Effective Health Care

Post-Traumatic Stress Disorder Nomination Summary Document

Results of Topic Selection Process & Next Steps

- Post-traumatic stress disorder will go forward for refinement as a systematic review. The scope of this topic, including populations, interventions, comparators, and outcomes, will be further developed in the refinement phase.

- When key questions have been drafted, they will be posted on the AHRQ Web site and open for public comment. To sign up for notification when this and other Effective Health Care (EHC) Program topics are posted for public comment, please go to http://effectivehealthcare.ahrq.gov/index.cfm/join-the-email-list1/.

Topic Description

Nominator: Health care professional association

Nomination Summary: The nominator outlines several issues with the current state of post-traumatic stress disorder (PTSD) treatment and is interested in a comparative effectiveness review of psychological and pharmacological treatments for PTSD. The nominator expressed interest in how the effectiveness of treatments may differ by factors such as types and severity of trauma experienced (including acute vs. chronic types of PTSD), timing of treatment initiation, patient preferences and therapeutic values, and demographic characteristics; and whether the results of those studies can be synthesized to enable clinicians to recommend particular PTSD treatments based on the presence of one or more of these factors.

Staff-Generated PICOS:
Population(s): Individuals with traumatic exposure (to include interpersonal or domestic violence/abuse, child abuse, sexual abuse/assault/rape, combat/military-related trauma, crime-related events, terrorism, natural disasters, injury survivors, refugees, and asylum seekers) leading to acute stress disorder (ASD) or PTSD diagnosis.
Intervention(s): General and specific types of pharmacotherapy and psychotherapy (including groupings of trauma-focused vs. not), to include complementary and alternative therapies
Comparator(s): Other general and specific types of pharmacotherapy, general and specific types of psychotherapy (including complementary and alternative therapies), and combinations of two or more of these general or specific pharmacotherapies or psychotherapies, in addition to wait list or placebo group participants
Outcome(s): Amelioration of symptoms (reduction in severity of symptoms): assessor-rated and/or self-rated stress symptoms; prevention/reduction of comorbid conditions

(depressive symptoms, anxiety symptoms, suicidal ideation/plans/attempts, substance use); remission (no longer having PTSD/ASD diagnosis); improved interpersonal/social functioning; improved quality of life; return to duty (military)
Setting(s): Outpatient and inpatient primary care or specialty mental health care settings

Key Questions from Nominator:

1. What patient characteristics (including those listed below) are associated with variations in treatment response/outcome? Is there sufficient evidence to support treatment matching based on patient characteristics or resources? What other implications, if any, for development of clinical practice guidelines?
   - **a.** Age (e.g., Children vs. Adults)
   - **b.** Sex/Gender (Men vs. Women)
   - **c.** Race/ethnicity
   - **d.** Socioeconomic Status (living situation)
   - **e.** Time since exposure to trauma
   - **f.** Prior exposure to trauma and other risk/protective factors for PTSD
   - **g.** Employment/Vocation (e.g., Military vs. Police)
2. Is there evidence that the type of traumatic event and degree/type of exposure affects the development of PTSD (and PTSD symptoms)? Are any current treatment approaches for PTSD more effective for victims of particular types of trauma, including those listed below?
   - **h.** War/Combat vs. Terrorism vs. Natural Disaster vs. Assault /Rape/Abuse
   - **i.** Acute/single exposure vs. Repeated/chronic exposure
   - **j.** Direct exposure vs. Indirect/media (location at time of exposure—degree of safety)
3. Is there evidence that practitioner variations in criteria used for diagnosis (e.g., DSM-IV vs. ICD-10) affects the identification of PTSD and/or referral for treatment services? Does this vary by age, sex, or other patient characteristics?

Considerations

- The topic meets all EHC Program selection criteria. (For more information, see http://effectivehealthcare.ahrq.gov/index.cfm/submit-a-suggestion-for-research/how-are-research-topics-chosen/.)

- Acute stress disorder (ASD) and PTSD are similar psychological disorders that develop in response to exposure to a traumatic event. The disorders combined represent a considerable number of adults and children in the US comprising a significant disease burden, especially among military personnel who are at elevated risk for exposure to trauma. Additionally, PTSD is complicated by its high rate of co-morbidity with other psychiatric disorders, most notably substance use disorders and major depressive disorder.

- PTSD treatments span psychological, pharmacologic, and complimentary and alternative medicine (CAM) domains. Various guidelines and systematic reviews have resulted in contradictory recommendations regarding these broad categories of treatments as well as the effectiveness of

specific treatments that fit into each of these areas. Therefore, clinical uncertainty exists about what treatment to select.

- There are no formal systematic reviews of treatment effectiveness by subpopulations of interest to the nominator (including types and severity of trauma experienced, acute vs. chronic types of PTSD, timing of treatment initiation, patient preferences and therapeutic values, and demographic characteristics). Given that no existing review fully meets the breadth of the nomination and a scan of the recent literature suggests that there is adequate evidence for a new review on this topic, this topic will move forward for a new systematic review on both adults and children.