conferences to complete decision tables.
- Staff will pose question about classification of adverse events to RTI authors of AHRQ report.
- Staff will identify additional information about clinically meaningful differences for scales listed in evidence profiles.
- Next conference call: October 1, 2014, 1pm ET. [The panel tested GoToMeeting but did not have a quorum for decision making and adjourned early.]
- [A GoToMeeting conference was held on November 17, 2014. A hybrid in-person/GoToMeeting conference is scheduled for December 14-15, 2014.]