



AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Disposition of Comments Organized by Theme

**Initial Decisions in Updating APA's (2017)
Clinical Practice Guideline for the Treatment of PTSD in Adults**

Available for public comment from March 21, 2023, to April 21, 2023.

**Population, Interventions, Comparators, Outcomes, Timing, and Setting (PICOTS)
Framework and Identified Systematic Reviews**

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1. Overall Comments on APA PTSD GUP's Proposed Framework and Systematic Reviews

Theme #1-A: Overall approach to updating the guideline (e.g., using meta-analytic data)

Commenter (Group or Individual?)	Comment	Panel Response
John H. Diepold, Jr., PhD (Individual)	- Guidelines can be both helpful and restrictive. - What is the rationale for these guidelines? I hope this is not an attempt to create laws/rules/standards for insurance companies to exclude some psychotherapy interventions.	Thank you for your comment. To date, no documented incidence of malpractice claims tied to a CPG has been reported to APA by psychologists. Further, the Legal and Regulatory Affairs department at APA routinely works on behalf of psychologist members when it becomes aware that third party payers, health care systems, or others are potentially misusing APA policy or not appropriately administering their own policies. In that regard, those with indication of misuse should bring this information to the attention of the appropriate offices at APA to determine a course of action. We would also like to respectfully point out that an advantage of CPGs is that they inform psychologists who are eager to adopt the most current and evidence-based approaches to treatment about what those treatments are.
Janice Muhr, PhD (Group: Psychotherapy Action Network)  April 16, 2023 Psychotherapy Action Network (PsiAN) advocates for accessible, affordable, and ethical psychotherapies with lasting impact for anyone who wants or needs them. PsiAN is a nonprofit organization with more than 5,200 individual members and 80 organizational partners. We have chosen to make most of our comments in the form of this letter because we found that		Thank you for your review and critical feedback of the PICOTS framework and identified systematic reviews. The responses to your comments have been organized into sections below.

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	our responses and the reasoning behind them were difficult to express within the framework of the survey provided. When the original American Psychological Associations (APA) PTSD clinical practice guidelines were published, PsiAN expressed extensive concerns that were endorsed by over 57,000 signatories of a petition. We are pleased that the APA Guidelines Update Panel (GUP) seems to have positively considered several of our concerns as articulated in that petition. For example, they added studies to include dual diagnosis patients and some additional modalities and interventions. However, we have significant concerns about the framework and current proposed path of the GUP. Our concerns fall into four main categories, with additional detail outlined below: 1. The questions used to frame the current approach are limiting and will likely lead future research and guidelines down a limited, ever narrowing path at a time of mental health crisis and increasing caseloads of PTSD. 2. The GUP is misapplying both the Institute of Medicine (IoM) framework and APA's definition of evidence-based treatment, which is a major weakness. 3. Problems arise from the GUP's approach and decision to rely entirely on meta-data. 4. This "guideline" is not an addition, but rather a reflection of past, aggregated work. It uses only meta-data that were published in the past, and the primary studies cited are significantly old and out of date and do not reflect current realities.	
Janice Muhr, PhD (Group:	1. Limiting questions	Thank you for your feedback. We plan to explore further interventions beyond exposure based. The guideline

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Psychotherapy Action Network)	1a. We are concerned that the framing questions that will guide the literature search for the new APA CPG will exclude and/or minimize the importance of credible efficacy studies of non-exposure based treatments, which provide a steadily growing evidence base. Crucially, we do not see much to suggest that, within this framework, the GUP will be able to meaningfully differentiate the experiences of members of diverse groups in treatment. Further, we see little sign that the mechanisms of treatment that effect change or lead to dropout will be illuminated.	recommendations will also be organized 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. The second type of recommendations are called "implementation considerations." These statements are consensus-based and focus on contextual and diversity considerations in applying the previous recommendation statement types into clinical practice. The third category "recommendations for research" are also expert, consensus-based recommendations highlighting the current gaps in the research literature and where more research is needed to address these gaps.
Janice Muhr, PhD (Group: Psychotherapy Action Network)	1b. These were also serious problems in the first APA CPG for PTSD. We hope that lessons learned (and cited in the special edition of <i>Psychotherapy</i> dedicated to that process and product) will inform this updated set of guidelines.	Thank you for your comment. The panel reviewed the special edition of <i>Psychotherapy</i> and plans to address the lessons learned in the guideline update.
Janice Muhr, PhD (Group: Psychotherapy Action Network)	1c. The GUP is using a framework that is defined in terms of population, intervention, comparator, outcome, timing, and setting (PICOTS) elements. PICOTS defines general categories on which the quality of studies can be evaluated but doesn't specify which outcome measures are meaningful for recovery from PTSD. Its value depends upon how the framework is defined by the GUP; it isn't enough to say that it is being followed, and to follow it rigorously would leave few studies for consideration. For example, according to PICOTS itself, high "strength of evidence" studies must "include all important intended and unintended effects including adherence and tolerability." While a systematic review referenced by the GUP, Jericho et al. (https://doi.org/10.1111/acps.13366), does report "treatment	Thank you for your comment. In the early stages of scoping, the panel used the Delphi method to complete an outcome prioritization survey. On this survey panel members rated outcomes from 1 "not important" to 9 "critical" for deciding about what treatment to recommend. <i>Critical outcomes</i> were defined as those that are essential and necessary to the treatment decision-making process between the therapist and patient while <i>important outcomes</i> were defined as those that were significant but not critical for making a decision.

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	acceptability,” there is little in it that can speak in a clinically meaningful way to study exclusions and drop-out, including their significance to outcome. This is a highly problematic feature of less high quality psychotherapy outcome research (Kocsis J, Gerber A, Milrod B, Roose SP, Barber JP, Thase ME, Perkins P, Leon AC: A new scale for assessing the quality of randomized clinical trials of psychotherapy. Comprehensive Psychiatry 2010 May-Jun;51(3):319-24), and is difficult to capture in the meta-data framework that this committee undertook, which profoundly limits its reflection of and applicability to real life clinical treatment.	In formulating guideline recommendations, the panel will weigh evidence related to critical outcomes more heavily than evidence related to other outcomes. Also, following the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system (Schünemann et al., 2013), the overall strength of the evidence for a recommendation can be no higher than the lowest quality of the evidence for the critical outcomes. For example, if one critical outcome had ‘high’ strength of evidence but the other critical outcome had ‘low’ strength of evidence, the global quality of evidence for that particular decision table or column in the grid would be ‘low,’ since that is the lowest strength of evidence for an individual critical outcome. Reference Schünemann, H., Brożek, J., Guyatt, G., & Oxman, A. (Eds.). (2013). <i>GRADE handbook</i>. https://gdt.gradepro.org/app/handbook/handbook.html
Janice Muhr, PhD (Group: Psychotherapy Action Network)	2. The IoM and APA guidelines regarding evidence 2a. We question how the Institute of Medicine (IoM) guidelines are being interpreted and believe they are being misapplied by the GUP. The IoM clearly states that clinical and research findings should both be incorporated when developing clinical practice guidelines, and warns against an “isolationist” approach that excludes one of these types of findings. Yet the APA GUP is privileging meta-data, while also inaccurately stating that it is adhering to the IoM’s framework.	Thank you for your comment. To address these concerns, the Advisory Steering Committee for development of clinical practice guidelines introduced two new types of recommendation statements in addition to the traditional efficacy recommendations based on a systematic review of the scientific evidence: “implementation considerations” and “recommendations for research.” The “implementation considerations” are consensus-based statements based on how to apply the previous recommendation statement types into clinical practice and include clinician experience. The “recommendations for research” category is also expert, consensus-based that notes the current gaps in the research literature and where more research is needed to address these gaps. Clinician

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		experience is also incorporated into the traditional recommendations when considering potential harms/burdens of treatments and preferences of patients.
Janice Muhr, PhD (Group: Psychotherapy Action Network)	2b. In his 2019 article, Clinical practice guidelines for post traumatic stress disorder: Are they still clinical?, from the 2019 special issue of <i>Psychotherapy</i>, Harold Kudler describes this oft-repeated misreading of the IoM: In practice, there is no basis for excluding mention of widely accepted clinical practices in a CPG solely based on the findings of the guideline's systematic reviews to be found in the IoM's Clinical Practice Guidelines We Can Trust. In fact, the IoM is explicit about the importance of balancing clinical and research findings in developing CPG recommendations..."The [IoM] committee is critical of the isolationist approach because it inhibits knowledge exchange between clinical content experts and methodologists, potentially degrading their abilities to appreciate the nuances of evidence and clinical questions pertinent to the formulation of recommendations." (p. 93, 96)	Thank you for your comment. We understand the concerns you raise and therefore introduce two new types of recommendations that will be incorporated in this guideline update as well as future clinical practice guidelines. The two new types of recommendations, implementation considerations and recommendations for research, will be consensus-based and will include additional literature that may not have met criteria to be included in a systematic review. The recommendations for research will also provide a call for more research in gaps the panel identified throughout the development of the guideline. Further, the statement in the IOM report regarding isolationist approach refers to the conduct of the systematic review and encourages interaction between the systematic reviewers and guideline developers to ensure clinician knowledge is considered as the methodologists conduct the review.
Janice Muhr, PhD (Group: Psychotherapy Action Network)	2c. The APA's own definition of evidence-based practice, which recognizes the three equally important components of research, clinical judgment and patient preference, is aligned with an accurate reading of the IoM, and it should be the basis for defining the evidence base for the Guidelines. The current proposed framework, like that of the current guidelines, relies primarily on research, and research derived from consideration of meta-data only rather than individual RCTs. It fails to integrate data from the latter two components of the definition of evidence-based practice. This problem could be diminished by broadening the research considered as a basis for the guidelines. While it appears that an effort has been made to look at a broader range of treatment approaches as well as treatment parameters, we believe this effort falls far short of the changes needed.	Thank you for your comment. In addition to traditional efficacy recommendations, the Advisory Steering Committee for development of clinical practice guidelines recently created two new types of recommendation statements. The first type, implementation considerations, are consensus-based and address how to implement the guideline recommended treatments in clinical practice. The second type, recommendations for research, are consensus-based and list areas where more research is warranted. Further, guideline recommendation decisions are made based on four factors: the overall strength of the evidence for efficacy, the balance of benefits versus harms/burdens (note, clinician and patient representative

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		input are included in the harms/burdens evaluation) of a treatment, patient values and preferences regarding a treatment (which also includes clinician input), and applicability. Overall, though, clinical practice guidelines are intended to be used as part of evidence-based practice, informing the best available research evidence component, to be used in conjunction with the clinician's expertise and patient's individual preferences, characteristics, and values.
Janice Muhr, PhD (Group: Psychotherapy Action Network)	3. Approach and Data Selection 3a. We believe that the evidence base upon which the GUP plans to develop guidelines remains fundamentally inadequate and misleading. The GUP has taken a disappointing, idiosyncratic, and unprecedented short-cut in not reviewing any primary research, not doing their own review of the research literature, and not including swaths of efficacy studies in affect-focused psychotherapies, or alternate kinds of research design that provide access to information about dimensions of psychotherapy process and outcome that can illuminate what diverse patients find helpful. The meta-data proposed as the basis of the guidelines includes no studies that have been published in the last five years.	Thank you for your comment. The IOM standards for clinical practice guideline development allow the use of existing systematic reviews as it is resource- effective and it avoids the potential cherry-picking of studies if the panel was to conduct its own review of the primary studies. However, the panel examined closely many of the studies included in the systematic reviews they used for additional information. The panel also considered change processes such as mechanisms and events and includes information on this in the full guideline document.
Janice Muhr, PhD (Group: Psychotherapy Action Network)	3b. The GUP's decision not to undertake their own reviews, but their decision to rely on meta-data alone to provide meaningful guidance for treatment recommendations is a highly problematic approach. Meta-data/meta-analyses are a technique designed to compare large studies using identical outcome measures across vast numbers of medical disorders, (ie., approaches for diabetes, wherein the primary outcome measure is well established, HGB A1C). They are over-used and have well-documented problems in mental health research; Ns of individual studies tend to be small and the number of moving parts in mental health research are far more complex than in general medicine (ie. research benchmarks: primary outcome measures, definitions of response and remission). (See Barber JP, Milrod B: Pitfalls of meta-analysis (letter). American Journal of Psychiatry 2004;61:1131.) While meta-analyses provide statistical power, at the same	Thank you for your comment. The IOM standards for clinical practice guideline development allow the use of existing systematic reviews as it is cost-effective, and it avoids the potential cherry-picking of studies if the panel was to conduct its own review of the primary studies. However, the panel examined closely many of the studies included in the systematic reviews they used for additional information.

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	time, they obscure critical elements of individual RCTs such as population, level of training of those providing the treatments under study, method of dealing with missing data.	
Janice Muhr, PhD (Group: Psychotherapy Action Network)	3c. Meta-data cannot capture individual study quality, which is the bread and butter of efficacy research, determining which studies deliver believable data, which could possibly be reliably reproducible and which are fatally biased. Meta-analyses lump all studies together, giving equal weight to studies, whether they are sloppily conducted or of high quality. (See Kocsis J, Gerber A, Milrod B, Roose SP, Barber JP, Thase ME, Perkins P, Leon AC: A new scale for assessing the quality of randomized clinical trials of psychotherapy. Comprehensive Psychiatry 2010 May Jun;51(3):319-24.)	Thank you for your comment. APA's clinical practice guideline development processes have safeguards in place to protect against bias. As you may be aware, the APA uses reviews that meet the Institute of Medicine (2011; now National Academy of Medicine) standards for developing systematic reviews or that have been subjected to a quality review using the AMSTAR-2 instrument (Shea et al., 2017). Individual studies included in the systematic reviews/meta-analyses must meet quality criteria in order to be included as detailed in the methods sections. References: Institute of Medicine. (2011). <i>Finding what works in health care: Standards for systematic reviews</i>. National Academies Press. https://doi.org/10.17226/13059 Shea, B. J., Reeves, B. C., Wells, G., Thuk, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E., & Henry, D. A. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. <i>BMJ</i>, 358, Article j4008. https://doi.org/10.1136/bmj.j4008
Janice Muhr, PhD (Group: Psychotherapy Action Network)	3d. By choosing to focus on the proposed systematic reviews alone, the GUP has introduced bias towards those treatments most studied rather than those most effective. Any possibility of guidelines that are clinically useful and meaningful to a generalizable group of patients in a variety of treatment settings is already not discernable given the sloppy lumping together of	Using systematic reviews is a fundamental and required part of developing clinical practice guidelines and helps to reduce bias in the process by reducing the potential for cherry-picking of selecting individual studies. Of course, the panel recognizes there are gaps in the literature and

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	individual studies. The GUP is certain to exclude empirical data that is complementary to that from RCTs.	drafted recommendations for research to highlight these gaps and promote research in those areas. Further, evidence from sources beyond RCTs (e.g., observational data) is used when evaluating potential harms and burdens of interventions as well as patient values and preferences, and these criteria are used along with the efficacy data from systematic reviews to make the guideline recommendations. Notwithstanding, the Advisory Steering Committee for development of clinical practice guidelines (ASC) understands that RCTs are the main source of data used in the systematic reviews because they are most likely to meet the quality criteria. The ASC has discussed this concern at length and believes it is important to adhere to best practices in the U.S. and internationally for guideline development, which clearly prioritize the use of systematic reviews for identifying and assessing evidence. Following such objective standards is particularly important given our guideline is issued by a guild. The methodologies suggested as alternatives to RCTs do not allow for causal inferences to be drawn with a significant degree of confidence. Recommending treatments that have not been systematically evaluated in a way that allows causal inferences is counter to one of the basic goals of a CPG, and a CPG would not be credible if it did not rely on a systematic review of high-quality efficacy data.
Janice Muhr, PhD (Group: Psychotherapy Action Network)	3e. This approach over-focuses on exposure therapies in part as an artifact of the proportion of studies done on them. This is highly problematic: it elides the serious problems of exposure treatment uptake among people with PTSD. Meta-data undercounts treatment dropout, which is very high for	Thank you for your comment. The panel has been working extremely hard in reviewing the evidence and developing recommendations which not only take into account the underlying evidence but also considers the harms and

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	exposure-based treatments, and while some people do better with exposure therapies, even "responders" often remain ill. With many non-exposure based studies having been completed recently, and others in the publication loop or underway presently, but not yet complete or published, the present effort by the GUP will necessarily not include these upcoming important studies and cannot capture these developments.	burdens, patient values and preferences, and applicability of the intervention.
JoAnn Brown (Individual)	My concerns about treatment guidelines cannot be expressed by answering survey questions and your reliance upon survey questions to evaluate comments is precisely the problem with your methodology. Complex issues cannot be distilled into check box answers 1a. There is an underlying assumption in your methodology- that any research published is quality research. That simply is not the case. When evaluating research, the reader often reads the abstract and conclusions without slogging through the tedious explanation of the research design and that is where one can tell if the study conclusions are valid and to which population the conclusion applies. No study is universally generalizable. Correlation is often mistaken for cause and effect. Attrition alone can invalidate results. Even experienced researchers make these mistakes. Meta analyses by their very nature omit the analysis of the research design that is necessary to evaluate the validity of the conclusions. All factors that effect the study conclusions should be clearly stated. A meta analysis does not include those provisos. The amount of poorly designed research published is really problematic and to make recommendations based upon flawed research is a disservice to our patients.	Thank you for your comment. APA added this additional public comment opportunity early in its guideline update process to increase transparency and opportunities for input, including via open ended response options. APA's clinical practice guideline development processes have safeguards in place to protect against bias. As you may be aware, the APA uses reviews that meet the Institute of Medicine (2011; now National Academy of Medicine) standards for developing systematic reviews or that have been subjected to a quality review using the AMSTAR-2 instrument (Shea et al., 2017). Individual studies must also meet certain quality criteria in order to be included in the reviews. References: Institute of Medicine. (2011). <i>Finding what works in health care: Standards for systematic reviews</i>. National Academies Press. https://doi.org/10.17226/13059 Shea, B. J., Reeves, B. C., Wells, G., Thuk, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E., & Henry, D. A. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. <i>BMJ</i>, 358, Article j4008. https://doi.org/10.1136/bmj.j4008

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JoAnn Brown (Individual)	1b. That being said, all human population research has similar design challenges, whether medical or mental health. In addition to the problems of selection, attrition and variable exclusion, mental health research has an outcome measure problem. Medical research outcome measures are objective, concrete and mathematical. Mental health outcome measures are subjective, abstract and not easily measured with numbers. Outcome measures for medical research are widely accepted and known to reflect improvement (a lower HA1C is known to be associated with a lower incidence of the development of Type II diabetes). What outcome measures for mental health subjects are universally proven to indicate improvement? How is improvement defined? What assumptions underlie the commonly used mental health measures and where did those measures originate? Even the BDI, which is probably the most widely used and accepted as valid measure of depression, is based upon self report not objective measures, and the assignment of numerical values to symptoms and results gives it the aura of a concrete value that does not really exist.	Thank you for your comment. In the early stages of scoping, the panel used the Delphi method to complete an outcome prioritization survey. On this survey panel members rated outcomes from 1 “not important” to 9 “critical” for deciding about what treatment to recommend. <i>Critical outcomes</i> were defined as those that are essential and necessary to the treatment decision-making process between the therapist and patient while <i>important outcomes</i> were defined as those that were significant but not critical for making a decision. In formulating guideline recommendations, the panel will weigh evidence related to critical outcomes more heavily than evidence related to other outcomes. Also, following the Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) system (Schünemann et al., 2013), the overall strength of the evidence for a recommendation can be no higher than the lowest quality of the evidence for the critical outcomes. For example, if one critical outcome had ‘high’ strength of evidence but the other critical outcome had ‘low’ strength of evidence, the global quality of evidence for that particular decision table or column in the grid would be ‘low,’ since that is the lowest strength of evidence for an individual critical outcome. Reference Schünemann, H., Brożek, J., Guyatt, G., & Oxman, A. (Eds.). (2013). <i>GRADE handbook</i>. https://gdt.gradeapro.org/app/handbook/handbook.html
Anonymous (Individual; #119)	My concerns about the panel's decision are reflected in PsiAN (the Psychotherapy Action Network's) letter to the guideline committee.	Thank you for your review and feedback. Please refer to the response to Psychotherapy Action Network's letter.

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JoAnn Brown (Individual)	1c. Another common problem with all human subjects research is that efficacy is often conflated with effectiveness and used to validate that the treatment is recommended. In fact, any research conclusion applies only to the group studied and then only as a group. It says nothing about whether any individual within or outside the group will respond to the treatment. In addition, variable exclusions have to be considered when deciding whether treatment guidelines apply to an individual patient. Meta analyses obscure this fact. Anyone who relies upon research for guidance about what treatment will benefit the patient would do well to remember this and have a variety of methodologies at hand to individualize treatment for the patient. I therefore reject treatment guidelines as the standard of care per se. In any ethical treatment of a patient, the treatment guidelines should be considered only as a basis for thinking about what might be the best course of treatment for any patient. Guidelines are also useful when trying to figure out why a treatment is ineffective and where corrections can be made. I would hope that any treatment guidelines published by a professional organization that has designated itself to define the standard of care would include that caveat. An honest assessment of the limitations of our work is the ethical and professional thing to do. Anything less is hubris.	Thank you for your comment. Evidence from sources beyond RCTs (e.g., observational data) is used when evaluating potential harms and burdens of interventions as well as patient values and preferences, and these criteria are used along with the efficacy data from systematic reviews to make the guideline recommendations. The Advisory Steering Committee for development of clinical practice guidelines (ASC) acknowledges that RCTs are the main source of data used in the systematic reviews. The ASC discussed this concern at length and recognized its importance to many members of the community, but ultimately believed it was critical to adhere to best practices in the U.S. and internationally for guideline development as described by the National Academy of Medicine (formerly the Institute of Medicine; IOM), which clearly prioritize the use of systematic reviews for identifying and assessing evidence. The challenge is that while systematic reviews can include studies other than RCTs, RCTs are the types of studies most likely to meet the rigorous quality criteria. To address these concerns, the ASC introduced two new types of recommendation statements in addition to the traditional efficacy recommendations based on a systematic review of the scientific evidence: “implementation considerations” and “recommendations for research.” The “implementation considerations” are consensus-based statements based on how to apply the previous recommendation statement types into clinical practice and include clinician experience. The “recommendations for research” category is also expert, consensus-based that notes the current gaps in the research literature and where more research is needed to

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Commenter (Group or Individual?)	Comment	Panel Response
		address these gaps. Clinician experience is also incorporated into the traditional recommendations when considering potential harms/burdens of treatments and preferences of patients.
Christine A. Courtois, PhD (Individual)	As you likely know, I chaired the 2017 guidelines for PTD and I want to acknowledge the amount of work that gets put into these guidelines. I'm most appreciative of members of the panel and their willingness to take on this complicated and time intensive project. All of my comments below and additional references are made within support of this effort. Additional SR and evidence-based contributions for the panel to consider including: Ellis, A. E., Simiola, V., Brown, L., Courtois, C., & Cook, J. M. (2018). The role of evidence-based therapy relationships on treatment outcome in adults with trauma: A systematic review. <i>Journal of Trauma & Dissociation</i>. Norcross, J. C., & Lambert, M. J. (Eds.). (2019). <i>Psychotherapy relationships that work. Volume 1: evidence-based therapist contributions</i>. (3rd Ed.). Oxford University Press. Wu, M. & Levitt, H. M (2020) A qualitative meta-analytic review of the therapist responsiveness literature: guidelines for practice and training. <i>Journal of Contemporary Psychotherapy</i>, 50, 161-175. https://doi.org/10.1007/s10879-020-20450-y Additional comment concerning COI and transparency: Although the multidisciplinary panel contains a great deal of diversity and includes attention to many diverse populations, it has an obvious bias towards CBT treatments. I question why the panel does not consist of individuals with additional orientations? I know for example that Howard Kudler, MD who has extensive experience as a clinician and administrator in academic settings and the VA and has a broad psychodynamic orientation was not	We appreciate your critical review and feedback on the PTSD GUP's scoping framework and identified systematic reviews and for sharing with us additional literature for the panel to consider. The panel is aware of Courtois and Brown's (2019) recommendations and will address the issues in the narrative of the guideline document. Psychodynamic therapy was included in the Hoffman et al (2018; AHRQ) primary review as well as the reviews that served to supplement the primary review (Choi et al., 2020; Jericho et al., 2022) however the panel is limited to what the existing systematic reviews present. The Advisory Steering Committee for development of clinical practice guidelines (ASC) introduced two new types of recommendation statements in addition to the traditional efficacy recommendations based on a systematic review of the scientific evidence: "implementation considerations" and "recommendations for research." The "implementation considerations" are consensus-based statements based on how to apply the previous recommendation statement types into clinical practice and include clinician experience. The "recommendations for research" category is also expert, consensus-based that notes the current gaps in the research literature and where more research is needed to address these gaps. Clinician experience is also incorporated into the traditional recommendations when

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Commenter (Group or Individual?)	Comment	Panel Response
	selected. He was very interested in serving and could have added to the diversity of orientations being considered. Would suggest adding him if there is still that option and heartily endorse him. Additional comment regarding a suggestion I recently made to Raquel Halfond: to incorporate planned debriefing to the ASC and/or new panel members by panel members after their completion of a set of guideline for purposes of communication and continuity. Finally, I attach the citations for a psychodynamic and two more general critiques and two journal issues devoted to the discussion/critique of the first set of APA guidelines for the treatment of PTSD in adults that may be of some interest to the panel going forward. A Berg, H. (2019). Evidence-based practice in psychology fails to be tripartite: a conceptual critique of the scientocentrism in evidence-based practice in psychology. <i>Frontiers in Psychology, Section on Theoretical and Philosophical Psychology</i>, 10. https://doi.org/10.3389/fpsyg.2019.02253 Courtois, C. A., & Brown, L. S. (2019). Guideline orthodoxy and resulting limitations of the American Psychological Association Treatment Guideline for PTSD in Adults. <i>Psychotherapy</i>, 56(3), 329-339. Dauphin, V. B., (2020). A critique of the American Psychological Association Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults.. <i>Psychoanalytic Psychology</i>, 37(2), 117- Brown, L. S., & Courtois, C. A. (Eds.). (September 2019). Special issue of <i>Practice Innovations</i> (4, 3) on Innovations in Treatment of Post-Traumatic Stress Disorder (PTSD) (Invited). Courtois, C. A., & Brown, L. S. (Eds.). (September 2019). Special issue of <i>Psychotherapy</i> (56, 3) on Controversies Related to the American	considering potential harms/burdens of treatments and preferences of patients. Thank you for the suggestion regarding conducting a debrief with the panel and the ASC. This suggestion was shared with the ASC and the ASC is interested in a debrief from future panels/chairs. As for COI and transparency, while a variety of factors are considered by the ASC in striving to seat a diverse panel, we cannot comment on specific individuals or why specific individuals were selected or not to be part of the panel. As you likely know, the evidence-base constrains what the panel can and cannot say in regard to specific interventions. It is our hope that panel members will review the literature fairly as scientists and clinicians, regardless of their training focus. The ASC strives to include experts with diverse theoretical orientations and during the call for nominations period, interested individuals are invited to share their theoretical orientation within the diversity matrix form.

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Commenter (Group or Individual?)	Comment	Panel Response
	Psychological Association Clinical Practice Guideline for PTSD in Adults (Invited).	
	Thanks for the opportunity to comment.	

2. POPULATION (P)

Theme #2-A: Definition of PTSD, Complex PTSD, Trauma, Comorbidity

Commenter (Group or Individual?)	Agreement with Population Definition?	Comment	Panel Response
Marylene Cloitre, PhD (Individual)	Generally, I agree	(1) Regarding CPTSD: Because this is a new diagnosis, there are no RCTs (other than DSM-5 populations made to fit CPTSD criteria) that have been conducted using CPTSD measures and enrolling patients with a primary diagnosis of CPTSD. There are a couple underway that should be finished this spring (2023).	Thank you for your comment. We agree that there is a need for more RCTs to look at Complex PTSD (CPTSD) Interventions. The panel's intention is to note this gap as a footnote in the guideline. We look forward to reading about the outcomes of the studies that you mentioned and would welcome your sharing those studies.
Christine A. Courtois, PhD (Individual)	Generally, I agree	Also, in terms of populations, those with PTSD alone, PTSD with dissociative subtype (per DSM5), and PTSD/CPSTD (per ICD-11 where criteria for both diagnoses are required) should be distinguished. It would also be critical to distinguish between types of trauma that were experienced. Presenting findings based on PTSD cluster or DSO cluster would also be very important since remission of PTSD symptoms does not mean remission of DSO symptoms.	Thank you for your review and feedback. The panel review will give an overview of the current DSM5 and ICD-11 definition and criteria on determining PTSD alone and complex PTSD. The panel did not overlook the types of traumas and the complexity of distinguishing symptoms associated with PTSD as well as CPTSD/DSO symptoms. The panel will include a discussion of the importance of the identification of trauma type and experiences in sub populations.
Julian Ford (Individual)	I have concerns	Complex PTSD should not be inferred from trauma history or a subset of symptoms. Since there are few if any outcome studies that assess CPTSD, including childhood abuse-related PTSD as a sub-population or a moderator would be most informative until CPTSD studies are done.	Thank you for your comments. While we philosophically agree that treatment recommendations should be written using a developmental lens, we are currently limited with how the individual studies within the included systematic reviews and meta-analyses

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Commenter (Group or Individual?)	Agreement with Population Definition?	Comment	Panel Response
			characterize the age groups. We will note this important limitation as a footnote in the guideline.
Anonymous (Individual; #122)	I have concerns	PTSD and complex PTSD are often very different experiences and would require different formulations and focus of treatment.	Thank you for your comment. We do intend to address the gaps identified in the AHRQ guidelines and review potential systematic reviews / meta-analyses to supplement AHRQ relative to PTSD and complex PTSD within the "Populations" category of the PICOTS framework for the panel review.
Anonymous (Individual; #87)	Generally, I agree	In my setting as a private practice EMDR certified clinician, the icd 11 complex PTSD diagnosis is little known/used, mostly due to lack of insurance recognition and reimbursement. In practice nearly all of my EMDR patients fit most if not all of this criteria in complexity of presentation.	Thank you for your feedback. The panel will include in the discussion the clinical landscape of trauma treatment since the introduction of a ICD-11 formal CPTSD criterion relative to the clinical identification, diagnosis, and treatment of complex PTSD.
Anonymous (Individual; #73)	Generally, I agree	Complex PTSD is a widely used term but is not specified as a diagnosis in the DSM-5. It causes confusion amongst clinicians when it is not in the DSM but is in ICD-11.	Thank you for this comment. The panel will acknowledge and address similarities and differences among DSM-5 PTSD, ICD-11 simple PTSD, and ICD-11 complex PTSD in its final review.
Janice Muhr (Group: Psychotherapy Action Network)	Generally, I agree	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Assoc Prof Christopher Lee (Individual)	Generally, I agree	it should include that most participants meet criteria for PTSD and set a benchmark of 70 or 80%, as long as referred for PTSD. this better matches real world clinics where people present for help with trauma	Thank you for this recommendation. The panel will take note this benchmark.
Les R. Greene (Individual)	I have concerns	You need to clarify how you will deal with issues of personality (and personality disorders), culture and comorbidity. A DSM based criterion is insufficient.	Thank you for this recommendation. We will consider evidence from a broad range of interventions. In addition, we plan to consider a range of outcomes including adverse events.

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Commenter (Group or Individual?)	Agreement with Population Definition?	Comment	Panel Response
Sarah L Granberg, LCSW, MAC, CTTS, SAP, CCTP (Individual)	I have concerns	Since the DSM-5-TR is the industry's diagnostic manual, I think that is the only standard that should be utilized. The ICD-11 reportedly notes diagnoses not in the DSM, such as C-PTSD.	Thank you for this comment. The panel will acknowledge and address similarities and differences among DSM-5 PTSD, ICD-11 simple PTSD, and ICD-11 complex PTSD in the final review.
Victoria Page, MSW, RSW (Individual)	Generally, I agree	I am a Registered Social Worker in Northern British Columbia Canada and I provide clinical services to individuals impacted by single and complex trauma. As a practitioner, as well as a complex PTSD "survivor", I have found the narrow criteria for diagnosing PTSD problematic for the majority of my clients. The broadening of the population concept will likely provide practitioners with the appropriate tool to provide services to clients who are currently being underserved or improperly diagnosed.	Thank you for your comment. We agree that it is important to review and adopt established guidelines and protocols endorsed by federal agencies and subjected to research. We are utilizing the AHRQ review. The populations included will depend on how the information is aggregated in individual studies within the systematic reviews and meta-analyses. The panel will acknowledge and address similarities and differences among DSM-5 PTSD, ICD-11 simple PTSD, and ICD-11 complex PTSD in the final review.
Barbara Milrod, M.D. (Individual)	I have concerns	This is the sloppiest review I have ever seen. The panel reviewed no actual data and stuck with meta-data, which notoriously hides study quality. I am shocked. These guidelines should be redone using competent reviewers.	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns

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Commenter (Group or Individual?)	Agreement with Population Definition?	Comment	Panel Response
			for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ The panel will further clarify in the guideline document that the 2018 AHRQ review will serve as the primary evidence base but that it then nominated several newer systematic reviews to meet the gaps that were identified in the primary review and include updated information. As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.

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2-A.1 The following comments were received via email (cpg@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
John H. Diepold, Jr., PhD (Individual)	PTSD with comorbid symptom presentations are symptoms and not the “problem” (although problematic).	The panel decided that PTSD symptom reduction and serious harms/adverse events were the most critical outcomes and that remission (no longer having symptoms), loss of PTSD diagnosis, quality of life, disability or functional impairment, prevention, or reduction of comorbid medical or psychiatric conditions would be the focus of the review.
Deepna Anand (Group: APA Board for the Advancement of Psychology in the Public Interest [BAPPI])	Thank you for the opportunity to review this document. BAPPI appreciates the thoughtful approach to updating the 2017 guidelines, and the membership remembers challenges associated with publication of those guidelines. We applaud the efforts to exercise extra care in updating the 2017 guidelines. We offer the following comments/ recommendations for consideration in approaching the update: Will complex PTSD be treated as a separate diagnosis or part of PTSD with similar guidelines offered, or will separate guidelines be offered?	Thank you for your comments/ recommendations. (1). The panel will include an overview of the current DSM-5-TR and ICD-11 definition and criteria on determining PTSD alone and complex PTSD. The panel appreciates the variability in how complex PTSD is defined and will take this into consideration as the guideline is being prepared. (2). Thank you for these recommendations. Karatzias (2019) has been reviewed by the panel and will be included in the final, small set of systematic reviews used to develop the guidelines. Coventry et al. (2020) was identified in the initial scoping and carefully reviewed. Bison et al. (2018) was published close to the date of the original PTSD panel and its studies are included as part of the AHRQ systematic review that will form the basis of the update. Ultimately the panel was limited to studies that were identified and included in the existing systematic reviews and meta-analyses that serve as the underlying evidence base.

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Theme #2-B: Including children/adolescents, older adults, and other populations

Commenter (Group or Individual?)	Agreement with Population Definition?	Comment	Panel Response
Marylene Cloitre, PhD (Individual)	Generally, I agree	(2) Consider describing populations by type of trauma. Veterans do less well in treatments than others. There are also gender effects. Childhood trauma was found to impact outcomes in a recent meta-analysis (see Karatzias et al., 2019). It elevates the meaning and impact of the work if trauma type and other moderators of outcome can be included in the report. P.S. The job ahead is no small task. Thanks to the panel for doing this hard work.	Thank you for your review and feedback. The panel has discussed the importance of trauma type, trauma population, gender, ethnic identity, and other factors (sexual identity/orientation; disability status) in understanding outcomes. We did not include these as moderators on the PICOTS because we worried that it would lead to exclusion of studies that did not include such moderators in analyses. Instead, we decided to use settings to increase the inclusion of studies across various groups. Further, the panel intends to examine these modifiers in the applicability section and determine if we have enough information provided to make clear recommendations on the current data and future research in determining what treatments work for whom.
Christine A. Courtois, PhD (Individual)	Generally, I agree	I believe it would be helpful to also develop a CPG for children and adolescents before much longer.	Thank you for your review and feedback. The panel agreed that a separate CPG for children and adolescents would be useful if possible, in the future.
Anonymous (Individual; #89)	Generally, I agree	What about trauma survivors under the age of 18?	Thank you for your review and feedback. The panel agreed that trauma-exposed children and adolescents are important but that a separate CPG would be recommended to address the large literature and do justice to the developmental issues.

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Commenter (Group or Individual?)	Agreement with Population Definition?	Comment	Panel Response
Gagnon. Andre (Individual)	Generally, I agree	Trauma also has to be treated in younger persons, children and adolescent. Such a process should be initiated for this population as well	Thank you for your review and feedback. The panel agreed that a separate CPG for children and adolescents would be useful if possible, in the future.
Anonymous (Individual)	I have concerns	Children and teens should be included in this; additionally, PTSD criteria is based on single event trauma, yet, many people have multiple events, even a lifetime, of trauma.. The criteria we currently have does not take the potential for chronic trauma into account, nor does it accurately identify chronic trauma sx's, as these more closely align with Borderline Personality Disorder and PTSD together or characteristics of each.	Thank you for your review and feedback. The panel agreed that trauma-exposed children and adolescents are important but that a separate CPG would be recommended to address the large literature and do justice to the developmental issues. We are adding Karatzias et al. 2019 and are including the Choi et al 2020 review which will include studies addressing chronic trauma and complex PTSD symptoms.
Lori Woehler, PsyD (Individual)	I have concerns	I believe the panel should include children and adolescents in scope for the population in order to increase earlier implementation of guidelines in the treatment of children experiencing trauma.	Thank you for your review and feedback. The panel agreed that trauma-exposed children and adolescents are important but that a separate CPG would be recommended to address the large literature and do justice to the developmental issues.
Tiffany Crawshaw (Individual)	I have concerns	Why are children and seniors excluded?	Thank you for your review and feedback. The panel agreed that trauma-exposed children and adolescents are important but that a separate CPG would be recommended for children to address the large literature and do justice to the developmental issues. Seniors and older adults are not excluded from the PICOTS and will be included. Bichescu et al. (2007) which includes older adults for example, is cited in the AHRQ review. Reference

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Commenter (Group or Individual?)	Agreement with Population Definition?	Comment	Panel Response
			Bichescu, D., Neuner, F., Schauer, M., & Elbert, T. (2007). Narrative exposure therapy for political imprisonment-related chronic posttraumatic stress disorder and depression. <i>Behaviour Research and Therapy</i> , 45(9), 2212-2220. https://doi.org/10.1016/j.brat.2006.12.006
Laurence Armand French (Individual)	Generally, I agree	I would also include Veteran Affairs and Indian Health Service/Bureau of Indian Affairs data bases.	Thank you for your review and feedback. We are including studies that include veterans and Native Americans.
Edward Hunter (Individual)	I have concerns	Sadly, the degree to which diversity and individual variation is considered in this is incredibly poor.	Thank you for your review and feedback. The panel has discussed in detail aiming to be as inclusive as possible of diversity under settings. Additional details will be included in the full guideline document and appendices.
Joan Monahan, LPC (Individual)	Generally, I agree	Inclusion criteria for the multidisciplinary panel to update clinical practice guidelines should include a more diverse representation of clinical professionals. Subsequently, including licensed professional counselors (LPCs) could offer another clinical perspective in future updates of APA's guidelines for treating any clinical diagnosis, especially with PTSD.	We appreciate your feedback and agree that a diverse representation of clinical professionals is necessary to offer a variety of clinical perspectives. The APA strives to promote diversity in its efforts and will incorporate this feedback for future endeavors.

2-B.1 The following comments were received via email (cpg@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
Anica Pless Kaiser (Group: Stress, Health, and Aging Research)	My name is Anica Pless Kaiser, I am a clinical research psychologist at the National Center for PTSD at VA Boston Healthcare System and am affiliated with the New England GRECC. I am also an assistant professor at Boston University Chobanian & Avedisian School of Medicine.	Thank you for your review and feedback. This is a very good point that RCTs often exclude those 65 and older. The Dinnen et al 2015 review is outside the 5-year update window, but we have now looked at it, and at least one of the RCTs it mentions is included in the AHRQ review. The panel is keeping a list of

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Commenter (Group or Individual?)	Comment	Panel Response
Program at VA Boston Healthcare System)	At VA Boston I co-direct the Stress, Health, and Aging Research Program (SHARP), with Drs. Spiro and Davison (copied here). SHARP studies the effects of military service on the health and well-being of aging Veterans using a lifespan developmental perspective. The aging population is growing, and will continue to do so in the coming decades. About half of military veterans are age 65 or older. We know that a vast majority of older adults experience trauma during their lifetime. Many are resilient and do not develop PTSD, but for those that do, symptoms can have a long-term impact if not treated. We as a group would like to submit a comment to the committee tasked with updating the PTSD treatment guidelines - to broadly consider aging and older adults when reviewing the literature and making recommendations. Older adults are often excluded from clinical trials or included in too few numbers to examine age-based comparisons. There are not many clinical trials in the literature that are specific to the treatment of PTSD in older adults, but there are a few (for example, studies examining the utility of prolonged exposure and narrative exposure therapy in older adult samples - see references below). We suggest that when samples and sample sizes allow, the committee look at literature that incorporates lifespan considerations such as treatment recommendations for older vs. younger adults, if treatment effectiveness differs based on time since index trauma, and the impact of aging-related factors such as chronic illness and complex medical and mental health comorbidities. Here are some relevant references (not an exhaustive list): Cook JM, McCarthy E, Thorp SR. Older adults with PTSD: brief state of research and evidence-based psychotherapy case illustration. Am J Geriatr Psychiatry. 2017;25(5):522–530.	modifiers and caveats we want to include in the report, especially in the applicability section and we will be tracking the important issues that you raise. More RCT trials need to include older adults.

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Commenter (Group or Individual?)	Comment	Panel Response
	Dinnen, S., Simiola, V., & Cook, J. M. (2015). Post-traumatic stress disorder in older adults: a systematic review of the psychotherapy treatment literature. <i>Aging Ment Health</i>, 19(2), 144-150. doi:10.1080/13607863.2014.920299 Lely JCG, Ter Heide FJJ, Moerbeek M, Knipscheer JW, Kleber RJ. Psychopathology and resilience in older adults with posttraumatic stress disorder: a randomized controlled trial comparing narrative exposure therapy and present-centered therapy. <i>Eur J Psychotraumatol</i>. 2022 Jan 28;13(1):2022277. doi: 10.1080/20008198.2021.2022277. PMID: 35126882; PMCID: PMC8815622. Thorp SR, Glassman LH, Wells SY, et al. A randomized controlled trial of prolonged exposure therapy versus relaxation training for older veterans with military-related PTSD. <i>J Anxiety Disord</i>. 2019;64:45–54. Please let us know if we can offer any additional information to support our comments, or if the committee has any questions for us. Thank you for your consideration. Best, Anica Pless Kaiser cc. Dr. Avron Spiro, Dr. Eve Davison	
Deepna Anand (Group: APA Board for the Advancement of Psychology in the Public Interest [BAPPI])	1. We agree with the PICOTS framework as a reasonable approach to update the guidelines. However, it is not clear if following this framework will address whether there are moderators of effectiveness by groups [e.g., what about gender differences, racial/ethnic differences, trauma and other population differences (e.g., veterans, those with childhood versus adult sexual trauma, etc.)?]. Basically, can it tell us what treatment is effective for whom under what conditions? This will be important to address in the update and is not explicit in the framework.	Thank you for your review and feedback 1. Understanding what works for whom and under what conditions is an important question. Given the reliance on systematic reviews and meta-analysis in the PICOTS framework for updates, there currently are not enough studies that analyze data across these significant group differences. Our approach has been to be sure that we include studies that are inclusive and represent these differences. We will list the lack of gender, trauma type, and ethnic analysis as a

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Commenter (Group or Individual?)	Comment	Panel Response
	2. Population: Excluding people at risk for developing PTSD and those with subsyndromal PTSD seems to be a lost opportunity. What is the rationale for this?	shortcoming. Our approach and intention however is to include as diverse a group as possible. In our applicability section, we will comment on these many important issues. We also have a new type of recommendation called implementation considerations that will allow us to address context and diversity implications. 2. The needs of those at risk for PTSD and subsyndromal PTSD are clearly important but the literatures should be presented as distinct. In order to do justice to the literature, we limited the scope of this guideline.
Ron Schlitter (Group: APA Committee on Sexual Orientation and Gender Diversity)	The group doing the revision work consider how to incorporate an intersectional lens from the start, as clients have multiple complex and layered aspects of their identities, and to be explicit about it.	Thank you for your review and feedback. Considerations of Intersectionality of identities, especially in light of trauma exposure which can be perpetrated based on assumed identity (e.g, gendered violence, hate violence) is important. Our approach given the status of the literature at this point is to use settings and populations. We can be explicit about the limitations of RCTs thus far in using an intersectional lens, and the degree to which gender and sexual diversity is addressed in the extant literature. The panel is ultimately limited to what the systematic reviews and meta-analyses report but in the applicability section it will note the importance of incorporating intersectionality into clinical practice.
Julie Koch (Group: APA Committee on Global Psychology [CGP])	CGP encourages the Guideline Update Panel (GUP) to continue to seek out international voices and contributors as they work to update the guideline. CGP encourages the GUP to incorporate issues of global concern, such as natural disasters, wars/conflicts, and forced migration, as they work to update the guideline.	The panel has endeavored to include studies from across the world, including lower and middle-income countries, to address international applicability of the guideline. The calls for public comment on the panel's initial decisions in its scoping framework and identified systematic reviews have also been disseminated internationally to the following groups: International Psychotherapy Institute, International Society of Psychiatric-Mental Health Nurses, The International

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Commenter (Group or Individual?)	Comment	Panel Response
		Association of Schools of Social Work, International Society of Interpersonal Psychotherapy, EMDR International, United for Global Mental Health, Complex PTSD Foundation, and Society for Psychotherapy Research.

3. INTERVENTION (I)

Theme #3-A: Effectiveness and harms of CBT / exposure therapies

Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
Marylene Cloitre, PhD (Individual)	Generally, I agree	(1) The CBT grouping is very large. Based on past guidelines, it seems likely that the effect sizes will differ by quite a lot across some of the CBTS, so it might be worthwhile to breakdown into subgroups.	Thank you for this feedback. We agree that CBT encompasses several approaches/ specific protocols. At this point, we have only defined the scope of the treatments that will be examined. We have not yet determined how the treatments will be grouped, or not, in the updated guidelines.
Julian Ford (Individual)	I have concerns	CBT should be subdivided into meaningfully different modalities and an affect regulation psychotherapy category should be added A present centered therapy category also should be added.	Thank you for this feedback. We agree that CBT encompasses several approaches/ specific protocols. At this point, we have only defined the scope of the treatments that will be examined. We have not yet determined how the treatments will be grouped, or not, in the updated guidelines.
Anonymous (Individual; #122)	I have concerns	There is much research that shows CBT and Exposure therapies to be ineffective. Psychoanalysis should also be included as there is promising research on analytic outcomes in the areas of trauma.	Thank you for this feedback. We will consider evidence for any individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.
Anonymous (Individual; #89)	I have concerns	As a trauma therapist and a trauma survivor I think that CBT and Exposure therapy are very dangerous approaches to treating PTSD and C-PTSD. This is supported by: structural dissociation; polyvagal theory; attachment theory; mindfulness; Triune Brain and bottom-up approaches.	Thank you for this feedback. We will consider evidence from a broad range of interventions. In addition, we plan to consider a range of outcomes including adverse events.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	Please see my article below outlining the ethics involved in promoting short-term symptom reduction PTSD therapies like CPT and PE: Gnaulati E. Potential ethical pitfalls and dilemmas in the promotion and use of American Psychological Association-recommended treatments for posttraumatic stress disorder. <i>Psychotherapy (Chic)</i> . 2019 Sep;56(3):374-382. doi: 10.1037/pst0000235. PMID: 31282713.	Thank you for sharing this. We will consider all follow-up data and include a broad range of outcomes beyond PTSD symptom severity.

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
Ann (Individual)	Generally, I agree	I would stress the importance of the use of both psychodynamic and psychoanalytic therapies in trauma treatment. Johnathan Shedler does a wonderful meta-analysis of the difference in outcomes between CBT and psychodynamic work. It is imperative that we evaluate the effectiveness of TF-CBT and its outcomes. Very little literature supports the proposed claims that TF-CBT is actually effective in managing trauma symptoms in the long term. One cannot cognitively process trauma, as it presents as an affective experience!	Thank you for this feedback. We will consider evidence for any individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.
Les R. Greene (Individual)	I have concerns	Given that you will be presumably relying exclusively on RCT data, as was done in 2017, wouldn't it be more honest and ethical to name the document something like "RCT based treatment recommendations for ptsd" rather than "clinical practice guidelines" since it is well established (including in APA's disclaimers) that other factors are crucially important in selection and implementation, such as patient motivation and preferences and clinician competence.	Thank you for your comment. Evidence from sources beyond RCTs (e.g., observational data) is used when evaluating potential harms and burdens of interventions as well as patient values and preferences, and these criteria are used along with the efficacy data from systematic reviews to make the guideline recommendations. The Advisory Steering Committee for development of clinical practice guidelines (ASC) acknowledges that RCTs are the main source of data used in the systematic reviews. The ASC discussed this concern at length and recognized its importance to many members of the community, but ultimately believed it was critical to adhere to best practices in the U.S. and internationally for guideline development as described by the National Academy of Medicine (formerly the Institute of Medicine; IOM), which clearly prioritize the use of systematic reviews for identifying and assessing evidence. The challenge is that while systematic reviews can include studies other than RCTs, RCTs are the types of studies most likely to meet the rigorous quality criteria.

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
			To address these concerns, the ASC introduced two new types of recommendation statements in addition to the traditional efficacy recommendations based on a systematic review of the scientific evidence: "implementation considerations" and "recommendations for research." The "implementation considerations" are consensus-based statements based on how to apply the previous recommendation statement types into clinical practice and include clinician experience. The "recommendations for research" category is also expert, consensus-based that notes the current gaps in the research literature and where more research is needed to address these gaps. Clinician experience is also incorporated into the traditional recommendations when considering potential harms/burdens of treatments and preferences of patients.
Gabriella Evans (Individual)	Generally, I agree	I believe CBT and other top down approaches to healing trauma should be used only in conjunction with bottom-up approaches.	Thank you for this feedback. We will consider evidence for any individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.
Anonymous (Individual)	I have concerns	CBT should not be recommended; it is often harmful to trauma sufferers.	Thank you for this feedback. We will consider evidence from a broad range of interventions. In addition, we plan to consider a range of outcomes including adverse events.
Guldeniz Yucelen, Psy.D. (Individual)	Generally, I agree	Cognitive behavioral therapies provide limitation to PTSD treatment as they do not work with sensorimotor experience and autonomic nervous system.	Thank you for this feedback. We will consider evidence for any individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
D Wagner LMFT (Individual)	Generally, I agree	While CBT, Family Systems therapy, sensorimotor and culturally adapted interventions can contribute greatly to the process of trauma resolution, the combined efficacy of psychodynamic and EMDR therapy (with parts work for dissociation) has proven to have the greatest efficacy in not only symptom reduction, but transforming maladaptively stored information and fixed beliefs in neural networks to an adaptive memory network that also contributes to decrease of temporary and high risk coping mechanisms as well. Without a psychodynamic framework with attention to attachment and stages of development, resolution tends to be temporary/limited.	Thank you for this feedback. We will consider evidence for any individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.
Ali Laura LMFT LLC (Individual)	I have concerns	Brief and CBT treatments have shown in my practice to have limited long term positive/adaptive results. EMDR and polyvagal therapies have shown to be the only long term effective treatment in my clients.	Thank you for this feedback. We will consider all follow-up data for any individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.
Angela Cusimano, PhD (Individual)	Generally, I agree	In my clinical experience, brief eclectic therapy and peer interventions are not at the caliber of our EBP's for PTSD: CPT, PE, and EMDR. I believe that CPT provided in a group format can be helpful but supportive group therapies are generally unhelpful and can even perpetuate PTSD symptoms, particularly in Veteran population (e.g. disability ratings, symptom comparison).	Thank you for this feedback. We will consider evidence for any individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer. We will also consider treatment format (e.g., individual vs group).
Judy Greenberger (Individual)	I have concerns	In my experience as a therapist and a client, CBT, brief therapy, psychodynamic therapy, and interpersonal therapy do not effect a significant improvement in dealing with PTSD, or complex PTSD, and should not be on this list. EMDR, somatic therapy should be employed before using some of the medications listed.	Thank you for this feedback. We will consider evidence for any individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.
Laura DeSantis (Individual)	I have concerns	Psychotherapies that focus on the body and nervous system should be prioritized over those that focus on changing thoughts and behaviors. We know that trauma is not stored in the prefrontal cortex, so it makes	Thank you for this feedback. We will consider evidence from a broad range of interventions. In

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
		little sense to prioritize therapies that primarily use that part of the brain. As a cPTSD specialist, I have never seen someone heal from trauma wounds using CBT. Moreover, many come to me feeling harm was done by CBT therapists who insisted their thoughts were "irrational," and that they had to change their way of thinking in order to feel safe. This is not only unethical, but it is not in line with our current understanding of how trauma impacts the brain and body. I would also like to suggest an addition of Internal Family Systems to the list of recommended interventions, as there is emerging research on its efficacy with cPTSD.	addition, we plan to consider a range of outcomes including adverse events.
Barbara Milrod, M.D. (Individual)	I have concerns	Again, see my response above. The panel reviewed only meta-data, which does not capture either the complexity of raw data, and obscures study design defects. Again, I have no faith whatsoever in these guidelines and urge the APA, with what limited credibility they still have in the field, to redo this utter mess. This was a nonsense non-review by evidently very lazy and uninformed reviewers. For shame. The entire enterprise casts a dark shadow on the organization itself for permitting this nonsense.	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
			sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.

3-A.1 The following comments were received via email (cpg@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
Janice Muhr, PhD (Group: Psychotherapy Action Network)	Importantly, the approach of the GUP centers on reviewing data from exposure-based therapies. Exposure-based therapies have been shown to have very high dropout rates among patients with PTSD and true remission represents a minority of treated cases. Thus, while exposure-based therapies have been assessed by a large number of studies and have been widely disseminated (in the VA system, for example), they have failed to stem the ever-growing tide of patients who suffer from highly symptomatic PTSD. For clinical and/or professional practice guidelines to be useful in helping people and reducing suffering, this crucial problem must be acknowledged.	Thank you for this comment. We plan to review data on a variety of therapeutic approaches, not only exposure therapy. We appreciate that the number of studies is greater for some approaches than others and that this does not necessarily mean that the more studied approach is superior. We also plan to examine dropout and adverse events and will consider this information when making overall recommendations.
Anonymous (Individual; received from	Dear Dr. Louise Gaston,	Thank you for this comment. We plan to review data on a variety of therapeutic approaches, not only exposure therapy. We appreciate that the number of studies is greater for some

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Commenter (Group or Individual?)	Comment	Panel Response
Dr. Louise Gaston, Ph.D.)	I have read your published articles in the <i>Combat Stress</i> journal, entitled "Adverse Effects of Trauma-Focused Therapies." I'm a young integrative psychotherapist in the United Kingdom. In 2021, I began receiving EMDR therapy for mild anxiety and occasional nightmares about my childhood, which were not interfering with my daily life. I had previously undergone traditional talk therapies for seven years, which effectively treated most of my PTSD symptoms resulting from childhood abuse. However, after starting EMDR therapy, my ability to handle stress gradually deteriorated, which I didn't initially attribute to the therapy due to the high-stress job I was in. In 2022, my therapist urged me to reprocess memories of my main abuser, which led to my life falling apart after just one session. I suffered from panic attacks and severe anxiety, and I had to take a break from work. My EMDR therapist recommended doubling the number of sessions to get through the trauma quickly, which only made things worse. I experienced sleep paralysis, constant nightmares, and flashbacks, and found myself crying hysterically on the kitchen floor most days. By reading your articles, I discovered that I was not alone in experiencing negative effects from EMDR therapy. I ended my treatment and began working with a new therapist, which has helped me feel somewhat better. Although I still have a lot of healing to do, I'm hopeful that I can recover. Thank you for raising awareness about the potential risks associated with trauma-focused therapies. Best wishes T...	approaches than others and that this does not necessarily mean that the more studied approach is superior. We also plan to examine dropout and adverse events and will consider this information when making overall recommendations.
Dr. Louise Gaston, Ph.D. (Individual)	To whom it may concern, You will find hereby some of my articles published in <i>Combat Stress</i>, a magazine for veterans and clinicians (see attachments).	Thank you for taking the time to share your concerns. We do plan to examine tolerability and acceptability of various treatment approaches, including adverse event data, and consider this information critical to making balanced recommendations. We also appreciate the efficacy and

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Commenter (Group or Individual?)	Comment	Panel Response
	For over 30 years, I have had many concerns about the use of trauma-focused therapies (PE, EMDR, and CPT) for treating PTSD, especially for veterans. Their dropout rates are very high, even in RCTs, and adverse effects are numerous and severe (see Pitman et al. (1991) cited below). However, their adverse effects have not really been studied for the last 30 years. Indeed, highly enthusiastic about trauma-focused therapies, RCT researchers have neglected to inquire about adverse effects of PE, EMDR and CPT, a fact which was even stated in the appendices of the 2017 APA guidelines for treating PTSD and which contradicted the main recommendations of the committee. In my expert opinion, as a clinician and a researcher specialized in PTSD, the popular recommendation to use, in a sine qua non fashion, trauma-focused therapies for treating PTSD is unethical. Finally, I wish to reiterate that, in evaluative research, there is a clear and major distinction between efficacy (derived from RCT settings) and effectiveness (derived from real-life settings), a scientific reality which is almost never acknowledged. Honestly, I am very skeptical about a true intention on the part of the APA to truly consider how much PTSD sufferers are damaged by trauma-focused therapies (especially veterans), because their use has been highly recommended by the APA, the VA, etc. Nonetheless, I am willing to give this APA committee a chance and thus submit the attached body of research, clinical realities, and reflections. Sincerely, Dr. Louise Gaston, Ph.D. TRAUMATYS 1-844-633-3326 www.traumatys.com	effectiveness distinction and intend to speak to this in our recommendations.

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Commenter (Group or Individual?)	Comment	Panel Response
	Pitman, R.K., et al. (1991). Psychiatric complications during flooding therapy for post- traumatic stress disorder. <i>Journal of Clinical Psychiatry</i> , 52, 17-20.	

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Theme #3-B: Psychopharmacological treatments

Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
Anonymous (Individual; #89)	I have concerns	Also why all the dangerous addictive medications. Now that THC and CBT are legal in most places - I think this should be added to the medication list.	Thank you for this feedback. We will consider evidence from a broad range of interventions. In addition, we plan to consider a range of outcomes including adverse events.
John C. Markowitz, M.D. (Individual)	Generally, I agree	How much expertise does this group of psychologists have to review the psychopharmacology of PTSD? Medication must be included in a treatment guideline, but is there more than one actual psychopharmacologist (a token psychiatrist) among the evaluators? That puts great weight on a single (non-member?) participant to speak for the American Psychological Association.	Thank you for your feedback questions related to the representation on the Panel. The goal was to be as representative as possible and include both researchers and clinicians across various professional disciplines with content and clinical expertise including a breadth of knowledge in psychopharmacology. The panel includes two psychiatrists and a psychiatric nurse practitioner, and the guideline draft will be circulated widely for public comment on the recommendations and full guideline.
Colette Smart, Ph.D., R.Psych. (Individual)	Generally, I agree	Query why propranolol (beta blocker) is not included under pharmacotherapy. For example, studies on memory reconsolidation therapy sometimes includes propranolol.	Thank you for your feedback. Recommendations for pharmacotherapy treatment will be based on an analysis of a comprehensive independent systematic review of the literature for treatment of PTSD in adults. The panel will consider evidence from a broad range of interventions. The panel will include in the review notes as to whether propranolol treatment on memory reconsolidation is found in any RCTs. In addition, we plan to consider a range of pharmacotherapeutics

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
			and non-pharmacotherapeutics outcomes including adverse events.

3-B.1 The following comments were received via email (cpg@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
John H. Diepold, Jr., PhD (Individual)	There is way too much emphasis on pharmacological interventions; we are psychologists.	Thank you for your comment. The goal was to be as representative as possible and include both researchers and clinicians across various professional disciplines with content and clinical expertise.

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Theme #3-C: Other interventions to consider

Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
Anonymous (Individual; #54)	Generally, I agree	Neurofeedback therapy and biofeedback should be separated from cognitive behavioral therapy. Parts work like ego state therapy or Internal Family Systems are often blended with other interventions and are often necessary in complex PTSD cases and I think they should be included. I am happy EMDR therapy has been included. I am certified in use of the intervention and find that I am often able to help people achieve remission from PTSD, depression, or anxiety with use of the disorder as measured by PCL-5, GAD 7, or PQH-9.	Thank you for your comment. We are limited to the underlying systematic reviews as to how they categorize the interventions. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ.
Marylene Cloitre, PhD (Individual)	Generally, I agree	(2) Consider adding “mixed modality” interventions as a subgroup. These are interventions that typically include coping skills and exposure interventions (either sequentially or integrated)	Thank you for your comment. We are limited to the current literature’s operationalization of interventions, and it would be difficult to include the various interventions that may be considered “mixed modality.”
Christine A. Courtois, PhD (Individual)	I have concerns	This is much more comprehensive than the last CPG; however, it still lacks inclusion of common factors/relational elements that now have systematic reviews to draw from. This omission was heavily critiqued in response to the original CPG.	Thank you for your comment. We agree that it is important to include common factors/relational elements but have limited our scope to include the critical and important outcomes described in the PICOTS table. Though to address the importance of common factors/relational, the panel will include two new types of recommendation statements in addition to the traditional / efficacy recommendation statements. The

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
			two new types of recommendations, implementation considerations and recommendations for research, will be consensus-based and will include additional literature that may not have met criteria to be included in a systematic review. The implementation considerations can include common factors/relational elements among other things. The recommendations for research will also provide a call for more research in gaps the panel identified throughout the development of the guideline. The full guideline document will also include a section(s) devoted to common factors/relational considerations.
Christine A. Courtois, PhD (Individual)	I have concerns	Emotionally focused treatment should also be included and has extensive empirical support and is now being applied in the individual, couple, and family treatment for trauma.	Thank you for your comment. The list of psychological interventions in the PICOTS table states "psychological interventions including, but not limited to" in order to allow the panel to consider additional interventions. We do intend to include emotionally focused treatment as part of the family-based therapies/interventions.
Christine A. Courtois, PhD (Individual)	I have concerns	The panel might also want to consider adding experiential and expressive therapies to this list of interventions and also leave open the option that other interventions might be included in the literature that is reviewed.	Thank you for your comment. The list of psychological interventions in the PICOTS table states "psychological interventions including, but not limited to" in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
			systematic reviews/meta-analyses to supplement the AHRQ.
Christine A. Courtois, PhD (Individual)	I have concerns	It also appears that couple therapy is missing., as are the "hybrid therapies such as STAIR and TARGET. Mindfulness/mentalization-based interventions such as meta-cognitive therapy should be included. There also seems to be a lack of inclusion of present-centered interventions. Computer/brain applications such as VR and other neurobiological treatment should also be included if data are available. Skill-building interventions and treatments like DBT and ACT ought to be included.	Thank you for your comment. The list of psychological interventions in the PICOTS table states "psychological interventions including, but not limited to" in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ.
Denise Sloan (Individual)	Generally, I agree	There is now strong evidence for written exposure therapy. It should be listed as a trauma focused intervention.	Thank you for your comment. Written Exposure Therapy was included in the AHRQ review conducted by Hoffman and colleagues in 2018. Given the date of the AHRQ review, the panel then supplemented a recent review conducted by DeJesus and colleagues (2024) that will serve as the underlying evidence for recommendation statements. Reference DeJesus, C. R., Trendel, S. L., & Sloan, D. M. (2024). A systematic review of Written Exposure Therapy for the treatment of posttraumatic stress symptoms. <i>Psychological Trauma: Theory, Research, Practice, and Policy</i>. Advance online publication. https://dx.doi.org/10.1037/tra0001659

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
Courtney Worley (Individual)	Generally, I agree	I would like to see Written Exposure Therapy included as an intervention considered separate from narrative exposure. These are two distinct interventions. A great deal of research supporting Written Exposure Therapy has emerged since the 2017 guidelines.	Thank you for your comment. Written Exposure Therapy was included in the AHRQ review conducted by Hoffman and colleagues in 2018. Given the date of the AHRQ review, the panel then supplemented a recent review conducted by DeJesus and colleagues (2024) that will serve as the underlying evidence for recommendation statements. Reference DeJesus, C. R., Trendel, S. L., & Sloan, D. M. (2024). A systematic review of Written Exposure Therapy for the treatment of posttraumatic stress symptoms. <i>Psychological Trauma: Theory, Research, Practice, and Policy</i>. Advance online publication. https://dx.doi.org/10.1037/tra0001659
Colette Smart, Ph.D., R.Psych. (Individual)	Generally, I agree	1. Do "polyvagal therapies" include methods such as Somatic Experiencing? Or would this be subsumed under "Sensorimotor therapies"? Suggest the former, given that Sensorimotor Psychotherapy is a standalone therapy.	Thank you for your comment. Polyvagal therapies include therapies that teach the brain circuitries responsible for fight, flight, or freeze to calm down. This may include methods such as somatic experiencing.
Colette Smart, Ph.D., R.Psych. (Individual)	Generally, I agree	2. Consider adding cognitive rehabilitation as a separate psychological category - that is, methods that primarily target cognitive function (NOT cognitive reappraisal) as a method of symptom improvement (e.g., executive function training, attentional bias training). If added, suggest moving neurofeedback to this category as it targets brain/cognitive function as the mechanism of action to improve emotional symptoms.	Thank you for your comment. The list of psychological interventions in the PICOTS table states "psychological interventions including, but not limited to" in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
			systematic reviews/meta-analyses to supplement the AHRQ.
Colette Smart, Ph.D., R.Psych. (Individual)	Generally, I agree	3. Consider adding memory reconsolidation therapy, either as a standalone or to better understand mechanism of action for EMDR.	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ.
Colette Smart, Ph.D., R.Psych. (Individual)	Generally, I agree	5. Assume that "interpersonal therapy" is broadly construed as opposed to just IPT - would attachment-oriented therapies be subsumed under interpersonal therapy? This will be particularly applicable and relevant to C-PTSD.	Thank you for your comment. We are ultimately limited by how the existing systematic reviews define interpersonal therapy.
Anonymous (Individual; #17)	Generally, I agree	Would be interested in seeing Acceptance and Commitment Therapy evaluated, as it has research and theoretical backing in use with PTSD.	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta analyses to supplement the AHRQ.
Anonymous (Individual; #119)	I have concerns	My concerns are reflected in the Psychotherapy Action Network's letter to the Guidelines committee. I think it is vital that psychoanalytic and existential-humanistic-person-centered therapies be highlighted along with the others as evidence-based interventions.	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
			PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ.
Ad de Jongh, Ph.D. (Group: PSYTREC – PsychoTrauma Expertise Centre)	Generally, I agree	We suggest the addition of terms for imagery-based treatments as these may not be captured within the other terms: eg Imagery Rescripting (IR); Imagery Rescripting and Reprocessing Therapy (IRRRT); Imagery Rehearsal Therapy (IRT)	Thank you for your comment. We are ultimately limited by how the existing systematic reviews define imagery-based treatments.
Jamie Miller (Individual)	I have concerns	The Seeking Safety model is the most studied and widely adopted model for PTSD / SUD and should be named.	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ.
Brenda Smith (Individual)	Generally, I agree	EMDR appears under recognized for the evidence already existing.	Thank you for your comment. EMDR is listed as one of the psychological interventions in the PICOTS table.
Lori Woehler, PsyD (Individual)	Generally, I agree	I recommend adopting established guidelines and protocols that have been endorsed by federal agencies and subjected to research (e.g. https://maps.org/research-archive/cluster/psilo-isd/pca1protocol.pdf)	Thank you for your comment. We agree that it is important to review and adopt established guidelines and protocols endorsed by federal agencies and subjected to research. We are utilizing the AHRQ review, and we will continue to review existing research and protocols.

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
Laura Van Sickle-Deavours (Individual)	Generally, I agree	I believe that ego state therapies should be included, especially for those with chronic developmental trauma who are diagnosed with PTSD.	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ.
Viann Nguyen-Feng (Individual)	Generally, I agree	I think complementary and integrative health approaches need further delineation (similar to the two sections above it), given the wide range of modalities that could fall under this category.	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ.
David Emerson (Group: Center for Trauma and Embodiment at Justice Resource Institute)	I have concerns	I would like to add for consideration under the Psychological Intervention section another framework that has been tested in two RCTs and several feasibility and a mechanism study - Trauma Center Trauma Sensitive Yoga (TCTSY)	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ review.

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
Edward Hunter (Individual)	I have concerns	I am not clear on what all is looked at. Many therapies, such as ACT and contextual approaches including radical behavior therapy do not appear. There is certainly short shrift given to diversity- just a bullet point on culturally adapted therapy. The problem in my view, which I will address later is will the overall approach which is based out of medicine, not psychology.	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ.
Anonymous (Individual; #56)	Generally, I agree	I do consider EMDR being a very effective evidence based treatment.	Thank you for your comment. We agree that EMDR has a sizeable evidence base, and it is included in the list of therapies under investigation.

3-C.1 The following comments were received via email (cpg@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
John H. Diepold, Jr., PhD (Individual)	- Practitioners who study and use any of the listed modalities do so through their own lens and experience, and are not necessarily using a pure version of any of the modalities. - Where are the “but not limited to” approaches listed in this guideline? - Are the listed interventions designed to manage and cope with the symptoms or to promote healing from the traumatic experiences? This needs to be made clearer. - Some of the listed psychological interventions are vague and generic, and open to interpretation. For example, aren't all psychotherapies interpersonal?	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We have not listed the “but not limited to” approaches to be inclusive of other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ. The basis of our current guideline is to find out what the research says with respect to the outcomes listed in the PICOTS table. The critical outcomes we are investigating include serious adverse events or harms, PTSD symptom reduction, and loss of PTSD diagnosis. There

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Commenter (Group or Individual?)	Comment	Panel Response
	There are other psychotherapy modalities, which are effective in the treatment of traumatic events, that are absent from the list psychological interventions. For example, client-centered approaches, Energy Psychology approaches (TFT, EFT), and Heart Assisted Therapy. Are these included in the “not limited to” category?	are also four additional categories of important outcomes we will be reviewing and commenting on (please see PICOTS table).
Deepna Anand (Group: APA Board for the Advancement of Psychology in the Public Interest [BAPPI])	- Written Exposure Therapy (WET; Sloan & Marx, 2019) has demonstrated strong beneficial effects in the treatment of PTSD, and we recommend that literature is reviewed to inform the guideline update. - There are reviews addressing the efficacy of interventions such as yoga and meditation. We would recommend that these be included in the guideline update. - The International Society for Traumatic Stress Studies (ISTSS) has outlined practice guidelines for PTSD (Forbes et al., 2020), and we recommend that this resource is reviewed to inform the guideline update. - Will you be including a standard for which interventions will be included or recommended? In other words, will you be operationalizing “efficacious” for the purpose of these guidelines? This is unclear from the framework.	Thank you for your comment. We do intend to include written exposure therapy. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ. We do intend to review the ISTSS practice guidelines. We also intend to include a rationale for which interventions will be included and recommended.
Amanda Martin, Ph.D., LMFT-S, LPC, BCN (Individual)	Hello, I am emailing due to I could not get the online form to work. I wanted to provide feedback on the recommendations and feel that EMDR therapy should be included in the best practice guidelines. I have attached references for studies that provide information on the effectiveness of EMDR. Thank you for your time.	Thank you for your comment. We agree that EMDR has a sizeable evidence base, and it is included in the list of therapies under investigation.

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Theme #3-D: Virtual interventions

Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
Dr Mirjam j. Nijdam (Individual)	Generally, I agree	Dear panel, I would like to suggest to include virtual reality exposure interventions in the category Psychological interventions. See for instance the following systematic review and meta-analysis: Eshuis, L.V., van Gelderen, M.J., van Zuiden, M., Nijdam, M.J., Vermetten, E., Olff, M., & Bakker, A. (2021). Efficacy of immersive PTSD treatments: a systematic review and meta-analysis of virtual reality and augmented reality exposure therapy and a meta-analysis of virtual reality exposure therapy. <i>Journal of Psychiatric Research</i> , 143, 516-527.	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions (such as virtual reality exposure interventions).
Courtney Worley (Individual)	Generally, I agree	It would also be nice to see information about provider recommended digital interventions as a stand alone (i.e. PTSD Coach) or prescribed in conjunction with psychotherapy (i.e. CPT Coach by VHA). It would be helpful to see information about FDA-cleared devices (e.g. alpha stim) that may be prescribed by a provider. I understand the research here is limited but patients and providers need clearer guidance for these devices and it would	Thank you for your comment. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” in order to allow the panel to consider additional interventions (such as therapy delivered in conjunction with apps) as long as they are “facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.”

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3-D.1 The following comments were received via email (cpg@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
Deepna Anand (Group: APA Board for the Advancement of Psychology in the Public Interest [BAPPI])	To the extent that they are on the market, we would recommend including technology-based interventions for PTSD. There are many apps, as well as virtual reality interventions for trauma-related symptoms (which would be excluded based on the review update being limited to full-syndrome PTSD). It seems important to acknowledge that and to identify whether there are any current tech-based interventions for full-syndrome PTSD. These would likely be under the purview of the FDA as a "medical device."	Thank you for your comment. The list of psychological interventions in the PICOTS table states "psychological interventions including, but not limited to" in order to allow the panel to consider additional interventions (such as virtual reality and interventions delivered in conjunction with other technologies) as long as they are "facilitated by a licensed/certified mental health provider and/or socially sanctioned healer." The needs of those at risk for PTSD and subsyndromal PTSD are clearly important but the literature is a separate one. In order to do justice to the literature, we limited the scope.

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Theme #3-E: Defining provision of services

Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
Sarah L Granberg, LCSW, MAC, CTTS, SAP, CCTP (Individual)	I have concerns	What in the world is a "socially sanctioned healer" and why would they be included in a clinical guideline?? This greatly concerns me with the "license" it would give people with no clinical training and therefore harm clients! In my 23 years in the field, I have never heard of hypnosis being an evidence-based therapy.	Thank you for this comment. The term socially sanctioned healer is not uncommon in the literature (Milling, 2023; Wampold, 2021). However, to better clarify we will add a definition to the full guideline document. APA is striving to be responsive to the cultural context in using this terminology. References Milling, L. (2023). <i>Evidence-based practice in clinical hypnosis</i>. American Psychological Association. Link. Wampold, B. E. (2021). Healing in a social context: The importance of clinician and patient relationship. <i>Frontiers in Pain Research</i>, 2, Article 684768. Link.
Joan Monahan, LPC (Individual)	Generally, I agree	Inclusion criteria for the multidisciplinary panel to update clinical practice guidelines should include a more diverse representation of clinical professionals. Subsequently, including licensed professional counselors (LPCs) could offer another clinical perspective in future updates of APA's guidelines for treating any clinical diagnosis, especially with PTSD.	We appreciate your feedback and agree that a diverse representation of clinical professionals is necessary to offer a variety of clinical perspectives. The APA strives to promote diversity in its efforts and will incorporate this feedback for future endeavors.
Tiffany Crawshaw (Individual)	Generally, I agree	Why are we including socially sanctioned healer? Isn't this an issue with competence and isn't the APA concerned with research, training and competence?	Thank you for this comment. The term socially sanctioned healer is not uncommon in the literature (Milling, 2023; Wampold,

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Commenter (Group or Individual?)	Agreement with Intervention Definition?	Comment	Panel Response
			2021). However, to better clarify we will add a definition to the full guideline document. APA is striving to be responsive to the cultural context in using this terminology. References Milling, L. (2023). <i>Evidence-based practice in clinical hypnosis</i>. American Psychological Association. Link. Wampold, B. E. (2021). Healing in a social context: The importance of clinician and patient relationship. <i>Frontiers in Pain Research</i>, 2, Article 684768. Link.

4. COMPARATOR (C)

Theme #4-A: Defining comparators

Commenter (Group or Individual?)	Agreement with Comparator Definition?	Comment	Panel Response
Christine A. Courtois, PhD (Individual)	Generally, I agree	Is there a way to include psychological interventions that might not be included in the list above? I suggest having continuous review of the literature simultaneous to the committee's ongoing work to pick up any work that has been accepted for publication or published.	Thank you for your comment. The list is not all encompassing. Interventions not on the list were considered. The panel was limited to the studies that were identified throughout the systematic reviews and meta-analyses. The panel has updated these reviews periodically through our process and will consider a final literature update before the document is finalized.
Julian Ford (Individual)	I have concerns	Other replicable manualized therapies should be added as a distinct comparator.	Thank you for your comment. As noted above, the list for comparators is not all encompassing. We have included evidence of active therapies as a comparator.
Anonymous (Individual; #119)	I have concerns	My concerns are reflected in the Psychotherapy Action Network's letter to the Guidelines committee. I think it is vital that psychoanalytic and existential-humanistic-person-centered therapies be highlighted along with the others as evidence-based interventions.	Thank you for your comment. The list of psychological interventions in the PICOTS table states "psychological interventions including, but not limited to" in order to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ.
Anonymous (Individual; #89)	I have concerns	Somatic Experiencing and polyvagal theory and Ego State theory should be added to this. Add THC and CBD and nutrition. Pharmacology alone would be ineffective	Thank you for your comment. As noted above, the list is not all encompassing. Interventions not on the list were considered, including where

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Commenter (Group or Individual?)	Agreement with Comparator Definition?	Comment	Panel Response
			systematic reviews examining RCTs included somatic-focused interventions.
Janice Muhr (Group: Psychotherapy Action Network)	Generally, I agree	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Les R. Greene (Individual)	I have concerns	As I'm sure you are aware, comparing a researcher's favored brand with a passive or bogus control merely reveals that doing something is better than doing nothing (to paraphrase Westen et al). I refer you to a recent paper of mine that spells out some of the issues regarding RCT design and methodology: Greene, L.R. (2021). The research-practice psychotherapy wars: The case of group psychotherapy in the treatment of ptsd. International Journal of Group Psychotherapy, 71, 393-423. DOI: 10.1080/00207284.2021.1890088	Thank you for providing this citation. Active comparators were included.
John C. Markowitz, M.D. (Individual)	Generally, I agree	One hopes the panel will give limited attention to studies based on showing a treatment works better than a sham or waiting list condition.	Thank you for your comment. Active comparators were included.
Guldeniz Yucelen, Psy.D. (Individual)	I have concerns	Treatment of PTSD symptoms require an individualized approach that takes into account the sensorimotor experience of the patient and cannot be manualized.	Thank you for your comment. We are limited to systematic reviews examining RCTs. While a manual is not necessarily a requirement, standardization of the intervention tested is needed to determine efficacy.
D Wagner LMFT (Individual)	I have concerns	I disagree with the use of exposure therapy for PTSD/C-PTSD as exposure stimulates the memory network holding the trauma, which emotionally dysregulates that can ultimately "grow" a dissociative process. During exposure, trauma arousal that includes epinephrine stimulating the vagus nerve which facilitates maladaptive storage of trauma in memory network, therefore exposure would reinforce the maladaptive storage.	Thank you for your point. We will be looking at both efficacy and scientific evidence of harms and burdens of all interventions examined.

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Commenter (Group or Individual?)	Agreement with Comparator Definition?	Comment	Panel Response
Joan Monahan, LPC (Individual)	Generally, I agree	Inclusion criteria for the multidisciplinary panel to update clinical practice guidelines should include a more diverse representation of clinical professionals. Subsequently, including licensed professional counselors (LPCs) could offer another clinical perspective in future updates of APA's guidelines for treating any clinical diagnosis, especially with PTSD.	We appreciate your feedback and agree that a diverse representation of clinical professionals is necessary to offer a variety of clinical perspectives. The APA strives to promote diversity in its efforts and will incorporate this feedback for future endeavors.
Barbara Milrod, M.D. (Individual)	I have concerns	Please see my past comments. This is a sloppy, uninformed and lazy review. During a time of mental health crisis, it is disgraceful that the APA would endorse this nonsense.	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information

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Commenter (Group or Individual?)	Agreement with Comparator Definition?	Comment	Panel Response
			on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Melissa Norberg (Individual)	Generally, I agree	Component analyses should be reviewed as well. We need to know if all components of a treatment should be included as part of a package.	Component studies are more limited at present, and we are dependent on how prior systematic reviews report their data. That said, we will be looking at change processes and talking about potential mechanisms of action.
Edward Hunter (Individual)	I have concerns	The approach broadly has to do with discrete interventions rather than applying principles to actual people.	Thank you for your comment. Yes, treatment matching is beyond the scope of this guideline. Potential treatment moderators will be discussed.

4-A.1 The following comments were received via email (cpg@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
Deepna Anand (Group: APA Board for the Advancement of Psychology in the Public Interest [BAPPI])	Comparators: The plan for guideline update includes comparisons to wait-list controls and no-intervention groups. We wonder whether the science is now sufficiently developed to include only comparisons to active treatments and shift away from inactive comparators? (We understand that active comparator studies can present challenges in the interpretation of results. For example, a finding of no difference between active treatments could possibly mean that they are equally effective or both equally ineffective. Can you comment on this?)	Thank you for your comment. Active comparators have been included in the review.

5. OUTCOME (O)

Theme #5-A: Defining “PTSD symptom reduction”

Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
Julian Ford (Individual)	I have concerns	PTSD symptom outcomes should be reported separately for each B-E criterion and not just in total. Behavioral dysregulation (impulsivity, aggression, addictions other than to substances) should be added. Only pathological dissociation and not dissociation globally should be examined.	Thank you for your feedback. While it is true that outcomes may differ by PTSD symptom cluster and true that clinicians could benefit from knowing whether particular treatments are more or less effective for particular symptoms clusters, the panel was charged with identifying treatments that are efficacious for the full PTSD syndrome. The panel recognized the value of identifying symptoms at a more granular level but going outside of our charge in this way would have added significant time to our review process with likely damage to the feasibility of the enterprise. Having said that, when information was presented at the symptom cluster, we considered it when reaching our recommendation decisions. We thought it was important to capture dissociation in our review process given its strong implication in complex PTSD. However, we doubted that we would find that the literature routinely distinguished pathological from nonpathological dissociation. It seemed to us that most studies measured dissociation in a dimensional (rather than categorical) way.

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Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
Anonymous (Individual; #117)	Generally, I agree	re: outcome - "PTSD symptom reduction" does this include total PTSD scale score, or are individual areas being assessed as well? for example, prazosin is beneficial for trauma nightmares, would an individual PTSD symptom study be included as well? These issues are relevant to those who prescribe medications for PTSD - we are interested treatments that treat part of the disorder, not just the whole.	For the purposes of our review, PTSD symptom reduction generally referred to the total symptom score, which indexes overall benefit to the full syndrome. While clinicians and clients have a well-justified interest in the effects of specific treatments for specific symptoms, our charge was to identify treatments that showed effectiveness for the full PTSD syndrome.
Ad de Jongh, Ph.D. (Group: PSYTREC – PsychoTrauma Expertise Centre)	Generally, I agree	We suggest as well as PTSD symptom reduction, that "Complex PTSD symptom reduction" is included as a separate outcome, as some studies report outcomes in the key ICD-11 cPTSD DSO symptoms (dysregulation, interpersonal functioning, sense of self) without using the ICD-II cPTSD criteria per se - ie using separate measures for each DSO symptom	The panel was charged with focusing on effective treatments for PTSD. We were mindful of the importance of complex PTSD to many consumers of our guidelines. We acknowledged this interest by including studies of patients suffering from complex PTSD. We also acknowledged it by tracking some of the symptoms that tend to distinguish PTSD from complex PTSD, i.e., dissociation and affect dysregulation. However, we did not aim to robustly determine whether the treatments in our review were effective for treating complex PTSD per se. We were aware that another group was undertaking the important work of identifying effective treatments for complex PTSD.

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Theme #5-B: Considering additional outcomes

Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
Christine A. Courtois, PhD (Individual)	Generally, I agree	To critical outcomes, I suggest adding serious risk taking behavior, criminal activity, and addiction intensification or relapse to the listing of serious adverse events. To important outcomes, add suicide attempts and behaviors and anxiety. To treatment acceptability, to other adverse events or harms, add inability to function/decompensation and other serious adverse events as included in the critical outcomes.	Thank you for your comment. In the early stages of scoping, the panel used the Delphi method to complete an outcome prioritization survey. On this survey panel members rated outcomes from 1 “not important” to 9 “critical” for deciding about what treatment to recommend. <i>Critical outcomes</i> were defined as those that are essential and necessary to the treatment decision-making process between the therapist and patient while <i>important outcomes</i> were defined as those that were significant but not critical for making a decision. The suicide attempts and behaviors outcome were included as an example under the “adverse events” umbrella as a critical outcome. The panel debated including GAD but decided that given that GAD is not assessed in the majority of RCTS and the need to keep the scope manageable, that we would not include it at this time. We do agree that GAD is a potential outcome that the field should examine in the future.
Marylene Cloitre, PhD (Individual)	Agree	No comment (Other than - Thank you for including functional impairment!)	Thank you for your review.
Anonymous (Individual; #122)	Generally, I agree	PTSD and especially complex trauma interfere with one's ability to feel safe in relationships. Therefore one's ability to engage with the therapist and external relationships for support should be an emphasized outcome.	Thank you for the review and feedback. Trauma certainly can disrupt attachment. Unfortunately, very few studies are included in meta-analysis and systematic reviews with attachment as an outcome, so this is not possible to include in the PICOTS at this

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Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
			time. It is our hope that social support will be addressed under the quality-of-life functional outcomes.
Anonymous (Individual; #119)	I have concerns	My concerns are reflected in the Psychotherapy Action Network's letter to the Guidelines committee in this area.	Thank you for your review and feedback. Please refer to the response to Psychotherapy Action Network's letter earlier in this document for further information.
Laura Dilly (Group: APA Committee on Children, Youth, and Families)	Generally, I agree	Given the evidence of high comorbidity between PTSD and interpersonal violence (IPV), our Committee urges consideration of intergenerational transmission of violence. Further, we hope that the panel highlights this aspect of clinical impact in the final guidelines. In reviewing outcomes outlined for consideration within the PICOTs framework, the noted quality of life improvement and functional outcomes are of significant interest to our committee. Specifically, improvements in the mentioned outcome areas of social/interpersonal functioning and home functioning may capture important changes associated with intimate relationship functioning and family functioning as PTSD can affect the entire family unit and improvement in symptoms may affect the entire family's functioning. We look forward to the panel's guidelines that might relate to individual's interpersonal and family relationships.	Thank you for the review and feedback. In most RCT studies the perpetration of intimate/family violence is not an outcome that is tracked but you make an interesting point. We will consider if any studies include these under outcomes as adverse events and comment on this as we continue. We are glad that you are interested in the quality-of-life outcomes, and we also hope it will provide more information addressing intimate and family functioning.
Colette Smart, Ph.D., R.Psych. (Individual)	Generally, I agree	Consider adding generalized anxiety disorder to the list of comorbidities, as per: Price M, Legrand AC, Brier ZMF, Hébert-Dufresne L. The symptoms at the center: examining the comorbidity of posttraumatic stress disorder, generalized anxiety disorder, and depression with network analysis. J. Psychiatr. Res. 2019;109:52–58. I have made a comment in Settings under the need to consider medical PTSD as a unique category. In terms of outcomes, disease burden and disability would be useful to include - these could	Thank you for your review and feedback. The panel debated including GAD but decided that given that GAD is not assessed in the majority of RCTS and the need to keep the scope manageable, that we would not include it at this time. We do agree that GAD is a potential outcome that the field should examine in the future. Given that currently most RCTs outside of medical trauma do not measure disease burden and disability, it currently does not make sense to

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Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
		presumably be subsumed under QOL/Functioning as per sections outlined here.	include in the PICOTS. The panel will make note of this suggestion and consider if it makes sense to comment upon this.
Jamie Miller (Individual)	I have concerns	The named outcomes are useful but it is essential to identify how studies have excluded important and clinically significant / severe comorbidities, eg people who are homeless, have cognitive impairment, are suicidal, are violent, are incarcerated, are psychotic, use have severe SUD or drug use disorders, etc. The PTSD is known to exclude these and drawing clinical conclusions without identifying this as a major weakness is a serious concern. Also iatrogenesis from PTSD study treatments and paying patients to attend PTSD treatments (which has occurred in numerous PE studies) is not addressed. In short, it's not enough to keep reporting outcomes, but these types of key clinical aspects need to be addressed.	Thank you for the review and feedback. We plan to note these limitations in the applicability section. Under settings, we have also tried to address some of these issues by qualifying criminal justice settings, homeless shelters, substance use facilities (etc.) in order to elucidate these issues.
Janice Muhr (Group: Psychotherapy Action Network)	Generally, I agree	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	Please see my article below as regards the importance for ethical reasons (client preference) of only including outcome measures that focus on lasting and meaningful change in client's overall well-being: Gnaulati E. Potential ethical pitfalls and dilemmas in the promotion and use of American Psychological Association-recommended treatments for posttraumatic stress disorder. <i>Psychotherapy (Chic)</i> . 2019 Sep;56(3):374-382. doi: 10.1037/pst0000235. PMID: 31282713.	Thank you for the review and feedback. The panel reviewed this article prior to defining the PICOTS and it influenced our decision to use quality of life and functioning outcomes.
Gagnon. Andre (Individual)	Generally, I agree	Some feel much relief but still show some vulnerabilities	Thank you for the review and feedback. We agree that post treatment clients may no longer have PTSD but still experience vulnerabilities.

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Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
Brenda M. Sedgwick (Individual)	Generally, I agree	I notice comorbid attentional deficit and / or issues with attentional focus that may be important to clarify through the protocol.	Thank you for the review and feedback. Hopefully the PTSD symptom reduction and/or loss of PTSD diagnosis will address some of the attentional changes.
Les R. Greene (Individual)	I have concerns	there are lots of problems with symptom checklists and the demand characteristics of the experimental setting.	Thank you for the review and feedback. Yes, there are limits to RCT methodology used in this approach as you suggest. Evidence from sources beyond RCTs (e.g., observational data) is used when evaluating potential harms and burdens of interventions as well as patient values and preferences, and these criteria are used along with the efficacy data from systematic reviews to make the guideline recommendations. The Advisory Steering Committee for development of clinical practice guidelines acknowledges that RCTs are the main source of data used in the systematic reviews. The ASC discussed this concern at length and recognized its importance to many members of the community, but ultimately believed it was critical to adhere to best practices in the U.S. and internationally for guideline development as described by the National Academy of Medicine (formerly the Institute of Medicine; IOM), which clearly prioritize the use of systematic reviews for identifying and assessing evidence. The challenge is that while systematic reviews can include studies other than RCTs, RCTs are the types of studies most likely to meet the rigorous quality criteria. To address these concerns, the ASC introduced two new types of recommendation statements in addition to the traditional efficacy recommendations

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Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
			based on a systematic review of the scientific evidence: "implementation considerations" and "recommendations for research." The "implementation considerations" are consensus-based statements based on how to apply the previous recommendation statement types into clinical practice and include clinician experience. The "recommendations for research" category is also expert, consensus-based that notes the current gaps in the research literature and where more research is needed to address these gaps. Clinician experience is also incorporated into the traditional recommendations when considering potential harms/burdens of treatments and preferences of patients.
Gabriella Evans (Individual)	Generally, I agree	I wonder if attachment security should be included as an outcome, particularly in C-PTSD	Thank you for the review and feedback. Attachment security and trust are important outcomes. Currently very few RCTs measure attachment security so that is why it is not included as an outcome at this point. The panel will make note of this and discuss if it makes sense to make this point in the final document.
Anonymous (Individual)	I have concerns	PTSD clients present with symptoms of depression that are trauma specific, yet these are often misdiagnosed as depression.	Thank you for your feedback.
Joan Monahan, LPC (Individual)	Generally, I agree	Inclusion criteria for the multidisciplinary panel to update clinical practice guidelines should include a more diverse representation of clinical professionals. Subsequently, including licensed professional counselors (LPCs) could offer another clinical perspective in future updates of APA's guidelines for treating any clinical diagnosis, especially with PTSD.	We appreciate your feedback and agree that a diverse representation of clinical professionals is necessary to offer a variety of clinical perspectives. While it is not possible to include individuals from every type of profession on each panel, the current panel includes a diverse range of individuals across professions and the community. The APA strives to

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Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
			promote diversity in its efforts and will incorporate this feedback for future endeavors.
Steven Marcus Ph.D. (Individual)	Generally, I agree	Some earlier studies in the 1980's or 1990"s did not report drop out data or possible harms from treatment.	Thank you for your feedback. Our update will be focusing on the more recent literature.
Judy Greenberger (Individual)	I have concerns	Specific known treatments, like EMDR therapy can make such dramatic difference in promoting affect regulation, functioning, and well being, that this should be tried first before going to any other treatment modality.	Thank you for your feedback. The goal of the update is to provide data from RCTs about the specific known treatments to guide such clinical decision-making.
Laura DeSantis (Individual)	Generally, I agree	Anxiety should be added to the list of comorbid disorders.	Thank you for your review and feedback. The panel debated including anxiety disorders such as Generalized Anxiety Disorder but decided that given that GAD is not assessed in the majority of RCTS and the need to keep the scope manageable, that we would not include it at this time. We do agree that anxiety disorders are a potential outcome that the field should examine in the future.
Jennifer West, Ph.D. (Individual)	Generally, I agree	Would include measure of posttraumatic growth – beyond baseline	Thank you for your review and feedback. This is an interesting idea. Currently most RCTs do not assess post-traumatic growth but the panel will discuss if this should be a future recommendation.
Viann Nguyen-Feng (Individual)	Generally, I agree	additional considerations: anxiety-related disorders; chronic pain/somatic symptoms	Thank you for your review and feedback. The panel debated including anxiety disorders such as GAD but decided that given that anxiety disorders such as GAD is not assessed in the majority of RCTS and the need to keep the scope manageable, that we would not include it at this time. We do agree that anxiety disorders are a potential outcome that the field should examine in the future. Perhaps in the next set of updates the data will be there. Similarly the majority of RCTs have not been noting pain/ somatic symptoms yet.

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Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
Barbara Milrod, M.D. (Individual)	I have concerns	These are not details that are adequately captured with the use of meta-data. Original RCTs should have been evaluated in detail.	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to

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Commenter (Group or Individual?)	Agreement with Outcome Definition?	Comment	Panel Response
			everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Melissa Norberg (Individual)	Generally, I agree	I think the panel should not only focus on outcomes, but also mechanisms.	Thank you for the review and feedback. Although clinical practice guidelines typically focus on outcomes, changes have been made to APA's process to also include a section in the full guideline document on change processes. Furthermore, there will also be two new types of recommendation statements in addition to the traditional efficacy recommendations based on a systematic review of the scientific evidence: "implementation considerations" and "recommendations for research." The "implementation considerations" are consensus-based statements based on how to apply the previous recommendation statement types into clinical practice and include clinician experience. The "recommendations for research" category is also expert, consensus-based that notes the current gaps in the research literature and where more research is needed to address these gaps. Clinician experience is also incorporated into the traditional recommendations when considering potential harms/burdens of treatments and preferences of patients.
Megan Spokas (Individual)	Generally, I agree	The committee may also find the following meta-analysis helpful in considering a review of serious adverse events and suicidal ideation as a comorbidity: Brooks, E., Spokas, M., & Goldschmidt, D. (2021). Exclusion of Suicidal Participants From Randomized Controlled Trials for Posttraumatic Stress Disorder: A Meta-Analysis. <i>Journal of traumatic stress</i> , 34(6), 1209–1218. https://doi.org/10.1002/jts.22610	Thank you for your review, feedback, and provision of the article. We will make a note of this issue most likely in the applicability section.

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5-B.1 The following comments were received via email (cpg@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
Sophie Haber-Sage (Group: Committee on Socioeconomic Status [CSES])	The Committee for Socioeconomic Status (CSES) appreciates the opportunity to review the updated APA PTSD Guidelines, which we believe are a significant improvement compared to the previous version. The PICOTS framework is helpful - however, we believe the framework could be strengthened by more intentionally including issues related to poverty, client's preferences, and socioeconomic status. According to APA's Recognition of Psychotherapy Effectiveness (2013), evidence-based practices are grounded on clinical expertise in the context of patient characteristics, culture, and preferences. As such, aspects related to treatment cost and availability should be included under 'Treatment Acceptability', as people with low-income and economically marginalized (LIEM) are more likely to drop out due to these economical constraints. Treatment cost and client preference for timing/type of treatment might be helpful to include under outcomes. We believe it is important to include socioeconomic status as a moderator of treatment, as people who experience economic marginalization have different experiences in the treatment of trauma. Please consider including this caveat within treatment acceptability and timing.	Thank you for your comment. The panel agrees that socioeconomic status is an important indicator in treatment acceptability. While cost-effectiveness of treatments is outside the scope of the guideline, the panel will mention in the guideline the role of socioeconomic status in the timing and type of treatment as well as acceptability of treatment. It is also hoped that the guideline can be a tool to help advocate for access to important and effective treatments for all people regardless of ability to pay.

6. TIMING (T)

Theme #6-A: Frequency of treatment and follow-up timepoints

Commenter (Group or Individual?)	Agreement with Timing Definition?	Comment	Panel Response
Christine A. Courtois, PhD (Individual)	Generally, I agree	A very important topic has to do with the sequencing of treatment, a controversial issue at present. Please discuss and also consider massed approaches. See the following article for a recent update on the discussion: Dyer, K. F., & Corrigan, J-P. (2021). Psychological treatments for Complex PTSD: A commentary on the clinical and empirical impasse dividing unimodal and phase-oriented therapy positions. <i>Psychological Trauma: Theory, Research, Practice, and Policy</i> , 13(8), 869-876. https://doi.org/10.1037/tra0001080	Thank you for your comment. The Timing inclusion criteria in the PICOTS table states “Any length, duration, intensity, and frequency of sessions” in order to allow the panel to consider interventions that are delivered in these various formats (e.g. massed, spaced, expanding spaced schedule, sequenced).
Julian Ford (Individual)	Generally, I agree	Attrition at follow-up should be carefully considered to account for potential over estimating of sustained benefits.	Thank you for your comment. We plan to examine attrition as an outcome over time including at follow-ups.
Anonymous (Individual; #89)	I have concerns	Typically folks don't seem to be given enough sessions to resolve trauma. I think 6 months would be the minimum	Thank you for your comment. We agree that long-term follow-ups are valuable to evaluate the impact of interventions. Therefore, the panel stated a preference for “studies that assessed follow-up at 6 months or longer.”
Anonymous (Individual; #56)	Generally, I agree	The length of the treatment depends on patient's symptomatology, comorbidity, current stressors, medical conditions, traumas, and resiliency.	Thank you for your comment. The panel will examine interventions of “Any length, duration, intensity, and frequency of sessions”.
Dr Mirjam J. Nijdam (Individual)	Generally, I agree	Although every session frequency is included in the Timing part, I think it is good to explicitly pay attention to highly intensive or 'massed' trauma-focused psychotherapies. In the Dutch guideline for PTSD from 2020 they have been recommended as third step-intervention (after insufficient response to two trauma-focused psychotherapies offered weekly). See for instance the following systematic review:	Thank you for your comment. The Timing inclusion criteria in the PICOTS table states “Any length, duration, intensity, and frequency of sessions” in order to allow the panel to consider interventions that are delivered in various formats including massed interventions.

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Commenter (Group or Individual?)	Agreement with Timing Definition?	Comment	Panel Response
		Sciarrino, N. A., Warnecke, A. J., & Teng, E. J. (2020). A systematic review of intensive empirically supported treatments for posttraumatic stress disorder. <i>Journal of Traumatic Stress</i> , 33(4), 443–454. After this systematic review came out, several additional large RCTs have been published on massed trauma-focused psychotherapies.	
Jamie Miller (Individual)	I have concerns	It is essential to report end-of-treatment outcomes. Often RCTs (and meta-analyses) look across the entire study period, which often includes followups. Those are useful but without explicitly identifying end-of-treatment results, it is not possible to identify the impact of the treatment. Also often studies do not report on ancillary treatments that occurred during the trials (especially during the followup periods), yet such ancillary treatments often have a big impact on outcomes (ie other therapies the patients are engaging in during the study, which may include residential care, required co-occurring SUD treatment, etc.).	Thank you for your comment. The panel will consider the outcomes listed that are available over follow-up durations of any length. We agree that not all studies report ancillary treatments that occurred during the trials and that they could impact outcomes.
Janice Muhr (Group: Psychotherapy Action Network)	Generally, I agree	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	Rather than "preferring" studies that assess follow up at 6 months or longer, studies should be limited entirely to abiding by this criteria since lasting and meaningful change should be the desired outcome, not short-term symptoms remission (once again for ethical reasons): Gnaulati E. Potential ethical pitfalls and dilemmas in the promotion and use of American Psychological Association-recommended treatments for posttraumatic stress disorder. <i>Psychotherapy (Chic)</i> . 2019 Sep;56(3):374-382. doi: 10.1037/pst0000235. PMID: 31282713.	Thank you for sharing this. We will consider all follow-up data and include a broad range of outcomes beyond PTSD symptom severity.
Ann (Individual)	I have concerns	If anyone honestly believes trauma symptoms can be relieved within 6 months, are kidding themselves. That is long enough to build a rapport and work their way towards managing some of the symptoms without actually processing the traumatic events.	Thank you for this feedback. We will consider evidence for any duration individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.

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Commenter (Group or Individual?)	Agreement with Timing Definition?	Comment	Panel Response
Assoc Prof Christopher Lee (Individual)	Generally, I agree	thin k follow up can be 3 months	Thank you for your comment. Indeed, the panel will consider interventions with “Any follow-up length” including those with only 3-month follow-ups.
John C. Markowitz, M.D. (Individual)	I have concerns	The definition presented here is confusing. "[P]reference for studies that categorize as short, medium, or long length" reads as no preference at all. What is this clause intended to convey?	Thank you for your comment. The panel agrees and will delete “with preference for studies that categorize as short, medium, or long length.”
D Wagner LMFT (Individual)	Generally, I agree	Because memory networks are involved with trauma recovery, short- or even medium-length therapy tends to fall short of full resolution.	Thank you for this feedback. We will consider evidence for any duration individual or group intervention that is facilitated by a licensed/certified mental health provider and/or socially sanctioned healer.
Joan Monahan, LPC (Individual)	I have concerns	The follow-up should be considered to begin three months or longer post-intervention.	Thank you for your comment. We will consider evidence for any duration with a preference for “studies that assessed follow-up at 6 months or longer.”
Judy Greenberger (Individual)	Generally, I agree	Acceptable.	Thank you for your comment.
Barbara Milrod, M.D. (Individual)	I have concerns	I do not see anything about intervening treatments, meaning all long term data are suspect. This was an exercise in futility	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the

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Commenter (Group or Individual?)	Agreement with Timing Definition?	Comment	Panel Response
			guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Debra Kaysen (Individual)	Generally, I agree	Generally less but if possible considering spacing of psychotherapy sessions (daily, biweekly, weekly, longer) would be great.	Thank you for your comment. The Timing inclusion criteria in the PICOTS table states "Any length, duration, intensity, and frequency of sessions" in order to allow the panel to consider interventions that are delivered in these various formats (e.g. massed, spaced, expanding spaced schedule).

7. SETTING (S)

Theme #7-A: Additional settings to consider

Commenter (Group or Individual?)	Agreement with Setting Definition?	Comment	Panel Response
Julian Ford (Individual)	Generally, I agree	Findings should distinguish between pure efficacy studies vs. effectiveness studies in real-world settings.	Thank you for this comment. We will take this into consideration. At present, we have only defined the scope of what will be included, and we have no restrictions on the type of setting that care is delivered in. Also, for each recommendation, the panel will consider the “Applicability” (generalizability) across PICOTS factors (population, intervention, comparators, timing, and setting) and consider if it has any concerns in any domain.
Anonymous (Individual; #89)	I have concerns	What about private practice?	We have no restrictions on the setting. Evidence from studies done in all settings (e.g., outpatient and inpatient primary care or specialty mental health care settings; community settings [e.g., churches, community health centers, rape crisis centers]; military settings; criminal justice settings; partial hospitalization; refugee camps) will be considered.
Colette Smart, Ph.D., R.Psych. (Individual)	Generally, I agree	Hospital settings (i.e., primary medical, not mental health) should also be included. There is a significant dearth of information available on the efficacy of treatments specifically for medical PTSD, despite this having a higher base rate than PTSD in the general population. Medical PTSD is also particularly prevalent in the ICU setting, and this is only likely to have increased in prevalence following the early waves of the COVID-19 pandemic when many individuals were hospitalized in the ICU. See: Marra A, Pandharipande PP, Patel MB. ICU delirium and ICU- related PTSD. Surg. Clin. North Am. 2017;97(6):1215–35.doi:10.1016/j.suc.2017.07.008.	Thank you for this comment and for sharing these articles. We will consider evidence from studies done in all settings, including hospital settings. We will also consider PTSD related to any type of traumatic event, including medical events.

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Commenter (Group or Individual?)	Agreement with Setting Definition?	Comment	Panel Response
		Nalbandian A, Sehgal K, Gupta A, Madhavan MV, McGroder C, Stevens JS, Wan EY, Nordvig AS, Shalev D, Sehwat TS. Post-acute COVID-19 syndrome. Nat Med. 2021;27(4):601–15.doi:10.1038/s41591-021-01283-z. Medical PTSD may also have unique characteristics compared to other etiologies of PTSD (see Edmondson's enduring somatic threat model) that warrant examination of PTSD with medical etiology as a unique group for analysis. Note that people may present with either single-incident medical PTSD (e.g., post-stroke PTSD) or complex PTSD in the context of chronic illness (e.g., childhood-onset chronic illness, ACEs, etc.).	
Gagnon. Andre (Individual)	I have concerns	All settings are not equal. A soldier or officer in the Army, a paramedic in one's own health group, a follower in one's own church. A measure of independence is often needed	Thank you for this comment. We will take this into consideration. At present, we have only defined the scope of what will be included, and we have no restrictions on the type of setting that care is delivered in.
Brenda M. Sedgwick (Individual)	Generally, I agree	It could be relevant to use reference "victim support and rape crisis centres". It may also be important to consult directly with sexual assault and domestic violence intervention centres for the most up-to-date terms of reference - rape or sexual assault for example.	Thank you for this suggestion. We will consult within and outside our group as needed to ensure we are using the most accurate and up to date language.
Anonymous (Individual)	I have concerns	The general public has a high rate of trauma but is not addressed here other than through churches; however, churches confound treatment. Private practices are where you are most likely to encounter PTSD; additionally, focusing on the populations above perpetuates the myth that these are the only people that experience PTSD. Finally, it leaves out a large part of the PTSD population that often goes unstudied because of the belief that these settings are where PTSD is most commonly found.	Thank you for this comment. We have no restrictions on the type of setting that care is delivered in. The population of focus will be any adults with PTSD or complex PTSD; there are no other restrictions to the population.
Joan Monahan, LPC (Individual)	I have concerns	All settings should include all educational settings (e.g., colleges, universities, elementary, middle, and high school grades).	Thank you for this comment. We have no restrictions on the type of setting that care is delivered in. However, the guidelines will be specific to adults, therefore educational settings

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Commenter (Group or Individual?)	Agreement with Setting Definition?	Comment	Panel Response
			for children and youth would not be included. A separate CPG will be recommended to address the large literature on PTSD in children and youth and do justice to the developmental issues.
Jennifer West, Ph.D. (Individual)	Generally, I agree	May need to include online platforms/settings as well.	Thank you for this comment. We have no restrictions on the type of setting that care is delivered in.
Barbara Milrod, M.D. (Individual)	I have concerns	I do not trust this panel because of their sloppiness and laziness	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information

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Commenter (Group or Individual?)	Agreement with Setting Definition?	Comment	Panel Response
			on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Edward Hunter (Individual)	I have concerns	What about a setting concerning cultural characteristics or even individual characteristics? At the very least, the guidelines need to include a recognition that the studies done are inherently flawed by a lack of attention to individual differences, and that the confidence in outcomes are far from what they purport in the original.	Thank you for this comment. The generalizability of the evidence across cultures, gender, etc. will be an important issue to discuss in the recommendations (implementation considerations) and full guideline document.

7-A.1 The following comments were received via email (cpg@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
Ritu Verma (Group: American Psychological Association of Graduate Students [APAGS])	We would support passage of APA's proposed initial decisions in updating the 2017 clinical practice guideline for the treatment of PTSD in adults with the following changes. <u>Population, Interventions, Comparators, Outcomes, Timing, Setting (PICOTS) Framework</u> • P.2 Replace churches with religious and spiritual centers	Thank you for this comment. Religious and spiritual center is a more inclusive term and we will switch to using this language. This will be included in the type of care delivery setting considered.

8. Overall Comments on the Identified Systematic Reviews

The following comments were received via email (cpq@apa.org)

Commenter (Group or Individual?)	Comment	Panel Response
Deepna Anand (Group: APA Board for the Advancement of Psychology in the Public Interest [BAPPI])	We weren't clear on the rationale for choosing these particular review articles (while leaving out others. Some examples that might be worthwhile include the following: dropout (Lewis, Roberts, Gibson & Bisson, 2020); a meta-anal by Lewis, Roberts, Andrew, Starling & Bisson, 2020; or another comparative one of meds (Capriani, Williams, et al., 2018). Again, we appreciate the thoughtfulness that is going into this very important update and the opportunity to comment!	Thank you for your comment. The panel agrees that it is important to address patient drop-out, and feels this issue as well as comparative medications are addressed within the included systematic reviews.
Ritu Verma (Group: American Psychological Association of Graduate Students [APAGS])	<u>Proposed Systematic Reviews / Meta-Analyses to Supplement Agency for Healthcare Research and Quality Review</u> Comment 1: We recommend the following systematic reviews/meta-analyses be included by the Panel: • Crombie, K. M., Adams, T. G., Dunsmoor, J. E., Greenwood, B. N., Smits, J. A., Nemeroff, C. B., & Cisler, J. M. (2023). Aerobic exercise in the treatment of PTSD: An examination of preclinical and clinical laboratory findings, potential mechanisms, clinical implications, and future directions. <i>Journal of Anxiety Disorders</i>, 102680. • Singewald, N., Sartori, S. B., Reif, A., & Holmes, A. (2023). Alleviating anxiety and taming trauma: Novel pharmacotherapeutics for anxiety disorders and posttraumatic stress disorder. <i>Neuropharmacology</i>, 109418. • Bryant, R. A., Dawson, K. S., Azevedo, S., Yadav, S., Cahill, C., Kenny, L., ... & Keyan, D. (2023). Augmenting trauma-focused psychotherapy for post-traumatic stress disorder with brief aerobic exercise in Australia: a randomised clinical trial. <i>The Lancet Psychiatry</i>, 10(1), 21-29.	Thank you for your comment and for providing these references. Regarding aerobic exercise and novel pharmacotherapeutics, the panel feels the former did not meet the criteria we identified for this guideline update, and the latter may be too new to have made it into the systematic reviews identified and met with the PICOTS framework. We anticipate that as the CPG undergoes further revisions in the future, the newer interventions may then be addressed. Regarding providing care via Telehealth, the panel will note the importance and utility of this mode of delivering evidence-based interventions in the narrative of the guideline document.

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Commenter (Group or Individual?)	Comment	Panel Response
Ritu Verma (Group: American Psychological Association of Graduate Students [APAGS])	Comment 2: Additionally,, we recommend incorporating reviews with diverse samples OR address the limitations of these new reviews (based on pervasive lack of representation across diverse groups - i.e., underrepresented racial/ethnic groups) - Inclusion and commentary for intergenerational trauma under cultural considerations. See articles: - Cerdeña, J. P., Rivera, L. M., & Spak, J. M. (2021). Intergenerational trauma in Latinxs: A scoping review. <i>Social Science & Medicine</i>, 270, 113662. - Isobel, S., Goodyear, M., Furness, T., & Foster, K. (2019). Preventing intergenerational trauma transmission: A critical interpretive synthesis. <i>Journal of clinical nursing</i>, 28(7-8), 1100-1113.	Thank you for your comment and for providing these references. The panel agrees that it is important to ensure representation by diverse patient populations and feels such groups are included in the systematic reviews identified.
Ritu Verma (Group: American Psychological Association of Graduate Students [APAGS])	Comment 3: We recommend the panel to include this additional complex PTSD review: Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., ... & Hutton, P. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and meta-analysis. <i>Psychological medicine</i>, 49(11), 1761-1775	Thank you for your comment and for providing this reference. After further review, the panel agreed to include the Karatzias 2019 reference as one of the underlying evidence for its recommendation statements.
Ritu Verma (Group: American Psychological Association of Graduate Students [APAGS])	Comment 4: Given the shift in the field to a higher percentage of telehealth providers, We recommend incorporating a review addressing telehealth considerations for PTSD treatment: Morland, L. A., Wells, S. Y., Glassman, L. H., Greene, C. J., Hoffman, J. E., & Rosen, C. S. (2020). Advances in PTSD treatment delivery: Review of findings and clinical considerations for the use of telehealth interventions for PTSD. <i>Current Treatment Options in Psychiatry</i>, 7, 221-241.	Thank you for your comment and for providing the reference. Regarding providing care via Telehealth, the panel will note the importance and utility of this mode of delivering evidence-based interventions in the narrative of the guideline document.
Sophie Haber-Sage (Group: Committee on Socioeconomic Status [CSES])	We have no issues with the MA and SR included, although it might be helpful to include examples of MA and SR on specific settings/populations that are particularly vulnerable to marginalization, poverty, and exploitation, given the significant variability on methodological rigor and outcomes (e.g., Malik et al., 2023, 'The effectiveness of trauma-focused interventions in prison settings';	Thank you for your comment and for providing these references. The panel agrees that it is important to ensure representation of diverse patient populations including racial diversity, military versus civilian populations, and other diverse patient characteristics and feels such settings and groups are included in the identified systematic reviews.

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Commenter (Group or Individual?)	Comment	Panel Response
	Ayano et al., 2020, 'A systematic review and meta-analysis of the prevalence of PTSD among homeless people).	
Janice Muhr, PhD (Group: Psychotherapy Action Network)	Lack of up-to-date research The GUP must include a review of studies conducted in the last five years. Below are recommendations of selected affect-focused studies and studies demonstrating problems with exposure-based therapies. These should be included in studies reviewed for the updated Guidelines. Cloitre, M., <i>et al.</i>, Treatment for PTSD related to childhood abuse: a randomized controlled trial. <i>The American journal of psychiatry</i> 167, 915-924, doi:10.1176/appi.ajp.2010.09081247 (2010). Hundt, N. E. <i>et al.</i> "It didn't fit for me:" A qualitative examination of dropout from prolonged exposure and cognitive processing therapy in veterans. <i>Psychological Services</i> 17, 414-421, doi:10.1037/ser0000316 (2020). Keefe, JR, Wiltsey Stirman, S, Cohen, ZD, DeRubeis, RJ, Smith, BN, Resick, P. In rape-trauma PTSD, patient characteristics indicate which trauma-focused treatment they are most likely to complete. <i>Depress Anxiety</i>. 2018; 35: 330– 338. https://doi.org/10.1002/da.22731 Kehle-Forbes SM, Meis LA, Spoont M, Polusny MA. (2015). Treatment initiation and dropout from prolonged exposure and cognitive processing therapy in a VA outpatient clinic. <i>Psychol Trauma</i>. Lester, K., Artz, C., Resick, P. A., & Young-Xu, Y. (2010). Impact of race on early treatment termination and outcomes in posttraumatic stress disorder treatment. <i>Journal of Consulting</i>	Thank you for your comment and for providing these references. The panel agrees that it is important to address related to patient drop-out, and the impact of exposure-based psychotherapies on patients. The panel feels such issues are included in the systematic reviews identified. Furthermore, the panel feels diverse patient populations are also included in the systematic reviews identified. The panel agrees that GUP consider reviews conducted in the last five years and is only including reviews that are published within the last five years. The panel is aware of the Courtois and Brown's (2019) recommendations and will address the issues in the narrative of the guideline document.

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Commenter (Group or Individual?)	Comment	Panel Response
	and Clinical Psychology, 78(4), 480–489. https://doi.org/10.1037/a0019551 Markowitz, J. C. <i>et al.</i> Is Exposure Necessary? A Randomized Clinical Trial of Interpersonal Psychotherapy for PTSD. <i>The American journal of psychiatry</i> 172, 430-440, doi:10.1176/appi.ajp.2014.14070908 (2015). Meffert, Susan M., Neylan, Thomas C., McCulloch, Charles E., et al: Interpersonal psychotherapy delivered by nonspecialists for depression and posttraumatic stress disorder among Kenyan HIV–positive women affected by gender-based violence: Randomized controlled trial (2021) PlosMedicine https://doi.org/10.1371/journal.pmed.1003468 Schnurr, P. P. <i>et al.</i> Comparison of Prolonged Exposure vs Cognitive Processing Therapy for Treatment of Posttraumatic Stress Disorder Among US Veterans: A Randomized Clinical Trial. <i>JAMA Network Open</i> 5, e2136921-e2136921, doi:10.1001/jamanetworkopen.2021.36921 (2022). Steenkamp MM, Litz BD: Prolonged Exposure Therapy in Veterans Affairs JAMA Psychiatry. 2014;71(2):211. Steenkamp, M. M., Litz, B. T. & Marmar, C. R. First-line Psychotherapies for Military-Related PTSD. <i>JAMA</i> 323, 656-657, doi:10.1001/jama.2019.20825 (2020). Steenkamp, M.M., Litz BT, Marmar CR: First line psychotherapies for military-related PTSD. JAMA online Jan 30, 2020. As a final comment, we strongly encourage the GUP to explicitly take up Christine Courtois and Laura Brown's recommendations for	

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Commenter (Group or Individual?)	Comment	Panel Response
	guideline updates in the introduction to the special issue of <i>Psychotherapy</i>, and make public their reasons for not following them when that is the case. We are happy to discuss these comments further, and hope the GUP will give them serious consideration. Sincerely, Linda Michaels, PsyD MBA (Chair); Janice Muhr, PhD (Treasurer) Barbara Milrod, M.D. Professor of Psychiatry Albert Einstein College of Medicine Harold Kudler, M.D. Associate Consulting Professor of Psychiatry and Behavioral Sciences Duke University Adjunct Professor of Psychiatry Uniformed Services University of the Health Sciences Sheila Frankfurt, PhD, LP VISN 17 Center of Excellence for Research on Returning War Veterans	
Julie Koch (Group: APA Committee on Global Psychology [CGP])	The Committee on Global Psychology is pleased to see that of the 7 systematic reviews, 4 were published in journals based outside of the US. We commend the group on including non-US studies as well as US-based studies.	Thank you for your comment and support.
John C. Markowitz, M.D. (Individual)	What follows is a general comment about the overall data gathering and review process. This is the reason I left your treatment guideline panel. After more than a year of unhurried discussion during which relatively little work occurred, it became apparent that the guideline panel would rely on other groups' systematized reviews and meta-analyses rather than doing its own. It is fine to use systematized reviews and meta-analyses	Thank you for your comment. The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across

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Commenter (Group or Individual?)	Comment	Panel Response
	as partial background material, but full reliance on them has serious disadvantages. 1. Published data are invariably dated. Because of the time required for data gathering, data analyses, document composition, and time to publication, meta-analyses do not include more recent research. The same goes for systematized reviews. The Hoffman et al. review dates from 2018, already at least five years old. 2. The dependence upon other groups' reviews, with little guideline panel delving into the primary literature, amounts to an organizational rubber stamping of borrowed work. When other organizations, such as the American Psychiatric Association, employ systematized reviews, they commission their own, including in them issues that other reviewers may not have considered but which have relevance to the field. It's the task of the treatment panel, who are experts in the field, to search for individual studies and reviews. In my time on the panel (admittedly early in the process), this responsibility did not seem to be emphasized. Rather, the plan was to focus on extant reviews. To put an organizational imprimatur on borrowed work diminishes the stature of the treatment guidelines and the organization.	healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. The panel understands that the AHRQ review has approached the five-year mark and therefore will be supplementing reviews published within the last five years for more updated information. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ References: Institute of Medicine. (2011). Finding what works in health care: Standards for systematic reviews. National Academies Press. https://doi.org/10.17226/13059 Shea, B. J., Reeves, B. C., Wells, G., Thuk, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E., & Henry, D. A. (2017). AMSTAR2: a critical appraisal tool

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Commenter (Group or Individual?)	Comment	Panel Response
		for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. BMJ, 358, Article j4008. https://doi.org/10.1136/bmj.j4008

9. Comments on the Primary Review (AHRQ, Hoffman et al., 2018)

Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
Christine A. Courtois, PhD (Individual)	Generally, I agree	If any available updates are completed during the course of the GUP's work, I suggest referring to them as well. See comment above about ongoing simultaneous review of in press or newly published research.	Thank you for your comment.
Ad de Jongh, Ph.D. (Group: PSYTREC – PsychoTrauma Expertise Centre)	I have concerns	We enthusiastically support an update to the guideline and believe it is timely. We are generally positive about the proposals for collating and reviewing the extant literature using the AHRQ reviews. The years since the last APA guidelines have seen important developments in the understanding and treatment of PTSD, building on the existing evidence base for several trauma-focused therapies. Recent research has produced innovations in modes of treatment delivery including digital, virtual reality, time-intensive and therapist-assisted treatments. There have been renewed efforts to adapt and test evidence-based treatments for specific populations such as refugees, military populations, survivors of childhood abuse, patients with comorbid conditions including personality disorders and people exposed to work-related trauma. Alongside this is emerging evidence for early and preventative treatments, and for the efficacy of existing treatments in treating complex PTSD presentations. Also, there have been important methodological innovations over the last few years, including more use of active controls, head-to-head treatment comparisons, network meta-analysis (NMA) and cost-effectiveness studies.	Thank you for your comments. The panel agrees there have been important methodological innovations in recent years including the use of active controls, head-to-head treatment comparisons, network meta-analyses. The panel feels these topics are included in the systematic reviews identified; however, the issue of cost-effectiveness is outside the scope of the guideline. The panel agrees that this is a rapidly developing area, and to the extent possible, updated information that meets quality criteria, if available and feasible, will be incorporated in the guideline document to the extent possible.

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Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
		We hope the updated guideline can review, and where possible, make recommendations in all these areas. We are pleased to see therefore, that the guideline committee has chosen to include seven additional systematic reviews to address gaps in the AHRQ 2018 review; and to support more robust recommendations on the comparative benefits of different treatments. As you say, the seven proposed additional reviews vary in their quality. We wish to raise some issues with a couple of these and make some suggestions for alternatives. Final note – updating reviews As this is a rapidly developing area, we recommend that additional surveys of the literature are carried out next year to update the AHRQ review alongside, and to perform network meta-analyses that include these studies.	
Janice Muhr (Group: Psychotherapy Action Network)	I have concerns	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	As a PsiAN board member I am in agreement with the the comments submitted by this organization challenging the above.	Thank you for your comment.
Les R. Greene (Individual)	I have concerns	In the paper I cited in an earlier comment, two extensive reviews of the group psychotherapy research literature for ptsd might be considered for inclusion.	Thank you for your comment. The panel agrees that consideration of group psychotherapy for PTSD is important to address and feels this mode of intervention is included in the systematic reviews identified.
Guldeniz Yucelen, Psy.D. (Individual)	I have concerns	This study excludes other important findings from qualitative and clinical studies, resulting in a biased summary of what works with PTSD based on research studies that have strict inclusion and	Thank you for your comment. APA's clinical practice guideline development processes have safeguards in place to protect

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Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
		exclusion criteria, and uses statistical methods that support their hypothesis.	against bias. As you may be aware, the APA uses reviews that meet the Institute of Medicine (2011; now National Academy of Medicine) standards for developing systematic reviews or that have been subjected to a quality review using the AMSTAR-2 instrument (Shea et al., 2017). Information from other types of studies such as observational studies and clinician and patient input, following best practices, can be used to provide information on potential harms and burdens and patients' values and preferences. References: Institute of Medicine. (2011). <i>Finding what works in health care: Standards for systematic reviews</i>. National Academies Press. https://doi.org/10.17226/13059 Shea, B. J., Reeves, B. C., Wells, G., Thuk, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E., & Henry, D. A. (2017). AMSTAR2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. <i>BMJ</i>, 358, Article j4008. https://doi.org/10.1136/bmj.j4008
Joan Monahan, LPC (Individual)	I have concerns	Future research is needed and should continue to monitor the efficacy of pharmacologic and nonpharmacologic treatments for PTSD. This can address the gaps in the literature.	Thank you for your comment. The panel will include a call for future research in the guideline document.

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Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
Tiffany Crawshaw (Individual)	I have concerns	Studies that are inconclusive? Why?	Thank you for your comment. APA's clinical practice guideline development processes used are to ensure the highest quality research and that resulting guidelines are reliable and trustworthy. As you may be aware, the APA uses reviews that meet the Institute of Medicine (2011; now National Academy of Medicine) standards for developing systematic reviews or that have been subjected to a quality review using the AMSTAR-2 instrument (Shea et al., 2017).
Steven Marcus Ph.D. (Individual)	Generally, I agree	Small number of studies or meta-analysis	Thank you for your comment.
Judy Greenberger (Individual)	I have concerns	Limited.	Thank you for your review.
Courtney Worley (Individual)	Generally, I agree	This Hoffman article was published in 2018 and did not have an opportunity to include the results of several seminal trials including a CPT and WET non-inferiority trial. Sloan, D. M., Marx, B. P., Lee, D. J., & Resick, P. A. (2018). A brief exposure based treatment for PTSD versus Cognitive Processing Therapy: A randomized non-inferiority clinical trial. <i>JAMA Psychiatry</i>, 75(3), 233-239. https://doi.org/10.1001/jamapsychiatry.2017.4249 Sloan, D. M., Marx, B. P., Resick, P. A., Young-McCaughan, S., Dondaville, K. A., Straud, C. L., Mintz, J., Litz, B., & Peterson, A. L., for the STRONG STAR Consortium (2022). Effect of Written Exposure Therapy versus Cognitive Processing Therapy on increasing treatment efficiency among military Service members: A randomized noninferiority trial. <i>JAMA Network Open</i>, 5(1), e2140911. https://doi.org/10.1001/jamanetworkopen.2021.40911	Thank you for your comments and references. The panel agrees that GUP considers reviews conducted in the last five years and is only including reviews that are published within that timeframe. While Hoffman (2018) nears that timeframe's limit, its quality as a systematic review is high; other reviews have been included to address any concerns about recency. The panel agrees that consideration of Written Exposure Therapy is important, and to the extent there is sufficient evidence in the identified reviews, this will be discussed in the updated guideline document.

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Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
		Additional citations related to WET in Active Duty and Veteran samples, and telemental health delivery include, but are not limited to the following: Sloan, D. M., Marx, B. P., Acierno, R., Messina, M. & Cole, T. A. (2021). Comparing Written Exposure Therapy to Prolonged Exposure for the treatment of PTSD in a Veteran sample: A non-inferiority randomized design. <i>Contemporary Clinical Trials Communications</i>, 22, 100764. https://doi.org/10.1016/j.conctc.2021.100764 LoSavio, S. T., Worley, C. B., Aajmain, S., Rosen, C., Stirman, S. W., & Sloan, D. M. (2021). Effectiveness of Written Exposure Therapy for posttraumatic stress disorder in the Department of Veterans Affairs Healthcare System. <i>Psychological Trauma: Theory, Research, Practice, and Policy</i>. Advance online publication. https://dx.doi.org/10.1037/tra0001148	
David Emerson (Group: Center for Trauma and Embodiment at Justice Resource Institute)	I have concerns	I would like to propose, in addition to the above, that the panel consider the following meta-analysis: Taylor, J., McLean, L., Korner, A., Stratton, E., & Glozier, N. (2020). Mindfulness and yoga for psychological trauma: systematic review and meta-analysis. <i>Journal of Trauma & Dissociation</i>, 21(5), 536-573. Link As well as specific research on TCTSY: van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. <i>The Journal of Clinical Psychiatry</i>, 75(6), Article 22573. Link and: Kelly, U., Haywood, T., Segell, E., & Higgins, M. (2021). Trauma-sensitive yoga for post-traumatic stress disorder in women Veterans who experienced military sexual trauma: Interim results from a	Thank you for your comment and for sharing with us these references. In the guidelines, we will be including systematic reviews that include yoga for PTSD. Individual RCT studies such as this will add to the panels understanding of effectiveness of these interventions.

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Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
		randomized controlled trial. <i>The Journal of Alternative and Complementary Medicine</i>, 27(Supp. 1), S45-S59. Link And: Price, M., Spinazzola, J., Musicaro, R., Turner, J., Suvak, M., Emerson, D., & van der Kolk, B. (2017). Effectiveness of an extended yoga treatment for women with chronic posttraumatic stress disorder. <i>Journal of Alternative and Complementary Medicine</i>, 23(4), 300-309. Link. And: Neukirch, N., Reid, S., & Shires, A. (2019). Yoga for PTSD and the role of interoceptive awareness: A preliminary mixed-methods case series study. <i>European Journal of Trauma & Dissociation</i>, 3(1), 7-15. Link And: Cattie, J. E., Allbaugh, L. J., Visser, K. H., Ander, I., & Kaslow, N. J. (2021). Tailoring trauma-sensitive yoga for high-risk populations in public-sector settings. <i>International Journal of Yoga Therapy</i>, 31(1), Article 15. Link	
Barbara Milrod, M.D. (Individual)	I have concerns	Meta-data, no matter how thorough they try to be, cannot capture study quality and study details. This was an unacceptable design choice. The laziness of this committee is shocking.	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount

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Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
			of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Further, each study must meet certain quality criteria in order to be included in the reviews. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Debra Kaysen (Individual)	I have concerns	I have some concerns about whether these reviews are adequately capturing non-Western-based publications or research conducted in LMIC's. If not, then this should be listed as a limitation or scoping issue. Couple of other reviews/meta-analyses to consider. Jericho, B., Luo, A., & Berle, D. (2022). Trauma-focused psychotherapies for post-traumatic stress disorder: A systematic	Thank you for your comments and references. Please note that the Jericho et al 2022 systematic review and network meta-analysis you recommended is already among the reviews chosen by the panel. However, based on your and others' recommendations, the panel has decided to re-consider the Mavranezouli et al 2020 systematic review. With regard to Kitchener et al

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Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
		review and network meta-analysis. <i>Acta Psychiatrica Scandinavica</i>, 145(2), 132-155. Kitchiner, N. J., Lewis, C., Roberts, N. P., & Bisson, J. I. (2019). Active duty and ex-serving military personnel with post-traumatic stress disorder treated with psychological therapies: systematic review and meta-analysis. <i>European journal of psychotraumatology</i>, 10(1), 1684226. Mavranezouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., ... & Pilling, S. (2020). Psychological treatments for post-traumatic stress disorder in adults: A network meta-analysis. <i>Psychological Medicine</i>, 50(4), 542-555. Lewis, C., Roberts, N. P., Andrew, M., Starling, E., & Bisson, J. I. (2020). Psychological therapies for post-traumatic stress disorder in adults: Systematic review and meta-analysis. <i>European journal of psychotraumatology</i>, 11(1), 1729633.	2019, while the panel is aware the Hoffman et al 2018 study (already chosen for the update process) pre-dates Kitchener, Hoffman's quality is indisputable and its coverage matches identified PICOTS well. With regard to Lewis et al 2020, the panel feels other, more recent reviews address the issues in Lewis.
Denise Sloan (Individual)	Generally, I agree	Some of the reviews listed have inaccurate information. For instance, Jericho et al. 2022 listed a Sloan et al. study 2011 as investigating WET but this study investigated expressive writing, not WET.	Thank you for your review. The panel will consider this when making recommendations. The panel also supplemented a recent review conducted by DeJesus and colleagues (2024) that will serve as the underlying evidence for recommendation statements. Reference DeJesus, C. R., Trendel, S. L., & Sloan, D. M. (2024). A systematic review of Written Exposure Therapy for the treatment of posttraumatic stress symptoms. <i>Psychological Trauma: Theory, Research, Practice, and Policy</i>. Advance online

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Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
			publication. https://dx.doi.org/10.1037/tra0001659
Denise Sloan (Individual)	Generally, I agree	As previously noted, some of the reviews have inaccurate information.	Thank you for your comment. APA uses reviews that meet the Institute of Medicine (2011; now National Academy of Medicine) standards for developing systematic reviews or that have been subjected to a quality review using the AMSTAR-2 instrument (Shea et al., 2017). Individual studies must also meet certain quality criteria in order to be included in the reviews. References: Institute of Medicine. (2011). <i>Finding what works in health care: Standards for systematic reviews</i>. National Academies Press. https://doi.org/10.17226/13059 Shea, B. J., Reeves, B. C., Wells, G., Thuk, M., Hamel, C., Moran, J., Moher, D., Tugwell, P., Welch, V., Kristjansson, E., & Henry, D. A. (2017). AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. <i>BMJ</i>, 358, Article j4008. https://doi.org/10.1136/bmj.j4008
Edward Hunter (Individual)	I have concerns	Hoffman is old. Meta-analysis adds to the homogenization of conclusions on the individual differences/cultural level.	Thank you for your comments and references. The panel agrees that GUP consider reviews conducted in the last five years and is only including reviews that are published within that timeframe. While the Hoffman (2018) review nears that timeframe's limit, its quality as a systematic review is high; other reviews have

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Commenter (Group or Individual?)	Agreement with Primary Review?	Comment	Panel Response
			been included to address any concerns about recency. The panel agrees that it is important to ensure representation by diverse patient populations and feels such groups are included in the systematic reviews identified.

10. Supplemental Review 1 (Complex PTSD, affect dysregulation, and dissociation; Choi et al., 2020)

Commenter (Group or Individual?)	Agreement with Review 1?	Comment	Panel Response
Marylene Cloitre, PhD (Individual)	Generally, I agree	There are a couple more high quality systematic reviews which would be helpful. They are: Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., ... & Hutton, P. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and meta-analysis. <i>Psychological medicine</i>, 49(11), 1761-1775. Coventry, P. A., Meader, N., Melton, H., Temple, M., Dale, H., Wright, K., ... & Gilbody, S. (2020). Psychological and pharmacological interventions for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network meta-analysis. <i>PLoS medicine</i>, 17(8), e1003262.	Thank you for your comment. Karatzias (2019) has been reviewed by the panel and will be included in the final, small set of systematic reviews used to develop the guidelines.
Christine A. Courtois, PhD (Individual)	Generally, I agree	My concern is whether CPTSD is going to be given legitimacy in this guideline, and not just complex forms of PTSD Please be sure to add descriptions of similarities and differences between PTSD and CPTSD as described in the ICD diagnosis. Also include a description of the dissociative subtype of PTSD. I would also support more attention to dissociative aspects of PTSD and CPTSD as these have been found to interfere with or impede the effectiveness of some interventions, even some with strong evidence support.	Thank you for this comment. The panel will acknowledge and address similarities and differences among DSM-5 PTSD, ICD-11 simple PTSD, and ICD-11 complex PTSD in its final review.
Julian Ford (Individual)	I have concerns	This review should not be a basis for any conclusions about complex PTSD because it mixes together childhood-related PTSD with military-related and "multiple trauma types"	Thank you for this comment. The panel will acknowledge and address similarities and differences among DSM-5 PTSD, ICD-11 simple PTSD, and ICD-11 complex PTSD in its final review

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Commenter (Group or Individual?)	Agreement with Review 1?	Comment	Panel Response
			and refrain, when possible, from making “multiple trauma type” conclusions.
Michael Bowers (Group: EMDR International Association)	I have concerns	Choi, H., Lee, W., Heo, S., & Kim, J. (2020) this SR defines the population as experiencing a 'complex trauma' rather than using the ICD-11 diagnostic construct of complex PTSD. This definition potentially distorts the literature gap it seeks to fill. Karatzias et al (2019), while less recent, is broader in scope - it includes 51 RCT's vs 42 in Choi et al (2020) - and has far more citations (213 vs 4). Choi et al (2020) also does not include any studies not available to Karatzias (2019), hence conferring no benefit by being more recently published. We suggest either replacing Choi et al (2020) with the Karatzias et al (2019) SR, which more is more specific in reviewing only studies on patients meeting strict ICD-11 complex PTSD criteria. The reference for this is: Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., ... & Hutton, P. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and meta-analysis. <i>Psychological medicine</i>, 49(11), 1761-1775.	Thank you for your comment. Karatzias (2019) has been reviewed by the panel and will be included in the final, small set of systematic reviews used to develop the guidelines.
Ad de Jongh, Ph.D. (Group: PSYTREC – PsychoTrauma Expertise Centre)	I have concerns	Choi, H., Lee, W., Heo, S., & Kim, J. (2020) We agree that including an additional Systematic Review (SR) to ensure coverage of the emerging evidence around treatment of complex PTSD is very sensible. However, this SR defines the population by having experienced a 'complex trauma' rather than using the ICD-11 diagnostic construct of complex PTSD. This potentially distorts the literature gap it seeks to fill, in that its applicability to treatment of complex PTSD rests on the assumption that PTSD arising from 'complex traumas' is the same construct. There is good reason to argue this is not a valid assumption.	Thank you for your comment. Karatzias (2019) has been reviewed by the panel and will be included in the final, small set of systematic reviews used to develop the guidelines.

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Commenter (Group or Individual?)	Agreement with Review 1?	Comment	Panel Response
		Karatzias et al (2019), while less recent, is broader in scope - it includes 51 RCT's vs 42 in Choi et al (2020) - and has far more citations (213 vs 4). Choi et al (2020) also does not include any studies not available to Karatzias (2019), hence conferring no benefit by being more recently published. For these reasons, we suggest either replacing Choi et al (2020) with the Karatzias et al (2019) SR, which more is more specific in reviewing only studies on patients meeting strict ICD-11 complex PTSD criteria. The reference for this is: Karatzias, T., Murphy, P., Cloitre, M., Bisson, J., Roberts, N., Shevlin, M., ... & Hutton, P. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: Systematic review and meta-analysis. <i>Psychological medicine</i>, 49(11), 1761-1775. https://pubmed.ncbi.nlm.nih.gov/30857567/	
Janice Muhr (Group: Psychotherapy Action Network)	I have concerns	See comments at end.	Thank you for your review and feedback. Please refer to the response to your letter above.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	Once again, as a PsiAN board member I am in agreement with the statement its leaders submitted regarding the limited nature of the studies included.	Thank you for your comment. The panel continues to work diligently to identify requisite reviews that meet the objectives for the task at hand. Please see response to PsiAN comments in Section #1-A.
Assoc Prof Christopher Lee (Individual)	Generally, I agree	should also include Mavranouzouli, I., Megnin-Viggars, O., Grey, N., Bhutani, G., Leach, J., Daly, C., ... & Pilling, S. (2020). Cost-effectiveness of psychological treatments for post-traumatic stress disorder in adults. <i>PloS one</i>, 15(4), e0232245.	Thank you for your comment. We understand that cost-effectiveness is important, however it falls outside the scope of the framework. When the APA clinical practice guideline initiative was formed in 2010, the Advisory Steering Committee decided that the goal of the guideline

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Commenter (Group or Individual?)	Agreement with Review 1?	Comment	Panel Response
			recommendations would be based solely on the best available science. The recommendations could then be used to advocate for coverage of the best treatments.
Guldeniz Yucelen, Psy.D. (Individual)	I have concerns	Does not include somatic based therapies, which have been shown to work the best with PTSD symptoms.	Thank you for your comment. The panel recognizes somatic based therapies as a treatment option for PTSD and will make related comments in its final review.
Lori Woehler, PsyD (Individual)	I have concerns	The journal that published this article has a limited impact factor, small and regional scope of peer reviewers, and limited range of other factors associated with research quality.	All systematic reviews considered have gone through an AMSTAR-2 quality rating process. Their quality will be considered when making recommendations. Please note as well that Karatzias (2019) has been reviewed by the panel and will be included in the final, small set of systematic reviews used to develop the guidelines.
Joan Monahan, LPC (Individual)	I have concerns	Inclusion of additional systematic reviews. To possibly include some longitudinal qualitative and quantitative analysis.	Thank you for your comment. Karatzias (2019) has been reviewed by the panel and will be included in the final, small set of systematic reviews used to develop the guidelines.
Judy Greenberger (Individual)	Generally, I agree	There is so much research done by organizations like EMDRIA whose therapists do trauma work, so that there should be a wider array of research articles used. The Netherlands has done a lot of research on the treatment of developmental trauma. de Jong	We appreciate this recommendation. The guideline will use systematic reviews, reviewed based on AMSTAR quality standards and will include PTSD literature for trauma occurring during early child development.
Julie Koch (Group: Committee on Global Psychology)	Generally, I agree	The Committee on Global Psychology is pleased to see that you are including several reviews that are in journals not based in the US. We commend your inclusion of international journals and scholarships. This comment applies to the other reviews based on international work as well.	Thank you for your comment and support.
Viann Nguyen-Feng (Individual)	I have concerns	I cannot access this article through my R1 university library. The article quality and peer review process are questionable, as the journal is not	All systematic reviews considered have gone through an AMSTAR-2 quality rating process. Their quality will be considered when making

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Commenter (Group or Individual?)	Agreement with Review 1?	Comment	Panel Response
		even listed on SJR (Link). The article has been cited 0 times according to the journal's website.	recommendations. Choi et al (2020) was selected as it specifically examined complex PTSD constructs of interest including emotion regulation, interpersonal functioning, and disturbances in self. Please note as well that Karatzias (2019) has been reviewed by the panel and will be included in the final, small set of systematic reviews used to develop the guidelines.
David Emerson (Group: Center for Trauma and Embodiment at Justice Resource Institute)	I have concerns	I agree but feel it is limited with respect to our model, TCTSY, because the largest RCT to date was published in 2021: Kelly, U., Haywood, T., Segell, E., & Higgins, M. (2021). Trauma-sensitive yoga for post-traumatic stress disorder in women Veterans who experienced military sexual trauma: Interim results from a randomized controlled trial. <i>The Journal of Alternative and Complementary Medicine</i>, 27(Supp. 1), S45-S59. Link	Thank you for your recommendation and we will keep this study in mind. In the guidelines, we will be using systematic reviews that include yoga for PTSD. Individual RCT studies such as this will add to the panels understanding of effectiveness of these interventions.
Barbara Milrod, M.D. (Individual)	I have concerns	Ditto above. ORIGINAL RCT DATA SHOULD HAVE BEEN EMPLOYED EVEN THOUGH IT WOULD HAVE REQUIRED MORE WORK and a better grasp of the moving parts of RCTs. For shame.	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns

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Commenter (Group or Individual?)	Agreement with Review 1?	Comment	Panel Response
			for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ The panel will further clarify in the guideline document that the 2018 AHRQ review will serve as the primary evidence base but that it then nominated several newer systematic reviews to meet the gaps that were identified in the primary review and include updated information. As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Denise Sloan (Individual)	Generally, I agree	There have been a number of important RCT studies published since this review so an updated literature search should be conducted.	We appreciate this comment and are limited to the use of published systematic reviews for the main review. Individual, more recent, RCT studies will add to the panels understanding of effectiveness of these interventions. The panel will consider doing a final update search before publishing the final guideline draft.

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Commenter (Group or Individual?)	Agreement with Review 1?	Comment	Panel Response
Edward Hunter (Individual)	I have concerns	Some consideration of culture.	Thank you for your comment; indeed, the panel will acknowledge and address considerations of culture in its final review.

10-A. Other Reviews or Studies on Complex PTSD

Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
Christine A. Courtois, PhD (Individual)	Karatzias, T., Murphy, P., Cloitre, M., & Bisson, J. (2019). Psychological interventions for ICD-11 complex PTSD symptoms: systematic review and meta-analysis. <i>Psychological Medicine</i>, 49(11), 1761-1775. DOI: http://doi.org/10.1017/S0033291719000436. Bisson, J. Ehlers, A., Matthews, R. & Pilling, S. (2007). Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta analysis. <i>The British Journal of Psychiatry</i>, 190(2), 97-104. DOI: https://doi.org/10.1192/bjp.bp.106.021402. Coventry, P. A., Meader, N., Melton, H., Temple, M., Dale., Wright, K., et al. (2020). Psychological and pharmacological intervention for posttraumatic stress disorder and comorbid mental health problems following complex traumatic events: Systematic review and component network analysis. <i>PloS Med</i> 17(8): e1003262. https://doi.org/10.1371/journal.pmed.1003262 Gathier, Anouk W; Verhoeven, Josine E; van Oppen, Patricia C; Penninx, Brenda W. J. H; Merckx, Maarten J. M; Dingemans, Pieter; Stehouwer, Kim M. K. S; van den Bulck, Carmen M. M; Vinkers, Christiaan H. (2023) Design and rationale of the restoring mood after early life trauma with psychotherapy (RESET-psychotherapy) study: A multicenter randomized controlled trial on the efficacy	Thank you for these recommendations. Karatzias (2019) has been reviewed by the panel and will be included in the final, small set of systematic reviews used to develop the guideline. Coventry et al. (2020) was identified in the initial scoping and carefully reviewed. Bison et al. (2018) was published close to the date of the original PTSD panel and its studies are included well included as part of the AHRQ systematic review that will form the basis of the update. Ultimately the panel was limited to studies that were identified and included in the existing systematic reviews and meta-analyses that serve as the underlying evidence base.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	of adjunctive trauma-focused therapy (TFT) versus treatment as usual (TAU) for adult patients with major depressive disorder (MDD) and childhood trauma. BMC Psychiatry. Vol.23 AN: 2023-39753-001	
Michael Bowers (Group: EMDR International Association)	Important studies that require special attention We would ask you to pay attention to several recent well-performed studies, specifically testing psychological treatments with patients meeting strict complex PTSD criteria: - Bohus, M., Schmahl, C., Fydrich, T., Steil, R., Müller-Engelmann, M., Herzog, J., ... & Priebe, K. (2019). A research programme to evaluate DBT-PTSD, a modular treatment approach for Complex PTSD after childhood abuse. <i>Borderline personality disorder and emotion dysregulation</i>, 6(1), 1-16. - Boterhoven de Haan, K. L., Lee, C. W., Fassbinder, E., van Es, S. M., Menninga, S., Meewisse, M. L., . . . Arntz, A. (2020). Imagery rescripting and eye movement desensitisation and reprocessing as treatment for adults with post-traumatic stress disorder from childhood trauma: randomised clinical trial. <i>Br J Psychiatry</i>, 1-7. doi:10.1192/bjp.2020.158 - Hoeboer, C. M., de Kleine, R. A., Oprel, D. A., Schoorl, M., van der Does, W., & van Minnen, A. (2021). Does complex PTSD predict or moderate treatment outcomes of three variants of exposure therapy?. <i>Journal of Anxiety Disorders</i>, 80, 102388 - van Vliet, N. I., Huntjens, R. J. C., van Dijk, M. K., Bachrach, N., Meewisse, M.-L., & de Jongh, A. (2021). Phase-based treatment versus immediate trauma-focused treatment for post-traumatic stress disorder due to childhood abuse: randomised clinical trial. <i>BJPsych Open</i>, 7(6), e211. doi:10.1192/bjo.2021.1057	Thank you for these recommended randomized control trials. Ultimately the panel was limited to studies that were identified and included in the existing systematic reviews and meta-analyses that serve as the underlying evidence base.
Ad de Jongh, Ph.D. (Group: PSYTREC – PsychoTrauma Expertise Centre)	Important studies that require special attention We would ask you to pay attention to several recent well-performed studies, specifically testing psychological treatments with patients meeting strict complex PTSD criteria:	Thank you for these recommended randomized control trials. Ultimately the panel was limited to studies that were identified and included in the existing systematic reviews and meta-analyses that serve as the underlying evidence base.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	- Bohus, M., Schmahl, C., Fydrich, T., Steil, R., Müller-Engelmann, M., Herzog, J., ... & Priebe, K. (2019). A research programme to evaluate DBT-PTSD, a modular treatment approach for Complex PTSD after childhood abuse. <i>Borderline personality disorder and emotion dysregulation</i>, 6(1), 1-16. https://pubmed.ncbi.nlm.nih.gov/30873283/ - Boterhoven de Haan, K. L., Lee, C. W., Fassbinder, E., van Es, S. M., Menninga, S., Meewisse, M. L., . . . Arntz, A. (2020). Imagery rescripting and eye movement desensitisation and reprocessing as treatment for adults with post-traumatic stress disorder from childhood trauma: randomised clinical trial. <i>Br J Psychiatry</i>, 1-7. doi:10.1192/bjp.2020.158 https://cris.maastrichtuniversity.nl/en/publications/imagery-rescripting-and-eye-movement-desensitisation-and-reproces-2 - Hoeboer, C. M., de Kleine, R. A., Oprel, D. A., Schoorl, M., van der Does, W., & van Minnen, A. (2021). Does complex PTSD predict or moderate treatment outcomes of three variants of exposure therapy?. <i>Journal of Anxiety Disorders</i>, 80, 102388 https://www.sciencedirect.com/science/article/pii/S0887618521000359 - van Vliet, N. I., Huntjens, R. J. C., van Dijk, M. K., Bachrach, N., Meewisse, M.-L., & de Jongh, A. (2021). Phase-based treatment versus immediate trauma-focused treatment for post-traumatic stress disorder due to childhood abuse: randomised clinical trial. <i>BJPsych Open</i>, 7(6), e211. doi:10.1192/bjo.2021.1057 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8612023/	
Jamie Miller (Individual)	The following meta-analysis should also be included. Sherman AD, Balthazar M, Zhang W, Febres-Cordero S, Clark KD, Klepper M, Coleman M, Kelly U. Seeking safety intervention for comorbid post-traumatic stress and substance use disorder: A meta-analysis. <i>Brain and Behavior</i>. 2023 Apr 10:e2999.	Thank you for this recommendation. Systematic reviews focusing on specific therapies alone were not selected to be part of the main review. That said, reviews such as this one will help inform discussion of treatment effectiveness and moderators particularly for co-occurring substance use disorders.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
Enrico Gnaulati Ph.D. (Individual)	It is important that the GUP continue to pay heed to some of the ethical concerns associated with current APA approved PTSD txs outlined in my article: Gnaulati E. Potential ethical pitfalls and dilemmas in the promotion and use of American Psychological Association-recommended treatments for posttraumatic stress disorder. <i>Psychotherapy (Chic)</i> . 2019 Sep;56(3):374-382. doi: 10.1037/pst0000235. PMID: 31282713.	Thank you for your comment. The panel will review the concerns noted in the 2019 special issue of <i>Psychotherapy</i> edited by Courtois & Brown.
Gagnon. Andre (Individual)	I suggest that the analysis and conclusions of different health agency regarding SSPT should be at least looked at: Israel, UK, INSERM in France, Germany, Holland to name some.	Thank you for your comment and for sharing with us these resources. The panel will discuss comparisons with conclusions from other guidelines from other organizations and countries in its final guideline document.
Guldeniz Yucelen, Psy.D. (Individual)	A Pilot RCT of A Body-Oriented Group Therapy For Complex Trauma Survivors: An Adaptation of Sensorimotor Psychotherapy Catherine C. Classen , PhD,Lesley Hughes , MSW,Carrie Clark , PsyD,Bonilyn Hill Mohammed , MEd,Patricia Woods , RN &Brendan Beckett , BA Pages 52-68 Received 11 Jan 2020, Accepted 29 Feb 2020, Published online: 18 May 2020	Thank you for these recommended articles. The panel update will be basing its recommendations on systematic reviews, rather than individual studies. However, individual studies such as the one suggested here will provide important information for moderating effects of treatment.
D Wagner LMFT (Individual)	Having specialized in mostly C-PTSD, dissociative disorders with attachment issues for 13 years utilizing primarily psychodynamic theory and EMDR therapy with Structural Dissociation as primary interventions, the efficacy of this constellation of interventions has proven to be clinically significant in resolving trauma. Use of CBT, DBT, and family systems to augment primary interventions has contributed to longterm resolution and tremendous decrease in treatment recidivism.	Thank you for your comment. We have included a review that will allow us to look at augmentation strategies and will also be able to comment on this in the final review.
Jennifer West, Ph.D. (Individual)	There is significant data suggesting that body-based frameworks are critical in the treatment of PTSD and complex trauma. In particular, Trauma Center Trauma Sensitive Yoga (TCTSY) has been found to offer significant benefit to healing and growth in various populations, and has demonstrated positive treatment outcomes even in cases of treatment-resistant PTSD. Listed below are a sample of studies, including RCTs, regarding TCTSY. Please note, all of these studies are about TCTSY specifically, though some use the terminology "trauma sensitive yoga" in lieu of TCTSY.	Thank you for these recommended articles. The panel recognizes trauma-informed yoga therapies as treatment options for PTSD and will make related comments in its final review.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	Cattie, J. E., Allbaugh, L. J., Visser, K. H., Ander, I., & Kaslow, N. J. (2021). Tailoring trauma-sensitive yoga for high-risk populations in public-sector settings. <i>International Journal of Yoga Therapy</i>, 31(1), Article 15. Link Kelly, U., Haywood, T., Segell, E., & Higgins, M. (2021). Trauma-sensitive yoga for post-traumatic stress disorder in women Veterans who experienced military sexual trauma: Interim results from a randomized controlled trial. <i>The Journal of Alternative and Complementary Medicine</i>, 27(Supp. 1), S45-S59. Link West, J., Liang, B., & Spinazzola, J. (2017). Trauma sensitive yoga as a complementary treatment for posttraumatic stress disorder: A qualitative descriptive analysis. <i>International Journal of Stress Management</i>, 24(2), 173-195. Link Price, M., Spinazzola, J., Musicaro, R., Turner, J., Suvak, M., Emerson, D., & van der Kolk, B. (2017). Effectiveness of an extended yoga treatment for women with chronic posttraumatic stress disorder. <i>Journal of Alternative and Complementary Medicine</i>, 23(4), 300-309. Link van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. <i>The Journal of Clinical Psychiatry</i>, 75(6), Article 22573. Link	
David Emerson (Group: Center for Trauma and Embodiment at Justice Resource Institute)	yes, thank you. These studies all refer to the model Trauma Center Trauma Sensitive Yoga (TCTS) though some use the general terminology "trauma sensitive yoga": Price, M., Spinazzola, J., Musicaro, R., Turner, J., Suvak, M., Emerson, D., & van der Kolk, B. (2017). Effectiveness of an extended yoga treatment for women with chronic posttraumatic stress disorder. <i>Journal of Alternative and Complementary Medicine</i>, 23(4), 300-309. Link.	Thank you for these recommended articles. The panel recognizes trauma-informed/trauma sensitive yoga therapies as treatment options for PTSD and will make related comments in its final review.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. <i>The Journal of Clinical Psychiatry</i>, 75(6), Article 22573. Link West, J., Liang, B., & Spinazzola, J. (2017). Trauma sensitive yoga as a complementary treatment for posttraumatic stress disorder: A qualitative descriptive analysis. <i>International Journal of Stress Management</i>, 24(2), 173-195. Link Kelly, U., Haywood, T., Segell, E., & Higgins, M. (2021). Trauma-sensitive yoga for post-traumatic stress disorder in women Veterans who experienced military sexual trauma: Interim results from a randomized controlled trial. <i>The Journal of Alternative and Complementary Medicine</i>, 27(Supp. 1), S45-S59. Link Cattie, J. E., Allbaugh, L. J., Visser, K. H., Ander, I., & Kaslow, N. J. (2021). Tailoring trauma-sensitive yoga for high-risk populations in public-sector settings. <i>International Journal of Yoga Therapy</i>, 31(1), Article 15. Link	

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11. Supplemental Review 2 (Pharmacological augmentation interventions; Hoskins et al., 2021)

Commenter (Group or Individual?)	Agreement with Review 2?	Comment	Panel Response
Janice Muhr (Group: Psychotherapy Action Network)	I have concerns	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	Once again, as a PsiAN board member I am in agreement with the statement its leaders submitted regarding the limited nature of the studies included.	Thank you for your feedback. Please see Section #1-A for a response to your feedback.
Tiffany Crawshaw (Individual)	I have concerns	This study says only included an N=5 for pharmaco vs. psychotherapy. It would seem APA would want a better comparison.	There are only a limited number of large scales randomized controlled trials that directly compare pharmacotherapy versus psychotherapy for the treatment of PTSD. Through the systematic reviews, we will carefully examine this comparison and should be able to comment on it in the final review.
Barbara Milrod, M.D. (Individual)	I have concerns	I do not think there is ANY place for meta-data or systematic reviews in treatment guidelines. For shame.	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the

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Commenter (Group or Individual?)	Agreement with Review 2?	Comment	Panel Response
			systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Edward Hunter (Individual)	I have concerns	All of this is based on an outmoded medical model of evaluating outcomes and what constitutes the intervention.	Thank you for your feedback. The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association.

12. Supplemental Review 3 (Overall update of the literature; Jericho et al., 2022)

Commenter (Group or Individual?)	Agreement with Review 3?	Comment	Panel Response
Christine A. Courtois, PhD (Individual)	Generally, I agree	Good to have network meta-analysis.	Thank you for your comment.
Michael Bowers (Group: EMDR International Association)	I have concerns	Jericho, Luo & Berle 2022 This is probably the most recent network meta-analysis (NMA) that has been published, and in that respect fulfils a very important role in supporting direct comparison between treatments, as well as potentially including up-to-date literature that the AHRQ review excludes. Its other strength is that differentiates between types of trauma-focused CBT's, unlike earlier NMA's such as Mavranezouli et al (2020). This aligns it with the approach of the previous APA guideline, that makes specific recommendations for different kinds of trauma-focused CBT, unlike the NICE (2018) guidelines that grouped them together. However, there are significant issues with the Jericho et al (2022) NMA that we think makes it unsuitable for supporting the goals of the update. In particular, and comparing it to the Mavranezouli et al (2020) NMA: - It includes fewer studies and participants in total (82 vs 90 trials, 5838 vs 6560 participants, 17 vs 22 interventions). - It makes no differentiation by the relative number of trials/participants for each intervention. This results in somewhat surprising findings that somewhat lack ecological validity. For example, metacognitive therapy, a treatment that is not routinely delivered anywhere outside of the setting in which it was developed, was found to be the most effective treatment based on two trials of fewer than	We agree that Jericho et al. (2022) is one of the most recent meta-analyses and that it differentiates different types of CBT. The former reasons were one of the main reasons this review was included, to be sure to have more recent wide scoping of randomized control trials. We further agree that there are known problems with network meta-analyses beyond more standard meta-analyses and for that reason, including some of the ones stated here, conclusions will be carefully vetted.

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Commenter (Group or Individual?)	Agreement with Review 3?	Comment	Panel Response
		11 participants in each arm. Given that small trials generally produce larger effects, this in our view severely limits the generalisability of the review. - It is also far less comprehensive in the range of treatments it surveys outside of CBT – for example, it does not include any group, digital, or guided self-help treatments, DBT or mindfulness based therapy. - Conversely it includes studies where the active arm is either an ACTIVE only or an ACTIVE + TAU. This is in direct contrast to Mavranouzouli et al (2020) where ACTIVE + TAU studies were excluded to prevents threats to the validity of the NMA comparisons. - It does not include longer-term follow up comparisons or remission comparisons. - It includes, at most, four studies that were too recent to be included in Mavranouzouli et al (2020), so in essence its later publication date is of limited benefit in improving up-to date scope. In our view, the relative benefit of Jericho et al (2022) in separating different kinds of trauma-focused CBT is outweighed by these validity issues, especially given it is unlikely to yield any changes to the already strong recommendations for several trauma focused CBT's. We would therefore recommend that the guideline update committee either replace Jericho et al's NMA with Mavranouzouli et al (2020), or at the very least include both to ensure both scope and rigour to recommendations on relative strengths of the full range of psychological treatments. The reference for this is:	

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Commenter (Group or Individual?)	Agreement with Review 3?	Comment	Panel Response
		Mavranetzouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., ... & Pilling, S. (2020). Psychological treatments for post-traumatic stress disorder in adults: A network meta-analysis. <i>Psychological Medicine</i> , 50(4), 542-555.	
Ad de Jongh, Ph.D. (Group: PSYTREC – PsychoTrauma Expertise Centre)	I have concerns	Jericho, Luo & Berle (2022) This is probably the most recent network meta-analysis (NMA) that has been published, and in that respect fulfils a very important role in supporting direct comparison between treatments, as well as potentially including up-to-date literature that the AHRQ review excludes. Its other strength is that differentiates between types of trauma-focused CBT's, unlike earlier NMA's such as Mavranetzouli et al (2020). This aligns it with the approach of the previous APA guideline, that makes specific recommendations for different kinds of trauma-focused CBT, unlike the NICE (2018) guidelines that grouped them together. However, there are significant issues with the Jericho et al (2022) NMA that we think makes it unsuitable for supporting the goals of the update. In particular, and comparing it to the Mavranetzouli et al (2020) NMA: - It includes fewer studies and participants in total (82 vs 90 trials, 5838 vs 6560 participants, 17 vs 22 interventions). - It makes no differentiation by the relative number of trials/participants for each intervention. This results in somewhat surprising findings that somewhat lack ecological validity. For example, metacognitive therapy, a treatment that is not routinely delivered anywhere outside of the setting in which it was developed, was found to be the most effective treatment based on two trials of fewer than 11 participants in each arm. Given that small trials generally produce	We agree that Jericho et al. (2022) is one of the most recent meta-analyses and that it differentiates different types of CBT. The former reasons were one of the main reasons this review was included, to be sure to have more recent wide scoping of randomized control trials. We further agree that there are known problems with network meta-analyses beyond more standard meta-analyses and for that reason, including some of the ones stated here, conclusions will be carefully vetted.

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Commenter (Group or Individual?)	Agreement with Review 3?	Comment	Panel Response
		larger effects, this in our view severely limits the generalisability of the review. - It is also far less comprehensive in the range of treatments it surveys outside of CBT – for example, it does not include any group, digital, or guided self-help treatments, DBT or mindfulness based therapy. - Conversely it includes studies where the active arm is either an ACTIVE only or an ACTIVE + TAU. This is in direct contrast to Mavranouzouli et al (2020) where ACTIVE + TAU studies were excluded to prevents threats to the validity of the NMA comparisons. - It does not include longer-term follow up comparisons or remission comparisons. - It includes, at most, four studies that were too recent to be included in Mavranouzouli et al (2020), so in essence its later publication date is of limited benefit in improving up-to date scope. In our view, the relative benefit of Jericho et al (2022) in separating different kinds of trauma-focused CBT is outweighed by these validity issues, especially given it is unlikely to yield any changes to the already strong recommendations for several trauma focused CBT's. We would therefore recommend that the guideline update committee either replace Jericho et al's NMA with Mavranouzouli et al (2020), or at the very least include both to ensure both scope and rigour to recommendations on relative strengths of the full range of psychological treatments. The reference for this is: Mavranouzouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., ... & Pilling, S. (2020). Psychological treatments for post-	

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Commenter (Group or Individual?)	Agreement with Review 3?	Comment	Panel Response
		traumatic stress disorder in adults: A network meta-analysis. Psychological Medicine, 50(4), 542-555. https://pubmed.ncbi.nlm.nih.gov/32063234/	
Janice Muhr (Group: Psychotherapy Action Network)	I have concerns	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	Once again, as a PsiAN board member I am in agreement with the statement its leaders submitted regarding the limited nature of the studies included.	Thank you for your feedback. Please refer to the detailed response to the submitted letter.
Assoc Prof Christopher Lee (Individual)	Generally, I agree	should also include the following network analysis as it includes more studies Mavranetzouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., . . . Pilling, S. (2020). Psychological treatments for post-traumatic stress disorder in adults: a network meta-analysis. Psychol Med, 50(4), 542-555. doi:10.1017/S0033291720000070	Thank you for this suggestion. We did carefully consider Mavranetzouli et al. (2020). We also looked at inclusion/exclusion criteria for these meta-analyses and sought to match them as closely as possible to our scoping (PICOTS). Because of the desire to have more recent literature included, Jericho et al. (2022) was selected.
Elan Shapiro (Individual)	I have concerns	I would like to see more recent publications included and as close to the current date as possible - this meta-analysis only looked at studies till 21 January 2020 -much has been published in the last 3 years	We are unaware of another more recent network meta-analysis regarding PTSD treatment and at some point, had to set a cutoff date for systematic reviews to be considered. One of the limitations of our process is indeed that more recent RCT studies may not be included, as they have not yet been included in systematic reviews. There will be a place in the report where we can discuss this and the emerging literature.
Guldeniz Yucelen, Psy.D. (Individual)	I have concerns	Excludes Sensorimotor Psychotherapy and other body based modalities due to lack of controlled studies. Although these approaches work very well with PTSD, it is an individualized treatment modality and difficult to compartmentalize with controlled studies.	Randomized controlled trials are part of the scoping for this review and accordingly many non-controlled trials will not be part of the formal review. However, there will be a place in the

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Commenter (Group or Individual?)	Agreement with Review 3?	Comment	Panel Response
			report where we can discuss this and the emerging literature.
Steven Marcus Ph.D. (Individual)	Generally, I agree	Limited review	The Panel's review will include the large AHRQ systematic review on PTSD as its basis. These additional systematic reviews were selected to address potential gaps in the AHRQ review. The panel has done a detailed search of the recent literature and selected key reviews to add where there were gaps. Not all gaps can be filled and not every systematic review conducted was selected for focus due to potential overlap or non-match with the scoping of the review (PICOTS).
Judy Greenberger (Individual)	Generally, I agree	Already mentioned that there needs to be a wider search of the literature.	The Panel's review will include the large AHRQ systematic review on PTSD as its basis. These additional systematic reviews were selected to address potential gaps in the AHRQ review. The panel has done a detailed search of the recent literature and selected key reviews to add where there were gaps. Not all gaps can be filled and not every systematic review conducted was selected for focus due to potential overlap or non-match with the scoping of the review (PICOTS).
David Emerson (Group: Center for Trauma and Embodiment at Justice Resource Institute)	I have concerns	I believe that our model, TCTSY, should also be considered, specifically given its efficacy in comparison to CPT, which is a gold-standard treatment. I feel that it is a mistake that yoga models have been left off the list in general and that our model specifically stands out for its empirical process: Kelly, U., Haywood, T., Segell, E., & Higgins, M. (2021). Trauma-sensitive yoga for post-traumatic stress disorder in women Veterans who experienced military sexual trauma: Interim results from a randomized controlled trial. <i>The Journal of Alternative and Complementary Medicine</i>, 27(Supp. 1), S45-S59. Link	Thank you for this recommended article. The panel recognizes trauma-informed/trauma sensitive yoga therapies as treatment options for PTSD and will make related comments in its final review. Individual RCTs such as this will add to the understanding of the efficacy of interventions; however, the update will be based on selected systematic reviews of the literature.

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Commenter (Group or Individual?)	Agreement with Review 3?	Comment	Panel Response
Barbara Milrod, M.D. (Individual)	I have concerns	Ditto above. There is no place for meta-data in treatment guidelines. This is an unprecedented choice. Lazy and irresponsible.	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ The panel will further clarify in the guideline document that the 2018 AHRQ review will serve as the primary evidence base but that it then

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Commenter (Group or Individual?)	Agreement with Review 3?	Comment	Panel Response
			nominated several newer systematic reviews to meet the gaps that were identified in the primary review and include updated information. As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Denise Sloan (Individual)	I have concerns	As previously noted, this review published some inaccurate information about some of the studies. For instance, Sloan et al., 2011 examined expressive writing, not written exposure therapy. that should not have been included in the review.	Thank you for this information. The panel will consider this when making recommendations. The panel also supplemented a recent review conducted by DeJesus and colleagues (2024) that will serve as the underlying evidence for recommendation statements. Reference DeJesus, C. R., Trendel, S. L., & Sloan, D. M. (2024). A systematic review of Written Exposure Therapy for the treatment of posttraumatic stress symptoms. <i>Psychological Trauma: Theory, Research, Practice, and Policy</i>. Advance online publication. https://dx.doi.org/10.1037/tra0001659
Edward Hunter (Individual)	I have concerns	These are more or less the same studies.	Jericho et al. (2022) seeks to provide a more recent review of the literature in comparison with the earlier AHRQ review. It does contain many of the same studies.

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12-A. Additional reviews / studies on PTSD treatments

Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
Dr Mirjam j. Nijdam (Individual)	As mentioned in previous comments, I would like to suggest to include the following two systematic reviews: - Eshuis, L.V., van Gelderen, M.J., van Zuiden, M., Nijdam, M.J., Vermetten, E., Olff, M., & Bakker, A. (2021). Efficacy of immersive PTSD treatments: a systematic review and meta-analysis of virtual reality and augmented reality exposure therapy and a meta-analysis of virtual reality exposure therapy. <i>Journal of Psychiatric Research</i> , 143, 516-527. doi: 10.1016/j.jpsychires.2020.11.030. - Sciarrino, N. A., Warnecke, A. J., & Teng, E. J. (2020). A systematic review of intensive empirically supported treatments for posttraumatic stress disorder. <i>Journal of Traumatic Stress</i> , 33(4), 443–454. doi: 10.1002/jts.22556.	Thank you for these recommendations. Both Eshuis et al. (2021) and Sciarrino et al (2020) were carefully considered when selecting a limited number of supplemental reviews. Neither of them were selected due to their more narrow scope but do provide important information on these therapies. We will be able to use reviews such as these to further qualify and inform recommendations.
Colette Smart, Ph.D., R.Psych. (Individual)	There is a severe lack of studies looking specifically at treatments for medical PTSD, which has unique features and treatment considerations. The panel should include this recent systematic review on the topic: Haerizadeh M, Sumner JA, Birk JL, Gonzalez C, Heyman- Kantor R, Falzon L, Gershengoren L, Shapiro P, Kronish IM. Interventions for posttraumatic stress disorder symptoms induced by medical events: a systematic review. <i>J Psychosom Res.</i> 2020;129:109908. I also referenced some prior reviews looking at PTSD post-COVID, which may be more prevalent in people who were hospitalized in the ICU (given ICU is a particular high-risk factor for medical PTSD).	Thank you for this recommendation. You are indeed correct that there is a lack of studies regarding medical-event related PTSD and there is an emerging literature on COVID-related PTSD. Studies such as these will help inform an examination of moderating factors regarding treatment recommendations.
Enrico Gnaulati Ph.D. (Individual)	It is important that the GUP continue to pay heed to some of the ethical concerns associated with current APA approved PTSD txs outlined in my article: Gnaulati E. Potential ethical pitfalls and dilemmas in the promotion and use of American Psychological Association-recommended treatments for posttraumatic stress disorder. <i>Psychotherapy (Chic)</i> . 2019 Sep;56(3):374-382. doi: 10.1037/pst0000235. PMID: 31282713.	Thank you for your comment. The panel will address these concerns in the guideline.
Gagnon. Andre (Individual)	I suggest that the analysis and conclusions of different health agency regarding SSPT should be at least looked at: Israel, UK, INSERM in France, Germany, Holland to name some.	Thank you for your comment and for sharing with us these resources.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
Ann (Individual)	Shedler, J. (2010). The Efficacy of Psychodynamic Psychotherapy. <i>American Psychologist</i> , Vol. 65(2) 98-109. Link	Thank you for sharing with us the reference, however the review is older than five years and therefore could not be included as part of the underlying evidence. The panel is limited to systematic reviews that are current (i.e., published within the last five years) as well as what the authors of the systematic reviews find in terms of the treatment efficacy.
Ashli Owen-Smith (Individual)	I would recommend that the panel consider listing The Trauma Center's Trauma-Sensitive Yoga as a vetted care model for PTSD and complex trauma. Here are some citations that support this: Cattie, J. E., Allbaugh, L. J., Visser, K. H., Ander, I., & Kaslow, N. J. (2021). Tailoring trauma-sensitive yoga for high-risk populations in public-sector settings. <i>International Journal of Yoga Therapy</i>, 31(1), Article 15. Link Kelly, U., Haywood, T., Segell, E., & Higgins, M. (2021). Trauma-sensitive yoga for post-traumatic stress disorder in women Veterans who experienced military sexual trauma: Interim results from a randomized controlled trial. <i>The Journal of Alternative and Complementary Medicine</i>, 27(Supp. 1), S45-S59. Link Nguyen-Feng, V. N., Hodgdon, H., Emerson, D., Silverberg, R., & Clark, C. J. (2020). Moderators of Treatment Efficacy in a Randomized Controlled Trial of Trauma-Sensitive Yoga as an Adjunctive Treatment for Posttraumatic Stress Disorder. <i>Psychological Trauma: Theory, Research, Practice, and Policy</i>. Advance online publication. http://dx.doi.org/10.1037/tra0000963 Owen-Smith, A., Black, H., Emerson, D., Cotner, M., Smith, H., Jackson, D., Ford, J. D., DeBar, L., DiClemente, R., & Hayat, M. J. (2021). A pilot study to adapt a trauma-informed, mindfulness-based yoga intervention for justice-involved youth. <i>International Journal of Yoga Therapy</i>, 31(1), Article_18. Link West, J., Liang, B., & Spinazzola, J. (2017). Trauma sensitive yoga as a complementary treatment for posttraumatic stress disorder: A qualitative	Thank you for these recommended articles. The panel recognizes trauma-informed/trauma sensitive yoga therapies as treatment options for PTSD and will make related comments in its final review.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	descriptive analysis. <i>International Journal of Stress Management</i>, 24(2), 173-195. Link Price, M., Spinazzola, J., Musicaro, R., Turner, J., Suvak, M., Emerson, D., & van der Kolk, B. (2017). Effectiveness of an extended yoga treatment for women with chronic posttraumatic stress disorder. <i>Journal of Alternative and Complementary Medicine</i>, 23(4), 300-309. Link van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. <i>The Journal of Clinical Psychiatry</i>, 75(6), Article 22573. Link	
Assoc Prof Christopher Lee (Individual)	Mavranetzouli, I., Megnin-Viggars, O., Daly, C., Dias, S., Welton, N. J., Stockton, S., . . . Pilling, S. (2020). Psychological treatments for post-traumatic stress disorder in adults: a network meta-analysis. <i>Psychol Med</i>, 50(4), 542-555. doi:10.1017/S0033291720000070	Thank you for this suggestion. We did carefully consider Mavranetzouli et al. (2020). We also looked at inclusion/exclusion criteria for these meta-analyses and sought to match them as closely as possible to our scoping (PICOTS). Because of the desire to have more recent literature included, Jericho et al. (2022) was selected.
Les R. Greene (Individual)	Schwartz, D., Barkowski, S., Strauss, B., Knaevelsrud, C., & Rosendahl, J. (2019). Efficacy of group psychotherapy for posttraumatic stress disorder: Systematic review and meta-analysis of randomized controlled trials. <i>Psychotherapy Research</i>, 29, 415-431. http://dx.doi.org.visn1kis.idm.oclc.org/10.1080/10503307.2017.1405168 Mahoney A; Karatzias T; Hutton P. (2019). A systematic review and meta-analysis of group treatments for adults with symptoms associated with complex post-traumatic stress disorder. <i>Journal of Affective Disorders</i>, 243, 305-321. http://dx.doi.org.visn1kis.idm.oclc.org/10.1016/j.jad.2018.09.059	We appreciate the recommendations from these reviews. Both reviews were included in our initial search for the literature. We will be able to comment on group therapies as interventions for PTSD.
Elan Shapiro (Individual)	Farrell D, Moran J, Zat Z, Miller PW, Knibbs L, Papanikolopoulos P, Prattos T, McGowan I, McLaughlin D, Barron I, Mattheß C and Kiernan MD (2023) Group early intervention eye movement desensitization and reprocessing therapy as a video-conference psychotherapy with frontline/emergency workers in response	Thank you for these recommended articles. The panel update will be basing its recommendations on systematic reviews, rather than individual studies. However, individual studies will provide important

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	to the COVID-19 pandemic in the treatment of post-traumatic stress disorder and moral injury—An RCT study. <i>Front. Psychol.</i> 14:1129912. doi: 10.3389/fpsyg.2023.1129912 Link Yurtsever, A., Konuk, E., Akyüz, T., Zat, Z., Tükel, F., Çetinkaya, M., Savran, C., & Shapiro, E. (2018). An eye movement desensitization and reprocessing (EMDR) group intervention for Syrian refugees with post-traumatic stress symptoms: Results of a randomized controlled trial. <i>Frontiers in Psychology</i>, 9. https://doi.org/10.3389/fpsyg.2018.00493 Moench, J., & Billsten, O. (2021). Randomized controlled trial: Self-care traumatic episode protocol (STEP), computerized EMDR treatment of COVID-19 related stress. <i>Journal of EMDR Practice and Research</i>. https://doi.org/10.1891/EMDR-D-20-00047 Acarturk, C., Konuk, E., Cetinkaya, M., Senay, I., Sijbrandij, M., Gulen, B., & Cuijpers, P. (2016). The efficacy of eye movement desensitization^[1] and reprocessing for post-traumatic stress disorder and depression among Syrian refugees: Results of a randomized controlled trial. <i>Psychological Medicine</i>. 46(12), 2583-2593. https://doi.org/10.1017/S0033291716001070 Bates, A., Rushbrook, S., Shapiro, E., Grocott, M., & Cusack, R. (2020). CovEMERALD: assessing the feasibility and preliminary effectiveness of remotely delivered eye movement desensitisation and reprocessing following Covid-19 related critical illness: A structured summary of a study protocol for a randomised controlled trial. <i>Trials</i>, 21(1), 1-3. https://doi.org/10.1186/s13063-020-04805-1 il-Jardiné, C., Evrard, G., Al Joboory, S., Tortes Saint Jamme, J., Masson, F., Ribéreau-Gayon, R., Galinski, M., Salmi, L.R., Revel, P., Régis, C.A., Valdenaire, G., Lagarde, E. (2018) Emergency room intervention to prevent post concussion-like symptoms and post-traumatic stress disorder. A pilot randomized controlled study of a brief eye movement desensitization and reprocessing intervention	information for moderating effects of treatment, including working with refugee populations, first responders, and computerized, therapist-assisted interventions.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	versus reassurance or usual care. Journal of Psychiatric Research. 103, 229-236. https://doi.org/10.1016/j.jpsychires.2018.05.024 Perri, R. L., Castelli, P., La Rosa, C., Zucchi, T., & Onofri, A. (2021). COVID-19, isolation, quarantine: on the efficacy of internet-based eye movement desensitization and reprocessing (EMDR) and cognitive-behavioral therapy (CBT) for ongoing trauma. Brain Sciences, 11(5), 579. https://doi.org/10.3390/brainsci11050579	
Laurence Armand French (Individual)	See comment re: VA/IHS/BIA data bases as well as those of the Department of Defense....	Thank you for your review and feedback. We are including studies that include veterans and Native Americans.
Viann Nguyen-Feng (Individual)	I recommend parsing out Complementary and Integrative Health approaches. AHRQ's "Pharmacologic and Nonpharmacologic Treatments for Posttraumatic Stress Disorder: 2022 Update of the PTSD-Repository Evidence Base" provides a couple of examples and citations for the following modalities, and more studies are likely available at this time: (1) Trauma-sensitive yoga: Kelly U, Haywood T, Segell E, et al. Trauma-sensitive yoga for post-traumatic stress disorder in women veterans who experienced military sexual trauma: interim results from a randomized controlled trial. J Altern Complement Med. 2021 Mar;27(S1):S45-S59. doi: https://doi.org/10.1089/acm.2020.0417. PMID: 33788599. Nguyen-Feng VN, Hodgdon H, Emerson D, et al. Moderators of treatment efficacy in a randomized controlled trial of trauma-sensitive yoga as an adjunctive treatment for posttraumatic stress disorder. Psychol Trauma. 2020 Nov;12(8):836-46. doi:	Thank you for these recommended articles. The panel recognizes trauma-informed/trauma sensitive yoga therapies as treatment options for PTSD and will make related comments in its final review.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	https://doi.org/10.1037/tra0000963. PMID: 32853015. Rhodes A, Spinazzola J, van der Kolk B. Yoga for adult women with chronic PTSD: a long-term follow-up study. J Altern Complement Med. 2016 Mar;22(3):189-96. doi: https://doi.org/10.1089/acm.2014.0407. PMID: 26863321. van der Kolk BA, Stone L, West J, et al. Yoga as an adjunctive treatment for posttraumatic stress disorder: a randomized controlled trial. J Clin Psychiatry. 2014 Jun;75(6):e559-65. doi: https://doi.org/10.4088/JCP.13m08561. PMID: 25004196 Zaccari B, Loftis J, Hubbard K, et al. Trauma-sensitive yoga and cognitive processing group therapies for women veterans with PTSD: a multisite randomized controlled trial adapted for COVID-19. Glob Adv Health Med. 2021;10:31. --> now published as: Zaccari, B., Loftis, J. M., Haywood, T., Hubbard, K., Clark, J., & Kelly, U. A. (2022). Synchronous telehealth yoga and cognitive processing group therapies for women veterans with posttraumatic stress disorder: A multisite randomized controlled trial adapted for COVID-19. Telemedicine and e-Health, 28(11), 1642-1650. https://doi.org/10.1089/tmj.2021.0612 (Other future work: Cattie, J. E., Allbaugh, L. J., Visser, K. H., Ander, I., & Kaslow, N. J. (2021). Tailoring Trauma-Sensitive Yoga for High-Risk Populations in Public-Sector Settings. International Journal of Yoga Therapy, 31(1). https://doi.org/10.17761/2021-D-20-00035)	

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	(2) Meditation --> see ARHQ list (3) Other CIH approaches listed in ARHQ Thanks for all of your work on this critical re-evaluation!	
Barbara Milrod, M.D. (Individual)	Hou, J. et al. Posttraumatic Stress Disorder and Nonadherence to Treatment in People Living With HIV: A Systematic Review and Meta-analysis. <i>Frontiers in psychiatry</i> 11, 834, doi:10.3389/fpsy.2020.00834 (2020). Markowitz, J. C. et al. Is Exposure Necessary? A Randomized Clinical Trial of Interpersonal Psychotherapy for PTSD. <i>The American journal of psychiatry</i> 172, 430-440, doi:10.1176/appi.ajp.2014.14070908 (2015). Foa, E. B. et al. Effect of Prolonged Exposure Therapy Delivered Over 2 Weeks vs 8 Weeks vs Present-Centered Therapy on PTSD Symptom Severity in Military Personnel: A Randomized Clinical Trial. <i>JAMA</i> 319, 354-364, doi:10.1001/jama.2017.21242 (2018). Steenkamp MM, Litz BD: Prolonged Exposure Therapy in Veterans Affairs The Full Picture <i>JAMA Psychiatry</i>. 2014;71(2):211. Kehle-Forbes SM, Meis LA, Spooon M, Polusny MA. (2015). Treatment initiation and dropout from prolonged exposure and cognitive processing therapy in a VA outpatient clinic. <i>Psychol Trauma</i>. Steenkamp, M. M., Litz, B. T. & Marmar, C. R. First-line Psychotherapies for Military-Related PTSD. <i>JAMA</i> 323, 656-657, doi:10.1001/jama.2019.20825 (2020). Cloitre, M. et al. Treatment for PTSD related to childhood abuse: a randomized controlled trial. <i>The American journal of psychiatry</i> 167, 915-924, doi:10.1176/appi.ajp.2010.09081247 (2010). Hundt, N. E. et al. "It didn't fit for me:" A qualitative examination of dropout from prolonged exposure and cognitive processing therapy in veterans. <i>Psychological Services</i> 17, 414-421, doi:10.1037/ser0000316 (2020).	Thank you for these recommended articles. The guideline update panel will be basing its recommendations on systematic reviews, rather than individual studies. However, individual studies will provide important information for moderating effects of treatment.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	Schnurr, P. P. et al. Comparison of Prolonged Exposure vs Cognitive Processing Therapy for Treatment of Posttraumatic Stress Disorder Among US Veterans: A Randomized Clinical Trial. JAMA Network Open 5, e2136921-e2136921, doi:10.1001/jamanetworkopen.2021.36921 (2022). Susan M. Meffert, Thomas C. Neylan, Charles E. McCulloch, et al: Interpersonal psychotherapy delivered by nonspecialists for depression and posttraumatic stress disorder among Kenyan HIV-positive women affected by gender-based violence: Randomized controlled trial (2021) PlosMedicine https://doi.org/10.1371/journal.pmed.1003468 Lester, K., Artz, C., Resick, P. A., & Young-Xu, Y. (2010). Impact of race on early treatment termination and outcomes in posttraumatic stress disorder treatment. Journal of Consulting and Clinical Psychology, 78(4), 480–489. https://doi.org/10.1037/a0019551 Keefe, JR, Wiltsey Stirman, S, Cohen, ZD, DeRubeis, RJ, Smith, BN, Resick, P. In rape-trauma PTSD, patient characteristics indicate which trauma-focused treatment they are most likely to complete. Depress Anxiety. 2018; 35: 330– 338. https://doi.org/10.1002/da.22731	
Debra Kaysen (Individual)	Thomas, F. C., Puente-Duran, S., Mutschler, C., & Monson, C. M. (2022). Trauma-focused cognitive behavioral therapy for children and youth in low and middle-income countries: A systematic review. Child and Adolescent Mental Health, 27(2), 146-160. Booyesen, D. D., & Kagee, A. (2020). The feasibility of prolonged exposure therapy for PTSD in low-and middle-income countries: a review. European Journal of Psychotraumatology, 11(1), 1753941. Kip, A., Iseke, L. N., Papola, D., Gastaldon, C., Barbui, C., & Morina, N. (2022). Efficacy of psychological interventions for PTSD in distinct populations-An	Thank you for these recommended articles. Given that this is an updated review, systematic reviews were selected within the last five years. Children and adolescents are not included in the scoping of the review. We do recognize the importance of literature in low and middle-income countries and within displaced populations. We should be able to comment on this in the final report.

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
	evidence map of meta-analyses using the umbrella review methodology. Clinical Psychology Review, 102239. Morina, N., Malek, M., Nickerson, A., & Bryant, R. A. (2017). Psychological interventions for post-traumatic stress disorder and depression in young survivors of mass violence in low-and middle-income countries: meta-analysis. The British Journal of Psychiatry, 210(4), 247-254. Morina, N., Malek, M., Nickerson, A., & Bryant, R. A. (2017). Meta-analysis of interventions for posttraumatic stress disorder and depression in adult survivors of mass violence in low-and middle-income countries. Depression and Anxiety, 34(8), 679-691. Turrini, G., Tedeschi, F., Cuijpers, P., Del Giovane, C., Kip, A., Morina, N., ... & Barbui, C. (2021). A network meta-analysis of psychosocial interventions for refugees and asylum seekers with PTSD. BMJ Global Health, 6(6), e005029.	
Denise Sloan (Individual)	this study was not captured in any of the reviews but is an important contribution to the evidence supporting WET Sloan, D. M., Marx, B. P., Resick, P. A., Young-McCaughan, S., Dondaville, K. A., Straud, C. L., Mintz, J., Litz, B., Peterson, A. L., and for the STRONG STAR Consortium (2022). Effect of Written Exposure Therapy versus Cognitive Processing Therapy on Increasing Treatment Efficiency Among Military Service Members: A Randomized Noninferiority Trial. JAMA Network Open, 5(1), e2140911. doi:10.1001/jamanetworkopen.2021.40911	Thank you for drawing our attention to this article. Written Exposure Therapy was included in the Hoffman et al (2018; AHRQ) primary review however the panel is limited to what the existing systematic reviews present.
Edward Hunter (Individual)	Have a look at Robyn Walser's work with ACT	Thank you for this recommendation. The panel is limited to what is presented in the underlying systematic reviews.
Megan Spokas (Individual)	Brooks, E., Spokas, M., & Goldschmidt, D. (2021). Exclusion of Suicidal Participants From Randomized Controlled Trials for Posttraumatic Stress Disorder: A Meta-Analysis. Journal of traumatic stress, 34(6), 1209–1218. https://doi.org/10.1002/jts.22610	Thank you for this recommendation. Suicidal ideation is included as part of our scoping under potential adverse events. Many PTSD-focused interventions do exclude patients who are actively suicidal, as it is assumed that stabilization of the ideation is the

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Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
		primary clinical presenting problem. We will be able to comment on these terms of recommendations for future research and limitations in this area.

13. Supplemental Review 4 (Comorbid PTSD and substance use disorder; Roberts et al., 2022)

Commenter (Group or Individual?)	Agreement with Review 4?	Comment	Panel Response
Jamie Miller (Individual)	I have concerns	The following meta-analysis should also be included. Sherman AD, Balthazar M, Zhang W, Febres-Cordero S, Clark KD, Klepper M, Coleman M, Kelly U. Seeking safety intervention for comorbid post-traumatic stress and substance use disorder: A meta-analysis. Brain and Behavior. 2023 Apr 10:e2999.	Thank you for your feedback. As you may be aware, there are many more meta-analyses reviewing the PTSD outcome literature than we could include in our process. We did not seek to review all the reviews. Some were inevitably excluded. We tended to rely on high quality reviews that included the broadest range of therapies. Roberts et al. (2022) included Seeking Safety. Sherman et al. (2023) was primarily focused on Seeking Safety.
Janice Muhr (Group: Psychotherapy Action Network)	I have concerns	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	Once again, as a PsiAN board member I am in agreement with the statement its leaders submitted regarding the limited nature of the studies included.	Thank you for your feedback.
Guldeniz Yucelen, Psy.D. (Individual)	Generally, I agree	"We found a relatively high level of dropout across studies" is the problem with controlled and manualized treatments for PTSD, which Sensorimotor Psychotherapy is able to overcome due to the individualized and tailored approach.	Thank you for your comment. It is true that controlled psychotherapy studies do not allow therapists as much flexibility that they typically have in practice. This a property of the research design and not necessarily the "manualized treatment." The APA's (2006) Evidence-Based Practice in Psychology model advises therapists to apply manuals flexibly with consideration of client values and preferences. To be included in APA's CPG, sensorimotor

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Commenter (Group or Individual?)	Agreement with Review 4?	Comment	Panel Response
			therapy would need to be studied in a controlled and rigorous way and shown to be repeatedly efficacious.
Joan Monahan, LPC (Individual)	Generally, I agree	Inclusion criteria for the multidisciplinary panel to update clinical practice guidelines should include a more diverse representation of clinical professionals. Subsequently, including licensed professional counselors (LPCs) could offer another clinical perspective in future updates of APA's guidelines for treating any clinical diagnosis, especially with PTSD.	We appreciate your feedback and agree that a diverse representation of clinical professionals is necessary to offer a variety of clinical perspectives. The APA strives to promote diversity in its efforts and will incorporate this feedback for future endeavors.
Tiffany Crawshaw (Individual)	I have concerns	CBT only? We need a better comparison	The panel considered a wide variety of interventions and comparisons but is ultimately limited to the available quality research.
Barbara Milrod, M.D. (Individual)	I have concerns	ditto above. Shame on you. You bring sloppiness and disgrace to the field	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are

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Commenter (Group or Individual?)	Agreement with Review 4?	Comment	Panel Response
			sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Debra Kaysen (Individual)	Generally, I agree	There are some other important reviews or pieces of data that should be included for PTSD/SUD reviews. Simpson, T. L., Goldberg, S. B., Loudon, D. K., Blakey, S. M., Hawn, S. E., Lott, A., ... & Kaysen, D. (2021). Efficacy and acceptability of interventions for co-occurring PTSD and SUD: A meta-analysis. <i>Journal of anxiety disorders</i>, 84, 102490. Saavedra, L. M., Morgan-Lopez, A. A., Hien, D. A., Lopez-Castro, T., Ruglass, L. M., Back, S. E., ... & Hamblen, J. (2021). Evaluating treatments for posttraumatic stress disorder, alcohol and other drug use disorders using meta-analysis of individual patient data: Design and methodology of a virtual clinical trial. <i>Contemporary Clinical Trials</i>, 107, 106479. Hien, D. A., Morgan-López, A. A., Saavedra, L. M., Ruglass, L. M., Ye, A., López-Castro, T., ... & Back, S. E. (2023). Project Harmony: a meta-analysis with individual patient data on behavioral and pharmacologic trials for comorbid posttraumatic stress and alcohol or other drug use disorders. <i>American Journal of Psychiatry</i>, 180(2), 155-166.	Thank you for your feedback. The panel considered a wide range of relevant reviews including these, but our process required that we make our ultimate decisions based on a smaller set of high-quality reviews.

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Commenter (Group or Individual?)	Agreement with Review 4?	Comment	Panel Response
Edward Hunter (Individual)	I have concerns	More of the same without an overarching PSYCHOLOGY framework (as opposed to a medical model framework of intervention).	Thank you for your feedback. The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association.

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14. Supplemental Review 5 (Family-based therapies; Sijercic et al., 2022)

Commenter (Group or Individual?)	Agreement with Review 5?	Comment	Panel Response
Julian Ford (Individual)	I have concerns	The review only has studies with CBT done with couples, or individual CBT with relationship outcomes so it should not be a basis for decisions about couples therapy broadly.	Thank you for your comment. The systematic review that we have included (Sijercic et al., 2022) was a systematic review and meta-analysis of individual and couple for PTSD and included clinical and intimate relationship outcomes. The panel will not be making recommendations for couples therapy broadly.
Laura Dilly (Group: APA Committee on Children, Youth, and Families)	Generally, I agree	The outlined systematic reviews appear to be appropriate for guiding the GUPs recommendations. In particular, we appreciate the inclusion of Sijercic et al. (2022) manuscript on family- and couples-based treatment modalities for PTSD. The inclusion of family- and couples-based treatment in the list of psychological interventions assures consideration of an important aspect of the continuum of interventions to address PTSD and its sequelae.	Thank you for your comment.
Janice Muhr (Group: Psychotherapy Action Network)	I have concerns	See comments at end.	Thank you for your feedback. Please refer to the Section #1-A for a detailed response to the letter.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	Once again, as a PsiAN board member I am in agreement with the statement its leaders submitted regarding the limited nature of the studies included.	Thank you for your feedback. Please refer to the detailed response to PsiAN's feedback earlier in the document.
Joan Monahan, LPC (Individual)	Generally, I agree	Inclusion criteria for the multidisciplinary panel to update clinical practice guidelines should include a more diverse representation of clinical professionals. Subsequently, including licensed professional counselors (LPCs) could offer another clinical perspective in future updates of APA's guidelines for treating any clinical diagnosis, especially with PTSD.	We appreciate your feedback and agree that a diverse representation of clinical professionals is necessary to offer a variety of clinical perspectives. The APA strives to promote diversity in its efforts and will incorporate this feedback for future endeavors.

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Commenter (Group or Individual?)	Agreement with Review 5?	Comment	Panel Response
Steven Marcus Ph.D. (Individual)	Generally, I agree	Family therapy is not a direct treatment for PTSD. It is an indirect treatment.	Thank you for your comment. The guideline document will provide a description of family therapy for PTSD based on guiding literature.
Judy Greenberger (Individual)	Generally, I agree	Where is the research from the most brilliant minds in trauma who are from the US? Why not used? How did you make the selections for meta analysis?	Thank you for your comment. The studies from US researchers have been included in many of the systematic reviews and meta-analyses that will be used by the panel.
Barbara Milrod, M.D. (Individual)	I have concerns	ditto above this is a lazy questionnaire. Obviously nothing meaningful could come out of this endeavor	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information

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Commenter (Group or Individual?)	Agreement with Review 5?	Comment	Panel Response
			on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.
Edward Hunter (Individual)	Generally, I agree	Interesting to include this consideration.	Thank you for your comment.

14-A. Other reviews or studies recommended for inclusion related to family-based therapies

Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
Laura DeSantis (Individual)	Hilary B. Hodgdon, Frank G. Anderson, Elizabeth Southwell, Wendy Hrubec & Richard Schwartz (2022) Internal Family Systems (IFS) Therapy for Posttraumatic Stress Disorder (PTSD) among Survivors of Multiple Childhood Trauma: A Pilot Effectiveness Study, Journal of Aggression, Maltreatment & Trauma, 31:1, 22-43, DOI: 10.1080/10926771.2021.2013375	Thank you for this recommended article. The update will be utilizing systematic reviews. Individual studies such as these can inform recommendations about emerging therapies and future research.

15. Supplemental Review 6 (MDMA augmentation; Tedesco et al., 2021)

Note: After further review, the Panel decided to replace Tedesco et al (2021) with Illingworth et al (2021) due to the heterogeneity of the data. The panel will reference this review within the narrative of the guideline.

Commenter (Group or Individual?)	Agreement with Review 6?	Comment	Panel Response
Julian Ford (Individual)	I have concerns	The PTSD studies reviewed have very small sample sizes and highly variable approaches to psychotherapy so it is not a basis for any conclusions about MDMA assisted therapy for PTSD.	The panel found itself in agreement with this comment, which contributed to our decision that MDMA-assisted Psychotherapy for PTSD has insufficient evidence to support it.
Janice Muhr (Group: Psychotherapy Action Network)	I have concerns	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Gagnon. Andre (Individual)	Generally, I agree	this field remains quite weak in research/clinical impact	The panel found itself in agreement with this comment, which contributed to our decision that MDMA-AT for PTSD has insufficient evidence to support it.
D Wagner LMFT (Individual)	Generally, I agree	While MDMA augmented therapy can show a benefit to symptom reduction, longitudinal efficacy is unknown. Additionally while it would be clinically administered, post-treatment increase in substance abuse/addiction may be problematic.	Thank you for your feedback.
Joan Monahan, LPC (Individual)	Generally, I agree	Inclusion criteria for the multidisciplinary panel to update clinical practice guidelines should include a more diverse representation of clinical professionals. Subsequently, including licensed professional counselors (LPCs) could offer another clinical perspective in future updates of APA's guidelines for treating any clinical diagnosis, especially with PTSD.	We appreciate your feedback and agree that a diverse representation of clinical professionals is necessary to offer a variety of clinical perspectives. The APA strives to promote diversity in its efforts and will incorporate this feedback for future endeavors.
Laura DeSantis (Individual)	Generally, I agree	It might be worthwhile to also consider Ketamine-assisted therapies	Thank you for your feedback. The panel decided to explore further ketamine-assisted therapies and will include this information in the guideline.

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Commenter (Group or Individual?)	Agreement with Review 6?	Comment	Panel Response
Viann Nguyen-Feng (Individual)	Generally, I agree	I like the Cureus approach to PPPR. However, I can only find one PPPR comment with this article... I suggest that the panel check the academic rigor of this review prior to inclusion.	Thank you for this comment. The panel decided to replace the Tedesco et al (2021) review with Illingworth et al (2021) review due to the heterogeneity of the data within the Tedesco review. All reviews go through a quality review via AMSTAR-2 tool.
David Emerson (Group: Center for Trauma and Embodiment at Justice Resource Institute)	I have concerns	I think our model, TCTSY, has been proven as effective more robustly than MDMA: Kelly, U., Haywood, T., Segell, E., & Higgins, M. (2021). Trauma-sensitive yoga for post-traumatic stress disorder in women Veterans who experienced military sexual trauma: Interim results from a randomized controlled trial. <i>The Journal of Alternative and Complementary Medicine</i>, 27(Supp. 1), S45-S59. Link van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: A randomized controlled trial. <i>The Journal of Clinical Psychiatry</i>, 75(6), Article 22573. Link Zaccari, B., Loftis, J. M., Haywood, T., Hubbard, K., Clark, J., & Kelly, U. A. (2022). Synchronous telehealth yoga and cognitive processing group therapies for women Veterans with posttraumatic stress disorder: A multisite randomized controlled trial adapted for COVID-19. <i>Telemedicine and e-Health</i>, 28(11), 1642-1650. Link West, J., Liang, B., & Spinazzola, J. (2017). Trauma sensitive yoga as a complementary treatment for posttraumatic stress disorder: A qualitative descriptive analysis. <i>International Journal of Stress Management</i>, 24(2), 173-195. Link Price, M., Spinazzola, J., Musicaro, R., Turner, J., Suvak, M., Emerson, D., & van der Kolk, B. (2017). Effectiveness of an extended yoga treatment	Thank you for your feedback and for the list of references. The list of psychological interventions in the PICOTS table states “psychological interventions including, but not limited to” to allow the panel to consider additional interventions. We do intend to include other PTSD therapies/interventions that are part of the AHRQ review or part of the proposed systematic reviews/meta-analyses to supplement the AHRQ review.

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Commenter (Group or Individual?)	Agreement with Review 6?	Comment	Panel Response
		for women with chronic posttraumatic stress disorder. <i>Journal of Alternative and Complementary Medicine</i> , 23(4), 300-309. Link	
Barbara Milrod, M.D. (Individual)	I have concerns	What about actually doing the lit searches yourselves? This is a self-referential, self-congratulatory endeavor that is evidently designed to hide difficulties that are huge and exist in treatment of PTSD and ignore anything that might be new or promising. For shame	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to

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Commenter (Group or Individual?)	Agreement with Review 6?	Comment	Panel Response
			everyone via the APA website regardless of tone or ad hominem attacks. Thank you.

Reference (replacing Tedesco et al., 2021)

Illingworth, B. J. G., Lewis, D. J., Lambarth, A. T., Stocking, K., Duffy, J. M. N., Jelen, L. A., & Rucker, J. J. (2021). A comparison of MDMA-assisted psychotherapy to non-assisted psychotherapy in treatment-resistant PTSD: A systematic review and meta-analysis. *Journal of Psychopharmacology*, 35(5), 501-511. <https://doi.org/10.1177/0269881120965915>

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16. Supplemental Review 7 (Updated review of pharmacological treatments for PTSD; Williams et al., 2022)

Commenter (Group or Individual?)	Agreement with Review 7?	Comment	Panel Response
Janice Muhr (Group: Psychotherapy Action Network)	I have concerns	See comments at end.	Thank you for your review and feedback. Please see Section #1-A above for a response to your feedback.
Enrico Gnaulati Ph.D. (Individual)	I have concerns	Once again, as a PsiAN board member I am in agreement with the statement its leaders submitted regarding the limited nature of the studies included.	Thank you for your comment and leadership. Our panel will delineate the limitations of our review in our final guidelines.
Joan Monahan, LPC (Individual)	Generally, I agree	Inclusion criteria for the multidisciplinary panel to update clinical practice guidelines should include a more diverse representation of clinical professionals. Subsequently, including licensed professional counselors (LPCs) could offer another clinical perspective in future updates of APA's guidelines for treating any clinical diagnosis, especially with PTSD.	We appreciate your feedback and agree that a diverse representation of clinical professionals is necessary to offer a variety of clinical perspectives. The APA strives to promote diversity in its efforts and will incorporate this feedback for future endeavors.
Tiffany Crawshaw (Individual)	I have concerns	Not sure what this has to do with psychologists' interventions.	Thank you for expressing your concerns. As mental health clinicians, we have consensus that an inter-professional treatment approach benefits patients. Psychologists and other therapists must be aware of medication treatment options to support patients through treatment, as some of them may be prescribed medications.
Barbara Milrod, M.D. (Individual)	I have concerns	ditto above. you are a lazy and irresponsible organization	The American Psychological Association (APA) follows best practices set forth for clinical practice guidelines development via the Institute of Medicine's (Now National Academy of Medicine) 2011 standards for guideline development. These standards are widely used across healthcare for

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Commenter (Group or Individual?)	Agreement with Review 7?	Comment	Panel Response
			guideline development, including by the American Psychiatric Association. These standards acknowledge that there will be differences between guideline developing organizations in their decision about the amount of overlap between the group drafting the guidelines and the group conducting the systematic reviews. The standards note concerns for potential bias/conflicts of interest (e.g., self-selecting particular articles to include) if there is not separation between these groups. Thus, to avoid potential bias, guideline panels may commission a separate group to do a de novo systematic review of the literature (if there are sufficient resources to be able to commission) or use existing systematic reviews that meet quality standards and are conducted by another group. APA's panel is using existing reviews that meet quality standards. Please find more information on best practices for clinical practice guideline development at the following link: https://www.ncbi.nlm.nih.gov/books/NBK209539/ As a reminder, all public comments and panel responses to comments are made available to everyone via the APA website regardless of tone or ad hominem attacks. Thank you.

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16-A. Other reviews or studies recommended for inclusion related to pharmacological treatments for PTSD

Commenter (Group or Individual?)	Comment	Panel Response
Anonymous (Group: Otsuka Pharmaceutical Company, Ltd [OPC]); #111)	Otsuka appreciates the opportunity to provide comments on the American Psychological Association (APA) update to the 2017 Clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults. Otsuka and its affiliates oversee research and development and commercialization activities for innovative products in North America. We seek to serve those with unmet medical needs in three important treatment areas: central nervous system, nephrology, and digital therapeutics. Otsuka is proud to be at the forefront of the research and development of new therapies designed to help patients with PTSD. Brexpiprazole was discovered by Otsuka Pharmaceutical Company, Ltd (OPC) and is being codeveloped by Otsuka and H. Lundbeck A/S (Lundbeck). Brexpiprazole is FDA approved in the United States for use in adult and adolescent patients for the treatment of schizophrenia and as an adjunctive therapy to antidepressants for adult patients with major depressive disorder. The clinical development program for brexpiprazole includes investigational studies for the following diseases: 1) agitation in Alzheimer's dementia; and 2) PTSD in adults. Specifically, the brexpiprazole adult PTSD clinical development program consists of three investigational clinical studies: Phase 2 [completed; pending publication] and two Phase 3 trials [ongoing; topline results to become available in 4Q2023]. Study descriptions are as follows: • Phase 2 multicenter, randomized, double-blind, placebo-controlled, 12-Week study evaluating the efficacy, safety, and tolerability of brexpiprazole (1-3 mg/day) as monotherapy, (sertraline, 100-200 mg/day) as monotherapy, or brexpiprazole (1-3 mg/day) plus sertraline (100-200 mg/day) treatment in adults with PTSD. [ClinicalTrials.gov (NCT03033069)] • Phase 3, multicenter, randomized, double-blind, 12-Week study evaluating the efficacy, safety, and tolerability of brexpiprazole (up to 3 mg/day) plus sertraline (up to 150 mg/day) treatment, or sertraline (up to	Thank you for your comment and offering this information. Our approach uses the PICOTS method which is based on information gathered from systematic reviews and meta-analyses that meet inclusion and quality criteria. The panel will include a section on other treatments reviewed but for which there is insufficient evidence within the guideline.

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Commenter (Group or Individual?)	Comment	Panel Response
	150 mg/day) monotherapy, or placebo, in adults with PTSD. [ClinicalTrials.gov (NCT04124614)] • Phase 3, multicenter, randomized, double-blind, 12-Week study evaluating the efficacy, safety, and tolerability of fixed-dose brexpiprazole (2 mg/day or 3 mg/day) plus sertraline (up to 150 mg/day) treatment, or sertraline (up to 150 mg/day) monotherapy, or placebo, in adults with PTSD. [ClinicalTrials.gov (NCT04174170)] As APA proceeds with update of the 2017 Clinical practice guideline for the treatment of PTSD in adults, Otsuka respectfully requests the Guideline Update Panel consider descriptive inclusion and reference to our robust late-stage development program of brexpiprazole use in adult PTSD. The design of the referenced trials enable assessment of brexpiprazole treatment (mono- and combination-therapy) versus sertraline active-control – a standard of care therapeutic option for PTSD management. We realize that the Guideline review and update process is a multi-year effort, and thus our intent with this request is to generate awareness of forthcoming pivotal data that can further inform existing scientific evidence. The Otsuka PTSD clinical development program represents our significant research interest to expand pharmacotherapeutic options for patients, given the high unmet Medical need and impactful burden of PTSD. We thank you for the opportunity to provide comments, and hope you will consider reference to brexpiprazole as a potential emerging therapy that is being systematically investigated for adult PTSD.	

17. Recommended studies / reviews related to cost-effectiveness of treatments

Commenter (Group or Individual?)	Other Reviews or Studies?	Panel Response
Ad de Jongh, Ph.D. (Group: PSYTREC – PsychoTrauma Expertise Centre)	Cost effectiveness data As well as basing recommendations on clinical safety and efficacy of treatments, there is emerging evidence on the relative cost-effectiveness of different treatments. This is an important consideration for providers, however it does not appear to fall within the scope of the guideline update. We would therefore recommend the committee consider including at least one SR or meta-analysis looking at cost effectiveness evidence, for example: Mavranetzouli, I., Megnin-Viggars, O., Grey, N., Bhutani, G., Leach, J., Daly, C., ... & Pilling, S. (2020). Cost-effectiveness of psychological treatments for post-traumatic stress disorder in adults. PloS one, 15(4), e0232245. https://pubmed.ncbi.nlm.nih.gov/32353011/	Thank you for your comment. We understand that cost-effectiveness is important, however it falls outside the scope of the framework. When the clinical practice guideline initiative was formed in 2010, the Advisory Steering Committee decided that the goal of the guideline recommendations would be based solely on the best available science. The recommendations could then be used to advocate for coverage of the best treatments.
Assoc Prof Christopher Lee (Individual)	Mavranetzouli, I., Megnin-Viggars, O., Grey, N., Bhutani, G., Leach, J., Daly, C., ... & Pilling, S. (2020). Cost-effectiveness of psychological treatments for post-traumatic stress disorder in adults. PloS one, 15(4), e0232245.	Thank you for your comment. We understand that cost-effectiveness is important, however it falls outside the scope of the framework. When the clinical practice guideline initiative was formed in 2010, the Advisory Steering Committee decided that the goal of the guideline recommendations would be based solely on the best available science. The recommendations could then be used to advocate for coverage of the best treatments.