# PTSD Treatment is More Effective When Patients Are Actively Involved in Therapy Choices

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A study of two standard therapies for post-traumatic stress disorder (PTSD) showed that outcomes are better when patient preference is taken into account when prescribing treatment.

While treatment with a selective serotonin reuptake inhibitor (SSRI) and treatment via prolonged exposure (PE) were both effective in the study, the best outcomes were observed in patients who were actively involved in treatment selection. The study by Nora C Feeny, PhD, Case Western Reserve University, Cleveland, OH, is the first direct comparison of an SSRI and exposure-based treatment, and it also highlights the need to consider the patient's preference when prescribing treatment.

Both sertraline (SER) and PE are effective treatments for PTSD, however, they represent very different options. With PE, patients are encouraged to directly approach the trauma memory and trauma-related fears. With SER, this level of engagement with trauma-related stimuli is not necessary.

Dr. Feeny and colleagues sought to understand how the two approaches compare in efficacy for chronic PTSD, and how patient preference for one form over the other may influence the treatment effect.

The study was a randomized preference trial. All subjects viewed a video in which the two treatments were described in a non-biased manner. Patients were then randomly assigned to be further randomized to one treatment or the other, or were permitted to select their treatment option. Patients entering the randomization arm were assigned to PE or SER without consideration of preference (though some patients inadvertently received their preferred treatment). Patients assigned to the "choice" arm were allowed to select their treatment, permitting investigators to determine how patient preference impacts treatment effect.

Out of 426 patients with a DSM-IV primary diagnosis of chronic PTSD, 200 were ultimately allocated to either the randomization arm or the choice arm.

The study population was primarily female with a history of adult sexual assault (31%), adult non-sexual assault (22.5%), or childhood assault (24%). Only 2.5% of patients' PTSD was a result of a combat related incident. The median time since trauma exposure was 12 years, and the average participant reported 9 additional trauma types aside from the target trauma. Nearly all had received prior psychiatric treatment.

"This was a large, diverse and clinically complex sample characterized by longstanding PTSD, extensive trauma exposure, high levels of previous treatment-seeking and substantial comorbidity," Dr. Fenny noted.

Psychopathology and function scales included the Structured Clinical Interview for the DSM-IV (SCID-IV), the PTSD Symptom Scale (PSS-I), the Hamilton Ratings Scale for Depression (HRSD-24), the PTSD Symptom Scale—Self-Report (PSS-SR), the Beck Depression Inventory (BDI), the State-Trait Anxiety Inventory (STAI), and the Sheehan Disability Scale (SDS).

*Highlights from the*
**American Psychiatric Association 163rd Annual Meeting**

SER was administered in a flexible dosing schedule (50-200 mg) under a standardized titration algorithm. Patients were treated in 10 weekly 30-minute sessions.

The PE arm received education about common reactions to trauma, breathing retraining, prolonged repeated exposure to the trauma memory, and repeated *in vivo* exposure to situations they were avoiding. Treatment occurred in 10 weekly sessions of 90 to 120 minutes.

"Overall, both PE and SER showed good efficacy," Dr. Feeny reported. "Globally, almost all the treatment effects for both arms were large. PE may have had a slight advantage in terms of magnitude of change and loss of the PTSD diagnosis at 10 weeks, which is generally consistent with the published literature."

The changes from baseline in key measures of PTSD are shown in Table 1. Treatment effects of 0.8 and higher are considered to have a large impact clinically.

**Table 1. Pre- to Post-Treatment Effect Sizes (ITT).**

| | Choice | | No-Choice | |
|---|---|---|---|---|
| | SER | PE | SER | PE |
| PSS-1 (severity | 1.42 | 1.95 | 0.95 | 1.35 |
| PDS (severity) | 1.68 | 1.74 | 0.99 | 1.41 |
| HRSD (depression) | 0.85 | 0.99 | 0.59 | 0.71 |
| BDI (depression) | 1.27 | 1.31 | 0.71 | 1.22 |
| STAI-S (anxiety) | 1.28 | 1.20 | 0.52 | 1.02 |
| SDS (functioning) | 0.83 | 0.81 | 0.66 | 1.04 |

Since this was an intention-to-treat analysis, which included patients who did not complete treatment, Dr. Feeny believes these results underestimate actual treatment impact.

"Importantly, there were clear effects on PTSD outcome of being randomized to the choice arm," she noted. "Patients who had no choice in their treatment had more diminished effects."

The most prominent effects were seen when there was a discrepancy between the treatment assignment and the patient's preference. Among patients who did not receive their preferred treatment 59% continued to experience PTSD, compared to 29% in non-discrepant cases. They also suffered more severe PTSD as well as depression and anxiety, though some of this effect may be due to lack of treatment adherence.

The study found evidence of lower SER dosage at the end of the study, less adherence to PE homework and lower treatment completion rates among the discrepant population. Mean SER dose was 144 mg/day for patients who chose SER compared with 62 mg/day for those who preferred PE but received SER ($p<0.001$).

In addition, the number of sessions completed was 7.69 for patients lacking discrepancy and 5.14 for those with discrepancy ($p<0.001$), and treatment completion rates were 73% and 49%, respectively ($p=0.002$).