PsiAN
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 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 It uses only meta-data that were published in the past, and the primary studies cited are significantly old and out of date and do not reflect current realities.

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.

1. **Limiting questions**

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.

These were also serious problems in the first APA CPG for PTSD. We hope that lessons learned (and cited in the special edition of *Psychotherapy* dedicated to that process and product) will inform this updated set of guidelines.

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 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.

2. The IoM and APA guidelines regarding evidence

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.

In his 2019 article, Clinical practice guidelines for post traumatic stress disorder: Are they still clinical?, from the 2019 special issue of *Psychotherapy,* 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)

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.

3. Approach and Data Selection

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.

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 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 .

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.)

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 individual studies. The GUP is certain to exclude empirical data that is complementary to that from RCTs.

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 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.

4. 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., *et al.,* Treatment for PTSD related to childhood abuse: a randomized controlled trial. *The American journal of psychiatry* **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. *Psychological Services* **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. *Depress Anxiety*. 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. *Psychol Trauma.*

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

Markowitz, J. C. *et al.* Is Exposure Necessary? A Randomized Clinical Trial of Interpersonal Psychotherapy for PTSD. *The American journal of psychiatry* **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) PlosMedicinehttps://doi.org/10.1371/journal.pmed.1003468

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).

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. *JAMA* **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 guideline updates in the introduction to the special issue of *Psychotherapy,* 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,

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