The 2017 Revised Clinical Practice Guideline for PTSD: Recommendations for Psychotherapy

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PTSD Consultation Lecture Series, September 2017
Overview

- Describe guideline development process
- Review psychotherapy recommendations
- Discuss clinical implications and practice changes
VA/DoD Clinical Practice Guideline (CPG) for the Management of Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder (2017)

- Guidelines are designed to provide information and assist decision making
- Guidelines are not intended to define a standard of care

www.healthquality.va.gov/guidelines/MH/ptsd
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<table>
<thead>
<tr>
<th>Name</th>
<th>Title/Role</th>
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| **Jonathon Wolf, MD** | Bethesda, MD |
Stages of Guideline Development

1. Formulate and prioritize Key Questions
2. Convene a patient focus group
3. Conduct systematic review
4. Convene face to face meeting with workgroup
5. Draft CPG recommendations
6. Release for external comment
7. Finalize and submit to Evidence Based Practice Work Group
2017 CPG is an update of the 2010 CPG
Methodology for 2017 based on Guide for Guidelines
Two levels of evidence appraisal:

- US Preventive Services Task Force (USPSTF) method for appraising the quality of individual studies
- Grading of Recommendations Assessment, Development and Evaluation (GRADE) method for appraising the quality of a body of evidence
GOOD if all the following are met:

- Comparable groups at start and follow-up (>80% follow-up)
- Reliable and valid measures
- Clearly defined interventions
- All important outcomes considered
- Appropriate attention to confounds in analyses
- For RCTs, intention to treat is used

FAIR

- Groups comparable at beginning but questionable at end
- Measures are acceptable but not the best
- Some but not all important outcomes considered
- Some but not all confounds are accounted for
- For RCTs, intention to treat is used

POOR if any of the following fatal flaws

- Groups comparable at beginning but not comparable at end
- Unreliable or invalid measures are used
- Key confounds given no attention
- For RCTs, no intention to treat
GRADE: Final Level of Confidence

**HIGH**
- Further research is *very unlikely* to change confidence in the estimate of effect.

**MODERATE**
- Further research is *likely* to have important impact on our confidence in the estimate of effect and *may* change the estimate.

**LOW**
- Further research is *very likely* to have an important impact on our confidence in the estimate of effect and is *likely* to change the estimate
- *Any estimate of effect is very uncertain.*

**VERY LOW**
Strength of a Recommendation Based on 4 Domains

1. Confidence in the quality of the evidence
   – (i.e., high, moderate, low, very low)

2. Balance of desirable and undesirable outcomes
   – (i.e., benefit v. harm analysis)

3. Values and preferences
   – (i.e., similar values, some variation, large variation)

4. Other implications, as appropriate, e.g.:
   – (e.g., Resource use, equity, acceptability, feasibility, subgroup considerations)

Final Recommendation

• Strength of a recommendation on a continuum:
  – **Strong For** (or “We recommend offering this option …”)
  – **Weak For** (or “We suggest offering this option …”)
  – **Weak Against** (or “We suggest not offering this option …”)
  – **Strong Against** (or “We recommend against offering this option …”)

  – **Insufficient** was used when their was a common practice (or a practice getting a lot of attention) that the committee wanted to comment on

## The net benefit of the intervention

<table>
<thead>
<tr>
<th>Quality</th>
<th>Substantial</th>
<th>Moderate</th>
<th>Small</th>
<th>Zero / Negative</th>
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<tr>
<td>Good</td>
<td>A</td>
<td>B</td>
<td>C</td>
<td>D</td>
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<tr>
<td>Fair</td>
<td>B</td>
<td>B</td>
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<tr>
<td>Poor</td>
<td>I</td>
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USPSTF 2007
A  **Strongly Recommend** to offer or provide ...

There is *good* evidence that the intervention improves important health outcomes -- *benefits substantially outweigh harm*.

B  **Recommend** to offer or provide ...

There is *fair* evidence that the intervention improves health outcomes -- *that benefits outweigh harm*.

C  **Consider** offering or providing ....

There is *poor* evidence that the intervention can improve health outcomes -- *balance of benefit and harm is too close to justify a general recommendation*.

I  **Insufficient Evidence is to recommend for or against providing** ...

Evidence that the intervention is effective is lacking or of poor quality, or conflicting, - *balance of benefits and harms cannot be determined*. 
### Key Questions

1. What is the effectiveness and safety of pharmacotherapy treatments for PTSD?

2. *What is the effectiveness and safety of psychotherapy treatments for PTSD?*

3. What is the effectiveness and safety of non-pharmacologic biological treatments, (e.g. stellate ganglion block, hyperbaric oxygen, TMS, etc) for PTSD?

4. Are complementary and integrative treatments (e.g., mind-body practices, natural products, animal-assisted therapy, and creative therapy) safe and effective either as primary treatments or adjunctive to standard treatments?

5. What combined treatment approaches are safe and effective in enhancing treatment response (e.g. 2 meds, med plus psychotherapy)?
### Key Questions

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<td>6.</td>
<td><em>What is the comparative effectiveness of medication and psychotherapy</em></td>
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<td>7.</td>
<td><em>What is the effectiveness and safety of psychotherapy treatments delivered in a group therapy setting?</em></td>
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<td>8.</td>
<td>What is the effectiveness and safety of collaborative care interventions?</td>
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<td>9.</td>
<td><em>What is the effectiveness and safety of treatment delivered via technology based modalities?</em></td>
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<td>10.</td>
<td>What treatments are safe and effective for acute stress disorder or acute stress reaction?</td>
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<td>11.</td>
<td><em>Is PTSD treatment safety and effectiveness altered by presence of comorbidities?</em></td>
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<td>12.</td>
<td>What is the safety and effectiveness of peer support approaches?</td>
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RECOMMENDATIONS
We recommend engaging patients in shared decision making (SDM), which includes educating patients about effective treatment options.

Shared Decision Making (SDM) is an approach in which providers and patients communicate together using the best available evidence to make decisions.
Shared Decision Making is Not:

• Giving your patient a brochure
• Telling your patient about only 1 option
• Always doing whatever your patient wants
• Forcing your patient to be involved in decisions
A Model of Shared Decision Making

**Choice Talk**
Convey that choice exists

**Option Talk**
Inform patients of treatment options in detail

**Decision Talk**
Help patients consider what matters most

We recommend individual, manualized trauma focused psychotherapy over other pharmacologic and non-pharmacologic interventions for the primary treatment of PTSD.

When individual trauma focused psychotherapy is not readily available or not preferred, we recommend pharmacotherapy or individual non-trauma-focused psychotherapy. There is insufficient evidence to recommend one over the other.
Trauma Focused Psychotherapy Defined

• Trauma focused psychotherapy is any therapy that uses cognitive, emotional, or behavioral techniques to facilitate processing a traumatic experience and in which the trauma focus is a central component of the therapy.
  – Just because a treatment includes some exposure or cognitive restructuring does not mean it would be considered a TF treatment.
Lee et al. (2016)  Systematic Review

- Included RCTs that used clinical interviews and active controls

<table>
<thead>
<tr>
<th></th>
<th>8-12 wk pre/post</th>
<th>9 month pre/post</th>
<th>9m. Between Group</th>
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<tr>
<td>SSRI/SNRI</td>
<td>1.43 (1.36 to 1.51)</td>
<td>2.51 (2.14-2.82)</td>
<td>.30 (.12-.47)</td>
</tr>
<tr>
<td>All TF Therapy</td>
<td>2.19 (2.01-2.37)</td>
<td>3.28 (3.02-3.54)</td>
<td>.75 (.57-.92)</td>
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<td>PE+CPT+EMDR</td>
<td>2.74 (2.50-2.97)</td>
<td>4.54 (4.16-4.91)</td>
<td>.80 (.57-1.03)</td>
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Both medication and psychotherapy are effective, but psychotherapy is more effective.

For every 100 people who receive the treatment, how many will no longer have PTSD after 3 months?

- **CPT/PE/EMDR**: 53
- **SSRIs**: 42
- **No Treatment**: 9

We recommend individual, manualized trauma focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioral therapies for PTSD, Brief Eclectic Therapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure.
Trauma Focused Cognitive Behavioral Therapy (TFCBT) Works

**Prolonged Exposure**
- Pre-Treatment
- Post-Treatment
- 9 Month Follow-up
- 5-10 Years

**Cognitive Processing Therapy**
- Pre-Treatment
- Post-Treatment
- 9 Month Follow-up
- 5-10 Years

TFCBT works with complex patients

PE v EMDR v WL in patients with a psychotic disorder

Suicidal ideation in patients receiving PE and CPT

Van den Berg et al., 2015

Gradus et al., 2013
TFCBT works in Veterans

CPT in veterans and civilians

Gobin et al., 2017

PE V PCT in women veterans

Schnurr et al., 2007
• **Specific Cognitive Behavioral Therapies**
  – These are manualized protocols that have been tested with RCTs such as Ehler’s cognitive therapy, Bryant’s CBT, etc

• **Brief Eclectic Psychotherapy (BEP)** is a therapy in which you practice relaxation skills, recall details of the traumatic memory, reframe negative thoughts about the trauma, write a letter about the traumatic event, and hold a farewell ritual to leave trauma in the past.
  – 16 sessions all based on Gerson’s manual (essentially TF CBT plus other components)
  – 4 trials (1 rigorous)
  – high drop out
Other recommended TF Psychotherapies - 2

- **Narrative Exposure Therapy (NET)** was developed for people who have experienced trauma from ongoing war, conflict, and organized violence. You talk through stressful life events in order (from birth to the present day) and put them together into a story.
  - Trials vary in length from 4-12 sessions
  - Some based on Schauer manual others not
  - 9 trials, all but 1 in refugees, most small

- **Written Narrative Exposure** involves writing about the trauma during sessions. Your therapist gives instructions on the writing assignment, allows you to complete the writing alone, and then returns at the end of the session to briefly discuss any reactions to the writing assignment.
  - Sloan Written Exposure Therapy
  - Resick writing account condition
Next step in treatment recommendations

If individual trauma-focused psychotherapy is not readily available or not preferred, then recommend:

- Pharmacotherapy:
  - Sertraline
  - Paroxetine
  - Fluoxetine
  - Venlafaxine

- Manualized individual non-trauma-focused psychotherapy
  - Present-Centered Therapy (PCT)
  - Stress Inoculation Training (SIT)
  - Interpersonal Psychotherapy (IPT)

There is insufficient evidence to recommend one over the other.
What About non-Trauma Focused Therapies?

We suggest the following individual, manualized non-trauma focused therapies for patients diagnosed with PTSD: Stress Inoculation Training (SIT), Present Centered Therapy (PCT), and Interpersonal Psychotherapy (IPT).

- **SIT**: is a form of cognitive restructuring targeting individual thinking patterns that lead to stress responses in everyday life.
- **PCT**: focuses on current problems in a patient’s life related to PTSD
- **IPT**: focuses on the impact the trauma has had on an individual’s interpersonal relationships
- **Evidence**:  
  - Each of these treatments was directly compared to a first line trauma-focused treatment and was shown to be similar  
  - Fewer number of trials than PE/CPT/EMDR  
  - Treatment effects not as large as the TF treatments
- **No recommendation on non-TF CBT because no studies identified**
What About Other non-Trauma Focused Therapies?

There is insufficient evidence to recommend for or against psychotherapies not specified in other recommendations, such as Dialectical Behavior Therapy (DBT), Skills Training in Affect and Interpersonal Regulation (STAIR), Acceptance and Commitment Therapy (ACT), Seeking Safety (SS), and supportive counseling (SC)

- Insufficient: Can be used when a treatment is being widely used and the work group wants to be clear about the evidence.
  - Insufficient does not mean that the treatment is ineffective. It means there is not enough evidence to determine one way or another. For example:
    - ACT: No RCT in PTSD population and ACT did not differentiate from PCT in a new trial in subsample with 80% PTSD (Lang, Schnurr, et al, 2016)
    - SS: In a SR not more effective than TAU for reducing PTSD sx
    - STAIR: Has not been studied as a stand alone PTSD treatment
    - SC: In some trials better than WL but vastly different tx manuals
There is *insufficient* evidence to recommend using individual components of manualized psychotherapy protocols over or in addition to the full therapy protocol.

- 4 RCTs have looked at adding cognitive restructuring to exposure with inconsistent findings.
- Another RCT looked at adding SIT to exposure and found no added benefit.
- CPT dismantling study found CPT, CPT-C, and written account all equivalent at post treatment.
  - Individual components were not better than full protocol.
We *suggest* manualized group treatment over no treatment. There is *insufficient* evidence to recommend using one type of group therapy over another.

- Note that “we suggest” here means something different than “we suggest” under non-trauma focused treatment (or other recs)
  - In this case we are saying it is better than nothing
  - We had a specific key question about group v. individual, so we looked at group treatments

- **Evidence:**
  - SR found group better than no treatment, but no specific group treatment was superior
    - Resick et al., 2015: group CPT = group PCT on clinician rated PTSD
  - No studies compared a specific individual treatment to group
    - Resick et al., 2017: Individual CPT > group CPT published after)
There is *insufficient* evidence to recommend for or against trauma-focused or non-trauma focused couples therapy for the primary treatment of PTSD

- 2 RCTS examining TF couples therapy
  - Monson et al., 2012: Cognitive Behavioral Conjoint Therapy (CBCT) v WL
  - Sautter et al., 2015: Couples Structure Approach Therapy v. family education
  - Both show support for TF couples therapy for PTSD and relationship satisfaction in identified patient (effects not as good in partner)

- Studies could not be considered together because they differed significantly in their approaches
- No studies comparing couples to individual
- But, CBCT is a VA rollout?
  - Makes sense for those patients looking for a couples approach to treatment.
We suggest internet-based cognitive behavioral therapy (iCBT) with feedback provided by a qualified facilitator as an alternative to no treatment.

- Important to understand that there is no evidence for purely online self help interventions – only those where there is support from a care manager, trained peer, therapist or other qualified facilitator

We recommend using trauma-focused psychotherapies that have demonstrated efficacy using secure video teleconferencing (VTC) modality when PTSD treatment is delivered via VTC.

- So far we know that exposure therapies, anger management and CPT can be delivered by VTC
- Other treatments have not been evaluated.
We recommend that the presence of a co-occurring disorder(s) not prevent patients from receiving other VA/DoD guideline-recommended treatments.

We recommend VA/DoD guideline-recommended treatments for PTSD in the presence of co-occurring substance use disorder (SUD).

We recommend an independent assessment of co-occurring sleep disturbance in patients with PTSD, particularly when sleep problems pre-date PTSD onset or remain following successful completion of a course of treatment.

We recommend Cognitive Behavioral Therapy for Insomnia (CBT-I) for insomnia in patients with PTSD unless an underlying medical or environmental etiology is identified or severe sleep deprivation warrants the immediate use of medications to prevent harm.
Summary of Main Findings

• Trauma focused psychotherapy is recommended over medications
• There are additional TF treatments added since the 2010 CPG (BEP, NET, written narrative therapy, other)
• SIT is no longer one of the most highly recommended treatments
• Includes effective non TF options (PCT, IPT, SIT)
• Evidence for Group not as strong as Individual
• Some treatments can be delivered via VTC
• Comorbidity is not a barrier to TF treatment
Differences With Other/Past Guidelines

• VA/DoD 2010:
  – Level A: Recommend CPT, PE, EMDR, SIT
  – Level B: Consider Brief Psychodynamic Therapy for patients with PTSD, Imagery Rehearsal Therapy (IRT) for treatment of nightmares and sleep disruption,

• APA 2017:
  – Strongly recommends CBT, CPT, CT, PE
  – Suggests BEP, EMDR, NET
  – There is insufficient evidence to recommend for or against offering Seeking Safety (SS) or relaxation (RLX).
CLINICAL IMPLICATIONS
• What should I do if my clinic relies heavily on group treatments?
• Are you saying that CPT group is not a recommended treatment?
• Our program tends to offer patients medication first but that is inconsistent with the guideline. What should we do?

Answer:

Administrative Solutions
• What if I am not trained in one of the recommended trauma-focused treatments?
• Is it okay to offer non-trauma focused treatments? What if that is what my patient wants? What if that’s what I think works best?
• What if I have tried one of the recommended trauma-focused treatments and it did not work?

Answer: Shared Decision Making
Please enter your questions in the Q&A box and be sure to include your email address.

The lines are muted to avoid background noise.
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SAVE THE DATE: Third Wednesday of the Month from 2-3PM (ET)

TWO MORE LECTURES ABOUT THE REVISED CPG for PTSD

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<th>Date</th>
<th>Topic</th>
<th>Speaker(s)</th>
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<td>October 18</td>
<td>The 2017 Revised Clinical Practice Guideline for PTSD: Recommendations for Medications</td>
<td>Matthew Friedman, MD, PhD</td>
</tr>
<tr>
<td>November 15</td>
<td>The 2017 Revised Clinical Practice Guideline for PTSD: Why It Matters for Primary Care Providers and What Resources are Available</td>
<td>Andrew Pomerantz, MD and Nancy Bernardy, PhD</td>
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