Detailed Recommendations of the APA GDP for the Treatment of PTSD[11]

Table 5a. *Efficacy of Psychological Interventions Compared to No Intervention*[12]

Topic[13]:	Recommendation:	Summary Rationale Statement[14]:
#1: Efficacy of Cognitive Behavioral Therapy	Among adult patients with PTSD, the panel strongly recommends that clinicians offer cognitive behavioral therapy compared to no intervention.	• There is moderate strength of evidence of a medium to large magnitude benefit for the critical outcome of PTSD symptom reduction. [15] • There is moderate strength of evidence of a medium to large magnitude benefit for three additional important outcomes: remission, loss of PTSD diagnosis, and prevention/reduction of comorbid depression. • There was insufficient/very low strength of evidence for the critical outcome of serious harms. The panel found no other interpretable evidence of serious harms.[16] • Benefits clearly outweigh harms/ burdens. • Patient values and preferences were considered but owing to unknown variability did not substantially factor into the recommendation. • There is no evidence that raises concern about applicability.
#2: Efficacy of Cognitive	Among adult patients with PTSD, the panel strongly	• There is moderate strength of evidence

[11] Please see Table 17 and Table 18 in Appendix L for a comparison of the strength of evidence ratings for critical and important outcomes for the psychological interventions and medications, respectively, for which the panel made substantive recommendations.

[12] These recommendations are framed as psychological intervention compared to no treatment for parsimony but they are based on data from the systematic review of randomized trials comparing psychological interventions to inactive control groups. Inactive control groups received either treatment as usual or wait-list controls (no treatment).

[13] The panel used a structured process to develop recommendations for each intervention. That process incorporated the following elements: 1) strength of evidence for benefits and harms of the intervention; 2) balance of benefits vs. harms/burdens; 3) patient values and preferences; 4) applicability. The decision-making process was incorporated into a Decision Table for each intervention and those Decision Tables are found in Appendix D.

[14] Magnitude of benefit indicates the size of the effect and is based on standardized mean differences (SMDs) for continuous outcomes, rated using the same criteria as the systematic review: approximately 0.2 or greater was rated as a small effect, 0.5 as a medium effect, and 0.9 or greater as a large effect. For dichotomous outcomes in which odds ratios were the measure of effect, an odds ratio of 1.44 was rated as a small effect, 2.47 a medium effect and 5.10 as a large effect, corresponding to the effect sizes of 0.2, 0.5 and 0.9 for small, medium and large effects for continuous outcomes (Chin, 2000). Strength of evidence (SOE) was rated, similarly to the systematic review, on the following scale: insufficient/very low, low, moderate and high. See the methods section for an explanation of the factors that determined SOE ratings.

[15] The number of articles for each outcome for benefits and for harms/burdens can be found in the decision tables for each intervention, in Appendix D.

[16] Based on additional literature review conducted by APA staff to further review harms. This applies to each time this is stated in this and subsequent tables.

Processing Therapy	recommends that clinicians offer cognitive processing therapy compared to no intervention.	of a medium to large magnitude benefit for the critical outcome of PTSD symptom reduction. • There is moderate strength of evidence of a medium to large magnitude benefit for two additional important outcomes: loss of PTSD diagnosis and prevention/reduction of comorbid depression. • There was insufficient/very low strength of evidence for the critical outcome of serious harms. The panel found no other interpretable evidence of serious harms. • Benefits clearly outweigh harms/ burdens. • Patient values and preferences were considered but owing to low certainty did not substantially factor into the recommendation. • There is no evidence that raises concern about applicability.
#3: Efficacy of Cognitive Therapy	Among adult patients with PTSD, the panel strongly recommends that clinicians offer cognitive therapy compared to no intervention.	• There is moderate strength of evidence of a medium to large magnitude benefit for the critical outcome of PTSD symptom reduction. • There is moderate strength of evidence of a medium to large magnitude benefit for four additional important outcomes: loss of PTSD diagnosis, prevention/reduction of comorbid depression, prevention/reduction of comorbid anxiety, and disability or functional impairment. • There is moderate strength of evidence of a small magnitude benefit for one additional important outcome: the physical component of quality of life. • There was insufficient/very low strength of evidence for the critical outcome of serious harms. The panel found no other interpretable evidence of serious harms. • Benefits clearly outweigh harms/ burdens. • Patient values and preferences were considered but owing to low certainty did not substantially factor into the recommendation. • There is no evidence that raises concern

		about applicability.
#4: Efficacy of Prolonged Exposure	Among adult patients with PTSD, the panel strongly recommends that clinicians offer prolonged exposure therapy compared to no intervention.	• There is high strength of evidence of a medium to large magnitude benefit for the critical outcome of PTSD symptom reduction. • There is high strength of evidence of a medium to large magnitude benefit for one additional important outcome: prevention/reduction of comorbid depression and moderate strength of evidence of a medium to large magnitude of benefit for one additional important outcome: loss of PTSD diagnosis. • There was insufficient/very low strength of evidence for the critical outcome of serious harms. The panel found no other interpretable evidence of serious harms. There was low strength of evidence that prolonged exposure therapy is associated with increases in PTSD symptoms in some patients. • Benefits clearly outweigh harms/ burdens. • Patient values and preferences were considered but owing to low certainty did not substantially factor into the recommendation. • There is no evidence that raises concern about applicability.
#5: Efficacy of Brief Eclectic Psychotherapy	Among adult patients with PTSD, the panel suggests that clinicians offer brief eclectic psychotherapy compared to no intervention.	• There is low strength of evidence of a small magnitude benefit for the critical outcome of PTSD symptom reduction. • There is low strength of evidence of a medium to large magnitude benefit for two additional important outcomes: prevention/reduction of comorbid depression and prevention/reduction of comorbid anxiety) and low strength of evidence of a small magnitude benefit for loss of PTSD diagnosis • There was insufficient/very low strength of evidence for the critical outcome of serious harms. The panel found no other interpretable evidence of serious harms. • Benefits slightly outweigh harms/ burdens. • Patient values and preferences were considered but owing to low certainty did not substantially factor into the