



Disposition of Comments

Draft Version of the *APA Clinical Practice Guideline for the Treatment of Chronic Musculoskeletal Pain in Adults*

Available for public comment from October 5, 2023, to December 4, 2023.

Introduction

The guideline development panel appreciates the many individuals and groups who have taken the time and energy to write thoughtful and detailed comments and critiques of the draft *APA Clinical Practice Guideline for the Treatment of Chronic Musculoskeletal Pain in Adults*. The panel has revised the guideline, as appropriate, based on the comments received from 27 individuals / groups. If the panel believed that the comment justified a change to the guideline document, a change was made and usually indicated in the response to the comment; if not, no changes were made.

Responses to public comments are organized into four sections. The first section contains responses from APA Boards and Committees while the second section contains responses to public comments submitted by larger groups and organizations. The third and fourth section contain responses to comments submitted by individuals either through APA's online public comment system or via email. Please note, while the panel attempted to specify the page numbers of edits in the guideline document, these page numbers may have changed in the final formatting of the guideline. Please use the page number as an approximation for the location of the change.

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Section 1: Panel Responses to Public Comments Submitted by APA Boards and Committees

Commenter (Group or Individual?)	Section	Comment	Panel Response
Jameca Woody Cooper, PhD (Group: CONA-Committee on Aging)	Process and Methods for the CPG	The Committee on Aging (CONA) is a six-member committee focused on the optimal development of older adults, expanded understanding of adult development and aging, and the delivery of appropriate psychological services to older persons. I present these comments on behalf of the entire committee. CONA welcomes the opportunity to comment on the Draft APA Clinical Practice Guideline for the Treatment of Chronic Musculoskeletal Pain in Adults. The Committee on Aging would like more attention given to older adults regarding the following areas. CONA appreciates the inclusion of age in the guidelines. In the section Process and Methods for the CPG in the Diversity of Samples Included in Reviews area (page 35), you state, “In the first review by Skelly and colleagues (2020), most samples included in the studies identified as female, non-Hispanic White and the average age range fell in the typical range included in reporting chronic pain.” What is the typical age range for reporting chronic pain? Please specify and clarify the relevance.	Thank you for your comment. We revised the statement by adding “according to the CDC, the percentage of adults reporting chronic pain in the last 3 months were between the ages of 45-64 (25.8%, respectively) and 65 and older (30.8%, respectively, Zelaya et al., 2020)”. We also expanded on this section to include calculations of demographic data reported in each of the individual studies within the systematic reviews and inserted additional data in Appendix H of the guideline. Reference Zelaya, C. E., Dahlhamer, J. M., Lucas, J. W., & Connor, E. M. (2020). <i>Chronic pain and high-impact chronic pain among U.S. adults, 2019</i> (Issue Brief No. 390). U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Health Statistics. Link



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Jameca Woody Cooper, PhD (Group: CONA)	Considerations for Treatment Implementation	On page 47, in the Cultural and Diversity competence section, please consider including formation concerning aging and the experience of pain. Although social, cultural, and economic variables are known to impact a person's experience of pain, age is also a factor.	Thank you for your comment. We agree that age is an important factor and have added this as a factor that influences the experience of pain (Mullins et al., 2022). Reference Mullins, S., Hosseini, F., Gibson, W., & Thake, M. (2022). Physiological changes from ageing regarding pain perception and its impact on pain management for older adults. <i>Clinical Medicine</i>, 22(4), 307-310. https://doi.org/10.7861%2Fclinmed.22.4.phys
KJ Conner (Group: APA Committee on Disability Issues in Psychology [CDIP])	Treatment Recommendations	Line 288 - What happens after these interventions are organized in the "other treatments reviewed" tier? What is the process/protocol necessary to obtain sufficient evidence? Will they seek further information to revisit these interventions?	The interventions where the panel indicated there was insufficient evidence to recommend for or against one intervention over another intervention mean that there was not enough evidence to make a recommendation and that more high-quality research is needed. The panel was limited to the studies that were included in the three underlying systematic reviews and meta-analyses and acknowledges that there may have been studies that were published after the publication of the systematic reviews and meta-analyses.



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KJ Conner (Group: APA CDIP)	Treatment Recommend- ations	Line 292 - States that the balance of benefits and harms/burdens slightly favors acupuncture, although this was from one study with low strength of evidence (Thomas et al., 2006). The strength/direction is labeled conditional, which is fair, but I suggest omitting acupuncture based on this level of evidence. Recommendations for chronic LBP would be stronger if the acupuncture section were omitted.	Thank you for your comment. Given the prevalence of and strong interest in the use of acupuncture in the realm of pain management, we felt it was important to report information about our findings.
KJ Conner (Group: APA CDIP)	Background and Justification: The Scope of the Problem	Line 373 - Some attention is warranted on how to make non-pharmacologic treatments more accessible.	Thank you for your comment. We agree that it is important to address how to make non-pharmacologic treatments more accessible. While that is not the scope of this review, we are hoping that the guideline serves as an impetus for such work.
KJ Conner (Group: APA CDIP)	Background and Justification: The Scope of the Problem	Line 396 - Some attention is warranted on how to make therapy more accessible for people with chronic pain.	Thank you for your comment. We agree that it is important to address how to make therapy more accessible. While that is not the scope of this review, we are hoping that the guideline serves as an impetus for such work.
KJ Conner (Group: APA CDIP)	Background and Justification: The Scope of the Problem	Line 410 - It might be helpful to include strategies that increase efficacy in prescribing non-pharmacological treatment options, including access barriers.	We hope that by providing these guidelines, clinicians will feel supported in using these strategies. We understand concerns related to the accessibility of treatments. By encouraging a person-centered approach and shared decision-making including the consideration of available resources, we believe that barriers will be discussed and addressed on a case-by-case basis to provide these treatment options.



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Rebecca Wilbur (Group: APA Committee on Disability Issues in Psychology [CDIP])	General	While I understand where the language and scope of 'intended use of guidelines' language comes from (an effort not to restrict psychologists' practice ineffectually), in other APA clinical practice guidelines, such as the Multicultural Guidelines or Sexual Minority Persons Guidelines there is substantial information regarding cultural awareness, including history of discrimination, language, systems of oppression, impact to daily life, etc., prior to this statement. Beginning this document without an acknowledgment of the culture of disability, including development and differences in language, the disability rights movement and the impact of disability culture through laws (ADA and subsequent acts), differences between visible and invisible disability is a huge oversight for a clinical practice guideline. This type of information was not excluded for other minority groups and it is unclear why the social psychology of invisible disability was almost completely omitted (with the exception of half a sentence in line 985 that references that pain may impact other elements of the person's life). Other clinical practice guidelines do discuss the impact to work, education, family, and socio-political impact but not for a group with a particular type of disability. I greatly appreciated the thoughtfulness that was taken in writing this document and discussion about potential bias in the taskforce and the	Thank you for your comment. We will include more information on the importance of considering cultural awareness in individuals with disabilities in the “implementation considerations” section. In this section, we will also reference APA’s (2022) <i>Professional practice guidelines for assessment and intervention with persons with disabilities</i> for clinicians to refer to as they work with this population with chronic musculoskeletal pain. We would like to note that APA’s (2017) <i>Multicultural guidelines</i>, and APA’s (2021) <i>Professional practice guidelines for psychological practice with sexual minority persons</i> are professional practice guidelines which differ from clinical practice guidelines. Clinical practice guidelines are focused on specific disorders and interventions and are based on a review of the scientific evidence, while professional practice guidelines are mainly concerned with how practice is conducted with particular populations or in particular settings. These guidelines are complementary to each other such that as providers use clinical practice guidelines, they are also encouraged to consult relevant professional practice guidelines. The panel identified “employment status / disability” as one of its important outcomes and attempted to search for this information in the underlying evidence for the recommendation statements, however there was a lack of reporting of this outcome in the individual studies that were included in the underlying systematic reviews and meta-analyses.
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		contribution that each perspective has made. I also believe that the review of the literature and meta-analyses is very thorough and clearly written in a manner that supports clinicians in their treatment recommendations and education with clients. However, in order for this to be considered an APA Clinical Practice Guideline, more consideration about the culture of disability (with special attention to invisible disability) is strongly recommended.	
Rebecca Wilbur (Group: APA CDIP)	Recommendations for Research	Line 319 - Where did this recommendation about weight loss come from?	Thank you for your question. The individual studies that were included in the underlying systematic reviews and meta-analyses included “weight loss / reduction” as one of its outcome measures.
Rebecca Wilbur (Group: APA CDIP)	Background and Justification: The Scope of the Problem	Line 539 - Chronic widespread "pain"?	Thank you for your feedback. We will further specify the term “chronic widespread pain” by inserting the following in the document as a footnote: “Chronic widespread pain” is, according to Mansfield and colleagues (2016), characterized by long-lasting pain in multiple body regions and is associated with other physical symptoms such as fatigue, concentration problems, and psychological distress. Chronic widespread pain is common, with an estimated general population point prevalence of 10%



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Rebecca Wilbur (Group: APA CDIP)	Considerations for Treatment Implementation	Line 985 - I would add "This type of invalidating experience may occur when seeking medical treatment, in the workplace, at school or within their family and likely contributed to increased stress and possibly behavior patterns that further impacted pain. Kattari, S. K, Olzman, M., & Hanna, M. D. (2018). "You Look Fine!": Ableist Experiences by People With Invisible Disabilities. Journal of Women and Social Work, 33(4), 477-492. Boyd (2012) Are some disabilities more equal than others? Conceptualising fluctuating or recurring impairments within contemporary legislation and practice, Disability & Society, 27:4, 459-469, DOI: 10.1080/09687599.2012.662828	Thank you for your recommendation. We modified the guideline accordingly.
Rebecca Wilbur (Group: APA CDIP)	Discussion	Line 1268 - The reviews of current guidelines is written in a way that is very succinct and makes them easy to compare.	Thank you.



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Ritu Verma (Group: APAGS)	General	The American Psychological Association of Graduate Students (APAGS) Committee is pleased to provide the following comment to the Clinical Practice Guideline for the Treatment of Chronic Musculoskeletal Pain in Adults. We hope that our comments will be helpful for revisions to the proposed guidelines. We are able to support the passage of the proposed guidelines in their current form. Comment 1: Line Edits- Line 1073: please change to “Cultural Humility and Diversity Competence” Line 1088: please update acronym to “LGBTQIA2s+” to reflect current acronym status Comment 2: Overall, the document reflects a person-centered approach to clinical work with individuals with musculoskeletal pain. It promotes shifting from a frame of clinician-driven expertise to one of collaboration where the clinician seeks to understand the lived experiences of the individual they are working with. Such an approach has noted to increase the strength of the therapeutic alliance and improve outcomes for the individual being served. This approach also allows for the integration of cultural humility across all aspects of treatment and assessment, which have previously been treated as “competencies” and not central components to achieving well-being for the patient.	Thank you for your comment. We will make the edits. Thank you. We truly believe in a person-centered approach to chronic pain treatment. We agree that qualitative research provides a unique perspective on the lived experience of chronic pain and do try to note this within the implementation considerations section. The panel though was limited to the data presented in the three systematic reviews and meta-analyses that served as the underlying evidence and we recognize this as one of the limitations of the methodology. However, these guidelines are focused on making recommendations for treatment which rely on treatment efficacy studies. These efficacy studies use a quantitative/experimental approach per the Institute of Medicine (IOM, now National Academy of Medicine) 2011 standards. However, the IOM allows observational studies and qualitative research in considering the harms and burdens and patient values and preferences of specific treatments to be considered as the panel reviewed the efficacy data. Further, additional ways to incorporate qualitative data into future CPGs is being considered by APA’s Advisory Steering Committee overseeing the clinical practice guidelines initiative.
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		One area that can be improved upon is the integration of qualitative-based research in the cited literature. Though three studies were cited, there was a single mention of a qualitative study in the body of the guidelines. This is an unfortunate oversight that can unintentionally perpetuate the prioritization of standardized data that oftentimes overlooks, at best, or silences, at worst, the experiences of historically marginalized and oppressed communities. Further, when it comes to understanding the individual experiences of adults with musculoskeletal pain, it is imperative that we actively include research that centers the words and lived experiences of these adults with more depth and nuance that is afforded by numbers and statistics.	



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Allison Gillens (Group: APA Committee on Early Career Psychologist s)	General	Thank you for the opportunity to review the draft of APA Clinical Practice Guideline (CPG) for the Treatment of Chronic Musculoskeletal Pain in Adults. Overall, the proposed comprehensively reviews recent systematic reviews of the scientific evidence for treatment of chronic musculoskeletal pain as well as limitations of current evidence. Appreciation is noted for the efforts to transparently identify how specific decisions were made as well as to clarify strengths and limitations of current evidence. After careful review of the draft, there are no major concerns identified from an early career lens.	Thank you for taking the time to review the document and sharing your feedback.



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Allison Gillens (Group: APA Committee on Early Career Psychologist s)	Considerations for Treatment Implementation	A minor suggestion is offered regarding the development and recognition of interprofessional competencies in pain. In the section on Professional Competence (lines 995-1011), several methods for demonstrating competence are noted including licensure, specialty training, and board certification. Unavailability of board certification in pain is specifically mentioned as a challenge to finding clinicians in the field with expertise (lines 1008-1009). Further clarification or revision of this statement may be helpful. Rehabilitation psychology, for instance, does include pain-related competencies for board certification. Assessment and intervention for pain may also be a part of clinical health psychology board certification. Some concern is noted that potential additional requirements for specific certifications would create additional financial and practical burdens for early career psychologists as they enter professional practice. Further, it is not clear that availability of board certification in pain would be the most efficient or best method to find clinicians with expertise in pain, though it certainly would reflect a high level of competency (and specialty identification) among clinicians who choose to pursue this.	Thank you for your comment. While the board certification process for other specialties in psychology (e.g., rehabilitation psychology) includes a section on pain, there is no specialization that is 100% focused on pain. This can pose a challenge when referring clinicians are looking for a pain psychology specialist. Thank you for your comment, we have modified the text for better clarity.



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Julie Koch (Group: Committee on Global Psychology)	General	These guidelines appear to be exclusive to practice in the US; the CGP does not have comments to add.	Thank you for your comment and review. While the individual studies identified within the three systematic reviews included studies from outside the U.S. (please see Appendix H for a comprehensive summary of the demographic data), we appreciate that all health care systems are different, and that this guideline may be more focused on practice in the U.S. Hopefully international organizations can consider our guideline as a foundation for when they create their own guideline.

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Section 2: Panel Responses to Public Comments Submitted by Groups / Organizations

Commenter (Group or Individual?)	Section	Comment	Panel Response
Amy Goldstein (Group: Alliance to Advance Comprehensive Integrative Pain Management [AACIPM])	General	The Alliance to Advance Comprehensive Integrative Pain Management (AACIPM) is respectfully submitting comments on the Draft APA Clinical Practice Guideline for the Treatment of Chronic Musculoskeletal Pain in Adults (the “draft guideline”). AACIPM is a multi-stakeholder collaborative comprised of more than 75 organizations representing people living with pain, public and private insurers, patient and caregiver advocates, researchers, purchasers of healthcare, policy experts, and 37 professional trade organizations representing the full spectrum of healthcare providers. These diverse experts are united in a shared interest to advance access to a value-based, person-centered model of integrative pain care focused on maximizing function and wellness that includes biomedical, psychosocial, complementary and integrative health, and spiritual care. It is with this unique perspective that the undersigned members of AACIPM respectfully offer the following comments. APA’s draft guideline focuses on an important and timely topic, given the related burden on individuals and society. We appreciate APA’s efforts to be transparent throughout the guideline development process and believe that the	We appreciate your careful review and critical feedback of the draft guideline.



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		APA’s draft guideline is strengthened by its multidisciplinary authorship. AACIPM has spearheaded this collective comment on behalf of the alliance and collaborating organizations – all of whom added to this comment. The collective supports the stated intentions of the guideline: to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists. However, upon reviewing the draft guidelines, we are concerned that the draft guideline does not fully align with those stated intentions.	
Amy Goldstein (Group: AACIPM)	General	Whereas many healthcare professionals provide biopsychosocial therapy, there is also a stark shortage of trained professionals who know what to do with people living with chronic pain. Individuals struggling with pain and co-morbid mental health issues are referred to psychologists and other mental health professionals who need to provide compassionate, competent care. However, the draft guideline seems quite ‘medical’ in its tone and we don’t see this document as guiding psychologists, specifically, in what they need to know to be most effective in their roles. Rather, the draft seems to be a much broader guideline regarding pain management treatments, including those wholly unrelated to behavioral health, many of which must be administered by non-psychologists. We strongly urge the APA to consider making their guideline narrower in scope,	Thank you for your comment. We further clarified in the guideline that it is intended for a “team approach” in treating chronic pain. Chronic pain is not a symptom, rather it is a disease that warrants a multidisciplinary approach. In early 2020, the APA developed an initiative to address the limited number of individuals trained to work with individuals with chronic pain via various workshops (e.g., Prasad et al., 2023 on the role of psychology in addressing pain and related opioid dependence). Prasad, R., Kelly, J., & Bruns, D. (2023). <i>The role of psychology in addressing</i>



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		focusing on psychological treatments and their place in a pain care plan.	<i>pain and related opioid dependence.</i> Nevada Psychological Association. Link
Amy Goldstein (Group: AACIPM)	General	Furthermore, we are concerned that the draft guideline would not serve to improve payor policy in any way that would be helpful to advancing patient care and improving coverage of behavioral health care for pain management. The content of many guidelines offered by professional associations is utilized by public and private healthcare payors to help determine which treatments are worthy of coverage and reimbursement. However, our alliance is concerned that the draft guideline, based on an extremely limited review of the evidence, will inadvertently draw into question the efficacy of some therapies. Our membership, including those representing private insurers, has expressed deep concern that the APA's draft guideline if finalized, could be used to deny care rather than to support care. If the scope of the draft guideline cannot be narrowed as suggested above, we strongly recommend that APA release its work as a white paper or other document that comes short of a formal guideline. Because of the lack of available evidence used as the basis of this draft guideline (just three systematic reviews that met established quality criteria), the APA might consider reframing their work so that it points out the evidence that we still need from researchers and unpacking the causes of suboptimal integrative pain care.	Thank you for your feedback. The coverage of treatments by insurers is beyond the scope of the guideline. The individual studies within the three systematic reviews/meta-analyses that served as the underlying evidence for the recommendation statements also did not address cost-effectiveness of the treatments. We want to emphasize that psychologists are well-equipped to manage pain beyond the system via a biopsychosocial approach and the guideline's scope was purposefully broad given the multidisciplinary care that is recommended for treating individuals with pain.



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Amy Goldstein (Group: AACIPM)	Considerations for Treatment Implementation	Cultural and Diversity Competence: We are grateful for the inclusion of this important section. Thoughtful attention to diversity-related considerations in pain management is vital to combat unintentional bias and stigmatization and to provide care that aligns with a patient's values, preferences, culture, and other individual characteristics. As we elaborate further below, however, advancing cultural diversity and competence should be threaded through the entire document, with key consideration of the potential unintended consequences of issuing a guideline based on limited evidence that may well impede care for those who cannot afford to pay for it out of pocket.	Thank you for your review. We will ensure that this is addressed throughout the document.
Amy Goldstein (Group: AACIPM)	Considerations for Treatment Implementation	Shared Decision Making: We appreciate the discussion on the importance of shared decision making between the provider and patient. Further, the focus on individuals with intellectual disabilities is valued, as they are often excluded from related discussions. However, while we are appreciative of the nod to caregiver involvement on line 1103, the draft guideline only alludes to caregiver involvement as it relates to those with an intellectual disability. Caregivers fit into shared decision making for many other vulnerable populations and should be addressed. We would urge the APA to	Thank you for your comment. We agree that caregiver involvement is an integral part of chronic pain care and is not limited to just one domain. We will expand by including existing literature that notes the caregiver involvement in treating individuals with chronic pain.

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		broaden their inclusion of a caregiver's role within the guideline, as caregivers are involved in the care of far more people living with pain than only those with an intellectual disability.	
Amy Goldstein (Group: AACIPM)	Considerations for Treatment Implementation	Trauma-Informed Care: There is no reference to trauma-informed care anywhere within the draft guideline. Given the high prevalence of trauma among the population both living with pain and receiving behavioral health care, there is a strong need for providers to utilize trauma-informed approaches to care when working with these individuals. Because this is guidance for treating pain aimed at psychologists, the absence of a trauma-informed lens seems conspicuous. We believe that the section "Role of Patient and Provider Factors in Treatment for the Problem" would be a good place to include information on both stigma and trauma-informed care. Lines 923-925 state that people with pain are often "defensive" and "skeptical", and the next paragraph states that these individuals may have limited trust in the health care system. When discussing how the person with pain needs validation from the provider in order to be open to a meaningful partnership, the guideline would benefit from added language about integrating trauma-informed care into one's practice.	Thank you for your feedback. We agree that this is an important area but unfortunately this was not specifically addressed in the studies that were in the underlying systematic reviews and meta-analyses.



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Amy Goldstein (Group: AACIPM)	Considerations for Treatment Implementation	Comorbidities: Our alliance and collaborating organizations believe a discussion of comorbidities in a guideline related to the intersection of pain and behavioral health care is vital. However, we feel that the discussion presented in the draft guideline could be improved. While we agree that the elements presented in lines 1024-1029 are important to screen, it is not clear how each relates directly to the topic of comorbidities. Further, there is no mention of substance-use disorders (SUD), including opioid-use disorders (OUD), within the draft guideline. Data supports that nearly half of patients with opioid use disorder have co-occurring pain. For a guideline aimed at psychologists working with people living with pain who are receiving behavioral health care, we find it unfathomable that there would be no mention of SUD or OUD within the comorbidities section. We strongly recommend that APA reconsider this section, ideally resulting in more explicit recommendations related to treating patients living with both chronic pain and SUD/OUD.	Thank you for your feedback. We have revised the sentence within former lines 1024-1029 for better clarity. We agree and recognize that substance use, and opioid use co-occurring disorders are important to address, however this was outside the scope of the guideline. The three systematic reviews that served as the underlying evidence for the recommendation statements also did not include studies that assessed opioid, or substance use disorders.
Amy Goldstein (Group: AACIPM)	Background and Justification: The Scope of the Problem	We are concerned that this section includes information that is outdated and misleading. The draft guideline currently relies largely on “Relieving pain in America: A blueprint for transforming prevention,”	Thank you for your comment. We reviewed the reports and updated the references in the guideline document accordingly. We are also aware that there have been updates on AHRQ’s

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		a 2011 report from the Institute of Medicine that was based on data from 2008. However, the top recommendation from that report was to convene a workgroup and create a national pain strategy. Since that time, those recommendations have come to fruition through both the “National Pain Strategy” and the “Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations.” Therefore, we are confused as to APA's reliance upon the IOM report from 2011 as opposed to the much newer and more fully-informed reports from 2016 and 2019; as well as AHRQ updates of their systematic review on nonpharmacologic therapies.	systematic review on nonpharmacological therapies for chronic pain, however the reviews were published after the panel’s initial search date.
Amy Goldstein (Group: AACIPM)	Background and Justification: The Scope of the Problem	The background section of the draft guideline perpetuates a pervasive stigma that conflates chronic pain with opioid use disorder and overdose death—a falsehood that can be easily mitigated by already documented facts. Public health reports of addiction or overdoses often fail to distinguish medical vs. nonmedical use, but overdoses have more than doubled at a time when 43% fewer opioids were prescribed. In fact, a CDC study (O'Donnell, 2020) showed that fewer than 10% of opioid overdose deaths were linked to a single prescribed opioid, while over 84% of fatalities involved an illicit drug (non-pharmaceutical fentanyl, heroin, cocaine or methamphetamine). Only 8% of overdose deaths in 2020 were related to prescription drugs alone.	Thank you for your comment. We have revised this section to characterize these current relationships and further clarified accurately.



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		The statement “public health impact of chronic pain has become more apparent by an ongoing opioid crisis” should be clarified or deleted, as concern about the opioid crisis has repeatedly harmed many patients with chronic pain who are being denied access to primary care (O'Malley, et al (2017); Lagisetty et al. (2021)).	
Amy Goldstein (Group: AACIPM)	Discussion	This section discusses the “Strengths and Limitations of the Systematic Reviews.” Our stakeholders are gravely concerned that the recommendations within the draft guideline are based on just three systematic reviews (Geraghty et al., 2021; Skelly et al., 2020; Williams et al., 2020) that met established quality criteria. Sweeping recommendations and the promulgation of an official guideline by the APA —based on so few evidentiary resources—have the potential for unintended consequences and may actually undermine access to care. While APA has been transparent regarding the lack of evidence, and has rightly emphasized the need for providers to use their best judgment and shared decision-making when selecting a treatment plan, the takeaway by most audiences will not likely reflect any such nuance. Treatment and, importantly, coverage decisions will be made on the recommendations and in light of the “lack of evidence.” We have seen recent examples of this sort of issue play out in real-time with the 2016 Centers for Disease Control and Prevention’s Guideline, where recommendations based transparently	Thank you for your comment. We respect and share your concerns. As you pointed out, our methodology approach limited us in terms of the literature that we were able to review. We hope that our guideline will not be used for nefarious purposes to deny coverage and have specifically clarified this further in the guideline document.



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		on “low” or “poor” quality of evidence were implemented strictly, compelling the agency to issue a corrective due to the large number of people living with pain whose treatment had been negatively impacted.	
Amy Goldstein (Group: AACIPM)	Discussion	We urge APA to consider widening its pool of evidence (we know of 11 systematic reviews of nonpharmacological treatments of chronic musculoskeletal pain published 2021-2023), or, alternatively, reframing the draft guideline as a white paper or other publication that doesn’t issue formal guidelines but rather discusses the evidence that we have, the evidence that we lack, what we need from researchers, and generally unpack the causes of suboptimal integrative pain care. Doing so is especially critical as the public health environment embraces a health equity lens. Coverage entities are likely to decide that the lack of evidence will not justify payment for many recommended treatments, leaving them available only to those who can pay for care out of pocket.	Thank you for your comment. Our initial review period was between February 2021 and April 2021 (with another review ending in April 2022). We appreciate that other reviews may have been published since that time or were about to be published, but unfortunately reviews that were published between mid-2022 to 2023 were outside the scope of the guideline.
Amy Goldstein (Group: AACIPM)	General	(This includes a General Comment Re: Exercise followed by a list of the Undersigned Individuals and Collaborating Organizations for this entire submission) Our alliance is confused and concerned with the selection of “Exercise” as the basis for comparison of the efficacy of all other pain treatments.	Thank you for your comment. We appreciate the concern about using exercise as a basis for comparison. Exercise was broadly defined and ranged from simple, self-directed movement to formal exercise under guidance of a specialist.

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		First and foremost, our patient representatives are concerned with the comparison to exercise because many people living with pain need to complete and/or engage in several other therapies before they are ready to access exercise as a treatment. Thus, comparing other treatments to exercise is futile in the case of any patient with debilitating severe pain.	
Amy Goldstein (Group: AACIPM)	General	Our representation from the field of Occupational Therapy reiterates this concern, stating that the draft guideline's failure to mention Activities of Daily Living (ADLs) is a missed opportunity. ADLs are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating. Many people with severe pain have difficulty with their ADLs, let alone being able to participate in an exercise program.	Thank you for your concern and for the additional details. As noted above, Exercise was broadly defined and ranged from simple, self-directed movement to formal exercise under guidance of a specialist. The studies that were identified within the systematic reviews that were used as the underlying evidence did include ADLs as one of its baseline measures.
Amy Goldstein (Group: AACIPM)	General	Additionally, exercise without consideration for appropriate type and dose as well as necessary modifications and a means by which a patient can assess and report their response to the exercise lacks specificity and reliability. It is important to differentiate self-adopted exercise from prescribed movement and therapeutic exercise as would be the case under a physical therapy plan of care. The Undersigned	Thank you for further clarification. Again, exercise was broadly defined and ranged from simple, self-directed movement to formal exercise under the guidance of a specialist. We agree that any exercise program should be personalized.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
		AACIPM and its collaborators sincerely thank APA for the steps it is taking to improve care for Americans living with MSK pain. We are truly grateful for the obvious effort that has gone into the proposed guidelines. We offer these comments to APA in the spirit of collaboration and person-centered pain care, and we sincerely thank you for considering our recommendations. Individual Signatories (Alphabetically) Paul Arnstein, PhD, RN, FNP-C, PMGT-BC, FAAN, Professor (Adjunct) MGH Institute of Health Professions Katie Bennett, JD, Law and Ethics Columnist, MedCentral Heather Finley, PhD, DBSM, Licensed Psychologist-Doctorate, Comprehensive Pain Program, The University of Vermont Medical Center Amy Goldstein, MSW, Director, Alliance to Advance Comprehensive Integrative Pain Management David L. Katz, MD, MPH, Past Director, Integrative Medicine Center at Griffin Hospital Brian Kaufman, DO Martha Lawrence, CEO & Co-Founder, AccendoWave	



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Commenter (Group or Individual?)	Section	Comment	Panel Response
		Natalia Morone, MD, MS, Associate Professor of Medicine, Boston University Chobanian & Avedisian School of Medicine Kate Nicholson, J.D., Executive Director, National Pain Advocacy Center Jon Porter, MD, Medical Director and Division Chief, Comprehensive Pain Program at the University of Vermont Medical Center, Director, Osher Center for Integrative Health at the University of Vermont Adam Seidner MD MPH, Chief Medical Officer, The Hartford Richard M. Vaglienti MD,MBA,FASA, Director WVU Center for Integrative Pain Medicine Organizational Signatories (Alphabetically) American Association of Naturopathic Physicians American Massage Therapy Association American Occupational Therapy Association American Physical Therapy Association American Society of Acupuncturists Andrew Weil Center for Integrative Medicine, College of Medicine, University of Arizona, Tucson, AZ	



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Commenter (Group or Individual?)	Section	Comment	Panel Response
		International Association of Yoga Therapists National Association of Social Workers National Pain Advocacy Center The Pain Community	
Amy E. Mager (Group: ASA: American Society of Acupuncturists)	The APA Clinical Practice Guideline for the Treatment of the Problem	INTRODUCTION Chinese Medicine is a whole-person model of care that not only affects the physical symptoms of the patient, but also addresses spiritual, emotional, and mental aspects of health. Integrative medicine approaches that include management of stress, anxiety, and inflammation are often more effective in treating chronic conditions than pharmacological treatment alone. (Roth et al, 2021). Acupuncture is documented as an effective treatment for mental emotional issues such as anxiety, with few side effects. (Li et al 2022)	Thank you for your comment and for sharing with us these references. The studies referenced were outside the scope of the search period for identifying systematic reviews and meta-analyses. Our initial review period was between February 2021 and April 2021 (with another review ending in April 2022). We understand and appreciate that this is one of the limitations of the guideline methodology. Acupuncture studies were also included in the systematic reviews that were used as the underlying evidence for treatment recommendations.
Amy E. Mager (Group: ASA)	The APA Clinical Practice Guideline for the Treatment of the Problem	MECHANISMS OF PAIN RELIEF Acupuncture is well-known for its effectiveness in the treatment of pain. There have been over 60 years of research on the effects of acupuncture. It has become popular around the world for reducing the suffering of both acute and chronic pain. The effect of acupuncture on specific painful conditions	Thank you for your comment. We were limited to larger systematic reviews and meta-analyses rather than individual studies as the basis for our evaluation. We appreciate that this is inherently associated with some limitations.



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		are well documented for low back pain, neck pain, osteoarthritis and many other specific conditions. (Nielsen et al 2022). The neural pathways have been mapped from acupuncture point stimulation, to the spinal cord to the deactivation of the pain centers in the brain. (Longhurst et al 2017, Zhang et al 2012) Acupuncture has been demonstrated to activate a number of the body's own natural pain killing opioids as well as improving the brain's sensitivity to opioids. (Harris et al 2009)	Thank you for sharing with us the review by Nielsen and colleagues (2022). Unfortunately, the review is outside the scope of the guideline as it covers the topic of "acute" pain. The review was also published after the panel's search, which we note and appreciate as one of the limitations in the methodology.
Amy E. Mager (Group: ASA)	The APA Clinical Practice Guideline for the Treatment of the Problem	Acupuncture has been demonstrated to reduce pain, stress and anxiety. Studies show that acupuncture may alleviate symptoms by lowering inflammation, modulating the immune response, and influencing nitric oxide production. Certain acupuncture points promote microcirculation. Acupuncture can also regulate the parasympathetic nervous system via the vagus nerve, which affects the cardiovascular, pulmonary and digestive systems. Acupuncture points Pericardium 6 and Stomach 36 mediate an anti-inflammatory response through the vagus nerveiii. It can decrease inflammatory markers that are present in many situations of pain, and arthritis. (Shi et al 2020) A number of other biochemicals involved in pain reduction have been found to be released or regulated by acupuncture stimulation, including GABA and substance P. (Zhao 2008). Acupuncture can reduce inflammatory	Thank you for your comment. The panel was limited to larger systematic reviews and meta-analyses rather than individual studies as the basis for our evaluation. Due to this restriction, we cannot add additional material that might be found in other sources as it has not gone through the rigorous review that high quality systematic reviews would require in order for the study to be included in the review. We appreciate that this is inherently associated with some limitations.

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		markers such as cytokines, and other inflammatory substances in the body.	
Amy E. Mager (Group: ASA)	The APA Clinical Practice Guideline for the Treatment of the Problem	Acupuncture has been demonstrated to be involved in neuroplasticity in the brain. (Maeda et al 2017). This work showed that acupuncture relieved symptoms and improved median nerve function at the wrist by distinct neuroplasticity in the primary somatosensory cortex following therapy. (Maeda et al 2017) Acupuncture initiates a process called purinergic signaling, in the body using adenosine and ATP for signaling and regulation in all tissues and organ systems (Burnstock 2014) This purinergic signaling is a central pathway that acupuncture activates, helps explain how acupuncture is effective in such a diverse array of clinical areas	Thank you for your comment. The panel made the decision to focus on Behavioral / psychological content, curriculum-based interventions (any curriculum-based intervention / program as long as there is a psychological / behavioral component within the intervention / program), as well as complementary and integrative treatments. Multimodal treatments were also considered and included. Studies on acupuncture that met the IOM standards were included.
Amy E. Mager (Group: ASA)	The APA Clinical Practice Guideline for the Treatment of the Problem	It is now understood that all nerve transmission requires ATP as a co-factor and the that the body uses purine levels as a primary background signal of both healthy function and tissue damage. Studies on mice demonstrate that those that were bred to be unable to bind to adenosine did not have pain relief from acupuncture. (Cai et al 2009, Bally et al 2017) ATP acts as a co-transmitter, or a short-term signaling molecule in nerves, both in the peripheral nervous system and central nervous system. ATP acts as a signal in neurotransmission, neuromodulation, neurosecretion,	Thank you for your comment. The panel made the decision to focus on Behavioral / psychological content, curriculum-based interventions (any curriculum-based intervention / program as long as there is a psychological / behavioral component within the intervention / program), as well as complementary and integrative treatments. Multimodal treatments were also considered and included.



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		and immunomodulating effects. It also has potent, long-term cell behavior. Pathological function of this purinergic signaling leads to many diverse diseases, such as migraines and headaches (Fried et al 2017), immune dysfunction and inflammation (Faas et al 2017), gout, cancer, autism, Alzheimer's, cardiovascular disease, endocrine function (Burnstock 2013) While pharmaceutical companies are currently attempting to develop drugs in all of these areas to inhibit or enhance purinergic signaling, (Borea 2016), safety is an issue as the balance of these compounds at the cellular level is delicate, and both too much and too little adenosine and ATP are associated with disease. However, stimulating improved self-regulation of purinergic signaling through acupuncture treatment is likely both effective and safe.	Studies on acupuncture that met the IOM standards were included.
Amy E. Mager (Group: ASA)	The APA Clinical Practice Guideline for the Treatment of the Problem	PART 2 Low Back Pain Numerous randomized control trials (RCTs) have been conducted on the benefits of acupuncture for the treatment of chronic LBP. With the exception of the 12 recent and/or small trials (all N<200), [Comachio et al 2016, Kong et al 2020, Luo et al 2019, Cho et al 2013, Weiss et al 2013, Yun 2012, Hunter 2012, Miao 2010, Zaringhalam 2010, de Carvalho 2018, Kizhakkeveetil et al 2017, Liu et al 2017] the RCTs have been summarized in over ten systematic reviews. Although several systematic reviews suggest that no clinically meaningful differences are observed between acupuncture and sham	Thank you for your comment. The panel was limited to larger systematic reviews and meta-analyses rather than individual studies as the basis for our evaluation. Due to this restriction, we cannot add additional material that might be found in other sources as it has not gone through the rigorous review that high quality systematic reviews would require in order for the study to be included in the review. We



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		acupuncture [Yuan et al 2008 , Xu et al 2013 , Taylor et al 2015], these trial designs remain controversial.(Linde et al 2010, MacPherson et al 2013 , Langevin et al 2011, Berman et 2010) Studies using sham acupuncture are no longer being funded with certain organizations. Clinical trials designs have been improving.	appreciate that this is inherently associated with some limitations.
Amy E. Mager (Group: ASA)	The APA Clinical Practice Guideline for the Treatment of the Problem	An analysis of pooled data (including patients with LBP) suggests that “acupuncture is effective...[and] decreases in pain cannot be explained solely in terms of placebo effects.” (Vickers et al 2018). Our conclusions focus on the pragmatic question pertaining to the effectiveness of acupuncture for the treatment of chronic LBP. Based on the literature the following conclusions can be drawn. The evidence supports the benefit of acupuncture for the treatment of chronic low back pain. • The most recent systematic reviews conclude that acupuncture is beneficial as adjunctive treatment to usual care. [Yuan et al 2008, Trigkilidas 2010, Hutchinson et al 2012, Xu 2013, Taylor 2014] The evidence supports the cost-effectiveness of acupuncture for the treatment of low back pain. • A systematic review and meta-analysis concluded that acupuncture is cost- effective when included in addition to usual care. (Taylor 2014) • Two large pragmatic trials suggest acupuncture adjunctive to other therapies is cost-effective.[Witt 2016, Thomas 2005]	Thank you for your comment. The panel was limited to high quality larger systematic reviews and meta-analyses rather than individual studies as the basis for our evaluation. Due to this restriction, we cannot add additional material that might be found in other sources as it has not gone through the rigorous review that high quality systematic reviews would require for the study to be included in the review. We appreciate that this is inherently associated with some limitations.



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Amy E. Mager (Group: ASA)	The APA Clinical Practice Guideline for the Treatment of the Problem	NECK PAIN Nearly 20 RCTs have assessed the value of acupuncture for the treatment of chronic neck pain. With the exception of five larger ($n \geq 100$) trials, [Freedman 2002, Liang 2011, Cameron 2011, Ho et al 2017, MacPherson et al 2015], the published RCTs have been summarized in three systematic reviews. [Barnes 2007, Trinh 2007, Fu et al 2009] Based on the literature the following conclusions can be drawn: The evidence supports the benefit of acupuncture for pain relief in chronic neck pain. • The most recent systematic reviews demonstrate efficacy of acupuncture for relieving pain at the end of treatment as compared to sham treatments and wait-list controls.[Trinh et al 2006, Fu 2009] The most recent systematic reviews demonstrate the effectiveness of acupuncture adjunctive to usual medical care as compared to usual medical care alone for pain and disability at the end of treatment and at short-term follow-up.[Trinh 2006, Fu 2009] o This is supported by a new RCT not included in the above reviews. [Liang 2011]	Thank you for your comment. The panel was limited to high quality larger systematic reviews and meta-analyses rather than individual studies as the basis for our evaluation. Due to this restriction, we cannot add additional material that might be found in other sources as it has not gone through the rigorous review that high quality systematic reviews would require for the study to be included in the review. We appreciate that this is inherently associated with some limitations.



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		• A single RCT suggests acupuncture provides long-term benefit (1-year follow-up) when used in addition to usual care. [MacPherson et al 2015] The evidence supports the benefit of acupuncture to improve range of motion in chronic neck pain. • The most recent systematic reviews demonstrate the efficacy of acupuncture as compared to sham treatment for improvements in range of motion (short- term).[Trinh et al 2006, Fu et al 2009] The evidence supports the cost-effectiveness of acupuncture for the treatment of chronic neck pain. • A large scale trial (n=3,451) demonstrated cost-effectiveness at 1 and 4 - years.[Witt et al 2006]	
Amy E. Mager (Group: ASA)	The APA Clinical Practice Guideline for the Treatment of the Problem	Conclusion In the context of ineffective and often dangerous pharmaceutical options for pain, acupuncture represents a safe and effective treatment option with a long track-record of successful use. The ASA appreciates the steps the APA is taking to improve care for Americans living with MSK pain. We are truly grateful for the obvious effort that has gone into the proposed guidelines. We offer these comments to APA in the spirit of collaboration and whole person-centered pain	Thank you for your comment. The panel was limited to the studies that were included in the three systematic reviews that served as the underlying evidence for the recommendations. Due to this restriction, we cannot add additional material that might be found in other sources as it has not gone through the rigorous review that high quality systematic reviews would require for the study to be included in the review.



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		care, and we thank you for considering our recommendations.	We appreciate that this is inherently associated with some limitations.
Amy E. Mager (Group: ASA)	Recommendations for Research	The ASA appreciates the steps the APA is taking to improve care for Americans living with MSK pain. We are truly grateful for the obvious effort that has gone into the proposed guidelines. We offer these comments to APA in the spirit of collaboration and whole person-centered pain care, and we thank you for considering our recommendations. REFERENCES Barnes PM, Bloom B, Nahin RL 2007: Complementary and alternative medicine use among adults and children: United States. Natl Health Stat Report 2008(12):1- 23. Berman BM, Langevin HM, Witt CM, Dubner R. 2010 Acupuncture for chronic low back pain. N Engl J Med. 363(5):454-61. Borea PA, Gessi S, Merighi S, et al. 2016 Adenosine as a Multi-Signalling Guardian Angel in Human Diseases: When, Where and How Does it Exert its Protective Effects? Trends Pharmacol Sci 2016;37:419–34. doi:10.1016/j.tips.2016.02.006 Burnstock G. 2014 Purinergic signaling in acupuncture. Science.	Thank you.



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		Burnstock G. Purinergic signalling in endocrine organs. <i>Purinergic Signalling</i> 2013;10:189–231. doi:10.1007/s11302-013-9396-x Cai, S., Garcia Rodriguez, L. A., Masso-Gonzalez, E. L., & Hernandez-Diaz, S. (2009). Uncomplicated peptic ulcer in the UK: trends from 1997 to 2005. <i>Alimentary Pharmacology & Therapeutics</i>, 30(10), 1039–1048. https://doi.org/10.1111/j.1365-2036.2009.04131.x Bally, M., Dendukuri, N., Rich, B., Nadeau, L., Helin-Salmivaara, A., Garbe, E., & Brophy, J. M. (2017). Risk of acute myocardial infarction with NSAIDs in real world use: bayesian meta-analysis of individual patient data. <i>BMJ (Clinical Research Ed.)</i>, 357, j1909–13. https://doi.org/10.1136/bmj.j1909 Cameron ID, Wang E, Sindhusake D 2011 A randomized trial comparing acupuncture and simulated acupuncture for subacute and chronic whiplash. <i>Spine (Phila Pa 1976)</i> 2011, 36(26):E1659-1665. Cho YJ, Song YK, Cha YY, Shin BC, Shin IH, Park HJ, et al. 2013 Acupuncture for chronic low back pain: a multicenter, randomized, patient-assessor blind, sham-controlled clinical trial. <i>Spine (Phila Pa 1976)</i>. 2013;38(7):549-57.	



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		Comachio J, Oliveira CC, Silva IFR, Magalhães MO, Marques AP. 2020 Effectiveness of Manual and Electrical Acupuncture for Chronic Non-specific Low Back Pain: A Randomized Controlled Trial. J Acupunct Meridian Stud. 2020;13(3):87-93. de Carvalho RC, Parisi JR, Prado WA, de Araujo JE, Silva AM, Silva JRT, et al. 2018 Single or Multiple Electroacupuncture Sessions in Nonspecific Low Back Pain: Are We Low-Responders to Electroacupuncture? J Acupunct Meridian Stud. 2018;11(2):54-61. Faas MM, Sáez T, de Vos P. 2017 Extracellular ATP and adenosine: The Yin and Yang in immune responses? Molecular Aspects of Medicine 2017;;1–11. doi:10.1016/j.mam.2017.01.002 Freedman J 2002 An audit of 500 acupuncture patients in general practice. Acupunct Med 20(1):30-34. Fried NT, Elliott MB, Oshinsky ML. 2017 The Role of Adenosine Signaling in Headache: A Review. Brain Sci 2017;7. doi:10.3390/brainsci7030030 Fu LM, Li JT, Wu WS: 2009 Randomized Controlled Trials of Acupuncture for Neck Pain: Systematic Review and	



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		Meta-Analysis. J Altern Complement Med 2009, 15(2):133-145. Harris, R. E., Zubieta, J.-K., Scott, D. J., Napadow, V., Gracely, R. H., & Clauw, D. J. (2009). Traditional Chinese acupuncture and placebo (sham) acupuncture are differentiated by their effects on μ-opioid receptors (MORs). <i>NeuroImage</i>, 47(3), 1077–1085. https://doi.org/10.1016/j.neuroimage.2009.05.083 Ho LF, Lin ZX, Leung AWN, Chen L, Zhang H, Ng BFL, Ziea ETC, Guo Y: 2017 Efficacy of abdominal acupuncture for neck pain: A randomized controlled trial. <i>PLoS One</i> 2017, 12(7):e0181360. Hunter RF, McDonough SM, Bradbury I, Liddle SD, Walsh DM, Dhamija S, et al. 2012 Exercise and Auricular Acupuncture for Chronic Low-back Pain: A Feasibility Randomized-controlled Trial. <i>Clin J Pain</i>. 2012;28(3):259-67. Hutchinson AJ, Ball S, Andrews JC, Jones GG. 2012 The effectiveness of acupuncture in treating chronic non-specific low back pain: a systematic review of the literature. <i>J Orthop Surg Res</i>. 2012;7:36. Kizhakkeveetil A, Rose KA, Kadar GE, Hurwitz EL. 2017 Integrative Acupuncture and Spinal Manipulative Therapy Versus Either Alone for Low Back Pain: A Randomized	



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		Controlled Trial Feasibility Study. J Manipulative Physiol Ther. ;40(3):201-13. Kong JT, Puetz C, Tian L, Haynes I, Lee E, Stafford RS, et al. 2020 Effect of Electroacupuncture vs Sham Treatment on Change in Pain Severity Among Adults With Chronic Low Back Pain: A Randomized Clinical Trial. JAMA Netw Open. 2020;3(10):e2022787. Langevin HM, Wayne PM, Macpherson H, Schnyer R, Milley RM, Napadow V, et al. 2011 Paradoxes in acupuncture research: strategies for moving forward. Evid Based Complement Alternat Med. 2011; :180805. doi: 10.1155/2011/180805. Epub 2010 Oct 11. PMID: 20976074 Li M, Liu X, Ye X, Zhuang L. 2022 Efficacy of acupuncture for generalized anxiety disorder: A PRISMA-compliant systematic review and meta-analysis. Medicine (Baltimore). 2022 Dec 9;101(49):e30076. doi: 10.1097/MD.00000000000030076. PMID: 36626458; PMCID: PMC9750622. Liang Z, Zhu X, Yang X, Fu W, Lu A: 2011 Assessment of a traditional acupuncture therapy for chronic neck pain: a pilot randomised controlled study. Complementary therapies in medicine 2011, 19 Suppl 1:S26-32.	



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		Linde K. NK, & Meissner K. 2010 Are sham acupuncture interventions more effective than (other) placebos? A re-analysis of data from the Cochrane review on placebo effects. <i>Forsch Komplementmed</i>;17(5):259- Liu L, Skinner MA, McDonough SM, Baxter GD. 2021 Acupuncture for chronic low back pain: a randomized controlled feasibility trial comparing treatment session numbers. <i>Clin Rehabil.</i> 2017;31(12):1592-603. Prepared by: Society for Acupuncture Research July 2021 www.AcupunctureResearch.org 27 Longhurst, J., Chee-Yee, S., & Li, P. (2017). Defining Acupuncture's Place in Western Medicine. <i>Scientia</i>, 1–5. Luo Y, Yang M, Liu T, Zhong X, Tang W, Guo M, et al. 2019 Effect of hand-ear acupuncture on chronic low-back pain: a randomized controlled trial. <i>J Tradit Chin Med.</i> 2019;39(4):587-98. MacPherson H, Vertosick E, Lewith G, Linde K, Sherman KJ, Witt CM, et al. 2014 Influence of control group on effect size in trials of acupuncture for chronic pain: a secondary analysis of an individual patient data meta-analysis. <i>PLoS One.</i> 2014;9(4):e93739. MacPherson H, Tilbrook H, Richmond S, Woodman J, Ballard K, Atkin K, Bland M, Eldred J, Essex H, Hewitt C et	



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		al: 2015. Alexander Technique Lessons or Acupuncture Sessions for Persons With Chronic Neck Pain: A Randomized Trial. <i>Ann Intern Med</i> 2015, 163(9):653-662. Nielsen, A., Dusek,J, Taylor-Swanson, L., Tick, H (2022). Acupuncture Therapy as an Evidence-Based Nonpharmacologic Strategy for Comprehensive Acute Pain Care: The Academic Consortium Pain Task Force White Paper Update <i>Pain Med.</i> 2022 Sep; 23(9): 1582–1612. Published online 2022 Jun 17. doi: 10.1093/pm/pnac056 PMCID: PMC9434305 Maeda, Y,, Kim, Y Kettner, Kim,J. Cina S, Malatesta, C , Gerber J., McManus, C., Ong-Sutherland R., Mezzacappa, P., Libby, A., Mawla, I., Morse, L., Kaptchuk, T, Audette, J and Napadow, N. 2017 Rewiring the primary somatosensory cortex in carpal tunnel syndrome with acupuncture <i>BRAIN</i> 2017: 140; 914–927 Miao EY. 2010 Effect of electroacupuncture on the third lumbar transverse process syndrome: A randomized controlled trial <i>Med Acupunct.</i> 2010;22(4):249-55. Roth A, Chan PS, Jonas W. <i>Glob Adv Health Med.</i> 2021 Addressing the long Covid crisis: integrative health, and long Covid. Nov 16;10:21649561211056597. doi: 10.1177/21649561211056597. eCollection 2021. PMID:	



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Commenter (Group or Individual?)	Section	Comment	Panel Response
		34820152. 2021 Global advances in health medicine 2021. Volume 10, pages 1 to 6. Shi ,G., Jian-Feng Tu 2, Wang , T , Wang, L. Lin , L. , Y., Li,, Y, Liu, C C 2022 Effect of Electro-Acupuncture (EA) and Manual Acupuncture (MA) on Markers of Inflammation in Knee Osteoarthritis J Pain Res 2020 Aug 26:13:2171-2179.PMID: 32904642 PMCID: PMC7457556 DOI: 10.2147/JPR.S256950 Taylor P, Pezzullo ,L, Grant SJ, Bensoussan, A. 2014 Cost-effectiveness of Acupuncture for Chronic Nonspecific Low Back Pain. Pain Pract. 2014;14(7):599-606. Teng chen, J Wang, Y., Wang, Y. and Chu, Y., 2022 Current understanding of the neural circuitry in the comorbidities of chronic pain and anxiety. Neuroplasticity, Article ID 4217593, 13 pages https://doi.org/10.1155/2022/4217593 Thomas KJ, MacPherson H, Ratcliffe J, Thorpe L, Brazier J, Campbell M, et al. 2005 Longer term clinical and economic benefits of offering acupuncture care to patients with chronic low back pain. Health Technol Assess. 2005;9(32):iii-iv, ix-x, 1-109.	



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		Trinh K, Graham N, Gross A, Goldsmith C, Wang E, Cameron I, Kay T: 2006 Acupuncture for neck disorders. Cochrane Database Syst Rev 2006, 3:CD004870 Trinh K, Graham N, Gross A, Goldsmith C, Wang E, Cameron I, Kay T:2007 Acupuncture for neck disorders. Spine (Phila Pa 1976) 2007, 32(2):236-243. Trigkilidas D. 2010 Acupuncture therapy for chronic lower back pain: a systematic review. Ann R Coll Surg Engl. 2010;92(7):595-8. Vickers AJ, Vertosick, EA, Lewith G, MacPherson H, Foster NE, Sherman KJ, et al. 2018 Acupuncture for Chronic Pain: Update of an Individual Patient Data Meta-Analysis. J Pain. 2018;19(5):455-74. Weiss J, Quante S, Xue F, Muche, R, Reuss-Borst M. 2013 Effectiveness and acceptance of acupuncture in patients with chronic low back pain: results of a prospective, randomized, controlled trial. J Altern Complement Med. 2013;19(12):935-41. Witt CM, Jena S, Brinkhaus, B, Liecker, B, Wegscheider, K, Willich SN: 2006 Acupuncture for patients with chronic neck pain. Pain 2006, 125(1-2):98-106.	



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		Witt CM, Jena S, Selim D, Brinkhaus, B, Reinhold T, Wruck, K, et al. 2006 Pragmatic randomized trial evaluating the clinical and economic effectiveness of acupuncture for chronic low back pain. Am J Epidemiol.;164(5):487-96. Xu M, Yan S, Yin X, Li X, Gao S, Han R, et al. 2013 Acupuncture for chronic low back pain in long-term follow-up: a meta-analysis of 13 randomized controlled trials. Am J Chin Med.;41(1):1-19. Yuan J, Purepong, N, Kerr DP, Park J, Bradbury I, McDonough S. 2008 Effectiveness of Acupuncture for Low Back Pain: A Systematic Review. Spine.;33(23):E887-E900. Yun M, Shao Y, Zhang Y, He S, Xiong, N, Zhang J, et al. 2012 Hegu acupuncture for chronic low-back pain: a randomized controlled trial. J Altern Complement Med.;18(2):130-6. Zaringhalam J, Manaheji, H, Rastqar, A, Zaringhalam M. 2010 Reduction of chronic non-specific low back pain: A randomised controlled clinical trial on acupuncture and baclofen. Chin Med.;5(1):15. Zhang, Z.-J., Wang, X.-M., & McAlonan, G. M. (2012). Neural Acupuncture Unit: A New Concept for Interpreting Effects and Mechanisms of Acupuncture. Evidence-Based	



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		Complementary and Alternative Medicine, 2012(3), 1–23. https://doi.org/10.1016/j.brainresbull.2007.08.003 Zhao, Z.-Q. (2008). Neural mechanism underlying acupuncture analgesia. Progress in Neurobiology, 85(4), 355–375. https://doi.org/10.1016/j.pneurobio.2008.05.004	
Julie Ording (Group: American College of Occupational and Environmental Medicine [ACOEM])	General	There are many quite positive things about this draft guideline and the authors are to be congratulated for their hard work!	Thank you.
Julie Ording (Group: ACOEM)	General	It may be more helpful for a reader to look at recommendations by diagnosis/body part. As written, it bounces from one body part to another and is fairly difficult to read for a treater.	Thank you for your comment. We were limited in how the systematic reviews defined and organized the interventions.
Julie Ording (Group: ACOEM)	General	Use of the term widespread pain suggests inclusion of fibromyalgia, although the footnote specifically excludes it. What is not excluded of widespread pain, but presumably is(?) and should be noted to be excluded, if appropriate, are other central pain disorders, and other psychologically-mediated disorders (?) Presumably, this is a nociceptive pain guideline (?).	While fibromyalgia is clinically characterized by widespread pain, we were limited in scope to the diagnoses included within the systematic reviews; thus, fibromyalgia and other conditions may have been excluded. Similarly, we maintained the same verbiage used within review articles in our guideline.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
		It is suggested that instead, consider not using re-labeling and instead use the original, widely used term be used to describe the section/literature/comparisons etc. to improve comprehension.	
Julie Ording (Group: ACOEM)	Process and Methods for the CPG	The review represents structuring around PICOTS, however, in searching the document, there isn't a list of PICOTS. Instead, there is one table with various domains. Those tend to be so generic that the scope and target is/are unclear.	Thank you for your comment. The PICOTS table can be found in Appendix E of the guideline. The domains incorporated into the table were intentionally broad as we wanted to cast a wide net of the literature.
Julie Ording (Group: ACOEM)	Process and Methods for the CPG	The document represents adherence to IOM standards. However, there are multiple criteria that this reviewer cannot find and do not appear to be met. E.g., nearly all of: Establishing Evidence Foundations for and Rating Strength of Recommendations 5.1 - For each recommendation, the following should be provided: - An explanation of the reasoning underlying the recommendation, including - a clear description of potential benefits and harms; - a summary of relevant available evidence (and evidentiary gaps), description of the quality (including applicability), quantity (including completeness), and consistency of the aggregate available evidence;	Thank you for your comment. The documentation of the panel's decision-making and drafting of recommendation statements can be found in the supplemental Grid spreadsheet. This Grid is an evidence-to-decision framework tool used to transparently document the panel's decision-making about each recommendation, including the elements noted in your comment. In this grid, the key questions incorporated from the appendix document of the systematic reviews are presented across the top row. Each column in the grid reflects a particular treatment or treatment comparison from the review while each row reflects a particular outcome (i.e., physical



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Commenter (Group or Individual?)	Section	Comment	Panel Response
		▪ an explanation of the part played by values, opinion, theory, and clinical experience in deriving the recommendation. ○ A rating of the level of confidence in (certainty regarding) the evidence underpinning the recommendation -A rating of the strength of the recommendation in light of the preceding bullets -A description and explanation of any differences of opinion regarding the recommendation ○ Note that above requires 2 ratings per recommendation.	functioning). The effect size along with relevant information (i.e., confidence interval, strength of evidence, etc.) is presented at the intersection of rows and columns. This is followed by information on the panel's ratings of the benefits, harms, balance of benefits vs. harms, patient values and preferences, applicability, and overall recommendation statement for each intervention or comparison of treatments.
Julie Ording (Group: ACOEM)	Process and Methods for the CPG	Search methods are not explicit and clear, i.e., not reproducible. While sympathetic to the problem of fiscal costs and trying to keep a guideline process manageable, line 653-654 severely limits the guideline to a reliance on other reviews. These limitations result in the problem of this review being a request to review 3 systematic reviews plus this guideline. There was not time to re-review reviews so we tried to focus on the accuracy of the end results.	Thank you for your comment. We do note the search methods that each of the three systematic reviews employed but we made this more explicit by creating a separate subsection titled "Systematic Reviews' Definition of Chronic Pain and Search Methods". We also added in APA's search methods for identifying systematic reviews and meta-analyses (please refer to Appendix I of the guideline). Overall, we were limited in the search methods employed by the three systematic reviews.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Julie Ording (Group: ACOEM)	Process and Methods for the CPG	As provided in lines 281-289 and noting the voting methods, these guidelines are naturally not evidence-based, or at least not directly so. Instead, they are expert consensus guidance that may be informed by evidence. Expert opinion guidance is still of value, especially where data are sparse. This is an important distinction and should be clear throughout so that there is no assumption of guidance that is primarily evidence-based. Considering that based on this review of systematic reviews, there is a large number of unknowns, yet while relying on a method of consensus voting, it seems as though the opportunity is present to get the panel's opinions on how to treat patients. This miss seems repairable (?).	Thank you for your comment. We organized the guideline into three types of recommendations. The first type is the traditional / efficacy recommendation, where systematic reviews of the scientific evidence are evaluated to determine the strength and direction of the recommendation, while considering harms/burdens, patient values and preferences and applicability of the treatment. Documentation of the panel's voting can be found in the supplemental grid / excel spreadsheet. The second type of recommendations are what's known as "implementation considerations." These statements are consensus-based on how to apply the previous recommendation statement types into clinical practice. The third category "recommendations for research" is also expert, consensus-based that notes the current gaps in the research literature and where more research is needed to address these gaps.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Julie Ording (Group: ACOEM)	Treatment Recommendations	Line 271. TAU has additional problems that should be noted. 1) practice patterns vary widely, so it may include whatever is regionally common especially among those who are doing the most enrollments in the trial (i.e., the treatment provided may be poor quality, non-evidence based and often is), and 2) practice patterns vary over time, so TAU is time-dependent.	Thank you for your comment. We agree and will include this additional note in the limitations section of the systematic reviews' definition of treatment as usual / usual care / attention control.
Julie Ording (Group: ACOEM)	Treatment Recommendations	Line 274. No treatment is not the equivalent to waitlisting as stated in the document. No treatment means there is neither a treatment provided nor an expectation for treatment. Waitlist control means there is an expectation for getting the presumptively effective treatment and it produces a natural bias that we have to wait to get the effective treatment (i.e., waitlist control bias). These biases are not the same.	Thank you for your review. We agree that no treatment is not the equivalent to a waitlist and have clarified the statement. We were limited to how the systematic reviews categorized the control groups as one combined the non-active control groups included "waitlist"
Julie Ording (Group: ACOEM)	Treatment Recommendations	The use of the term nonpharmacologic (lines 145-146) is confusing because many things not included as defined, are nonpharmacologic. Further subsumed under that is "physical modalities" which is jargon. These produce a reading/comprehension burden that carries further in the document.	Thank you for your comment. The term "physical modalities" is commonly used, and we will further clarify by adding the following definition: "physical modalities are types of electrical, thermal, or mechanical energy that can cause physiological changes and that are commonly used in physical therapy treatment"
Julie Ording (Group: ACOEM)	Treatment Recommendations	The term complementary and integrative treatments are then defined as both certain discrete treatments, while also including multidisciplinary treatment which naturally may/should include things in the other category.	Thank you for your comment. We utilized the definitions that were used in the systematic reviews and some of them differed in terms of what they



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Commenter (Group or Individual?)	Section	Comment	Panel Response
			included as complementary and integrative treatments. Multidisciplinary treatment was separately identified and included in the guideline.
Julie Ording (Group: ACOEM)	Treatment Recommendations	The guideline recommends exercise in several areas. However, it does not specify what exercise(s). The literature supports that some exercises are helpful over others and they differ by disorder (e.g., quad strengthening is effective for knee OA; directional stretch for LBP....in neither case are generic stretching exercises demonstrably effective though widely performed). This means that to be useful and to avoid people being sent to a waste of time set of treatments, one has to know what the exercises are that are supposed to be performed and know that that is being administered.	We agree that there is a clear need for specific, directed exercises to be provided and ordered based on the area involved and the type of injury. Unfortunately, there are issues in systematic reviews when the concept of exercise therapy is lumped together without specificity. This may be due also to lack of specificity in the studies themselves. In either case the purpose of these guidelines is not to inform medical practitioners about what therapy they should order, but rather to provide information to mental health practitioners regarding commonly ordered treatments and, to the extent possible based on the lack of specific studies, the general likelihood of effect. Thus, we do not address therapy that would be ordered by other providers to the extent of specificity you are asking about. Thank you for allowing us to describe this issue with our guidelines.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Julie Ording (Group: ACOEM)	Treatment Recommendations	The first item listed under chronic LBP is manipulation. What do sham-controlled studies show re. manipulation? How is this determination of efficacy made? This is a prescription for DCs/DOs, etc. to prescribe unlimited sessions going on for years accruing thousands of dollars in needless/ineffective expenses. In one recent memorable case, the insurer finally put the brakes on after \$2,000 accumulated and stuck the patient with the bills. This is not an evidence-based recommendation, but it may be the panel's expert opinion. It should be clearly stated as such. Stress reduction also has poor evidence of efficacy.	Thank you for your comment. The coverage of treatments by insurers is beyond the scope of the guideline. The individual studies within the three systematic reviews/meta-analyses that served as the underlying evidence for the recommendation statements also did not address cost-effectiveness of the treatments. We hope that our guideline will not be used for nefarious purposes to deny coverage and have specifically clarified this further in the guideline document.
Julie Ording (Group: ACOEM)	Treatment Recommendations	Multidisciplinary rehab costs >\$50-100K in California. This guideline states that "based on the small benefit?" This brings up the lack of inclusion of costs in the guidelines development which should be part of the decision-making process. Why would one advocate for such high costs for "small" benefit. This further brings up the problem of hierarchy. Such an intervention should be a fairly selective intervention only after other things are tried and various criteria are met.	Thank you for your comment. The purpose of this guideline is to inform non-medical practitioners regarding commonly used treatment for chronic pain and, to the extent possible given the studies available, the likelihood of success with those treatments. It is not meant to provide information on the number of treatments needed to achieve minimally meaningful clinic improvement or other measures that could help define the number of treatment or success of treatment for individual patients. Thus, it is important that these guidelines not be used to



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Commenter (Group or Individual?)	Section	Comment	Panel Response
			determine or support questions of length of treatment or specific types of treatment to be used in specific patients
Julie Ording (Group: ACOEM)	Treatment Recommendations	In particular, without differentiating nociceptive v. nociplastic v. neuropathic v. psychogenic chronic pain, we think it creates quite a bit of difficulty. But, if this guideline is based upon only 3 systematic reviews that others have done, these new concepts (especially nociplastic pain) is not going to be covered with that literature being more recent.	Thank you for your comment. We are indeed limited by the articles used as a basis for the review and the verbiage employed in that literature.
Julie Ording (Group: ACOEM)	Implementation Considerations	We struggle quite a bit with this guideline not giving parameters on recommended treatment durations. For example, while it is fine to say for chronic low back pain that manipulation can be offered, without putting evidence guardrails on how many and how often leaves these guidelines open to abuse and misuse. We can see the chiropractors using that section endless numbers of visits. We wondered "when we were going to see a statement on functional improvement?" but did not find it. This is possibly another guideline that does not make the evidence-based point that this is not about "what makes my pain better" but instead "how does this improve my ability to do typical activities of daily living."	Thank you for your comment. We agree that we did not put parameters around the recommended treatment durations based upon lack of current research to guide such recommendations. We do feel this is something that should be discussed and determined between patient and provider based upon perceived cost/benefit of the services received. We agree that chronic pain treatment should focus on function and quality of life rather than the reduction of pain. We included indicators of pain in this review as they were included in the systematic reviews that were used to develop these guidelines; however, we



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Commenter (Group or Individual?)	Section	Comment	Panel Response
			also included psychological factors of chronic pain treatment as additional indicators of function and quality of life.
American Counseling Association (ACA; Group)	General	ACA does not have a comment to share at this time.	Thank you for taking the time to review the document.



Section 3: Panel Responses to Public Comments Submitted by Individuals

Commenter (Group or Individual?)	Section	Comment	Panel Response
Sarah Edmonds, PhD (Individual)	General	I see that many of your recommendations are for CBT, even though there are now other types of therapies addressing chronic musculoskeletal pain that are superior to CBT, among them EAET (Emotional Awareness and Expression Therapy), PRT (Pain Reprocessing Therapy) and ISTDP (Intensive Short Term Dynamic Therapy). I hope you will look at the following reference lists and revise your recommendations. Articles by Dr. Howard Schubiner Intensive Short-term Dynamic Psychotherapy Somatic Conditions, update August, 2023 (PDF) Annotated Bibliography for Psychophysiologic Disorders and chronic Pain (PDF) I'm a psychologist in private practice trained in EAET and ISTDP.	Thank you for your comments and references. We were limited to larger systematic reviews and meta-analyses rather than individual studies as the basis for our evaluation. We appreciate that this is inherently associated with some limitations and do not intend to offend any providers with expertise in other treatment modalities.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Mark Lumley (Individual)	General	I am grateful to the members of the review panel for volunteering to take on this challenging project. They have worked very hard and generated a substantial document, which undoubtedly reflects hundreds of hours and many challenging discussions and compromises. This work is a thankless job, and the receipt of criticisms and recommendations in this comment section may be disheartening. I appreciate the panel reading and considering the many suggestions that have been made, and that I make now.	Thank you.



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Mark Lumley (Individual)	General	I share Dr. Frank Keefe’s concern that pain itself is relegated to a secondary outcome, whereas physical and mental health/emotional functioning are primary outcomes. This unfortunate bias (against targeting pain reduction may reflect the views of the panel fields that have traditionally focused on functioning (e.g., physical and occupational therapy), the relatively small effects of CBT on pain reduction, and the growing influence of ACT, which explicitly does not target pain reduction. Yet, pain reduction is the primary outcome sought by patients, is the “first” outcome covered in the Williams et al. Cochrane review, and reflects the primary treatment goal of many emerging therapies and a substantial number of practitioners.	Thank you for your review and feedback. The trend to focus more on function rather than pain severity/pain intensity has occurred recently (e.g., Becker et al., 2018; Elder et al., 2017; Mallick-Searle et al., 2021; Turk et al., 2016). . Other than hypnosis, most psychological interventions do not purport to reduce pain; they are more so focused on physical functioning and performance. Psychological interventions alone rarely see a reduction in pain, and ideally are best used in combination with medical interventions. References Becker, W. C., DeBar, L. L., Heapy, A. A., Higgins, D., Krein, S. L., Lisi, A., Makris, U. E., & Allen, K. D. (2018). A research agenda for advancing nonpharmacological management of chronic musculoskeletal pain: Findings from a VHA state-of-the-art conference. <i>Journal of General Internal Medicine</i>, 33, 11-15. https://doi.org/10.1007/s11606-018-4345-6 Elder, C. R., DeBar, L. L., Ritenbaugh, C., Rumpitz, M. H., Patterson, C., Bonifay, A., Cowan, P., Lancaster, L., & Deyo, R. A. (2017). Health care systems support to enhance Patient-Centered care: Lessons from a primary care-based chronic pain management initiative. <i>The Permanente Journal</i>, 21, 85-90. https://doi.org/10.7812/TPP/16-101
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Commenter (Group or Individual?)	Section	Comment	Panel Response
			Malick-Searle, T., Sharma, K., Toal, P., & Gutman, A. (2021). Pain and function in chronic musculoskeletal pain—treating the whole person. <i>Journal of Multidisciplinary Healthcare</i>, 14, 335-347. https://doi.org/10.2147%2FJMDH.S288401 Turk, D. C., Fillingim, R. B., Ohrbach, R., & Patel, K. V. (2016). Assessment of psychosocial and functional impact of chronic pain. <i>The Journal of Pain</i>, 17(9), T21-T49. https://doi.org/10.1016/j.jpain.2016.02.006
Mark Lumley (Individual)	General	My larger concern, however, is that a very conservative approach to creating guidelines was used, focusing solely on those treatments that have generated much traditional academic interest and resulted in large meta-analyses—specifically only Williams et al. for psychological treatments. The resulting recommendations are what have been noted for quite some time: “Use CBT, and secondarily, ACT and mindfulness.” These approaches certainly have dominated the research literature and generated the most clinical trials and meta-analyses. Yet there are several substantial limitations of this approach and the resulting recommendations.	We appreciate the feedback, and we understand that there are limitations to the methodology used in this process, including all the items that you noted in your comment.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Mark Lumley (Individual)	General	First, the effect sizes of these approaches—particularly with respect to pain reduction but also improving physical and emotional functioning—are quite modest. Williams et al. (2020) report small effects of CBT compared to inert controls, and very small effects compared to active controls. My read of many additional reviews suggests similarly modest effects of ACT and mindfulness approaches. These approaches are certainly better than nothing and likely have important value (lower side effects and risks) compared to many medical interventions, but what should practitioners do about the rather small benefits of these recommended therapies? Considering alternative approaches that offer the possibility of larger benefits is high on their list.	We appreciate the feedback, and we understand that there are limitations to the methodology used in this process, including all the items that you noted in your comment. We recommend clinicians use the current literature with their decision-making, ensuring that clinicians discern the quality and type of evidence as well as the patients' preference in the decision-making process.



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Mark Lumley (Individual)	General	I also am struck by the absence of other approaches that, although not appearing in Williams et al. (2020), have substantial literatures of their own. Other commenters have mentioned the failure to note clinical hypnosis, a concern that I echo. There also is a 2020 systematic review (Abbass et al., <i>Psychotherapy and Psychosomatics</i>) that reviews 17 RCTs of short-term psychodynamic therapy for “functional” somatic disorders, many of which are musculoskeletal pain problems, demonstrating substantial and lasting benefits in symptom reduction. There is much empirical support for “trauma-focused” and other pain interventions that target a change in brain processing of fear circuitry and the “learned” of pain chronicity. These include EMDR (as mentioned by another commenter; see meta-analyses by Tesarz), and Emotional Awareness and Expression Therapy (EAET), which has a growing body of supportive research. Pain Reprocessing Therapy has been shown in an impressive RCT to yield very substantial pain reductions for low back pain. These and related approaches, such as Cognitive Functional Therapy (better known to physical therapists), adopt a fundamentally different model of pain which is grounded in contemporary pain neuroscience (see Moseley, Wager, Apkarian, and many others), whereas the other approaches (CBT, ACT, MBRS) seem to be agnostic with respect to underlying pain mechanisms and generally view pain as “chronic” and needing to be managed	We appreciate the feedback, and we understand that there are limitations to the methodology used in this process, including all the items that you noted in your comment. We also attempted to include the most relevant studies based on our methodology. Prior to embarking on the project, a public comment period was slated that included studies that were recommended by the public and modifications were made based on public feedback. We recommend clinicians use the current literature with their decision-making, ensuring that clinicians discern the quality and type of evidence as well as the patients’ preference in the decision-making process.
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AMERICAN
PSYCHOLOGICAL
ASSOCIATION

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Commenter (Group or Individual?)	Section	Comment	Panel Response
		(coped with, lived with) rather than treated and reduced. (Continued in subsequent comment)	



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Mark Lumley (Individual)	General	(continued from earlier comment) These newer approaches view many cases of pain (especially primary or nociplastic pain) as driven largely by changeable brain processes and, hence, able to be substantially reduced and occasionally eliminated. Many of us who do research, practice, and professional training in this space are witnessing tremendous interest in these newer psychological approaches among researchers, clinicians, and patients, many of whom are witnessing substantial benefits from these approaches than the recommended approaches. I recognize that these newer interventions have not yet generated the scope of empirical study and meta-analytic review like CBT, ACT, and mindfulness-based approaches, and preliminary demonstrations of increased efficacy—as well as interest—might not warrant extensive “top-line” coverage in these guidelines. However, without providing information on these emerging models and therapies, the Guidelines are likely to have much less impact than they could. *** Thus, I strongly urge the Panel to add a section on “Emerging Treatments” or something similar, to inform readers about where the field seems to be moving and the potential for greater treatment efficacy with a broader range of therapies.	Thank you for your comment. We have noted the limitations of the guideline in the report itself and we can confirm that we used the most recent version of the Cochrane review (Williams et al., 2020). While this guideline does not address emerging treatments, we too look forward to seeing systematic reviews and meta-analyses of them in future literature.
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Commenter (Group or Individual?)	Section	Comment	Panel Response
		(Side note: The panel should make sure that they are using the most recent version of the Williams et al. Cochrane review, which was modified on-line about 1 year after it was published after a significant error was pointed out. Their initial effect sizes comparing ACT to active controls have been cut in half with the change to the Thorsell 2011 data.)	
Howard H Schubiner (Individual)	General	The APA will be releasing a high level review of psychological treatments for chronic painful conditions in 2024. Yet, all of the data comprising the report comes prior to 2021. While there have not been high levels meta-analyses in the last couple of years, there have been major studies published showing significant and even dramatic results in this field. Ignoring those studies will make the APA guidelines hopelessly out of date and most probably irrelevant as soon as they are published. The focus of psychological therapies on CBT, ACT and mindfulness-based interventions would make sense if those are the only psychological intervention available that are evidence based. However, it should be noted that the effectiveness of these three intervention is small and not sustained. Therefore, emphasis on them as the only approved psychological interventions will be met with little excitement.	Thank you for your comment. We were limited to larger systematic reviews and meta-analyses rather than individual studies as the basis for our evaluation. We appreciate that this is inherently associated with some limitations and do not intend to offend any providers with expertise in other treatment modalities.



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Howard H Schubiner (Individual)	General	In the last couple of years, there have been solid randomized, controlled trials of two emerging psychological therapies: Pain reprocessing therapy (PRT) and emotional awareness and expression therapy (EAET). These therapies have even appear to have some superiority to CBT, and the observed effect sizes—as well as many, many clinical observations—suggest that they are likely to be more powerful than CBT as well as ACT and mindfulness-based interventions. EAET has been listed as an approved treatment for chronic painful conditions by the US Department of Health and Human Services. I would suggest that the authors of this report create a section of this report that discussed these two emerging therapies. I will post a set of references in separate comments. Thank you very much. References - Set one of references: 1. Hsu MC, Schubiner H. Recovery from Chronic Musculoskeletal Pain with Psychodynamic Consultation and Brief Intervention: A Report of Three Illustrative Cases. <i>Pain Medicine</i>, 2010, 11: 977-980.	Thank you for your comment. We were limited to larger systematic reviews and meta-analyses rather than individual studies as the basis for our evaluation. We appreciate that this is inherently associated with some limitations and do not intend to offend any providers with expertise in other treatment modalities.
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	Evidence, and Critical Review. Current Rheumatology Reports. 2019, 21: 30-38. 13. Bellomo, T., Schrepf, A., Kruger, G.H., Lumley, M.A., Schubiner, H., Clauw, D.J., Williams, D.A., & Harte, S.E. Pressure pain tolerance predicts the success of emotional awareness and expression therapy in patients with fibromyalgia. Clinical Journal of Pain. 2020, 36: 562-566. 14. Abbass, A, Town, J, Holmes, HJ, Luyten, P, Cooper, A, Russell, L, Lumley, MA, Schubiner, H, Allinson, J, Bernier, D, De Meulemeester, C, Kroenke, K, & Kisely, S. Short-term psychodynamic psychotherapy for functional somatic disorders: A meta-analysis of randomized controlled trials. Psychotherapy and Psychosomatics, 2020,89:363-370. 15. Yarns, B.C., Lumley, M.A., Cassidy, J.T., Steers, W.N., Osato, S., Schubiner, H., & Sultz, D.L. Emotional awareness and expression therapy achieves greater pain reduction than cognitive behavioral therapy in older veterans with chronic musculoskeletal pain: A preliminary randomized comparison trial. Pain Medicine. 2020, 21: 2811-2822. References - Set two of references: 16. Kohns, DJ, Urbanik, CP, Geisser, ME, Schubiner, H, & Lumley, MA The effects of a pain psychology and neuroscience self-evaluation	
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		internet intervention: A randomized controlled trial. <i>Clinical Journal of Pain</i>. 2020, 36: 683-692. 17. Lumley MA, Krohner S, Marshall LM, Kitts T, Schubiner H, Yarns BC. Emotional Awareness and Other Emotional Processes: Implications for the Assessment and Treatment of Chronic Pain. <i>Pain Management</i>. 2021, 11(3): 325-332. 18. Maroti D, Ek J, Widlund RM, Schubiner H, Lumley MA, Lillengren P, Bileviciute-Ljungar I, Ljotsson B, Johansson, R. Internet-administered Emotional Awareness and Expression Therapy for Somatic Symptom Disorder: A Preliminary Efficacy Trial. <i>Frontiers in Psychiatry</i>, 2021, 12 (104). 19. Holmes HJ, Yamin JB, Krohner S, Rapport L, Grekin, ER, Schubiner H, Lumley MA. Effects of a Sexual Health Interview among Arab American Women: An Experimental Disclosure Study. <i>Archives of Sexual Behavior</i>. 2021, 50:373–384. 20. Abbass, A, Lumley, MA, Town, J, Holmes, HJ, Luyten, P, Cooper, A, Russell, L, Schubiner, H, De Meulemeester, C, & Kisely, S. Short-term psychodynamic psychotherapy for functional somatic disorders: A systematic review and meta-analysis of within-treatment effects. <i>Journal of Psychosomatic Research</i>. 2021, 145: 145, 110473, https://doi.org/10.1016/j.jpsychores.2021.110473. 21. Ashar YK, Gordon A, Schubiner H, Uipi C, et. al., Lumley MA, Wager TD. Pain Reprocessing Therapy for Chronic Back Pain: A Randomized Controlled Trial with Functional Neuroimaging.	
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		JAMA Psychiatry. 2022;79(1):13–23. doi:10.1001/jamapsychiatry.2021.2669 22. Maroti D, Ljotsson B, Lumley MA, Schubiner H, Hallberg H, Olsson PA, Johansson R. Emotional processing and its association to somatic symptom change in Emotional Awareness and Expression Therapy for Somatic Symptom Disorder: A preliminary investigation of mechanisms of change. <i>Frontiers in Psychology</i>, 2021, 12, Article 712518. 23. Krohner, S., Yamin, J.B., Ziadni, M.S., Carty McIntosh, J.N., Schubiner, H., & Lumley, M.A. Emotional Awareness and Expression Interview: Examining interview content and patient experiences in two medical samples. <i>Journal of Clinical Psychology in Medical Settings</i>. 2023: 30, 520-530. 24. Maroti, D., Lumley, M.A., Schubiner, H., Lilliengren, P., Bileviciute-Ljungar, I., Ljótsson, B., & Johansson, R. (in press). Internet-based emotional awareness and expression therapy for somatic symptom disorder: A randomized, controlled trial. <i>Journal of Psychosomatic Research</i>, 2022, 163, Article 111068. 25. Schubiner, H., Jackson, B., Molina, K.M. et al. Racism as a Source of Pain. <i>Journal of General Internal Medicine</i>. 2023: 38: 1729–1734. doi.org/10.1007/s11606-022-08015-0	
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Commenter (Group or Individual?)	Section	Comment	Panel Response
		26. Tankha H, Lumley MA, Gordon A. Schubiner H Uipi C, Harris J, Wager TD, Ashar, YK. "I don't have chronic back pain anymore": Patient Experiences in Pain Reprocessing Therapy for Chronic Back Pain. Journal of Pain, 2023. https://doi.org/10.1016/j.jpain.2023.04.006. 27. Krohner, S., Town, J., Cannoy, C.N., Schubiner, H., Rapport, L.J., Grekin, E., Lumley, M.A. Emotion-focused psychodynamic interview for people with chronic musculoskeletal pain and childhood adversity: A randomized controlled trial. Journal of Pain, 2023, in press. 28. Schubiner H, Lowry WJ, Heule M, Ashar Y, Lim M, Mekaru S, Kitts T, Lumley MA. Application of a clinical approach to diagnosing primary pain: Prevalence and correlates of primary back and neck pain in a community physiatry clinic. Journal of Pain, 2023, in press. 29. Donnino, M.W., Thompson, G.S., Mehta, S., Paschali, M., Howard, P., Antonsen, S.B., Balaji, L., Bertisch, S.M., Edwards, R., Ngo, L.H. and Grossestreuer, A.V., 2021. Psychophysiologic symptom relief therapy for chronic back pain: a pilot randomized controlled trial. Pain Reports, 6(3).	



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Lynn Webster (Individual)	General	Strengths Specifies “guidelines” are not mandatory or a replacement for professional judgment Specifies that dearth of evidence is not evidence a treatment cannot be effective Emphasizes shared decision-making between clinicians and patients Transparent panel selection and methods	Thank you.
Lynn Webster (Individual)	General	Areas for Improvement Place “nonpharmacologic” in title to better represent guideline. Emphasize that until the following barriers change, little else will change in medical care: “The panel strongly supports reimbursement of services that improve functioning in individuals with chronic musculoskeletal pain.”	Thank you for your feedback and review of the guideline. We revised the title of the guideline to reflect the focus on nonpharmacological treatments for chronic musculoskeletal pain. If there were individual studies within the reviews that served as the underlying evidence that included pharmacologic agents, we noted this in the guideline. Thank you. We inserted this emphasis and added additional literature that describes the barriers in care.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Lynn Webster (Individual)	General	“The over-prescription of opioids for the treatment of chronic pain is a major contributor to the opioid epidemic in the U.S., which is a current public health emergency.” Causes of the opioid crisis are multi-factorial, and the wording of the quoted sentence is too simplistic. See this study for additional context on the opioid crisis: Nadeau SE, Wu JK, Lawhern RA. Opioids and Chronic Pain: An Analytic Review of the Clinical Evidence. Front Pain Res (Lausanne). 2021 Aug 17;2:721357. doi: 10.3389/fpain.2021.721357. PMID: 35295493; PMCID: PMC8915556.	Thank you for your feedback. We revised the statement by weakening the emphasis on the role of over-prescription of opioids as a factor of the opioid epidemic.
Lynn Webster (Individual)	General	Regardless, as a purported clinical practice guideline, the current document would do better to emphasize the relevant population, which is people with chronic musculoskeletal pain. Clinical practices in pain management may lack tailoring to the individual patient and over-rely on high-risk treatments that may include opioids. Consider more careful and accurate wording such as this.	Thank you for your feedback. The guideline is specifically focused on adults who experience chronic musculoskeletal pain. We encourage tailoring of pain management to individuals and encourage non-pharmacological treatments.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Lynn Webster (Individual)	General	During the systematic review, did the panel have the opportunity to evaluate the following manuscript? Tick H, Nielsen A, Pelletier KR, et al. The Pain Task Force of the Academic Consortium for Integrative Medicine and Health. Evidence-based Nonpharmacologic Strategies for Comprehensive Pain Care. A Consortium Pain Task Force White Paper December 15, 2017. The manuscript presents a rigorous and spirited dissection of the evidence base and might be better represented as an analysis of research gaps rather than a practical guideline for use by busy providers.	Thank you for your comment and for sharing with us this review. The systematic review falls outside the scope of the guideline and the publication date is older than five years.
Lynda Marshall (Individual)	General	As an individual with several two areas of scoliosis, degenerative bone disease, and cervical kyphosis (also known as lordosis or "military neck"), I am quite familiar with debilitating chronic back and neck pain that can severely inhibit my ability to walk, stand, and sit and that can cause excruciating headaches. My choice of treatment has been chiropractic care, which has enabled me to live normally without any opioid or other pain medication (as long as I am diligent in my appointments).	Thank you for taking the time to review the draft guideline and for your comment. We did not seek to exclude chiropractic care in this guideline. Unfortunately, none of the studies that were included in the meta-analyses mentioned this specifically beyond spinal manipulation. We believe it is important to have all representatives of health care and this is why different domains, including nursing, physical therapy, and people with lived chronic pain experience have been appointed to the panel.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Lynda Marshall (Individual)	General	I was disappointed to see that the list of other professions involved in development of the guidelines involved only traditional medical professions (other than mental health providers). Although you listed what I assume is chiropractic care (manipulation) and acupuncture in your grid, I did not see one reference to including chiropractors, chiropractic research, or acupuncturists in your discussion. In addition, I question whether your research references were sufficiently informed to include chiropractic care in their research. The medical community can be very biased against non-medical/surgical care, and I have to question whether that bias has affected research and conclusions. If you are going to assess these interventions in your guidelines, it seems to me you would want to include professionals in those fields in your discussions with non-psychological professions.	Thank you for your comment. Acupuncture and spinal manipulation were included in the reviews that served as the underlying evidence for recommendations. We want to emphasize that the guideline is not a standard of care rather the recommendations are based on a systematic review of the scientific evidence. The guideline was developed by a multidisciplinary panel that included physical therapy, nursing, social work, psychologists, and individuals living with chronic pain.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Lynda Marshall (Individual)	General	I also question why you would include nursing in your consultations. Nurses (registered nurses) are not licensed to diagnose or prescribe treatments for any pain; if you consulted with advanced practice registered nurses or nurse practitioners, perhaps that should be specified, although that seems redundant with consulting other medical professionals or physicians. In short, if your guidelines are meant to provide guidance for all treatment modalities, you should include consultations and research in all of the modalities.	Thank you for your feedback. We further clarified in the guideline that the document is intended for a “team approach” in treating chronic pain. Chronic pain is not a symptom, rather it is a disease that warrants a multidisciplinary approach. The guideline was developed by a multidisciplinary panel that included physical therapy, nursing, social work, psychologists, and individuals living with chronic pain.



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Lynda Marshall (Individual)	General	I believe APA has overstepped its boundaries in these guidelines. Is it APA's place, or within the scope of a psychologist's license, to advise patients or clients on which non-psychological treatment they should choose for chronic pain? In these guidelines, it appears APA has taken on the role of deciding which treatment methods are best for patients without being able to diagnose the underlying cause of that chronic pain or considering whether the underlying cause of the chronic pain may be better addressed through one method or another, and without involving the non-medical/surgical health providers (such as chiropractors or acupuncturists) in their consultations, discussions, and research. Although it might be helpful and even appropriate for a psychologist to identify various non-psychological interventions with their patients, many, many lay people can identify the same interventions, and the scope of these guidelines goes far beyond that. When APA has to include other professions in developing guidelines, has it not gone well beyond the scope of psychology? Other treatment options for chronic pain involve a VAST body of education, research, and data that go far beyond what psychologists should be discussing with patients, especially given the influence and power dynamic of the therapeutic relationship.	Thank you for your review and feedback. As these terms are used in APA policy, “guidelines” include pronouncements, statements, or declarations that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists or for individuals or organizations that work with psychologists. In contrast to standards, guidelines are aspirational in intent. Chronic pain is not a symptom, rather it is a disease that warrants a multidisciplinary approach. During the development of this guideline, we benefited from the experience of a broad range of providers (physical therapists, nurses, social workers and occupational medicine physicians, as well as individuals with lived experiences of pain). We want to emphasize that psychologists are well-equipped to manage pain beyond the system via a biopsychosocial approach and the guideline’s scope was purposefully broad given the multidisciplinary care that is recommended for treating individuals with pain.
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Commenter (Group or Individual?)	Section	Comment	Panel Response
		I would suggest that APA's guidelines be limited to evidence-based psychological interventions, rather than trying to provide guidelines for choosing treatments beyond the scope of APA's and psychologists' expertise.	
Helena Turner, LMFT (Individual)	General	The guidelines do not include discussion of EMDR in the treatment of chronic pain, despite research comparing EMDR to TAU for chronic pain as early as 2009 with positive results. I recommend discussing the EMDR research as well. The guidelines will be incomplete without it.	Thank you for your review and comment of the guideline. We were limited to the studies that were included in the three identified systematic reviews. Across these reviews, we did not identify any efficacy nor comparative effectiveness trials for EMDR.
Joseph D. Cautilli, PhD (Individual)	General	While the document briefly covers Behavioral therapy vs. active control or vs. treatment, I believe this document would be greatly enhanced by covering Fordyce's model of chronic pain. It is a solid evidenced-based model and not including it in detail for the document may lead insurance providers not to cover it.	Thank you for your review and comment of the guideline. We were limited to the studies that were included in the identified systematic reviews. Fordyce's model is the foundation for the many psychological interventions that were used, even though the model may not have been mentioned specifically in the studies.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Monica Carsky, PhD (Individual)	Treatment Recommendations	This document omits any mention of the use of clinical hypnosis for pain relief, despite a long history of its use and a large research base (see, for example, Open Pain J. Author manuscript; available in PMC 2011 Jun 13. Published in final edited form as: Open Pain J. 2010; 3(1): 39–51. doi: 10.2174/1876386301003010039 for numerous references. I find this an insult to the many psychologists who use hypnosis or teach it to their pain patients to ameliorate suffering. There is also no mention of research on psychosomatic syndromes and their treatment (see, eg, the work of Alla Landa PhD and colleagues at Columbia.)	Thank you for your review and comment of the guideline. We were limited to the studies that were included in the identified systematic reviews. There was not sufficient evidence to include hypnosis. The intention is not to insult clinicians that provide hypnosis but there were other specific interventions not included in the systematic reviews and the panel has commented within the guideline the limitations of the systematic reviews. Psychosomatic syndromes were outside the scope of the guideline.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Francis (Frank) Keefe (Individual)	General	Strengths—This guideline is generally well organized and written. Among the strongest sections are those focused on process and methods. These appear in several sections (pages 3-5, 22-26; 29-37). This fit well with the current emphasis on open science and transparency since they would enable others to reproduce/replicate the procedures used in the review process. Also, noteworthy in this regard is the section on Vetting and Appointment of Members of the panel. Knowing the make-up of the panel helps readers better understand how the findings obtained were interpreted. Finally, the fact that an external review is being sought and that comments made might influence the final version of the guideline is a plus.	Thank you for your review and comment.



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Francis (Frank) Keefe (Individual)	General	Weaknesses 1—One of the most disappointing aspects about the evaluation of the evidence for this guideline is the decision that was made to focus on indices of “physical functioning and performance), instead of reports of pain severity/intensity, as the primary outcome when evaluating the literature. This is disappointing for several reasons. First, pain is a phenomenon that at its essence is psychological in nature (see IASP definition of pain—Pain is an unpleasant sensory and emotional experience.....). Given that this guideline was developed by the APA the failure to focus on pain as the primary outcome is surprising.	Thank you for your review and feedback. The trend to focus more on function rather than pain severity/pain intensity has occurred recently (e.g., Becker et al., 2018; Elder et al., 2017; Mallick-Searle et al., 2021; Turk et al., 2016). . Other than hypnosis, most psychological interventions do not purport to reduce pain; they are more so focused on physical functioning and performance. Psychological interventions alone rarely see a reduction in pain, and ideally are best used in combination with medical interventions. References Becker, W. C., DeBar, L. L., Heapy, A. A., Higgins, D., Krein, S. L., Lisi, A., Makris, U. E., & Allen, K. D. (2018). A research agenda for advancing nonpharmacological management of chronic musculoskeletal pain: Findings from a VHA state-of-the-art conference. <i>Journal of General Internal Medicine</i>, 33, 11-15. https://doi.org/10.1007/s11606-018-4345-6 Elder, C. R., DeBar, L. L., Ritenbaugh, C., Rumpitz, M. H., Patterson, C., Bonifay, A., Cowan, P., Lancaster, L., & Deyo, R. A. (2017). Health care systems support to enhance Patient-Centered care: Lessons from a primary care-based chronic pain management initiative. <i>The Permanente Journal</i>, 21, 85-90. https://doi.org/10.7812/TPP/16-101
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Commenter (Group or Individual?)	Section	Comment	Panel Response
			Malick-Searle, T., Sharma, K., Toal, P., & Gutman, A. (2021). Pain and function in chronic musculoskeletal pain—treating the whole person. <i>Journal of Multidisciplinary Healthcare</i>, 14, 335-347. https://doi.org/10.2147%2FJMDH.S288401 Turk, D. C., Fillingim, R. B., Ohrbach, R., & Patel, K. V. (2016). Assessment of psychosocial and functional impact of chronic pain. <i>The Journal of Pain</i>, 17(9), T21-T49. https://doi.org/10.1016/j.jpain.2016.02.006



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Francis (Frank) Keefe (Individual)	General	Second, as noted in this guideline the NIH roadmap and IMMPACT highlight that pain is perhaps the key outcome to be considering when reviewing treatments for persistent pain (see statement in this guideline on p. 46 “Both the IMMPACT and NIH Roadmap variables recognize that pain is a dimension that is intrinsically related to other multiple dimensions of outcome which include physical, social, and psychological variables.” Third, and consistent with this point, throughout this document there is an emphasis on the need to be patient-centered. People suffering from persistent pain routinely report that pain is their primary concern. It is also the primary concern of their family members as well as most health professionals. The reason is that it is linked to so many outcomes. A person who has completed a course of treatment but continues to report moderate to severe pain is also likely to suffer psychological and, because the pain occurs in a social context, will elicit responses from health professionals (e.g. additional diagnostic procedures, additional surgeries, etc.) and from family/friends/coworkers (encouragement to rest, taking over chores/responsibilities) that can undo gains in physical function and performance.	Thank you for your comment. The trend to focus more on function rather than pain severity/intensity has been recently documented (e.g., Becker et al., 2018; Elder et al., 2017; Mallick-Searle et al., 2021; Turk et al., 2016). We also have individuals with lived experience on the panel, and this is consistent with their experiences as well in that they identified improved quality of life and functioning as important outcomes in the treatment of chronic pain. References Becker, W. C., DeBar, L. L., Heapy, A. A., Higgins, D., Krein, S. L., Lisi, A., Makris, U. E., & Allen, K. D. (2018). A research agenda for advancing nonpharmacological management of chronic musculoskeletal pain: Findings from a VHA state-of-the-art conference. <i>Journal of General Internal Medicine</i>, 33, 11-15. https://doi.org/10.1007/s11606-018-4345-6 Elder, C. R., DeBar, L. L., Ritenbaugh, C., Rumptz, M. H., Patterson, C., Bonifay, A., Cowan, P., Lancaster, L., & Deyo, R. A. (2017). Health care systems support to enhance Patient-Centered care: Lessons from a primary care-based chronic pain management initiative. <i>The Permanente Journal</i>, 21, 85-90. https://doi.org/10.7812/TPP/16-101
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Commenter (Group or Individual?)	Section	Comment	Panel Response
			Malick-Searle, T., Sharma, K., Toal, P., & Gutman, A. (2021). Pain and function in chronic musculoskeletal pain—treating the whole person. <i>Journal of Multidisciplinary Healthcare</i>, 14, 335-347. https://doi.org/10.2147%2FJMDH.S288401 Turk, D. C., Fillingim, R. B., Ohrbach, R., & Patel, K. V. (2016). Assessment of psychosocial and functional impact of chronic pain. <i>The Journal of Pain</i>, 17(9), T21-T49. https://doi.org/10.1016/j.jpain.2016.02.006
Francis (Frank) Keefe (Individual)	General	Third, for the most part, studies of psychological treatments have not been powered to detect changes in physical functioning and performance. Some of these studies do not include the types of physical functioning and performance that were the primary outcomes of interest in this document. As a result, these psychological treatments may not have fared as well in this analysis of studies, particularly when compared to exercise intervention studies (which are powered to detect these changes and routinely incorporate measures of physical functioning and performance).	Thank you for your comment. We appreciate that there were many limitations with the studies that were included with the systematic reviews that were used as the underlying evidence. These were noted in the limitations section of the guideline.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Francis (Frank) Keefe (Individual)	Considerations for Treatment Implementation	Weaknesses—The section on “Considerations for Treatment Implementation” has a number of limitations. First, much of what is included in this section is not based on the type of high quality evidence that is heralded as so very important in the earlier parts of the guideline. As a result, there is a very abrupt transition in writing style and the critical lens/voice being used when the reader get to the “Considerations...” section.	Thank you for your review and comment. It is important that clinicians and researchers remain abreast of the latest research; however, for items that may not be a part of the specialist knowledge base, we will provide additional information to ease the burden. Moreover, we reviewed the document and removed the word “recommend” when such a stance was not indicated.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Francis (Frank) Keefe (Individual)	Considerations for Treatment Implementation	Second, there is minimal empirical evidence for many of the statements made in this section. Many of these statements have face validity but compelling evidence from published studies are lacking. Along these lines, this guideline criticizes prior guidelines as being biased since they are based on opinion, yet opinion features strongly in this section.	Thank you for your comment. To minimize the impact of bias we developed a panel that is comprised of individuals representing a wide range of experience in the realm of pain. We organized the guideline into three types of recommendations. The first type is the traditional / efficacy recommendation, where systematic reviews of the scientific evidence are evaluated to determine the strength and direction of the recommendation, while considering harms/burdens, patient values and preferences and applicability of the treatment. Documentation of the panel's voting can be found in the supplemental Grid / excel spreadsheet. The second type of recommendations are what's known as "implementation considerations." These statements are consensus-based on how to apply the previous recommendation statement types into clinical practice. The third category "recommendations for research" is also expert, consensus-based that notes the current gaps in the research literature and where more research is needed to address these gaps.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Francis (Frank) Keefe (Individual)	Considerations for Treatment Implementation	Third, this section places a substantial burden on the practicing clinician vis a vis the research and guideline literature. Repeatedly the clinician is asked to “consider” “refer to suggestions made in the literature”, “review the literature”, “consider processes involved” and engage in other tasks that depend on a deep and broad understanding of the research and theory in this area. One example on p. 44 “The panel also recommends clinicians refer to the five steps of translating research into action, according the RE-AIM framework...” How is the clinician expected to follow this recommendation in clinical practice? (Particularly given that it is listed as, a “recommendation” though the evidence supporting it is not evaluated in a thorough enough fashion to meet the guideline’s specifications. Considered overall, the burden placed on practicing clinician in this section (and in other sections) is excessive and beyond what can be reasonably expected not only from clinicians, but also from researchers who have spent years working in this space. It is recommended that the panel carefully consider the burden and challenges of the many tasks they are asking clinicians to undertake. It is possible that they can offer suggestions on how to accomplish these tasks in an efficient fashion.	Thank you for your comment. We reviewed the document and removed the word “recommend” in the implementation considerations section when such a stance was not indicated. The reference to the RE-AIM framework was to serve as one of the ways of translating research into clinical practice and it was not intended to be a recommendation.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Francis (Frank) Keefe (Individual)	Considerations for Treatment Implementation	Finally, there are several particularly weak sections of this part of the guideline. The section on change processes is one of these and is mainly based on the literature of psychological treatment of depression.	Thank you for your comment. We expanded this section to include examples of change processes and mechanisms related to the treatment of chronic pain.
Francis (Frank) Keefe (Individual)	Discussion	Weaknesses— “How the APA CGP Compares to Other Treatment Guidelines...” This section is the weakest in this document. It consists of a simple listing of descriptions of differences/similarities evident in different guidelines. The lack of synthesis and integration of the material is notable. The subsection on strengths and limitations of systematic reviews repeats much of what is said earlier in this document. Considered overall, much of what is in this section could be presented in a Table.	Thank you for your comment. We will revise this section to include a table.
Francis (Frank) Keefe (Individual)	Discussion	Weaknesses—How does the evidence base for the treatments considered in this review compare to the evidence base for medical/surgical treatments. This guideline offers many criticisms of the quality of the literature in this area. To provide perspective to the reader, it would be helpful if a section were included that commented upon/compared the quality of research supporting medical/surgical treatments for persistent pain vs the quality of research for treatments discussed in this guideline.	Evaluating medical/surgical treatments was outside the scope of the guideline. We appreciate that such information could be helpful; however, given a decision was made not to make such comparisons unless they could be made for all available pain treatments and the scope of the latter is too large to include in this present work.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Adam J. Rush, MD (Individual)	General	It has been conclusively proven that prescription opioids are not the cause of the opioid misuse crisis. Any document which states, “The over-prescription of opioids for the treatment of chronic pain is a major contributor to the opioid epidemic in the U.S., which is a current public health emergency,” is worse than useless. By publishing such a deeply flawed guideline the APA will worsen chronic pain management by strengthening unnecessary barriers between patients and treatments, and will worsen the opioid epidemic by distracting from the actual causes. I also point out that it’s human nature to reject an entire message even when only part of the message is flawed. Ludicrous and harmful statements in one portion of the practice guideline make it less likely that worthwhile portions, like discussions of exercise and ACT, will be appreciated. My strong recommendation is that this entire process be restarted beginning with the literature review. Nadeau, Wu & Lawhern 2021 is a good place to start. Nadeau SE, Wu JK, Lawhern RA. Opioids and Chronic Pain: An Analytic Review of the Clinical Evidence. <i>Front Pain Res</i> (Lausanne). 2021 Aug 17;2:721357. doi: 10.3389/fpain.2021.721357. PMID: 35295493; PMCID: PMC8915556.	Thank you for your review and comment. We agree that prescription opioids were not the sole <u>cause</u> of the opioid crisis, but studies have identified that they played a role in its onset (Moshfegh et al., 2019; Rasu et al., 2013). We revised the sentence by removing the word “major” and instead noted that it was one of the contributors of the opioid epidemic. The scope of our guideline did not include pharmacologic comparisons; thus, pharmacologic interventions were not specifically assessed. References Moshfegh, J., George, S. Z., & Sun, E. (2019). Risk and risk factors for chronic opioid use among opioid-naïve patients with newly diagnosed musculoskeletal pain in the neck, shoulder, knee, or low back [Commentary]. <i>Annals of Internal Medicine</i>, 170(7), 504-505. https://doi.org/10.7326/m18-2261 Rasu, R. S., Sohraby, R., Cunningham, L., & Knell, M. E. (2013). Assessing chronic pain treatment practices and evaluating adherence to chronic pain clinical guidelines in outpatient practices in the United States. <i>The Journal of Pain</i>, 14(6), 568-578. https://doi.org/10.1016/j.jpain.2013.01.425



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Commenter (Group or Individual?)	Section	Comment	Panel Response
John (Individual)	General	All of these studies are low quality and show little to no effect because CBT doesn't work for people. CBT is teaching people they are the problem, rather than the source of the problems; Systemic policy, like drug scheduling. Until those policies are addressed and resolved, CBT will continue to be ineffective and a waste of time. This is... teaching people domestic abuse is their fault.	Thank you for your review of the document. Panel members have heard from many with pain that CBT has helped them cope more effectively with their pain to improve the quality of life and increase function while reducing their sense of suffering. There were several studies done through PCORI that showed the positive impact of CBT on pain. Although there is strong evidence for CBT interventions in other domains (e.g., Williams et al., 2020) we postulate that methodology issues may account for the quality and effect issues observed.



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Bailey Rose (Individual)	General	The CDC and every medical authority has established that rx opioids were not the cause of the “opioid crisis” in the US so demonizing this vital class of meds for pain throughout your recommendations and refusing to acknowledge their rightful place in pain treatment for some patients is irresponsible, bad medicine and glaringly highlights your obvious bias and agenda against both opioids and this patient population. Opioids have been a safe and effective pain treatment for thousands of years and to exclude them in favor of low quality treatments is ludicrous and shows that none of you who wrote these recommendations has ever known severe pain that lasts for years. As a 40+ year member of the pain community, I’m disappointed in what you have published because we deserve better. I actually think exercise, CBT and therapy can be quite beneficial for pain along with your other recommendations but what you fail to mention is that without meds such as opioids first, none of these other treatments are possible for some. Opioids allow some that are suffering the ability to get out of bed to do the exercises and to get to the therapist and your recommendations fail to mention or even acknowledge this. You have a responsibility to do better.	Thank you for reviewing the document. We agree that prescription opioids were not the sole <u>cause</u> of the opioid crisis, but studies have identified that they played a role in its onset (Moshfegh et al., 2019; Rasu et al., 2013). We revised the sentence by removing the word “major” and instead noted that it was one of the contributors of the opioid epidemic. The scope of our guidelines did not include pharmacologic comparisons; thus, pharmacologic interventions were not specifically assessed. References Moshfegh, J., George, S. Z., & Sun, E. (2019). Risk and risk factors for chronic opioid use among opioid-naïve patients with newly diagnosed musculoskeletal pain in the neck, shoulder, knee, or low back [Commentary]. <i>Annals of Internal Medicine</i>, 170(7), 504-505. https://doi.org/10.7326/m18-2261 Rasu, R. S., Sohraby, R., Cunningham, L., & Knell, M. E. (2013). Assessing chronic pain treatment practices and evaluating adherence to chronic pain clinical guidelines in outpatient practices in the United States. <i>The Journal of Pain</i>, 14(6), 568-578. https://doi.org/10.1016/j.jpain.2013.01.425



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Tyler Green (Individual)	General	My main issue is that this guideline doesn't help patients who are already coping to the greatest extent possible and require some type of pharmacological treatment. If a patient is already doing meditation, exercise, and physical therapy, and has a healthy outlook on their pain, then the only remaining option is pharmacological treatment. Make that crystal clear, and deeply explicit, because as is its likely to be interpreted as psychological treatment is adequate on its own. Which it isn't. Further, there's not enough reference to the deadly physiological consequences of unrelieved severe pain, and that psychological interventions are insufficient for SEVERE pain. Make that explicit.	Thank you for taking the time to read the guidelines and submit comments. Literature has shown that pain is best addressed by a biopsychosocial rather than a unimodal approach to care. The guideline did not include pharmacologic interventions as it was outside the scope; thus, we are not taking any formal stance on this form of treatment.
Maxx P Lamb (Individual)	Treatment Recommendations	You don't address how exercise can have deleterious effects on people with a range of musculoskeletal conditions like Ehlers Danlos Syndrome, for who research has pretty conclusively shown that it can make it worse half the time. Make it clear that exercise can and does worsen pain for a range of conditions, but especially Ehlers Danlos Syndrome.	Thank you for your review of the document. Given the scope of the project, we did not look at specific conditions; however, we did emphasize the importance of individualized care, which includes consideration for specific conditions



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Commenter (Group or Individual?)	Section	Comment	Panel Response
Daniel (Individual)	General	I have arthrogryposis multiplex congenita. Please look that up. It is a muscular skeletal condition. No doctor seems to know anything about it. They don't know how to treat it. I have chronic pain with it. I am not treated for chronic pain. I have severe inflammation with it. I tell him my physical brings my psychological because of severe pain. To never be heard.	Thank you for your review of the document. We are sorry to hear that you are having this difficulty. Given the scope of the project, we did not look at specific conditions; however, we did emphasize the importance of individualized care, which includes consideration for specific conditions. We suggest contacting the National Organization for Rare Diseases. They may be able to provide information, recommendations and help to better understand AMC.
N. (Individual)	General	People with chronic pain from physical disabilities, physical injuries, musculoskeletal conditions – their pain is not psychological, don't treat it like it is. Physical pain is not psychological.	Thank you for your review of the document. In every health care condition, there is a component of the psychological impact on a person. Not just in pain but in cancer, heart disease, diabetes and even stroke. While the cause is not psychological, it does affect how one copes, and the latter can directly impact the primary medical condition itself.



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John McFadden, M.D. (Individual)	General	A recent reply to a Medscape article-a twitter post. Surely Dr. Claw knows of the suffering. See new posts Conversation John McFadden, M.D., Pain Medicine(Ret) @drjohnhaiti Medscape should be ashamed to post this. Anyone connected has not laid awake all night in pain. Opioids and non opioids for pain cure nothing. What else gives timely pain relief? medscape.com 'Nopoids' for Chronic Pain: Only When Nothing Else Works Dr Neha Pathak interviews Dr Daniel Clauw about how opioids fit into the treatment armamentarium when managing chronic pain. 8:03 PM · Oct 2, 2023 . 429 Views View post engagements McFadden, J. [@drjohnhaiti]. (2023, October 2). <i>Medscape should be ashamed to post this. Anyone connected has not laid awake all night in pain. Opioids and non opioids</i> [Tweet]. Twitter. Link A good example is the patient with the Fibromyalgia Syndrome of disc origin. Most with	Thank you for taking the time to comment and for sharing the posts. It seems the comments relate to opioids and a specific diagnosis. The scope of our document did not focus on either (reference PICOTS) but it is for the reasons you outline that we repeatedly emphasize a need for individualized care.
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Commenter (Group or Individual?)	Section	Comment	Panel Response
		the full syndrome suffer from multiple painful discs and have little or nothing for relief. 8:07 PM · Oct 2, 2023 . John McFadden, M.D. Clinton, MS 601 956 1856 FYI: I told Daniel Claw years ago that the fibromyalgia syndrome was of disc origin, No other part of the anatomy produces pain that lasts for years in the lower cervical spine.	



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John McFadden, M.D. (Individual)	General	Background: I operated a pain clinic from 1982 until 2003 and saw mostly spine pain patients. Over the years I had several research projects and wrote the first paper on awake discography. In 1988 I began examining the anterior cervical spine in those with neck pain which led me to discover that the fibromyalgia syndrome is of intervertebral disc origin. Currently X is my primary interest in attempting to encourage others in several countries to look more closely at the disc as the origin of the fibromyalgia syndrome with the easiest way would be to perform pre and post anterior cervical fusion at C5-C6 12 point FMS exams Google Scholar. (n.d.). <i>discogram mcfadden jw</i> [Search results]. Google. Link McFadden, J. [@drjohnhaiti]. (n.d.). <i>Tweets</i> [Twitter profile]. Twitter. Retrieved October 18, 2023, from Link McFadden, J. W. (2002). Anterior cervical spine tenderness: The key to the fibromyalgia examination [Editorial]. <i>Journal of Neurological and Orthopaedic Medicine and Surgery</i>, 22(1&2), 11-15. Link I have had the Fibromyalgia Syndrome and multiple painful discs since 1976. The problems lie with the spine pain researchers and others. They	Thank you for your work in FMS. As noted in reply to your previous comment, the scope of the guideline did not focus on specific diagnoses (please refer to Appendix E of the guideline for the panel’s scoping framework), but it is for the reasons you outline that we repeatedly emphasize a need for individualized care.
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		seem to be mostly following the non surgical literature and not thinking on their own. For medications one may simply go to patients disabled with pain and ask what they need for restorative sleep and less pain. to function a bit better. Also for the chronic fatigue, depression, anxiety, etc. The surgical options are often ignored. For example most with the fibromyalgia syndrome never are told that if the disc pain is gone the related FMS tender points and muscle spasm disappear. If the intradiscal stem cells work will the FMS patients be told about this form of treatment? How many times have you seen any of the below discussed in the current spine pain/FMS literature? Internal disc disruption(syndrome) The most common cervical disc becoming painful and also undergoing surgery is C5-C6 Palpation of the anterior cervical spine reveals That neck pain of disc origin is always worse on one side Is your neck, thoracic or low back pain more severe on the right or left	
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Commenter (Group or Individual?)	Section	Comment	Panel Response
		How many of your FMS tender points were positive prior to spine surgery in the lower cervical spine or lower lumbar spine The point of maximum tenderness in the low back was at the intercrestal line, below or above Please, do pain patients need your guidelines? Will your guidelines contribute to various civil and criminal charges brought against physicians and other medical providers seeing chronic pain patients in particular? John McFadden, M.D., Pain Medicine(Ret) Clinton, MS fibromyalgia001@gmail.com 601 956 1856	



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Section 4: Panel Responses to Public Comments Received via Email

Commenter (Group or Individual?)	Section	Comment	Panel Response
Lisa Lombard, PhD (Individual)	General	Considering mind-body practices that are hypnotically informed is important for pain management. What were the findings related to the use of hypnosis?	Thank you for taking the time to read the document and provide comments. We were limited to the interventions examined in the literature reviewed, and hypnosis was unfortunately not included as a comparator in these studies.