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INTRODUCTION

Guideline Orthodoxy and Resulting Limitations of the American Psychological Association's *Clinical Practice Guideline for the Treatment of PTSD in Adults*

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This article introduces the special issue in which we explore problems and limitations inherent both in the development and implementation of the American Psychological Association's (APA) *Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder in Adults.* As Chair (Christine A. Courtois) and member (Laura S. Brown) of the guideline development panel, we were in a unique position to observe how certain decisions made by the APA regarding how this guideline should be produced led to flaws in the final product. In this special issue, we address problems that may be inherent in many clinical practice guidelines for psychotherapists. Our authors explore the importance of a more ecologically-informed model for such guidelines, one that would take into account the body of research on the psychotherapy relationship, psychotherapy process, and a broad range of psychotherapy outcomes. We end with recommendations APA might take to generate future clinical practice guidelines that are well-founded in APA's own definitions of evidence-based practice, and more attuned to APA's increasing attention to the specialized concerns of clients who come from socially marginalized groups.

Clinical Impact Statement

Question: This article provides an overview of issues that have been raised about the recently published American Psychological Association's *Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder in Adults* and introduces the special issue on this topic. ***Findings:*** The authors agree that many of the critiques of these guidelines have merit. ***Meaning:*** Clinicians will be able to use the material in this article and those that make up this issue to help in critically analyzing and thoughtfully applying guideline findings to their work with trauma survivors, as well as to consider obtaining additional formal education in trauma treatment modalities. ***Next Steps:*** The authors recommend steps that APA should take when developing other clinical practice guidelines, most notably, that future guidelines should be integrated into the larger body of scholarship on psychotherapy process and outcome and trauma and its treatment.

Keywords: clinical practice guidelines, Institute of Medicine, American Psychological Association's *Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder*, trauma treatment

When we first heard that the American Psychological Association (APA) was launching an initiative to develop clinical practice guidelines (CPGs) on the treatment of posttraumatic stress disorder (PTSD), each of us, as experienced trauma psychologists, submitted letters indicating our interest in serving on the guideline development panel (GDP). We did so even though we knew from

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We wish to acknowledge the hard work of all members of the Guideline Development Panel who, while they may not share many of our views, engaged with vigor and integrity around the difficult issues inherent in the development of the guideline document. We also wish to acknowledge the contributions of American Psychological Association staff members assigned to the panel, members of the Advisory Steering Committee, and outside consultants who were brought in to educate us about the project.

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experience with similar projects at the APA that treatment guidelines were difficult to develop and usually generated a fair amount of controversy among those involved in their development. They also tended to evoke strong reactions from clinicians and often the consumers who were the supposed beneficiaries of these documents. Both of us were nominated by the Division of Trauma Psychology, of which each of us is a past president, and selected by APA as members of the GDP, with one of us (Christine A. Courtois) agreeing to serve as chair. We each brought specific expertise that we believed would be of value to the development of guidelines on trauma treatment. Christine A. Courtois has been a leader in publishing on the treatment of adult survivors of child sexual abuse and complex trauma, and Laura S. Brown has been at the forefront of publishing on the topic of cultural competence in trauma treatment as well as contributing to the fields of feminist theory and practice, complex trauma, and forensic trauma practice.

We were to learn that this project was being undertaken under the aegis of both the APA Professional Practice and Science Directorates, each of which provided staff support. Adding to the importance of this project was that it was APA's initial foray into developing CPGs according to the standards set by an outside organization, namely, the Institute of Medicine (IOM) of the National Academy of Sciences. The IOM has been at the forefront of guideline development, and its imprimatur is necessary for a professional organization's guideline to be included in the Guideline International Network (GIN), a significant achievement in establishing the scientific credibility of an organization's guidelines and APA's goal in this effort. The guideline process was directed by an Advisory Steering Committee (ASC), a group of nine psychologists convened by APA leadership in 2011 for this task (these background issues are discussed in detail elsewhere by Hollon & Teacher, this issue, and in Hollon et al., 2014).

The PTSD guideline was the first to be undertaken by APA due to several factors. Primary among them was the availability of a very recently completed systematic review of the treatment outcome literature for PTSD based on data from randomized controlled trials (RCTs), conducted according to IOM's stringent specifications. In anticipation of producing a guideline on treatment of PTSD, the APA had been instrumental in suggesting the topic to the Agency for Health Care Research and Quality (AHRQ). That agency then accepted the topic and delegated the production of a systematic review to the Research Triangle Institute–University of North Carolina Evidence-Based Practice Center (RTI-UNC EBPC). Thus, it was not commissioned directly by APA, a fact that may have contributed to some of the difficulties that the panel struggled with during its attempts to generate a guideline document that would be useful for psychologists.

The intent of having this review available—and thus to not have to produce it de novo–was to considerably shorten the entire process for the panel. However, given that the initiative to develop guidelines using a method unfamiliar to most of the 12 multidisciplinary members of the panel (one social worker, one primary care doctor, two psychiatrists, and six psychologists along with two consumer members) meant they had a steep learning curve throughout almost the entire process. Right from the start, APA staff and outside experts provided training modules on every step of the model for the members of the panel. What was originally planned as a 2-year project lasted nearly five (so it nearly exceeded the 5-year window after which it would have needed to be updated before this first version was even produced!) It also led to considerable "guideline fatigue" among the panel members who had allotted 2 or even 3 years in their professional planning schedules to accommodate the commitment to this project. As a result, the final drafting of the document was left largely to the chair and vice-chair, along with the dedicated APA staff, after which it was distributed to the panel for its approval before being forwarded to the APA Council of Representatives.

Mindful of being the first to produce such a CPG, APA's Professional Practice and Science Directorates instructed our committee to hew very closely to the IOM model and attempted to shield the process from outside pressure or undue influence (although recent news that two psychologist employees of insurance companies, one a member of the depression GDP and one a member of the ASC, has left us uncertain as to the degree to which the PTSD guidelines were in fact kept safe from external influences and pressures). As news of this development is just breaking, we are sure this issue will receive much more discussion. We seek to interweave some of the most relevant points made so far by the various clinical divisions of APA into this introduction.

This strategy by APA staff and members of the ASC may have also led, unfortunately, to the process being less influenced by all of APA's previous deliberations on what constituted an evidence base for treatment (APA Presidential Task Force on Evidence-Based Practice, 2006). For the two of us, as well as some other members of the panel, it soon became apparent that this guideline was being developed in a relative vacuum, one in which the long history of psychotherapy outcome research was treated as if nonexistent. The net result of this decision on the part of APA Professional Practice and Science Directorates as to how to proceed was inflexible even when requests for flexibility were made by members of the panel. The effect of this was that the guideline group was provided only a highly restricted body of research on which to draw, with exclusionary criteria that removed the bulk of the available evidence-based studies of trauma treatments, something that distressed several panel members who had a deep familiarity with the trauma treatment research literature. We were also reminded repeatedly by several non-psychologist members of the panel of the inadequacy of clinical judgment and that it was last among factors to be considered in determining the treatment strategy to be pursued with a patient. We raised the issue that the APA evidence-based definition relied on three elements of which clinician judgment and expertise was one, but this was largely disregarded. The guideline panel was also discouraged from utilizing almost the entire literature on evidence-based relationship elements contributing to psychotherapy outcome, a fact that is roundly critiqued in the article by Norcross and Wampold (2019), who have systematically studied the contributions that relationship elements make to treatment outcome.

Therefore, the results of the panel's work should not have been surprising, despite efforts on the part of several members to make the resulting product more reflective of all prior evidence-based research on psychotherapy outcomes and the importance of relationship elements in the treatment of trauma patients. What was produced was a document that was clearly restricted to the goal established by the APA leadership, the ASC, and the Professional Practice and Science Directorates. This was primarily to review the RCT-based treatment outcome research contained in the systematic review and documented in *evidence tables* prepared by the

RTI-UNC EBPC staff based on the requests of the panel. These were then analyzed and documented via a *decision table* matrix, leading to a set of recommendations for those treatments determined to have the strongest evidence base available within the review's identified timeframe. The panel was also asked to conduct some treatment comparisons and to make recommendations based on available research regarding pharmacotherapy and followed the same procedures for these analyses (American Psychological Association, 2017a). All evidence and decision tables are available in the document's appendixes on the guideline website. The full CPG and its supporting documentation are available at https://www.apa.org/ptsd-guideline with a companion website at https://www.apa.org/about/offices/directorates/guidelines/context. Of note: The criteria used to make recommendations for the APA guideline were more stringent than the criteria currently established by the IOM, which do refer to the clinical utility of a guideline, a topic addressed in the Kudler article in this special issue.

As has been the case for all other PTSD guidelines, the strongest recommendations were given to cognitive–behavioral treatments, because these have the highest number of RCT trials and thus the largest amount of that type of evidence as to their effectiveness in reducing symptoms of PTSD. However, the fact that cognitive–behavioral approaches dominate the type of research reviewed by the AHRQ does not necessarily mean that this constitutes the entire universe of outcome evidence regarding what might be effective. In sum, there are simply far more studies of the CBT modality that are funded for RCTs for PTSD than for almost all other approaches to trauma treatment combined. The issue of bias inherent in the research literature reviewed, the fact that funding affects what the science of a topic is likely to appear to be, as an issue of sociology of knowledge, was one raised by Laura S. Brown and mostly ignored, when discussions about the final product occurred. This was despite repeated discussions about making sure that the included RCTs had been analyzed regarding issues of bias, creating a bias paradox. Obviously, one type of bias is no better than another.

Following the analysis of the data from the systematic review that was compiled in the decision tables, the panel decided on treatment recommendations, the initial document was drafted and made available first to members of the ASC who provided feedback that led to the first document revision. This document was then posted on the APA website for public comment for 60 days before its finalization. The 890 comments that were received reflected considerable dissatisfaction on the part of clinicians, particularly trauma specialists, who felt that the document was overly prescriptive of and restricted to one type of treatment, identified symptom reduction as the primary (and possibly the sole) outcome of concern and largely ignored the need to treat additional and more complex issues that typically arise in working with traumatized clients, disregarded the literature on the significance of the treatment relationship, and omitted discussion of other forms of treatment and their important and ongoing contributions to the treatment of trauma. These comments were consistent with those raised by both of us and several other members of the panel that, for the most part, were deemed less important than the stringent criteria by which a study made it into the AHRQ review. All comments were read by panel members and aggregated into several main topic areas for response. The final version of the guideline was subsequently revised to a limited degree (two recommendations were revisited and one was changed) and some changes were made to the narrative part of the document based on the comments before the finalized document was presented to the APA Council of Representatives for a vote during its February 2017 meeting.

There, it generated similar vocal critical responses from representatives of the clinical divisions, including the division of Trauma Psychology. Only after an amendment calling for the development of a companion professional practice guideline (PPG)[1] on the treatment of PTSD was made by Christine A. Courtois and included in the motion to approve the clinical practice guideline for PTSD did the members of council vote their approval of the document. After a year's delay, the PPG project is now underway within APA under the aegis of the Board of Professional Affairs and the Committee on Professional Practice and Standards. Once an initial draft of that document is produced, it will also be posted on the APA website for a 60-day comment period. As with the CPG, the document will then be revised and finalized with attention to the comments before being sent to the Council of Representatives for ratification as a companion APA professional practice guideline to the clinical practice guideline for PTSD.

The APA Clinical Practice Guideline for the Treatment of PTSD in Adults

The reader of the report will note that most of the document is taken up with a description of the guideline development process and the recommendations, with a narrative section largely devoid of a discussion of PTSD and its complexities beyond its symptom picture. It minimally addresses the literature on relationship and "common factors" and transtheoretical evidence-based treatment variables having to do with the treatment relationship between therapist and patient as a significant element of treatment—regardless of problem treated or technique used. This omission occurred despite Laura S. Brown, Christine A. Courtois, and one other member of the panel having authored several multipage documents on precisely these topics to be integrated into the final product. Because the entire topic of psychotherapy outcome research was deemed peripheral to the guideline, that work was reduced several times over to a few paragraphs or dropped entirely from the discussion. This document says little about other evidence-based treatments (i.e., APA Presidential Task Force on Evidence-Based Practice, 2006) that are either currently in common use for the treatment of PTSD or those that are emerging with evidence-informed support (or have a strong theoretical foundation supporting its development and use) but have not yet been tested in an RCT. This is regrettable, given the APA's own definition of Evidence-Based Practice, which may be found online at https://www.apa.org/practice/resources/evidence/index that includes exactly the types of evidence that the guideline panel was

[1] APA has two types of guidelines, Clinical Practice Guidelines (CPGs), which make recommendations based on systematic reviews and analysis of outcome data, and Professional Practice Guidelines (PPGs), which discuss a treatment population and provide consensus authoritative guidance on important elements of treatment of that population (APA, 2015).

required to ignore, along with clinical expertise in patient characteristics, context, culture, and preferences (APA, 2005).

Any role for somatosensory-based, alternative, or complementary treatments, almost none of which had been included in the scope of the systematic review, similarly was not something the panel was free to consider. Given the ever-increasing understanding from research and practice that constitutes the growing edge of the field of trauma treatment, of the mind–body effects of trauma and their expression as somatic and medical (as well as psychological) symptoms, this seemed especially egregious, and yet again, entirely predictable given the framework within which the panel was required to operate.

These are emerging treatments for which there is a very small research literature, and no clinical trials, but a great deal of clinical information in the form of peer-reviewed articles and scholarly books. These omissions persisted despite attempts on the part of several clinician panel members to provide a more inclusive narrative section that "spoke to clinicians" and that discussed other evidence-informed and evidence-supported treatment options besides those that were formally endorsed in the guideline document based on its restrictive criteria. We pointed to the discussion sections of other PTSD guidelines where a number of these issues have been included (see Hamblen et al., this issue, for a comparison of the findings of the five most recent sets of PTSD guidelines, and Hollon & Teacher, this issue, for their take on the topic limitations and their suggestion for expanded discussion in any future guideline or any future iteration of this PTSD guideline).[2]

The entire issue of treating persons from culturally marginalized groups and the interaction of intersectional identities with trauma was equally marginalized in the final report, despite a lengthy contribution by the several panel members for whom cultural competence in trauma practice is the specialty that led to our inclusion on the panel. Given the powerful contribution of intersectional identities and cultural contexts to the experience of trauma and the idioms of distress that might affect treatment, this was a worrisome omission, inconsistent with directions being taken by the APA in other aspects of its work.

We note that the narrative section of the guideline did include minimal information on patient preferences and treatment choices (a review of the PTSD literature on preferences that had been independently conducted by a member of the panel and her research team was made available to and used by the panel for this purpose) and on adverse events/burdens of treatment (another review of the PTSD literature on this topic was conducted by a staff member of the Practice Directorate, as this information was not easily discerned and was not readily available in many of the studies) that had not been included in as much detail in other PTSD guidelines. This was a positive, albeit small, step, given what we know about the importance of client feedback to psychotherapy outcome (Cooper & Norcross, 2016). In addition, because so much time had elapsed since the original systematic review had been produced by the RTI-UNC EBPC, a decision was made by the panel to conduct a supplementary but less stringent review of additional RCT literature published since that time to determine if any additional data had emerged that would influence any of the recommendations. Additional support for eye movement desensitization and reprocessing therapy (EMDR) and for narrative exposure therapy (NET) was suggested by these additional data, findings that were noted in the report.

While trying to remain faithful to the process established by the IOM as represented to the panel by APA staff, we recognized that the guideline would be overly prescriptive and conservative and we believed it would not provide what the average clinician needed in terms of practical treatment guidance. It was difficult for us to believe that this was APA's intention, although as the process moved forward it appeared as if some APA staff and some panel members believed that having the most limited range of evidence was what was called for in the IOM process.

We had divided loyalties: wanting to support what was intended as a good faith effort (and not undermine it or other members of the panel) while feeling as though we were letting our colleagues and patients down in the process. We were concerned about how the guidelines would be responded to by our clinical colleagues, concerns that turned out to be on target when their comments started arriving and petitions developed. Our mixed feeling weighed upon us throughout the process.

We had shared these concerns repeatedly with each other and other panel members, the APA Professional Practice and Science Directorates, staff assigned to the guideline project, and with members of APA's ASC to little avail. We ended the process concerned that psychologists (as well as other mental health professionals and third parties such as family members and insurance companies) unfamiliar with trauma treatment might mistake the recommendations of this guideline for the final word about treating trauma, rather than as guidance and a starting point. After all the work that had been put in, we each came away from the process dissatisfied and with a sense that an overcorrection had occurred in the direction of creating the most cautious, conservative document possible. We wish to convey our understanding and valuing of the role of research, but not its overly prescriptive use to prematurely foreclose options, especially in a field as young as trauma psychology and treatment.

This problematic process and its outcome became the catalyst for this special issue of *Psychotherapy* and the companion special issue of *Practice Innovations.* It is still our hope to influence the APA guideline development process going forward. When we were offered the opportunity to organize and edit these special issues in a peer-reviewed format that would be available to practicing psychotherapists and psychotherapy researchers, we received a platform from which to make our concerns known to a broader audience. We also wanted to publicly join with the critics and let them know that they had been heard.

APA's Evidence-Based Treatment Definition and IOM Standards

A little history about APA's relationship to the entire construct of Evidence-Based Practice is necessary context here. In 2005, under the leadership of then APA president Ronald Levant (see Silver & Levant, 2019), a task force was established that yielded a very broad and thoughtful paradigm for a definition of evidence-based treatment consisting of three main elements: (a) the best research available; (b) clinical expertise, judgment, and authoritative writing; and (c) client values and context, including their

[2] One is planned but is not yet scheduled. A new AHRQ systematic review on the treatment of PTSD was published the year after the completion of the APA guideline.

preference and choice (APA Presidential Task Force on Evidence-Based Practice, 2006). This model—that an evidence base could arise via a range of methodologies and epistemologies—reflected a sociology of knowledge that understands that hegemonic paradigms for knowledge claims are almost always problematic and likely to exclude emerging data that may over time upend current accepted truths.

The IOM standards that were used are very different from APA's own definition of what are acceptable sources of evidence. IOM's standards are narrow, more exclusionary, and less likely to take issues of intersectionality and context into account. PTSD does not happen to a generic creature with a human genome; it occurs in the life of a person with complex intersectional identities, variable access to resources, and the likelihood, in the case of marginalized people, of continued reexposure to the index trauma or events that are close in meaning to it, as well as epigenetic changes to the expression of genes due to repeated trauma exposure. Yet the guideline was written as if all trauma held the same meaning, all traumatized persons were generic, and all required or would be helped by the same treatment.

As part of this restriction and of concern, there was almost no mention in the guideline of recent and ongoing advances in the understanding of early life trauma and its consequences, particularly those having to do with attachment studies and ever-increasing findings on the neurobiology of trauma and its developmental impact. Nor was much attention given to relational elements of treatment, even given that the majority of trauma treatment literature now emphasizes the significance of the treatment relationship as both a catalyst and a treatment element (especially when the trauma was or is interpersonal in its commission), additive to whatever the technique is used.

The panel was not allowed to integrate any of the research on the evidence-based psychotherapy relationship variables despite those being made available. We essentially ignored the data that specific interventions only account, at best, for 8%, and at worse, around 1–2% of the outcome variance in psychotherapy (Norcross & Lambert, 2018). Instead, we focused on that tiny percentage as if it were the only thing worth attending to. We also dowplayed all information about treatment alliance (8% of the variance outcome for face to face psychotherapy with adults in addition to entirety of the therapy relationship, not only the alliance; Norcross and Wampold, personal communication, May 7, 2019) in favor of a restricted data set about specific interventions researched in a particular manner. From our perspective, these topics and additional treatment guidance could have and should have been included in an expanded narrative as contained in other available PTSD treatment guidelines (i.e., Department of Veterans Affairs & Department of Defense, 2017; International Society for Traumatic Stress Studies (ISTSS), 2018; National Institute for Health and Care Excellence (NICE), 2018; Phoenix Australia Centre for Posttraumatic Mental Health, 2013).

This truncated approach we believe, was particularly problematic for another reason, namely that the field of trauma psychology is relatively young. The contemporary study of trauma is now ~50 years old and has had an exponential pace of development, making it difficult for academics and researchers (much less the average clinician) to keep up with the latest findings. The original concept in the field that trauma was that it was primarily a fear phenomenon and response based on physical forms of trauma that were experienced or observed, and thus a variant of anxiety disorder. As such, it distracted much of the field of trauma psychology for decades from other, important sources of traumatic stress, especially of the sort that routinely and repetitively occurred over the course of childhood and was often of a more emotional form. The work of Schore (1993, 2003a, 2003b), who building on the research of Bowlby and integrating it with more contemporary attachment studies and developmental/neurobiological findings, explored the ways in which problematic attachment experiences could be traumatic and developed affect regulation theory and a companion treatment model, interpersonal neurobiology. Freyd (1996) developed the model of betrayal trauma theory based on the relationship between victim and perpetrator found in many forms of interpersonal trauma. She reported that the closer the relationship, the greater the betrayal, leading to a higher likelihood of more severe responses.

The neurobiology of trauma, an emerging central focus of thinking in the trauma psychology world, was not even considered until well into the 1990s when J. Krystal, in a presentation at a conference of the ISTSS began to suggest that overly frequent activations of the stress response system, the hypothalamic-pituitary-adrenal (HPA) axis, might be contributing to the symptom picture of PTSD. Kellner, Baker, and Yehuda's (1997) work examining the role of cortisol in PTSD, which emerged around the same time, also shed new light on how PTSD developed in response to a traumatic stressor. Porges' polyvagal theory was later to come on the scene (Porges, 2001). Although this work is highly influential in trauma psychology today, and influences many of the growing number of mind–body approaches to trauma treatment, failed to make the cut for inclusion in the AHRQ review because of its relative newness.

Further, the construct of complex or developmental/dissociative trauma only began to see the light of day in the late 1980s. In 1992, Herman, based on the study of child trauma victims and adult survivors, first used the term *complex PTSD*, and Van der Kolk, describing the same phenomenon, used the term *disorders of extreme stress not otherwise specified* (DESNOS) (Herman, 1992). Both of these constructs were presented as attempts to expand professional understanding of trauma's consequences beyond the identified symptoms of what has become known as classic PTSD, a definition originally based principally on studies of combat trauma (as defined in the *Diagnostic and Statistical Manual of Mental Disorders [DSM]*, from 1980 to the present [American Psychiatric Association, 1980]). Complex or developmental trauma, which is now well-recognized and studied (Courtois & Ford, 2009, 2013) describes the more layered, complex, and all-encompassing developmental effects of early trauma exposure on children and adolescents. None of this was addressed in the guideline document; the interaction between a history of complex trauma and adult exposure to the *DSM* Criterion A form of trauma was also never considered, although almost every clinician panel member raised this issue.

All of this is to say that trauma psychology's capacity to understand what constitutes a trauma, what expected biopsychosocial and existential reactions might emerge in response to a wide range of very different kinds of trauma exposure and experience, and thus the profession's ability to develop effective treatments for both reducing symptoms as well as restoring self and life capacities for growth, is truly in, if not its infancy, perhaps only in its

early childhood and may be only now moving into adolescence. Trauma exposure and response are treatment challenges that demand innovative thinking. It was built for what Norcross and Wampold refer to as "tailoring the therapy to the client" (Norcross & Wampold, 2011). Like many adolescent disciplines, be they trauma psychology or the effects of angiogenesis on cancer growth, it is easy to enthusiastically adopt and become somewhat evangelical about the effects of one or two treatments. In this instance, because psychological treatments for trauma that were adapted from modalities for treating anxiety (prolonged exposure) and depression and rape (cognitive and cognitive–behavioral therapies) were already being studied in academic and institutional settings, it should have surprised no one that these treatments had a larger body of research, including RCTs, supporting their efficacy.

The resultant omissions and exclusions unfortunately combined to make the results of the guideline less than credible to the large number of clinicians who have been treating trauma survivors over the past 5 decades. As would be expected of any treatment, the interventions that reached criteria for approval, namely, prolonged exposure, cognitive behavioral therapy, cognitive processing therapy, narrative exposure therapy, and EMDR can all be helpful to some trauma survivors some of the time. They can also be problematic for some survivor clients, when applied in the absence of attention to therapeutic alliance, client personal and environmental resources, race, culture, context, and preference.

We want to be very specific in heralding and supporting treatments that are successful in reducing PTSD symptoms–and in some cases symptoms of depression and anxiety as well—at the end of treatment and in follow-up that—can further lead to significant positive changes in the affected client's cognitions and beliefs. They are important interventions that clinicians ought to consider. But as important as they are, they are *not the only strategies that work for traumatized individuals*. All do—for some of the people, some of the time, and in some circumstances. But they are largely (although not exclusively) focused on symptom reduction and PTSD/complex PTSD are much more than a set of symptoms. However, their effectiveness at reducing the symptoms in the PTSD criterion set does not mean that these treatments are the cure for trauma-related disorders and should now be applied to every traumatized person. The research reviewed by the panel is replete with information about high drop-out rates from studies and regressions in symptoms at follow-up in some cases. It fails to attend to what most trauma therapists believe is the most basic principle of trauma treatment, the establishment of safety for the client prior to undertaking a trauma-processing intervention, in the client's environment and in the therapeutic relationship. Moreover, this document is largely lacking in attention to human diversity and generalizability of findings. Most worrisome of all, these treatments remain bound to the fear-based model of trauma, ignoring the growing evidence that relational, attachment-based, somatic, and nonverbal approaches to trauma treatments may be more effective, especially when the nature of the trauma involved is more attachment/betrayal-based and not only fear-based.

Although the necessary work of discussing how a clinician should assess whether any of these interventions might be appropriate with a particular client fell by the wayside in the guideline, this is a very important consideration, worthy of its own line of research and is attended to in other PTSD guidelines, namely, the Phoenix Australia Centre for Posttraumatic Mental Health (2013) and the Department of Veterans Affairs and Department of Defense (2017). Although the three-phase transtheoretical ecological model of trauma treatment proposed by Harvey (1996) emphasizes safety of the client prior to engaging in interventions, this clinically derived foundational recommendation was nowhere to be found in the guideline; nowhere, because the evidence supporting it was not arrived at through RCTs, but rather via decades of clinical work with survivors. Had APA's definition of acceptable evidence-based practice been used (APA, 2005), this and other treatment information would doubtless have been in the narrative section of the guideline.

In producing these special issues of *Psychotherapy* and *Practice Innovations*, we have sought a more flexible framework in which experts in the field of trauma treatment, psychotherapy outcome, and culturally competent treatment, could expand on questions of how best to work with trauma survivors. Clinicians must be informed not only by the trauma literature and research but also by the larger literatures on psychotherapy outcome, therapeutic relationship, cultural humility, and context in psychotherapy. They must become familiar with, and able to think critically about, the emerging mind–body treatments for PTSD that are theoretically supported, such as sensorimotor psychotherapy (SP) and somatic experiencing (SE) that, because they are being developed outside of academic psychology, thus far have few or no RCTs to support them. Instead, these therapies have a growing body of qualitative clinical reports of good outcome for clients, some of whom are resistant to verbal or exposure treatments. Clinicians must also be open to integrative approaches such as SP and secondary innovations such as Brainspotting (based on EMDR) and to innovative drug interventions (i.e., medical marijuana, LSD or MDMA [aka Ecstasy]) that are currently being researched, in addition to the standard psychopharmacological approaches, and emerging treatments for comorbid disorders such as depression (i.e., ketamine, psilocybin, and transcranial magnetic stimulation [TMS]). Other treatment delivery methods such as group treatments and telehealth adaptations and massed versus longer duration applications of the same treatment are also in need of additional attention and investigation.

Researchers in the field of trauma treatment must also open themselves up to approaches to treatment that seem unfamiliar or difficult to comprehend. Thirty years ago, EMDR was ridiculed by many psychological scientists because its mechanisms of action seemed odd at best. Now there is a robust empirical literature, which includes many RCTs showing its effectiveness and unique mechanism of change with a range of trauma survivor populations. As it is the case that many current researchers in trauma therapy accidentally backed into investigating trauma with extant models for treating anxiety and depression extant paradigms of distress—with extant well-funded labs and university appointments, most of the emerging and innovative work being done in trauma psychology is occurring outside of academic contexts. The field of trauma treatment cannot advance if researchers remain constrained by their own comfort zones and never venture outside of them to seriously study mind–body, mindfulness, neurofeedback, and other trauma treatments that are being avidly studied and utilized in the trenches of trauma treatment today. We also recognize that there are problems that can arise in the development and application of new treatment methodologies and we encourage therapists

to do so cautiously, with attention to any adverse reactions, and after providing the client with informed consent to be treated with a novel, untested, or unresearched intervention. In our respective writing, we both have repeatedly urged our clinical colleagues to be mindful of these issues and to have connections with other providers in the form of consultation and supervision where they can articulate and discuss their treatment approaches. Clinicians must also maintain an awareness of the challenges of working with this population and the fact that they can be profoundly personally affected in the form of vicarious trauma or secondary traumatic stress responses. Due to these and associated countertransference responses and reactions, they may be blind to their own dynamics and reactions to their clients, leading to problematic responses and treatments. This is another reason why ongoing consultation and supervision are warranted.

Conversely, one of the challenges facing psychology is that of what Peterson (2006) has referred to as "scientism," a thoughtless, almost religious adherence to the notion that if something emerges from the logical positivist empiricist tradition that it is "true" science, and that knowledge claims reflecting any other epistemic paradigm are to be rejected as heretical—or just plain useless. Trauma treatment cannot afford scientism or any other form of epistemic orthodoxy. The field of trauma psychology is dealing with people whose suffering is immense. Its needs for treatments that reflect the specific realities of the specific trauma survivor are growing daily. It is our greatest wish that these two special issues will encourage therapists to think critically, and researchers to think openly, rather than proceeding as if, post the guideline, all that needs to be known about trauma treatment has been codified.

This Special Issue

We were both intrigued when presented with the opportunity to develop this special issue of *Psychotherapy* by Editor Mark Hilsenroth. We have attempted a broad-based approach to discussion of the guideline, including attention to the perspectives that informed APA's framework for the guideline panel; we invite the reader to think critically about what these authors have to say. We believe that we have prepared an issue that is rich with information of interest to working clinicians, our primary goal. Other members of the PTSD guideline panel are represented among our authors; we were not the sole dissenting voices but simply the most vocal and we continue in that tradition here.

The issue is organized sequentially, roughly into three sections. The first offers background information beginning with an overview of the guideline effort on the part of APA and the decisions that went into adopting the Institute of Medicine standards to get APA-generated treatment guidelines into the GIN. Authors Steve Hollon and Beverly Teachman are past and current chairs respectively of the APA Guideline Advisory Steering Committee. This is followed by an article by Kristin Silver and Ron Levant who discuss how the APA guideline does not follow the elements of the evidence-based definition developed by the Task Force empaneled by Levant in 2005 when he was APA president. The next article, a guide to guidelines, an important update of a now classic article by the same title by Forbes et al., published in 2010, offers a comparison of the findings of four recently updated guidelines (Department of Veterans Affairs & Department of Defense, 2017; ISTSS, 2018; NICE, 2018; Phoenix Australia Centre for Posttraumatic Mental Health, 2017) along with the newly produced APA guideline written by Jessica Hamblen and colleagues, each of whom was a member of one or more of the included guideline panels.

The second section involves critiques of the guideline by Enrico Gnaulati who thoughtfully discusses possible ethical issues and dilemmas as well as Harold Kudler who asks if the CPGs based solely on RCT data are still clinical. John Norcross and Bruce Wampold, in an eloquent contribution, take issue with the lack of attention to relationship dimensions as part of the guideline. In an equally eloquent article, Bryant-Davis describes the existential/spiritual and intersectional dimensions of trauma and how these were not adequately included in the guideline document. She calls for much broader attention to these issues.

The third section contains articles about the knowledge and skills needed to advance the treatment of trauma. These issues also received little mention in the guideline even with regards to recommended treatments. There is much anecdotal information about clinicians treating trauma without having received any prior appropriate information or training to do so and the application of specific methods (including those that are most recommended) without proper training and other preparation. Tragically, these situations are not infrequent and often result in clients being retraumatized rather than helped and constitute a violation of ethics regarding competency to treat. Joan Cook, Elana Newman, and Vanessa Simiola describe the Division 56-sponsored project that resulted in the development of a set of knowledge, skills, and attitudinal competencies needed to treat trauma based on an expert consensus conference they organized. The opinions of the involved experts led to a set of specialized competencies and the codification of these training competencies by the APA (APA, 2015). Jana Henning and Bethany Brand take this discussion further as they present information indicating that trauma competencies and related concepts have been and continue to be mostly absent from the formal professional psychology training curricula. This absence is costly to trainees and novice therapists in particular but especially to traumatized clients. These authors, both clinical faculty members who have been involved in improving trauma training, provide an overview of different issues that arise and recommendations for working with students and trainees.

We are grateful for the opportunity to have served on the GDP and to discuss its methods and findings in this special issue and its companion issue of *Practice Innovations*, despite the many frustrations that we encountered. It is certainly our hope that the topics discussed in both issues will stimulate APA to move beyond a strict interpretation of the IOM standards that were applied in a way that limited discussion about other evidence-informed treatments and auxiliary information about trauma, its consequences, and challenges/opportunities in treatment. We also hope that this special issue stimulates the reader in carefully and critically appraising treatment options when working with traumatized patients. We repeat our belief that the future holds new discoveries both about the theories and consequences of trauma and innovative ways of offering treatment tailored to the idiosyncratic needs of each client and their unique circumstance and preferences. We also believe that new sequences and applications will be developed, and treatment integrations and "hybrid" models will prevail to offer different approaches for comprehensive treatment.

Suggestions for the Future

We end with making a set of suggestions for the future, many of which are consistent with those provided in this issue by Norcross and Wampold (2019), and some of which have begun to be addressed in the recently completed APA CPG for depression. Although some of these suggestions may seem radical to some readers, they seem reasonable to us because of the serious repercussions and consequences of guideline documents which may lead individuals, groups, and organizations to the erroneous conclusion that the recommended treatments are the end-all, case closed. An associated problem would be if these were to be the only treatments certified to be covered by insurance companies. Because the recommended treatments are of the short term (and often manualized) variety, this may be very enticing for insurance companies who are attempting to limit costs and increase profits, without regard to the client's clinical needs and status.

To improve the process and product of future guideline development, we encourage APA to proceed as follows:

(1) Carefully and critically assess whether the IOM standards based on the bio-medical model are ones that will work well for its psychotherapy guidelines going forward. We believe that for psychology to simply adopt those standards, even the revised and more clinically responsive ones, is to invite a failure of credibility among practicing psychologists. The paradigm that APA used for the PTSD guideline must be changed to be much more inclusive of the full range of evidence-based and informed practice (APA Presidential Task Force on Evidence-Based Practice, 2006). We support Norcross and Wampold's suggestion for a suspension of the guideline development process until this issue is worked out.

(2) If the APA continues to use IOM standards to meet GIN requirements (a goal that was intended to "get APA to the table," one which we support in spirit), it must supplement the narrower research findings with other information about the treatment population under study. Each clinical practice guideline should be accompanied by a companion PPG or a website (or both) on the population of interest that is published simultaneously with the CPG. This should not require special pleading to the organization's Council of Representative to occur.

(3) Future guideline panels must use the APA definition of what constitutes an evidence base (APA Presidential Task Force on Evidence-Based Practice, 2006). It seems self-defeating to us that APA has spent years, and many economic, staff, administrative, and member resources, on developing a more complete definition of the evidence base only to have it cast aside for the development of its CPGs. Psychology and psychotherapy have a construct for the acceptance of knowledge claims that reflects our unique history as a discipline of both science and practice.

(4) Select as the GPD chair a clinical researcher who is familiar with the guideline development process. One of the factors that hampered Christine A. Courtois's effectiveness as a chair was that she was brand new to the process, having been a clinician rather than a researcher for her entire career. She had previously cochaired or been a member of other guideline development efforts, but those relied on clinical consensus and a review of the available research and were not limited to RCT quantitatively-based studies. On this PTSD panel, one of the non-psychologist members was, conversely, very familiar with the IOM standards and the research process (he had worked with the RTI-UNC EBPC group in conducting the systematic review and in the original analysis of the data that was then used by APA; see Jonas et al., 2013), making him the *de facto* authority on the process. Although his input was valuable and extensive, it became a major factor in the exclusion of the psychotherapy outcome and cultural competence material from the final product. Although conflicts of interest were carefully discerned for each member of the panel before their appointment and the process was deliberately transparent (per IOM), we do not recommend such a dual role in the future, even though it is most helpful and necessary to have panel members who are very familiar with the standards and methodology.

(5) Be attentive to information about cultural competence, cultural humility, and the effect of intersectional identities on people's experiences of trauma, e.g., APA' s *Multicultural Guidelines: An Ecological Approach to Context, Identity, and Intersectionality* (APA, 2017b), as well as similar guidelines for practice with girls and women, men and boys, and lesbian, gay, bisexual, and transgender people should be required reading for all members of all CPG panel members, and drafts of any guideline should be reviewed for adherence to APA's guidelines for practice with members of marginalized groups.

(6) APA must take seriously the selection, inclusion, and input of consumer members. Unfortunately, on our panel, one of the two consumer members who had had extensive experience in the mental health system both as a consumer and an advocate for others dropped out early, feeling alienated and judged. The other consumer member gave limited input and repeatedly conveyed how not "real world" our deliberations sounded to him as he wondered how they applied to the combat vets he worked with. Consumers of trauma therapy know what is working, and not working for them; our failure to listen more actively to their voices, and those of their therapists especially during the comment phase, was probably the most serious omission of this entire process. Although it was acknowledged that some of the panel members were, in fact, consumers (not identified as such), APA should seek to seat as panel members some psychologists who are themselves identified as consumers (in this case, trauma survivors), whose dual

identities as professionals and consumers alike, might expand and improve clinical deliberations.

(7) APA must give practitioners a strong voice in all CPGs. Their treatment views and innovations must be heard and valued. APA's stance has seemed to be overly directed toward getting membership in the Guidelines International Network and insurance coverage for recommended treatments rather than giving insurers and other third parties information about the needs of the population as well as the myriad treatments that are available. Although manualized, short-term treatments certainly have great value for some, they may often be deficient in meeting the complicated needs of many trauma survivors.

(8) In a related vein, as we write this, the clinical divisions of APA are producing commentary regarding news of the inclusion of two psychologists employed by insurance companies, one on the depression GDP and one on the ASC. Although this was defended due to having been an open and transparent process, we believe this to be misguided. The IOM and APA's own Conflict of Interest standards indicate problems with such dual relationships and they should be scrupulously avoided in the future.

(9) Future guidelines for PTSD should explicitly call for the incorporation of trauma competencies as part of professional training in recognition of the ubiquity of trauma exposure in the general population and its high representation in the clinical population (see articles by Cook, Newman & Simiola and Henning & Brand, this issue, for a good overview of these issues). APA through Division 56 efforts now has a set of competencies that can be offered as a part of the standard curriculum at different levels of expertise and in different topic areas. The days when trainees have to work with a trauma client without any knowledge base or preparation to draw upon (a very common and concerning scenario for both client and trainee) should be put behind us. Supervision that also attends to the needs of trainees and practitioners treating trauma survivors is also sorely needed (see article by Henning & Brand, this issue, and Ellis et al., in the companion issue of *Practice Innovations*, for additional discussion). Working in the trauma field involves a need for and a commitment to lifelong learning. In addition to their preferred orientation and standard ways of practicing, practitioners might want to receive training and certification in either evidence-based treatments or others that are theoretically-based and that provide extensive rather than minimal training and associated supervision on which to base certification.

(10) Be incorporative of all treatments. The rich tradition of psychoanalytic/dynamic approaches in the field of trauma treatment was absent from any mention in this guideline, even though one of the treatments, brief eclectic psychotherapy, received a conditional recommendation. In line with many of the comments received by the GDP, Dauphin (in press) has written a critique regarding the absence of attention to psychodynamic approaches and their significant role in the past and contemporary treatment of trauma, which should be attended to in any future iteration of this guideline.

(11) All CPG panels should be provided with information regarding psychotherapy outcome variables, and the evidence base for the common factors prior to beginning deliberations. Treatment of a diagnosis occurs always and only in the context of a psychotherapeutic relationship. No guideline panel should be again allowed to ignore the treatment relationship literature in arriving at its conclusions.

(12) APA cannot afford timidity or rigidity in the name of pure science. In 1988, when Christine A. Courtois published the first edition of *Healing the Incest Wound*, she had no RCTs on which to rely, only an in-depth literature review of obscure texts and articles and the findings of a small qualitative study (Courtois, 1988). Had she waited for such findings to emerge, the field of trauma treatment would have been robbed of one of its most influential and classic volumes on the treatment of adult survivors of incest and other child sexual abuse. When Judith Herman published *Trauma and Recovery* in 1992, she had the evidence base of more than a decade of clinically treating survivors of trauma and results of qualitative studies (Herman, 1992). Again, had she waited for an RCT to support the three-phase model of trauma treatment, or the development of the construct of complex trauma, the field of trauma studies would have been delayed and diminished. When Laura S. Brown wrote *Cultural Competence in Trauma Treatment* in 2008, there were no RCTs on which she could rely, simply the evidence base of clinical expertise and a growing body of literature about trauma's intersection with the experience of cultural marginalization (Brown, 2008). We cite these examples to point out that guidelines that require the level of purity that was imposed on the PTSD panel are likely to miss something important.

(13) Seek to integrate findings and recommendations with those of other treatment guidelines on the same topic. For example, at present, there are nine CPGs or PPGs for the treatment of PTSD in adults (see Hamblen et al., this issue), all of which have analyzed the same the same body of research studies and findings, although surprisingly, they sometimes drew different conclusions and made different recommendations, depending on key questions and critical outcomes. It would be much less redundant and more cost-effective for data to be pooled and for various organizations to work together to produce an integrated document. The DOD/VA is currently consolidating all research studies

into a master database for just that reason (see Hamblen et al., this issue). The ISTSS guideline provides a model from a multidisciplinary organization that produced a sophisticated guideline. It is hoped that the APA guideline will either get integrated with these other efforts or become similarly sophisticated in the future based on feedback, along with research and clinical advances.

(14) APA should be very clear that the trauma field is anything but stagnant and that new findings are being made on a continuous and seemingly daily basis. The leaders of the field have learned of the need to be incorporative of this new information and to be flexible in treatment applications. In 2015 at the ISTSS annual meeting, some of the most respected leaders in the field of trauma theory and treatment, including several whose initial research findings led to the overemphasis on the fear-based model of trauma and cognitive–behavioral treatment for its symptoms, came together in a symposium they called, "What I've Changed My Mind About, and Why". It focused on the many changes that have resulted in the field as a consequence of new findings and understandings. Laura S. Brown was in the audience and, at its conclusion, approached panel members to ask if they would spread the word of their changed perspectives so that those in the field not fortunate enough to be in the audience could hear their astonishing reversals. In the article generated by that symposium, the authors wrote in their abstract:

> Major issues raised included the increasingly clear limitations to the fear-based model that has advanced the field. While treatments for PTSD have improved, there are some aspects of trauma exposure that cannot be entirely repaired. Research providing an evidence base to treatment has led to overly specific treatment guidelines that may obscure more general principles of effective treatment. Treatment might be viewed as a way to increase the plasticity of the brain in the context of processing social cues. A variety of novel and integrative therapies include comprehensive holistic care, exercise, returning to competitive work, logotherapy, mindfulness, enhancing well-being and resilience, and medications with novel mechanisms, such as ketamine. (Yehuda et al., 2016, p. 1)

Viewpoints such as these are being repeated in editorial comments (Hoge & Chard, 2018; Steenkamp, 2016; Yehuda & Hoge, 2016) about the status of treatment and the equivalence of the effectiveness of different treatments (notably interpersonal psychotherapy [Markowitz et al., 2015] and present-centered therapy [Foa et al., 2018]) with the CBT approaches that carry the "strongly recommended" imprimatur. These editorial writers make clear that "the jury is still out" and any foreclosure around one or more treatment or method is premature.

In conclusion, APA has much to gain, and, in our opinion little to lose, by developing guidelines that are truly *psychological* in their epistemologies. It is our fondest hope that the recommendations that we laid out here to our organization through these two linked special issues will move APA in the direction of doing just that. Psychology needs to get past its inferiority complex about whether it is a "real" science and recognize that it is a psychological science—a science informed by a range of paradigms, one whose sociology of knowledge is expansive rather than restrictive. Perhaps, as a former member of the APA Board of Directors remarked recently to Christine A. Courtois, psychology needs to develop its own paradigm that relies on its own expertise, suggesting the need for an Institute of Psychology. The fissures in the apparently solid rock of logical positivist empiricism that have been revealed by the PTSD guideline process hopefully will allow psychologists, researchers, educators, clinicians, and policymakers, to see the yet unmined gold in the larger epistemic world.

The Hebrew Bible has a saying, "The stone which the builders rejected has become the cornerstone." Innovations in psychotherapy practice, and in trauma practice, have often begun with that rejected stone—and are now cornerstones of our practice. We hope that these special issues intrigue the reader, evoke curiosity, and get our discipline engaged in turning over information one more time.

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