Abstract

The American Psychological Association (APA) developed this updated guideline to provide recommendations on treatments for posttraumatic stress disorder (PTSD) in adults. Highlights of this updated version include two new types of recommendation statements to complement the traditional recommendation statements: implementation considerations (which focus on contextual factors, change processes, and more) and research recommendations (which focus on gaps in the research literature). The updated version also includes information on the diversity of the included participants, discussion of change processes, greater discussion of equity, diversity, and inclusion, and more.

This guideline used methods recommended by the Institute of Medicine's (2011a) report, *Clinical Practice Guidelines We Can Trust.* Those methods are designed to produce guidelines that are based on evidence and patient preferences and are transparent, free of conflict of interest, and worthy of public trust. The guideline used 15 systematic reviews and meta-analyses (compared to the one used in the original guideline) that met the quality criteria for the traditional recommendations. The two new types of recommendations also include other types of literature as well as expert consensus. The guideline update panel (GUP) consisted of health professionals from the disciplines of psychology, psychiatry, social work, and nursing, as well as a community member (patient representative). The GUP made recommendations based on (1) strength of evidence; (2) treatment outcomes and the balance of benefits vs. harms and burdens of interventions; (3) patient values and preferences; and (4) applicability of the evidence to various treatment populations for the traditional recommendations. In selecting which outcomes would be used to judge an efficacious PTSD treatment, the Panel decided that PTSD symptom reduction, loss of PTSD diagnosis, and serious adverse events or harms (e.g., active suicidal intent, serious self-harm, or suicide) were most critical. Of note and unique to this clinical practice guideline (CPG), the Panel further decided to develop additional categories of outcomes that were less critical but still important related to complex presentations and functional outcomes: reduced comorbidity (prevention or reduction of depression, substance use, affect dysregulation, suicidal ideation, or dissociation); clinically meaningful change (response to treatment, PTSD remission, good end state functioning) and maintenance of treatment gains; and quality of life and functioning (quality of life improvement, functional outcomes [e.g., work, social/interpersonal, home, return to work or active duty]). Other harms and burdens of particular treatments were also examined, including dropout, patient and provider burden, potential side effects, and adverse events leading to withdrawals.

It is hoped that this guideline will be used as one piece of evidence-based practice to inform the available evidence to be used together with clinician expertise and patients' values, preferences, and individual characteristics as part of shared decision-making about PTSD treatment to improve lives.

Keywords: posttraumatic stress disorder, PTSD, adults, treatment, clinical practice guideline

Intended Use of Guidelines

This guideline is aspirational in nature and not intended to create a requirement for practice. It is not meant to restrict scope of practice in licensing laws for psychologists or other independently licensed professionals, nor limit coverage for reimbursement by third-party payers. The guideline is also not intended to be used within a legal or judicial context to imply that psychologists or other independently licensed professionals are required to comply with any of its recommendations.

The term "guidelines" refers to statements that suggest or recommend specific professional behavior, endeavor, or conduct for psychologists and may also be useful for other clinicians. They differ from standards in that the latter are mandatory and may be accompanied by an enforcement mechanism. Thus, guidelines are aspirational and intended to facilitate the continued systematic development of the profession and to help assure a high level of professional practice by psychologists. Guidelines are not intended to be mandatory or exhaustive and may not be applicable to every professional and clinical situation. They are not definitive, and they are not intended to take precedence over the judgment of psychologists. Please refer to the APA's (2015) *Professional Practice Guidelines: Guidance for Developers and Users* for a discussion of the several types of guidelines produced by APA. Clinical practice guidelines are an important tool for determining intervention options, but not the only resource.

Clinicians are encouraged to consider the report from the APA Presidential Task Force on Evidence-Based Practice (2006), *Evidence-Based Practice in Psychology,* as well as APA's (2021) *Professional Practice Guidelines on Evidence-Based Psychological Practice in Health Care,* which emphasize the integration of best available research to date; with patient characteristics, culture, and preferences; and clinical expertise when making treatment decisions. In reviewing the recommendation statements, the Guideline Update Panel ("the Panel") reminds the reader that a lack of evidence about a treatment does not imply that a particular treatment is not efficacious. Multiple reasons may account for the findings reported in this document, including (but not limited to) gaps in the literature related to particular treatments or limitations in the specific literature reviewed by the Panel, based on methodological constraints, all of which will be discussed later in the guideline document. Ultimately, when clinicians are developing treatment plans, they are encouraged to do so in a shared decision-making process with the patient in which all relevant information about options is presented to help inform the process.

Advisory Steering Committee Statement on the Evidentiary Bases of Clinical Practice Guidelines

A mission of the Advisory Steering Committee for development of clinical practice guidelines is to guide the field in its efforts to continue developing and disseminating evidence about psychotherapy and other interventions. Clinical practice guidelines represent the state of the literature and leading recommendations to guide high-quality clinical care. This statement is intended to encourage attention toward current evidence while acknowledging the state of psychotherapy science and inherent limitations of our current processes and evidentiary base.
Read the full statement.

Executive Summary

Scope

This guideline provides updated recommendations for the treatment of posttraumatic stress disorder (PTSD) in adults, based on systematic reviews of the scientific evidence. Fifteen (15) systematic reviews and meta-analyses (Almeida et al., 2024; Borgogna et al., 2024; Choi et al., 2020; DeJesus et al., 2024; Hoffman et al., 2018; Hoskins et al., 2021; Illingworth et al., 2021; Jericho et al., 2022; Karatzias et al., 2019; Öst et al., 2023; Roberts et al., 2022; Sijercic et al., 2022; van de Kamp et al., 2023; Williams et al., 2022; Zhang et al., 2023) that were determined to be most relevant to the Panel's scope served as the basis for this guideline. This guideline addresses the efficacy of psychological, pharmacological, augmentation, complementary and integrative treatments, and psychedelics, as well as the comparative effectiveness of psychological, pharmacological, complementary, and integrative approaches, and psychedelics for the treatment of PTSD and complex PTSD in adults. In addition, the guideline addresses the harms and burdens of treatment and patient[1] values and preferences. Evidence for efficacy and comparative effectiveness were reviewed separately; the Panel did not infer efficacy from comparative effectiveness data. The reviews underlying this guideline did not address children and adolescents (ages 18 and younger) with PTSD, people at risk of developing PTSD, and people with subsyndromal PTSD. These topics are important but beyond the scope of this guideline.[2] The Process and Method section details the Panel's decision-making throughout the guideline update process.

It is important to note that "insufficient evidence" indicates that there was not enough high-quality data included in the selected systematic reviews for the Panel to provide definitive recommendations. Insufficient evidence for a given treatment does not mean that there is evidence that the treatment is ineffective. Rather, insufficient evidence can be due to (a) a lack of relevant studies within the time frame of this review, (b) a very small number of relevant studies, (c) a lack of relevant studies conducted by research teams beyond the treatment developer(s), or (d) the reviewed studies were deemed to have inadequate sample size to render a responsible recommendation decision. In addition, the Panel may have concluded that the evidence was "insufficient" even if multiple studies examined a particular intervention if the studies in question did not yield robust (consistent) findings or lacked critical comparisons.

Highlights of this updated guideline include two new types of recommendation statements to complement the traditional ones: implementation considerations (which focus on contextual factors, change processes, and more) and research recommendations (which focus on gaps in the research literature), more information on the diversity of the included participants, discussion of change processes, greater discussion of equity, diversity, and inclusion, and more. The guideline also used 15 systematic reviews and meta-analyses (compared to one used in the original guideline) that met the quality criteria for the traditional recommendations. The two new types of recommendations also include other types of literature as well as expert consensus.

Background

Posttraumatic stress disorder (PTSD) is a significant public health concern due to its severe impact on quality of life and functioning. PTSD is described in the American Psychiatric Association's (2022) *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (DSM-5, text rev.). PTSD is also described in the World Health Organization's (2019) *International Classification of Diseases for Mortality and Morbidity Statistics* (11th ed.), which distinguishes between a pared-down PTSD and a complex PTSD diagnosis. Regardless of definition, PTSD is characterized by exposure to a potentially traumatic event or events, the development, and persistence of specific trauma-related mental health symptoms beyond initial reactions (defined as several weeks or one month), and functional impairment.

A common human phenomenon, trauma exposure underlies the worldwide 5.6% lifetime prevalence of PTSD, encompassing over 450 million adults and children (Benjet et al., 2016). The greatest achievement of clinical practice guidelines for the treatment of PTSD is their reach and implementation to help resolve symptoms of posttraumatic stress among these millions of individuals around the world. It is hoped that this guideline will be used as one piece of evidence-based practice to inform the available evidence to be used together with clinician expertise and patients' values, preferences, and

1 To be consistent with discussions of evidence-based practice in other areas of health care, we use the term "patient" to refer to the adult, older adult, couple, family, group, organization, community, or other populations receiving psychological services. However, we recognize that in many situations there are important and valid reasons for using such terms as client, consumer, or person in place of "patient" to describe the recipients of services.

2 For more information on treating traumatic stress and PTSD in children and adolescents, please refer to the National Child Traumatic Stress Network and the child and young people section in the United Kingdom's National Institute for Health and Care Excellence 2018 Guideline for PTSD. For an example meta-analysis of pediatric psychological interventions, see Hoppen et al. (2024).

individual characteristics as part of shared decision-making about PTSD treatment to improve lives.

Process and Method

APA develops its clinical practice guidelines (CPGs) in accordance with best practices for guideline development set forth by the former Institute of Medicine (IOM, 2011a; now National Academy of Medicine). Undertaking the creation of a guideline requires several key decisions. APA's Advisory Steering Committee issued a call for nominations (including self-nominations) for individuals to serve as Panel members from a variety of relevant backgrounds (lived experience/patient representative, psychology, psychiatry, social work, nursing) with content knowledge, clinical experience, or methodological expertise. Conflicts of interest (financial and nonfinancial) were considered and managed both during Panel member selection and throughout the guideline update process. The Panel used the Population, Interventions, Comparators, Outcome, Timing, and Settings (PICOTS) framework to formulate the scope of its inquiry. PICOTS is a standard and systematic approach to conducting literature reviews across all fields of evidence-based medicine (Samson & Schoelles, 2012).

In selecting which outcomes would be used to judge an efficacious PTSD treatment, the Panel decided that PTSD symptom reduction, loss of PTSD diagnosis, and serious adverse events or harms [e.g., active suicidal intent, serious self-harm, or suicide] were most critical. The Panel further decided to develop additional categories of outcomes that were less critical but still important: reduced comorbidity [prevention or reduction of depression, substance use, affect dysregulation, suicidal ideation, or dissociation]; clinically meaningful change [response to treatment, PTSD remission, good end state functioning] and maintenance of treatment gains; and quality of life and functioning [quality of life improvement, functional outcomes (e.g., work, social/interpersonal, home, return to work or active duty)]. Other harms and burdens of particular treatments were also examined, including dropout, patient and provider burden, potential side effects, and adverse events leading to withdrawals.

This guideline provides an update to APA's (2017) clinical practice guideline for PTSD in adults;[3] and it was developed in a series of phases, based on 15 systematic reviews and meta-analyses. The Panel began the process by reviewing the PICOTS from the 2017 PTSD guideline, which was adapted from the Agency for Healthcare Research and Quality's (AHRQ; Jonas et al., 2013) systematic review on psychological and pharmacological treatments for PTSD in adults.

The Panel primarily based its recommendations on data found in systematic reviews/meta-analyses of the PTSD treatment literature conducted within five years of the Panel's work. The Panel sought to consider reviews that were judged as "high quality" (e.g., low bias) as determined by meeting Institute of Medicine (IOM, 2011b) or A Measurement Tool to Assess Systematic Reviews-Second Version (AMSTAR-2) quality standards (Shea et al., 2017); however, supplementary systematic reviews with lower quality were included to address important additional outcomes or gaps in the literature base. While this is consistent with rigorous medical intervention guideline development, the Panel noted this approach can have undesirable effects on psychotherapy guideline development because studies exploring the efficacy of psychotherapy are not equally likely to be tested or tested with a similar frequency across forms of psychotherapy, in part, due to potentially less funding for psychotherapy research than pharmaceutical research (e.g., challenges identifying non–self-report/objective, targeted psychotherapy mechanisms often expected to obtain NIMH funding, presence of additional funding for pharmaceutical research from for-profit companies).

The Panel considered four factors as it drafted recommendations based on IOM standards (2011a): (1) overall strength of the evidence; (2) the balance of benefits vs. harms/burdens; (3) patient values and preferences; and (4) applicability breadth or limitations. Based on the combination of these factors, the Panel made a "recommendation" or "conditional recommendation" for or against each particular treatment or concluded that there was "insufficient evidence" to be able to make a recommendation either for or against the specific treatment. These decisions were made for each recommendation in comparison with another specific intervention, treatment as usual, or no treatment. The Panel used a tool called a "Grid" to document its decision-making process for each recommendation statement. This grid can be found in Appendix J (linked separately).

Discussion

The APA guideline is the first update of the previous 2017 guideline for the treatment of PTSD in adults. The guideline has been updated to conform to the updated template from APA's Advisory Steering Committee for development of clinical practice guidelines, which includes two new types of recommendations that are based on expert-consensus as well as based on the literature that may not have met criteria for inclusion in a systematic review or meta-analysis. The first type of recommendations is implementation considerations, which address contextual and other factors in daily clinical practice, and may include the following areas and more relating to implementing treatments:

- Equity, diversity, and inclusion,

3 Members of the 2017 Guideline Development Panel for the Treatment of PTSD in Adults were Christine A. Courtois (chair), Jeffrey Sonis (vice chair), Laura S. Brown, Joan Cook, John A. Fairbank, Matthew Friedman, Joseph P. Gone, Russell Jones, Annette La Greca, Thomas Mellman, John Roberts, and Priscilla Schulz. APA staff for the 2017 clinical practice guideline were Lynn F. Bufka, Raquel Halfond, and Howard Kurtzman.

- Consideration for what patients need to know about informed consent,
- The role of provider and patient factors in treatment for PTSD,
- Barriers to treatment,
- Treatment engagement,
- Monitoring response to treatment,
- Mechanisms of change in treating PTSD, and
- Cultural humility and diversity competence, and other contextual considerations.

The Panel also noted areas where more research is needed on p. 18. These areas include harms and burdens reporting, assessing and defining outcomes of interest, developing systematic reviews and meta-analyses, design and inclusion of clinical trials (e.g., community-based comparative effectiveness research, adaptive trials/MOST, implementation/hybrid trial designs, and qualitative methods), increasing research with diverse populations (e.g., race, ethnicity, socioeconomic status, older adults, disability, sexual orientation, gender identity), and advocacy for increase in research funding to address important gap areas identified by the Panel.

The updated PTSD clinical practice guideline also serves as a companion document to two professional practice guidelines that were recently approved by the APA Council of Representatives as APA policy: APA's (2024a) *Guidelines for Working with Adults with Complex Trauma Histories* ("complex trauma guidelines") and APA's (2024b) *Guidelines on Key Considerations for Working with Adults with PTSD and Traumatic Stress Disorder* ("trauma guidelines"). The trauma guidelines are based on professional literature and expert consensus on issues related to practicing with specific populations with PTSD and traumatic stress disorder. The complex trauma guidelines are also based on the scientific and professional literature on trauma psychology and provide further guidance for treating patients with complex trauma histories.

Treatment Recommendations

In reviewing the recommendations from the Panel, it is important for the reader to be familiar with the definition of several terms as follows:

- **Intervention Names** are based on how they appeared in the systematic reviews, which may differ somewhat from how some interventions might have been named or conceptualized by clinicians in everyday conversation. The Panel notes that the classification of interventions varied across systematic reviews.
- **Treatment as usual (TAU)** refers to the care customarily provided in a particular context. The Panel notes that TAU was inconsistently defined across studies. Thus, comparisons with TAU lack precision.
- **No treatment** means that no active treatment was provided (e.g., waitlist).
- **Efficacy** is defined as the benefit (or lack thereof) of an intervention compared to an inactive control.
- **Comparative effectiveness** is defined as comparing at least two different active treatments to each other to assess the benefits (or lack thereof) of one (or combination) versus the other (or combination).

The recommendations below are organized into the following tiers:

- First-line recommendations are supported by the most high-quality evidence and are worded as **"recommend (Strength/Direction: Strong For)"** or **"recommend against (Strength/Direction: Strong Against),"**
- Second-line recommendations are based on less or weaker evidence and are worded as **"suggests (Strength/Direction: Conditional For) or suggests against (Strength/Direction: Conditional Against)."**
- When there is **"insufficient evidence"** or **"no difference in effect"** to be able to make recommendations for or against interventions, these interventions are listed as **other treatments reviewed** to inform guideline users that there was evidence available about these interventions in the underlying systematic reviews, and that these interventions were considered by the Panel even though the evidence was not yet sufficient to justify a recommendation.