Post-traumatic stress disorder: management

Consultation on draft guideline - Stakeholder comments table

11/06/2018 to 23/07/2018

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AAMET International	Consultation Question 2 Evidence Review D	259-274 261 262 262 272 1074	General 43 2-3 41 3-5 n/a	**Question 2**: In the economic modelling section for Psychological Interventions for the Treatment of PTSD in Adults CSACTs emerge as highly cost-effective; fourth most cost-effective in one model and second most cost-effective in another. Trauma-focussed Cognitive Behavioural Therapy (TF-CBT) is only more cost-effective when completed in 8 or less sessions. *"Clinical Evidence Statement": "Sub-analysis by specific intervention suggests some differential effects of combined somatic and cognitive therapies, with the largest effect observed for Emotional Freedom Techniques (EFT)".* This strongly suggests that it would be appropriate to assign scarce research pounds to EFT specifically rather than the CSACTs group in general. Cost savings with EFT are potentially enormous for NHS due to: • EFT's potential for a high treatment effect with fairly minimal cost compared to other interventions • Ease of teaching EFT and effective self-administration of EFT • Empowering a self-help tool has cascading impact during the life course of the patient; the empowerment itself as well as the practicality of having an easily deployed stress-reducing tool.	Thank you for your comment. The cost effectiveness of CSACTs (and any other intervention) is determined by both their effectiveness and the associated costs, including intervention costs and other costs further down the treatment pathway (e.g. healthcare and personal social service costs incurred by people who did not respond to treatment, and also respective costs incurred by people who remitted). The committee considered the results of the guideline economic analysis and noted the cost effectiveness of CSACTs. However, they also noted the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms, and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for CSACTs. The committee also expressed concerns about the generalisability of results given the more restricted trauma types and the broader inclusion criteria of the included studies on CSACTs in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD. Therefore, after

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				• Utility of EFT for co-morbidity, e.g. complex PTSD with all its attendant symptomologies, additional mental and physical health issues and addictions Some of these points are already researched to some degree; see also comment number 5 below. Re: costs considered in the analysis. Appendix J, page 1074 indicates that the cost of the intervention is a key component. Since the number of sessions required to treat using EFT/TFT is much lower than that required for TF-CBT and other methods (and much lower than the 15 sessions required for SE), ordinary reasoning would suggest that EFT/TFT should be regarded as highly cost-effective. Clinicians with an appropriate background can be trained in EFT in a matter of weeks – and if appropriately supervised can deliver effective treatment for PTSD.	taking all evidence and additional considerations into account, they decided to make no recommendation for CSACTs. The rationale behind recommendations of psychological interventions for adults with PTSD, including the above considerations, is provided in the 'Rationale and Impact' section of the PTSD guideline evidence report D.
AAMET International	Consultation Question 2 Evidence Review D	212-217 272	General 3-5	Once EFT, an acupoint tapping method, has been taught to a patient, it is a skill that empowers him/her to increase his/her current psychological wellbeing, as well as in the years after the treatment. This reduces costs by reducing the need for any further interventions.	Thank you for your comment. The committee considered the clinical benefits of EFT, as well as the cost effectiveness of combined somatic and cognitive therapies (CSACTs, which include EFT and TFT), as indicated by the guideline economic analysis. However, they also noted the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms,

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					and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for CSACTs. The committee also expressed concerns about the generalisability of results given the more restricted trauma types and the broader inclusion criteria of the included studies on CSACTs in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD. Therefore, after taking all evidence and additional considerations into account, they decided to make no recommendation for CSACTs.
AAMET International	Consultation Question 2 Evidence Review D	261 262 278 1074	43 2-3 15 n/a	Comment number 2 above is partially calculated. Of the 16 listed interventions for which NMAs were conducted, in the base case analysis, CSACTs came fourth. When a beneficial effect of up to 3 months post-treatment was assumed, CSACTs came second. We further note that for individuals who require more than 8 sessions of TF-CBT, CSACTs according to cost would be the next port of call. Therefore the potential cost savings to the NHS compared to other approved treatments indicates a substantial motivation to have EFT/Thought Field Therapy (TFT) as research priorities. In the light of comment numbers one and two above, we suggest that details within the economic modelling exercise pertaining to number of sessions needed to treat could be checked to ensure that the longer number of sessions required for SE (15) is considered separately from the	Thank you for your comment. The mean number of sessions of CSACTs in the economic modelling was set to 4, based on the average resource use reported in the RCTs that were included in the NMA that informed the economic analysis. No studies on SE were included in the NMA. This means that the higher intensity of SE provision has had no negative impact on the guideline model costings or the cost effectiveness results for CSACTs. In fact, the number of sessions assumed in the guideline model is lower than those needed for EFT (6 according to your comment), thus favouring CSACTs by reducing the intervention cost. As an additional

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				shorter number of sessions needed for EFT (6). It is important that this opportunity for cost savings within the NHS is not missed. EFT has been shown to be effective for the treatment of PTSD and using fewer sessions than TF-CBT, therefore involving less cost.	note, in response to stakeholder comment's SE has now been removed from the CSACT class. The committee considered the results of the guideline economic analysis and noted the cost effectiveness of CSACTs. However, they also noted the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms, and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for CSACTs. The committee also expressed concerns about the generalisability of results given the more restricted trauma types and the broader inclusion criteria of the included studies on CSACTs in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD. Therefore, after taking all evidence and additional considerations into account, they decided to make no recommendation for CSACTs. On the other hand, the committee considered the breadth of evidence for TF-CBT in terms of both self- and clinician-rated PTSD symptomatology, the data availability on other outcomes and at follow-up,

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					as well as the cost effectiveness of TF-CBT relative to other interventions. The rationale behind recommendations of psychological interventions for adults with PTSD, including the above considerations, is provided in the 'Rationale and Impact' section of the PTSD guideline evidence report D.
AAMET International	Consultation Question 3			EFT can be integrated into other methods, as noted above in comment number 11 for EMDR. It can also be integrated within TF-CBT easily, with the main structure of the TF-CBT treatment retained. There may be an exceptional synergy in combining EFT into already-recommended treatments; this requires further research.	Thank you for your comment. The committee did not agree that it was appropriate to recommend EFT integrated into EMDR or TF-CBT as there was no evidence for this type of combined intervention and the committee did not consider this as a priority for further research.
AAMET International	Consultation Question 3			**Question 3**: An excellent summary of solutions to challenges pertaining to both service-users and health professionals working with PTSD is provided within the article: *Church and Feinstein 2017, The Manual Stimulation of Acupuncture Points in the Treatment of PTSD: A Review of Clinical Emotional Freedom Techniques*.* Pages 198-200 provide explanation under each of the following headings: • Few EFT sessions are needed to reduce PTSD • Improvements are substantial and lasting • EFT is safe with a low risk of adverse events	Thank you for your comment and for drawing our attention to the Church 2017 systematic review. That systematic review has now been checked and no additional references that meet inclusion criteria were identified. Please see Evidence report D, Appendix A, for the full review protocols for the psychological treatment of PTSD in adults.

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				• Minimal training is needed to use EFT • EFT is effective in both individual and group sessions • EFT can remediate both psychologic and physiologic symptoms • EFT can be delivered via electronic communication media *Medical Acupuncture, Volume 29, Number 4, 2017 DOI: 10.1089?acu.2017.1213 https://www.ncbi.nlm.nih.gov/pubmed/28874920 This article may have been automatically excluded within the Evidence Review as, although it is mostly based on review of RCTs, it is not specifically designed as such.	
AAMET International	Consultation Question 4 Guideline	29 18	13-15 12-18	**Question 4**: It is not clear how a diagnosis of PTSD is distinct from having clinically important symptoms since a diagnosis requires being above a certain threshold, and being 'clinically important' also requires being above a certain threshold. The two thresholds are not defined, instruments are not specified, so thresholds for differing instruments are of course undefined, and the differences between being diagnosable and having clinically important symptoms is very opaque. It might be helpful to list accepted instruments and have them in an appendix. It may also be helpful to not use the phrase you are defining in the definition. It would also be	Thank you for your comment. The definition in the glossary has been amended in response to your suggestion so that the phrase 'clinically important symptoms' is not in the definition of clinically important symptoms. As outlined in the glossary, clinically important symptoms are typically referred to or seen in studies which have not used a clinical interview to arrive at a formal diagnosis of PTSD and instead have only used self-report measures of PTSD symptoms. In response to your question, there may often be no difference between diagnosis and clinically important symptoms as for scales which map on to diagnostic criteria, scoring above the clinical threshold may be sufficient to receive a

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				useful to define thresholds for differentiating between a diagnosis and being 'clinically significant' on each instrument, or any other conditions that may differentiate these categories. In short, it is muddy. However, what does come across is a desire to recognise that if an individual does not warrant a full-fledged diagnosis of PTSD, the suffering of PTSD is acknowledged and treatment itself for PTSD is indeed probably still warranted.	diagnosis. However, not all scales map on to diagnostic criteria and not all studies require participants to meet diagnostic criteria for PTSD, and evidence from these studies has been included in the guideline and informed recommendations for those with PTSD. The committee did not consider it appropriate to include the instruments and thresholds in the appendix of the guideline as the cut-offs used by studies and by the review are based on the best available evidence which may be subject to change.
AAMET International	Consultation Questions			Re Questions 2 and 3: XX has been asked by other NHS mental health EMDR professionals on several occasions to teach clients EFT to support their complex EMDR intervention. On these occasions, feedback was positive that clients were better able to deal with EMDR interventions delivered in 50-minute sessions whilst it has been shown that it takes 90-minutes to process a difficult memory using EMDR. This repeated anecdotal evidence demonstrates significant and important cost savings as well as seamless and synergistic integration of the modalities. Further research is therefore again warranted.	Thank you for your comment. The committee do not consider routine datasets to be better or equivalent to RCT data as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading. The committee decided that a recommendation could not be made for EFT based on the evidence for clinical and cost-effectiveness when weighed up against additional considerations including uncertainty in the effects given the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms, and the limited follow-up data

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					(there was no follow-up data in comparisons with a non-active comparator) for CSACTs. The committee also expressed concerns about the generalisability of results given the more restricted trauma types and the broader inclusion criteria of the included studies on CSACTs in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD.
AAMET International	Evidence Review D	1253		Study ID Sebastian 2017: We believed this to be an important paper for EFT for PTSD. Please could we be advised why meta-analysis results were considered "not appropriate to extract".	Thank you for your comment. Sebastian et al. (2017) systematic review could not be included in its entirety as review questions and inclusion/exclusion criteria were not sufficiently similar to our review protocol. This systematic review was checked for any relevant references, however, no additional studies that met inclusion criteria were identified.
AAMET International	Evidence Review D	162 270 212-217	5-6 11-16 General	**Karatzias 2011** compares EMDR and EFT. However it is only included in this review as an EMDR study despite satisfying criteria for inclusion as an EFT study. In this study there were no significant differences in treatment efficacy between the two interventions and *"evidence suggests non-significant differences between EMDR and EFT on PTSD"* Failure to include evidence from Karatzias 2011 in the CSACT category is an omission that may significantly change the balance of evidence and needs to be addressed prior to issue of the final guideline.	Thank you for your comment. Both EMDR and EFT arms of the Karatzias 2011 study were included and considered in both the pairwise analyses and the NMA. The committee decided that a recommendation could not be made for EFT based on the evidence for clinical and cost-effectiveness when weighed up against additional considerations including uncertainty in the effects given the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for

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					outcomes other than self-rated PTSD symptoms, and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for EFT. The committee also expressed concerns about the generalisability of results given the more restricted trauma types and the broader inclusion criteria of the included studies on EFT in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD.
AAMET International	Evidence Review D	162 270 278 284	5-6 11-16 16-19 26-28	The inclusion of Karatzias 2011 with the accepted evidence for CSACT would expand efficacy reliability in at least two ways. 1: This study covers a range of traumas in the civilian population, thereby expanding the populations for which there is substantiated efficacy for EFT beyond the military. 2: As this study uses Clinician Administered PTSD Scale, it provides evidence the committee finds more compelling than the subjective self-administered scales. This would begin to redress the *"very limited evidence for clinician-rated PTSD symptomatology"* noted by the review committee. 3: Follow-up is also included	Thank you for your comment. Both EMDR and EFT arms of the Karatzias 2011 study were included and considered in both the pairwise analyses and the NMA. The committee decided that a recommendation could not be made for EFT based on the evidence for clinical and cost-effectiveness when weighed up against additional considerations including uncertainty in the effects given the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms, and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for EFT. The committee also expressed concerns about the generalisability of results, even though evidence is not restricted to

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					military veteran populations the range of trauma types was more restricted than for recommended trauma-focused interventions. In addition, the broader inclusion criteria of the included studies on EFT in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD, raised questions about generalisability.
AAMET International	Evidence Review D	212-217	General	The CSACTs category includes EFT, TFT and SE. EFT and TFT both include acupoint stimulation combined with cognitive and mindfulness elements. SE is based on somatic mindfulness. Therefore the methods are sufficiently distinct to warrant a separate category such as 'Acupoint and Cognitive Combination Therapies' (ACCT) with separate research and treatment recommendation considerations. See also comment number one above.	Thank you for your comment. In response to your and other stakeholders' comments, somatic experiencing has now been removed from the combined somatic and cognitive therapies class and is considered in its own class.
AAMET International	Evidence Review D	272 284 277	5-7 28-29 9-11	The committee has put forward that *"there is no evidence that they [CSACTs] might be appropriate in cases where the recommended interventions are not (i.e. for specific indications)".* However, *"Sub-analysis by trauma type also suggests some differential effects with larger effects observed for military combat veterans"* (p272), suggesting CSACTs could provide treatment choice for people with military combat trauma, where it is considered EMDR may be less effective (p277).	Thank you for your comment. In response to stakeholder's comments, somatic experiencing (SE) has been removed from the CSACT class. The amended sub-analysis by trauma type revealed a trend for a statistically significant difference with relatively larger effects observed for military combat-related trauma than for witnessing war as a civilian. However, there is also a trend for a subgroup difference by specific intervention with relatively larger effects observed for EFT relative to TFT and it is difficult to make sense of the trends for subgroup differences as specific intervention and

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					trauma type sub-analyses are confounded by the fact that both EFT studies are for military combat trauma and both TFT studies are for individuals who have witnessed war as a civilian. The committee did not consider it appropriate to recommend EFT only for military combat veterans as the evidence was too limited both in terms of quantity and breadth and depth. The committee also discussed the added complication of determining relative efficacy for specific groups as there was not a specific review question to address this and the NMA and economic analysis were not restricted by population.
AAMET International	Evidence Review D	276 279	8-21 18-20	Complex PTSD is noted as requiring ongoing management. All 4 of the studies for EFT and TFT that were accepted were for multiple incident traumas, indicating that even higher treatment effects for single incident trauma studies may be observed with further research. It also indicates that both EFT and TFT may have an especial efficacy potential with complex PTSD. As many of our EFT practitioners have case studies indicating complex PTSD symptoms and co-morbidity may be alleviated to the point where no further costs to the NHS are incurred, further and extensive research in this particular area and for single incident trauma treatment with EFT and TFT is duly warranted.	Thank you for your comment. The committee decided that a recommendation could not be made for EFT or TFT based on the evidence for clinical and cost-effectiveness when weighed up against additional considerations. These additional considerations included uncertainty in the effects given the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms, and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for EFT or TFT. The committee also expressed concerns about the

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					generalisability of results given the more restricted trauma types and the broader inclusion criteria of the included studies on EFT and TFT in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD. The committee did not consider it appropriate to recommend EFT or TFT only for people with complex PTSD as the evidence was too limited both in terms of quantity and breadth and depth. The committee also discussed the added complication of determining relative efficacy for specific groups as there was not a specific review question to address this and the NMA and economic analysis were not restricted by population.
AAMET International	Evidence Review D	278 284 271	16-19 26-32 46-50	From the section "*Rationale – Why the committee made the recommendations"* Concern has been expressed that although there is evidence of clinical and cost effectiveness for CSACTs:- "*no follow-up data were available*" . However follow-up data are available. The following is taken from the abstracts of the relevant studies: **Church 2013** "In a within-subjects longitudinal analysis, 60% no longer met the PTSD clinical criteria after three sessions. This increased to 86% after six sessions for the 49 subjects who ultimately received EFT and remained at 86% at 3 months and at 80% at 6 months. The results are consistent with that of other published reports showing	Thank you for your comment. Follow-up data is not extracted if it is only available for one arm as in the case of studies where participants in the control arm are offered the active intervention after post-intervention assessment as is the case in Church 2013, Connolly 2011 and Robson 2016, or where data is combined across groups (EFT and TAU) for follow-up as in the case of Geronilla 2016. There is evidence for associated outcomes including anxiety and depression symptoms and

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				EFT's efficacy in treating PTSD and comorbid symptoms and its long-term effects." **Connolly 2011** "Reductions in trauma symptoms were sustained at a 2-year follow-up assessment." **Geronilla 2016** "Participant gains were maintained at three and six-month follow-up" **Robson 2016** "There was some evidence of persisting benefit 19 months later." "*the evidence for outcomes other than PTSD symptoms was very limited*" However data is recorded for outcomes other than PTSD symptoms as follows: **Church 2013** "Besides the reduction in PTSD symptoms noted, subject values for the cluster of psychological distress symptoms observed to co-occur with PTSD, such as anxiety and depression, also dropped. Insomnia also improved significantly. Subject gains were noted to remain reliably stable over time for the conditions assessed in this study." (Page 6 of study under 'Results', page 158 of Journal) **Connolly 2011** "Results suggest that TFT significantly reduces symptoms of anxiety, depression, anger/irritability, defensive avoidance, dissociation, impaired self-reference, and tension reduction behaviors, as well as the severity and frequency of PTSD symptoms" (Discussion: Summary of Findings, paragraph 1)	sleeping difficulties, however, this is restricted to single-study analyses. There is also very limited evidence on clinician-rated PTSD symptomatology, an outcome that can be blinded and there was no evidence for this outcome in comparisons with a non-active comparator. The committee maintain that a recommendation cannot be made for EFT or TFT based on the evidence for clinical and cost-effectiveness when weighed up against these additional considerations.

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				Geronilla 2016 "Psychological conditions such as anxiety and depression also declined significantly, as did physiological markers of insomnia and pain" (Abstract) "very limited evidence for clinician-rated PTSD symptomatology" **Church 2013** Although this study used the self-report instrument PCL-M, subjects were all clinically supervised. *"Method. Subjects. The subjects were recruited through online announcements and referrals from individual clinicians throughout the United States. To be eligible for this study, the subjects were required to meet the clinical criterion for PTSD (Q50) on the PTSD Checklist Military (PCL-M; National Center for PTSD, 2008). All subjects were also required to be under the care of a clinician from a VA or another licensed health care facility because the EFT coaching intervention was delivered as a complementary and supportive supplement to the standard of care."* See also comment number 8 above re use of CAPS in Karatzias 2011 study comparing EFT to EMDR. The above data, combined with the generalisability data from Karatzias 2011 suggest that the committee need to review their decision that "*the evidence was not quite sufficient to warrant a recommendation at this time*". At the very least this topic needs to be prioritised as an area for	

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				further research. There is evidence available to dismiss the majority of the concerns expressed by the committee.	
AAMET International	Evidence Review D Evidence Review H Consultation Questions 3 and 7	283 283 20	1-2 16-40 n/a	One of the strengths of EFT is that it can be self-administered effectively and correctly with minimal material support. As the committee is very interested in computerised delivery of services to those who are not ready for a therapeutic relationship, where there are long waiting lists, etc, EFT is a worthy research priority. We further note that EFT specifically was designed for self-administration by non-professionals, making it exceptionally appropriate for this type of research.	Thank you for your comment. The committee did not feel that it was appropriate to recommend a computerised self-administered version of EFT as there was no evidence for this intervention and the committee did not consider this as a priority for further research.
AAMET International	Evidence Review D	284	21-32	The juxtaposition of CSACTs *"requiring greater scrutiny and deliberation"* and *showing "a high effect and good ranking … relative to other interventions"* with a lack of prioritisation for research requires justification absent from the current version of the review.	Thank you for your comment. The committee considered the clinical benefits of CSACTs, as well as the cost effectiveness. However, they also noted the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms, and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for CSACTs. The committee also expressed concerns about the generalisability of results given the more restricted trauma types and the broader inclusion criteria of

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					the included studies on CSACTs in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD. Therefore, after taking all evidence and additional considerations into account, they decided to make no recommendation for CSACTs. However, given that results looked promising (although uncertain) a research recommendation has been added for emotional freedom techniques (EFT), given the larger effect sizes observed in the pairwise meta-analysis for EFT than thought field therapy (TFT) the other intervention included in the CSACT class. The rationale behind recommendations of psychological interventions for adults with PTSD, including the above considerations, is provided in the 'Rationale and Impact' section of the PTSD guideline evidence report D.
AAMET International	Evidence Review D Evidence Review H Consultation Questions 3 and 7	284 19	34-40 Para 3 (apprehension engaging)	The committee observed *"a higher rate potential harm of trauma-focused CBT in terms of a significantly higher rate of drop-out relative to waitlist, and a small but still statistically significant higher drop-out where trauma-focused CBT augmented treatment as usual or medication relative to treatment as usual/medication-only. The committee discussed potential reasons for this higher rate of discontinuation, and speculated that trauma-focused CBT may be less acceptable to people who are not ready to directly confront traumatic memories"*	Thank you for your comment. The committee discussed the evidence suggesting a potential harm of trauma-focused CBT in terms of a significantly higher rate of drop-out relative to waitlist, and a small but still statistically significant higher drop-out where trauma-focused CBT augmented treatment as usual or medication relative to treatment as usual/medication-only. The committee discussed potential reasons for this higher rate of discontinuation, and speculated that trauma-

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				The very nature of TF-CBT requires that patients relate distressing events. The significantly high drop-out rate may indicate patients being re-traumatised by the very story they are telling. Whereas we note that EFT is explicitly and centrally organised around the core principle that the client is not to experience any overwhelming intensity of emotional distress. Many strategies have been developed to ensure this. Using acupoint tapping, the client is guided to approach the traumatic memory in an extremely graduated way, and in cases of severe trauma, the emotional distress is addressed using partial therapeutic dissociation. In clinical situations patients may retain privacy of details of traumatic events whilst receiving effective treatment and can self-administer without needing to recall details of an incident. The content-free, distress-free capacity of this method indicates a unique strength that addresses these highly relevant committee concerns. Extract from **Geronilla 2016** p39 "*There are many components to the method, including strategies to minimize the client's distress and to enable a gradual approach to his or her most severe traumatic memories. It is guided by the free-associative flow of the client's thoughts, beliefs, memories, emotions, and bodily sensations. Tapping on acupoints appears not only to be calming, but also to*	focused CBT may be less acceptable to people who are not ready to directly confront traumatic memories, are not able to engage due to functional impairment from associated symptoms, and/or have difficulties in building a trusting therapeutic relationship. As existing recommendations for non-trauma-focused symptom-specific CBT interventions, modifications of trauma-focused therapies for those with additional needs (including complex PTSD), and engagement strategies for those with difficulties in building trust in the therapeutic relationship (based on the qualitative evidence [see evidence review H]) have the potential to address some of these reasons for discontinuation, the committee agreed that the potential for benefit was greater than the potential for harm. The committee also noted that effects on discontinuation only reached the threshold for clinical importance for the comparison against waitlist where there may be an additional incentive for waitlist participants not to drop-out, given that access to the intervention is contingent upon continuing in the trial. Furthermore, offering EMDR as an option for those with non-combat-related PTSD, or supported computerised trauma-focused CBT as an alternative lower intensity intervention, allows people who may not find trauma-focused

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				facilitate this free flow of cognitive, emotional, and sensory-somatic material (Mollon, 2008). *Although the observer of EFT might gain the impression that "tapping" is the core component, this would obscure the clinical reality that the practitioner is attending closely to the contents of the client's mind and words and physiological responses. All these cognitive, emotional, and somatic components are targeted with EFT by using carefully selected words and phrases mirroring those used by the client.* *This requires considerable skill and attunement to the client. While there may be an overall aim to address a list of traumatic memories, the practitioner must take account of what is foremost in the client's thoughts and emotions, and work with the inherent psychodynamics that lead both toward and away from trauma in an approach-avoidance conflict. Clients with PTSD will always tend to be fearful of recalling their worst traumas since these threaten to evoke overwhelming emotions, such as intense anxiety, anger, shame, and guilt. A core dilemma in working with PTSD is that the client's traumatic memories need to be addressed if he or she is to recover, but to do so will present a danger of retraumatization and worsening of symptoms (Mollon, 2005). The practitioners in this study worked to maximize the gentle and nontraumatizing nature of EFT, beginning with the less intense material to enable the client to develop increasing trust in the method, with ensuing feelings of*	CBT acceptable to access another psychological intervention if they prefer. The committee considered the clinical benefits of EFT as well as the cost effectiveness. However, they also noted the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms, and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for EFT. The committee also expressed concerns about the generalisability of results given the more restricted trauma types and the broader inclusion criteria of the included studies on EFT in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD. Therefore, after taking all evidence and additional considerations into account, they decided to make no recommendation for EFT. The rationale behind recommendations on psychological interventions for adults with PTSD, including the above considerations, is provided in the 'Rationale and Impact' section of the PTSD guideline evidence report D.

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				safety—and no adverse results were reported."	
AAMET International	Evidence Review D Consultation Questions 3 and 7	288	7-9	*"It is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and physical health."* We note that XX, Chair of our AAMET Research Team, is an NHS employee, Primary Care Mental Health Worker at XX. XX has discerned a strong trend that people who come for assessment have been treated for anxiety when there was an underlying Post Traumatic Stress Disorder. Therefore, XX work indicates a necessity for more primary care workers to take PTS into account when assessing. Furthermore XX uses the most effective intervention for PTS which in her extensive clinical experience is EFT. Their previous efforts have often included TF-CBT of various duration of treatment. Further EFT and TFT research efforts can focus on populations that have failed to benefit from TF-CBT or EMDR.	Thank you for your comment. The committee noted that there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms if there is no response to treatment. The committee agreed that it is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and physical health. Therefore they prioritised this area as one for further research. As specified in the scope, the recognition and assessment sections from the 2005 guideline were not included in this update. In line with NICE processes, the 2005 content has been carried across to this updated guideline. However, the evidence on recognition and assessment has not been reviewed and we are not able to make any changes to this section (except where they are necessary in order to clarify meaning). The committee do not consider routine datasets to be better or equivalent to RCT data as we cannot be sure that the populations treated with various

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					interventions are the same and to assume so would be potentially misleading. The committee considered the clinical benefits of EFT/TFT as well as the cost effectiveness. However, they also noted the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms, and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for EFT/TFT. The committee also expressed concerns about the generalisability of results given the more restricted trauma types and the broader inclusion criteria of the included studies on EFT/TFT in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD. Therefore, after taking all evidence and additional considerations into account, they decided to make no recommendation for EFT/TFT.
AAMET International	Evidence Review D Consultation Question 7	374-5	n/a	Re topic "Critical Outcomes": PTSD scales included. The Harvard Trauma Questionnaire (HTQ) is not mentioned in the list of included assessment scales. The HTQ was developed to assess trauma symptoms across cultures, and given the multicultural population targeted by this guideline it warrants inclusion. The lack of inclusion of	Thank you for your comment. The list of assessment scales in the review protocols are intended to be illustrative rather than exhaustive

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				the HTQ could perhaps even be seen as an example of cultural insensitivity. The Nemiro 2015 study, which used the HTQ to assess trauma due to sexual gender-based violence (SGBV) within a refugee population, directly compared EFT to CBT and found them equivalent. It also included 3 and 6 month follow-ups. Inclusion of this study within the evidence review for CSACT would add further breadth to this category, where the committee has expressed concerns regarding breadth. See also comment numbers 7-9 above. https://energypsychologyjournal.org/abstracts/abstracts-energy-psychology-journal-volume-7-number-2-november-2015/efficacy-of-two-evidence-based-therapies-emotional-freedom-techniques-eft-and-cognitive-behavioral-therapy-cbt-for-the-treatment-of-gender-violence-in-the-congo-a-randomized-controlled-trial/ Efficacy of Two Evidence-Based Therapies, Emotional Freedom Techniques (EFT) and Cognitive Behavioral Therapy (CBT), for the Treatment of gender Violence in the Congo: A Randomized Controlled Trial doi 10.9769/EPJ.2015.7.2.AN Ashley Nemiro, North Carolina State University Sarah Papworth, Royal Holloway University of London, United Kingdom	and any validated scale measuring PTSD symptomatology, including the HTQ, was included. Thank you for drawing our attention to the Nemiro 2015 study. Unfortunately, it has not been possible to further assess the eligibility of the study as this paper is not available through the UCL libraries or British library. As a result this study has now been added to the excluded studies list (with 'Paper unavailable' as the reason for exclusion).

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				"*Conclusion: The results of the current study are consistent with previously published reports demonstrating that both EFT and CBT are robust evidence-based treatments for PTSD. Both are well tolerated by refugee populations and appropriate for the treatment of SGBV. The group treatment delivery format is cost-effective, clinically effective, and appropriate for settings in which time and resources are limited. Taken together with previous research, this study indicates that both EFT and CBT should be considered treatments of choice for clinicians and institutions tasked with the welfare of refugees, especially those suffering from PTSD*."	
AAMET International	Evidence Review D	General 212-217	General	We welcome inclusion of 'combined somatic and cognitive therapies' (CSACTs) in the listed psychological interventions for the treatment of PTSD in adults. However we are surprised that Somatic Experiencing (SE) is included in the same category as the acupoint tapping techniques Emotional Freedom Techniques (EFT)/Thought Field Therapy (TFT). The Brom 2017 paper (the only paper included on SE) states that *"The focus of the therapy is on creating awareness of inner physical sensations, which are seen as the carriers of the traumatic memory ... The client learns to monitor the arousal and downregulate it in an early phase by using body awareness, and applying self-regulatory mechanisms*	Thank you for your comment. In response to your and other stakeholder's comments, somatic experiencing has now been removed from the combined somatic and cognitive therapies class and is considered in its own class.

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				like engagement in pleasant sensations, positive memories, or other experiences that help regulate arousal." By contrast, EFT engages with the full somatic, cognitive, and emotional experience, using acupoint tapping to facilitate processing and rapid discharge of distress. According to the paper, SE is based around 15 sessions, which is a much longer treatment than is usual with EFT and other acupoint tapping methods (Church 2013 EFT 6 sessions, Connolly 2011 TFT 1 session, Geronilla 2016 EFT 6 sessions, Robson 2016 TFT 1 session). See also comment number 19 below. We commence our comments by first addressing consultation questions 2, 3 and 4 above and then continue with comments that arise from our reading of the draft Guideline and Evidence Review materials.	
AAMET International	Evidence Review H Consultation Questions 2, 3 and 7	20		As a corollary of point 13 above, as groups are more cost-effective than individual therapies, and the methods in their most basic forms are easily taught, for example within a peer support group setting, this particular characteristic of EFT may revive group treatment for PTSD as a viable option. See also extract from Connolly 2011 within comment number 16 below. See also conclusion from Nemiro 2015 (quoted within comment number 20 below). Nemiro used group EFT with refugees for trauma following sexual gender-based violence.	Thank you for your comment. All included EFT and TFT studies are individual interventions. The committee did not consider that it was appropriate to recommend group EFT as there was no eligible evidence for this intervention Thank you for drawing our attention to the Nemiro 2015 study. Unfortunately, it has not been possible to further assess the eligibility of the study as this paper is not available through the UCL libraries or British library. As a result, this study has now been

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					added to the excluded studies list (with 'Paper unavailable' as the reason for exclusion).
Anna Freud National Centre for Children and Families	Guideline	General	General	We are concerned that the guideline does not explicitly outline that Narrative Exposure Therapy (NET) is subsumed under Trauma-focused Cognitive-Behaviour Therapy (tfCBT). This means professionals may not consider NET as a treatment option unless they read the evidence documents. We would therefore suggest to outline more clearly at the start of the NICE guideline which approaches have been reviewed as evidence-based trauma-focused therapies and to state that all of these are classified as 'tfCBT'.	Thank you for your comment. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. However, in response to your and other stakeholder's comments, we have now made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and the examples of specific interventions (in the glossary) have been added to the recommendation.
Anna Freud National Centre for Children and Families	Guideline & Evidence	General	General	Even though complex PTSD has now been added as a diagnosis in ICD-11, no review of the research and treatment evidence or treatment recommendations have been outlined in the current guidelines. The prevalence rates of CPTSD have been estimated to range from 0.6% in a USA community sample to 13% in a veteran sample (Wolf et al., 2015). In a treatment-seeking trauma clinic outpatient sample, 75.6% met the proposed ICD-11 criteria for CPTSD (Karatzias et al., 2016). In a sample of survivors of childhood institutional abuse, the prevalence of CPTSD was found to be 21.4% (Knefel & Lueger-Schuster, 2013). All of these studies highlight the urgent need for a review of the available evidence as well as treatment recommendations which we think should be included in the	Thank you for your comment and for drawing our attention to the Karatzias et al. (2016), Knefel & Lueger-Schuster (2013), and Wolf et al. (2015) citations. In response to your, and other stakeholder's comments and the publication of ICD-11 we have amended the recognition recommendation to include explicit reference to complex PTSD and the symptoms of complex PTSD have been added to

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				guidelines. In the absence of recommendations for CPTSD there is also a risk that treatment for CPTSD will be considered to be the same as for PTSD, which may or may not be the case.	this recognition recommendation as additional bullet points. Although the evidence was limited on interventions for people who have complex PTSD, the evidence suggested that trauma-focused therapies could also benefit this group. Based on their experience, the committee proposed ways of modifying interventions to address the barriers people with complex PTSD might have to engaging in treatment, like helping the person manage any issues that might be a barrier to engaging with trauma-focused therapies (such as dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception), building in extra time to develop trust with the person (by increasing the duration or the number of therapy sessions according to the person's needs), and avoiding an abrupt end to treatment by planning ongoing support.
Anna Freud National Centre for Children and Families	Guidelines	General	General	On a wider service level, PTSD treatment according to these guidelines may not be made available to the population of Looked After Children where there is no specialist LAC service in the borough. Looked after children are often denied service access to generic CAMHS services when they do not meet the threshold (e.g. no risk of suicide). In clinical practice it has been our observation that PTSD in looked after children is often not	Thank you for your comment and for drawing our attention to the Morris et al. (2015) citation. In response to your comment, the promoting access recommendation has been amended and looked-after children and young people have been added to the list of specific populations of people with

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				recognised, especially in small children under 7 years (partly due to a lack of research and clear assessment guidelines). Research shows that the prevalence of clinically important PTSD symptoms in looked after children who present with emotional and behavioural difficulties can be up to 75% (Morris et al., 2015). We know from the evidence-base that early intervention in the treatment of PTSD is important. Raising awareness about this group of vulnerable children in the guidelines and the need for thorough assessments of PTSD in this group may help bring this issue to the attention of CAMHS professionals.	PTSD who may have additional needs in terms of access.
Anna Freud National Centre for Children and Families	Guidelines & Evidence	General	General	Our clinical practice and research have highlighted that especially individuals with prolonged and repeated exposure to trauma often have limited capacity to self-soothe and regulate their emotions. This in combination with high levels of shame and guilt can in turn lead to a narrowed window of tolerance which adversely affects the ability to fully engage in and benefit from trauma-focused therapy (this may particularly apply to CPTSD and to individuals who experienced prolonged childhood trauma). We think it would be worth mentioning this complexity in the guidelines and, if possible, the available evidence on how to work with it. A longer 'stabilisation' phase with focus on e.g. self-compassion and/or emotion regulation skills may be helpful (where it is expected that these additional symptoms may not sufficiently be addressed through tfCBT).	Thank you for your comment. The recommendation for people with additional needs includes those with complex PTSD, and recommends adaptations that may be needed to treatment, including: helping people manage other issues (including dissociation or emotional regulation) that may be a barrier to engaging with trauma-focused therapies; ensuring adequate time is included in treatment for the person to establish trust; increasing the number of trauma-focused sessions according to need; planning any ongoing support the person needs.

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Anna Freud National Centre for Children and Families	Guideline	8	21	Another principle of care should be behavioural activation and social inclusion through activity groups (e.g. visiting museums, gardening etc.), ideally in combination with symptom management input (grounding strategies etc.) - these groups could be offered before, during and after PTSD treatment.	Thank you for your comment. No eligible evidence was identified for behavioural activation or for interventions similar to those you describe (e.g. practical support, nature-assisted therapies). On this basis the committee did not consider it appropriate to make a recommendation for these interventions.
Anna Freud National Centre for Children and Families	Guideline	9	14	Based on our clinical experience we think that it would be important to raise awareness among professionals that the type of accommodation allocated to individuals with Post-Traumatic Stress Disorder (PTSD) can have a detrimental effect and needs consideration at assessment (e.g. confined space may trigger flashbacks – reminder of prison cell) - may apply more to refugees / asylum seekers	Thank you for your comment. In response to your, and other stakeholder's, comments the maintaining safe environments recommendation has been amended to include the guidance that users of the guideline should *'avoid exposing people to triggers that could worsen their symptoms or stop them from engaging with treatment, for example, assessing or treating people in noisy or restricted environments...*'
Anna Freud National Centre for Children and Families	Guideline	10	17	We are concerned this may be misleading or too open for interpretation without examples. The interventions on offer are evidence-based, so there is limited scope to make big changes to the treatment, yet it is still possible to take into account e.g. religious factors (e.g. not offering therapy at times of prayer, Ramadan etc.) and language (e.g. culture-specific expression of distress / using emotional language that matches individual's understanding etc.).	Thank you for your comment. The committee agreed that these considerations were covered by the recommendation that screening, assessment and interventions should be culturally and linguistically appropriate for service users, and did not think that it was appropriate to be more prescriptive as necessary adaptations will differ by individual and are best addressed at the individual level.
Anna Freud National Centre for	Guidelines	10	17	The guidelines seem to imply that all therapeutic approaches subsumed under tfCBT are effective across cultures. However, there is a lot of evidence that NET is	Thank you for your comment. The guideline used a class approach for analysis and Narrative Exposure Technique (NET) is included within the trauma-

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Children and Families				particularly effective with the refugee and asylum seeking population where individuals have experiences repeat and multiple traumas. If this fits with the review of the evidence, it may be worth mentioning this, so that clinicians can make a more informed choice whether to use tfCBT or NET with refugees and asylum seekers.	focused CBT class. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. We have also made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and examples of specific interventions (in the glossary) have been added to the recommendation. Sub-analyses by specific intervention (within the trauma-focused CBT class) suggests some differential effects but within-subgroup heterogeneity remains high and benefits are observed across all interventions (although statistical significance varies). Similarly, sub-analyses by trauma type suggests some differences with larger effects associated with some trauma types but these are difficult to disentangle as the larger effects are associated with the single smaller study subgroups. In summary, benefits of trauma-focused CBT were seen across a wide range of specific types of trauma-focused CBT intervention

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					of varying durations, and for different types of trauma. However, heterogeneity is high across outcomes and could not be accounted for by planned sub-analyses (by multiplicity of trauma, specific intervention, diagnostic status at baseline, or trauma type). The committee speculated on other potential causes of this heterogeneity, including sub-optimal patient to treatment matching. Based on these discussions, the committee drafted the recommendation about the content and structure of trauma-focused CBT in a way that allowed enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set. The committee did not think that there was sufficient evidence to recommend NET specifically for the refugee and asylum seeking population as there were only two studies (N=57) reporting different outcomes (self- versus clinician-rated PTSD symptomatology). The committee also discussed the added complication of determining relative efficacy for specific groups as there was not a specific review question to address this and the NMA and economic analysis were not restricted by population.
Anna Freud National	Guideline	11	3	We think it would be important to add the following information:	Thank you for your comment. In response to your and other stakeholder's comments, the planning

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Centre for Children and Families				- The importance of being transparent about the effectiveness of the PTSD treatment (e.g. between x-y% of people are treated successfully) - given that exposure to and talking about traumatic events can cause high levels of distress, clients need to know what the likelihood of remission is in order to give informed consent for treatment. Being transparent that symptoms (intrusions, flashbacks) tend to increase initially during exposure treatment before improvements are noticed - this is important in order to manage expectations and to ensure continued engagement in treatment.	treatment recommendation has been amended and the information about proposed interventions that should be provided now includes *'the likelihood of improvement and recovery'*, *'what to expect during the intervention, including that symptoms can seem to get worse temporarily'* and *'that recovery is more likely if they stay engaged with treatment'*.
Anxiety UK	Guidelines	9	1.4.2	We would like to see an addition to this statement so that the support services provided by charitable and third sector organisations are also referenced as at present, the document refers almost exclusively to NHS support.	Thank you for your comment. The committee did not consider it appropriate to reference provision available through third sector organisations in this recommendation, as information and support could be available through third-sector organisations or could be available through NHS or social care-commissioned services.
Anxiety UK	Guidelines	10	1.4.7	Again, as per point (1) – we would like to see reference made to the provision available through third sector organisations. We would also like to see relevant third sector organisations that specifically support those with PTSD etc. included in the guidelines produced for both the public and for healthcare professionals.	Thank you for your comment. The committee did not consider it appropriate to reference provision available through third sector organisations in this recommendation, as practical and emotional support and advice could be available through third-sector organisations or could be available through NHS or social care-commissioned services.
ARREST	Guideline	15	24	The low or very low quality of research demonstrated in Evidence Review C (as described above) does not provide	Thank you for your comment. GRADE considers quality of evidence, but also considers four other

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				evidence for the recommendation not to offer psychological debriefing. Given the quality of the evidence, one could equally recommend the opposite: do not offer the alternatives which were compared to debriefing in those studies (psycheducation/ attention placebo/ no treatment).	domains in making recommendations, namely, balance between desirable and undesirable effects, values and preferences, and whether the intervention represents a wise use of resources. Single-study evidence at 1-year follow-up shows a clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects are at best non-significant. On this basis the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.
ARREST	Guideline	35	8-9	The rationale states that evidence on debriefing showed no clinically important benefit and potentially harmful effects. Whilst this statement accurately summarises the committee's judgement described in Evidence Review C, it does not accurately summarise the evidence on debriefing described in the same review. An accurate summary, according to NICE's criteria, would state that the effect of debriefing is very uncertain and likely to be changed by future research.	Thank you for your comment. GRADE considers quality of evidence, but also considers four other domains in making recommendations, namely, balance between desirable and undesirable effects, values and preferences, and whether the intervention represents a wise use of resources. Single-study evidence at 1-year follow-up shows a clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects are at best non-significant. On this basis the committee agreed that this recommendation should remain unchanged, as

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					offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.
ARREST	Evidence Review C	69-70	3rd and 9th studies listed	We note that the GRADE quality of evidence from these two studies with a one-year follow-up is very low.	Thank you for your comment. GRADE considers quality of evidence, but also considers four other domains in making recommendations, namely, balance between desirable and undesirable effects, values and preferences, and whether the intervention represents a wise use of resources. Single-study evidence at 1-year follow-up shows a clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects are at best non-significant. On this basis, the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.
ARREST	Evidence Review C	69-74	Column 6	The quality of the evidence from every study of debriefing (listed in Tables 25-28) is either low or very low. Given NICE's definitions of evidence quality, it follows either that: 1. any estimate of the effect (positive, negative, or non-existent) of debriefing is very uncertain; or that	Thank you for your comment. GRADE considers quality of evidence, but also considers four other domains in making recommendations, namely, balance between desirable and undesirable effects, values and preferences, and whether the intervention represents a wise use of resources. Single-study evidence at 1-year follow-up shows a

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				2. further research on debriefing is very likely to have an important impact on NICE's confidence in the estimate of the effect of debriefing and is likely to change the estimate.	clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects are at best non-significant. On this basis, the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.
ARREST	Evidence Review C	125-6	General	The textual summary of debriefing evidence also continually notes the low or very low quality of studies, meaning that any effect of debriefing is either very uncertain or likely to be changed by further research. While noting the poor quality of research, the summary lists 14 randomised controlled trials (RCTs) pointing towards a benefit of debriefing, and 7 pointing towards a negative impact on symptoms. A further 9 studies are also described as harmful, but with harm defined as discontinuing the RCT, which may be harmful for researchers but not necessarily participants. Two RCTs are described as showing clinically important and statistically significant harm at one-year follow-up. The GRADE quality of evidence of both RCTs was noted in Table 25 (pp69-70, as noted above) as very low.	Thank you for your comment. GRADE considers quality of evidence, but also considers four other domains in making recommendations, namely, balance between desirable and undesirable effects, values and preferences, and whether the intervention represents a wise use of resources. Single-study evidence at 1-year follow-up shows a clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects are at best non-significant. On this basis, the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.

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ARREST	Evidence Review C	131	4th line from bottom	The review states that there was "limited evidence of harmful effects of debriefing at 1-year follow-up." This statement is not supported by the evidence presented. As noted above, that evidence is limited to two very low quality RCTs. According to NICE's GRADE criteria, the correct conclusion from those two RCTs is that any estimate of the effect of debriefing is very uncertain. An uncertain effect, from studies relying on probability estimates, does not support the committee's confidence that harm outweighs benefit. In contrast, the committee's judgement makes it very difficult for researchers to seek funding for research of better quality into debriefing, creating a vicious circle for aspiring researchers, in which poor quality evidence is misinterpreted to conclude that debriefing is harmful, which makes it hard to gain approval for better debriefing research, which reinforces the persistence of a poor quality research base.	Thank you for your comment. GRADE considers quality of evidence, but also considers four other domains in making recommendations, namely, balance between desirable and undesirable effects, values and preferences, and whether the intervention represents a wise use of resources. Single-study evidence at 1-year follow-up shows a clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects are at best non-significant. On this basis, the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.
ARREST	Evidence Review C	131	Final paragraph	The review states that, "There is evidence...that...debriefing...is unlikely to have a clinically important effect...". No such evidence is presented in the review. Rather, the evidence presented shows, according to NICE's own criteria, that any estimate of the effect of debriefing is very uncertain or likely to be changed by further research. The statement that "debriefing is at best ineffective" appears to ignore the quality of evidence, and does not accurately summarise the evidence if the quality of	Thank you for your comment. GRADE considers quality of evidence, but also considers four other domains in making recommendations, namely, balance between desirable and undesirable effects, values and preferences, and whether the intervention represents a wise use of resources. Single-study evidence at 1-year follow-up shows a clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects are at best non-significant. On this

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				evidence is ignored, as twice as many RCTs are described as pointing towards benefit than towards harm for research participants.	basis, the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.
ARREST	Supplementary Material 1	18	3	We accept the definitions of the overall quality of outcome evidence using profiles based on Grading of Recommendations Assessment,Development and Evaluation (GRADE), in particular that: 1. with very low quality evidence, any estimate of effect is very uncertain; and 2. with low quality evidence, further research is very likely to have an important impact on the confidence the National Institute for Health and Care Excellence (NICE) places in the estimate of effect, and is likely to change the estimate.	Thank you for your comment.
Association for Family Therapy and Systemic Practice (UK)	Guideline	General	General	The wording of the guideline has changed from recommending trauma-focused psychological therapy (CBT and EMDR) to predominantly recommending TF-CBT and EMDR. This effectively can limit client choice and therapist flexibility to tailor therapy to the person's values and context, which can impact on efficacy. The Cochrane review below found that psychological therapies were effective for the treatment of PTSD in children and adolescents. Although they found a slight advantage for CBT they said there was insufficient evidence to differentitate different effectiveness for different therapy models. It is also interesting that components of TF-CBT	Thank you for your comment. The guideline used a class approach for analysis. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. However, in response to your and other stakeholder's comments, we have now made some changes to the wording of the trauma-focused CBT

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				(especially for children and young people) borrow heavily from other therapy models (including systemic therapy models such as Narrative therapy and Narrative Exposure Therapy in working with the trauma narrative) so it is unlikely that the 'effective ingredients' of the therapy packaged as TF-CBT are unique and not found in other therapy models. To limit based on packaging is not ethical, and does not make any sense, when other trauma-focused therapy models have been shown to be effective. The previous wording of trauma-focused psychological therapy, in our opinion offered better guidance for therapists and better flexibility for people who use trauma services. Gillies D, Taylor F, Gray C, O'Brien L, D'Abrew N. Psychological therapies for the treatment of post-traumatic stress disorder in children and adolescents. Cochrane Database of Systematic Reviews 2012, Issue 12. [DOI: 10.1002/14651858.CD006726.pub2]	recommendations to make clear that we are referring to a class of interventions and examples of specific interventions (in the glossary) have been added to the recommendation. Gillies et al. (2012) is listed in excluded studies (Appendix K) of Evidence report B. This systematic review could not be included in its entirety as review questions and inclusion/exclusion criteria were not sufficiently similar. This systematic review was checked for any relevant references, however, no additional studies that met inclusion criteria were identified.
Association for Family Therapy and Systemic Practice (UK)	Guideline	General	General	In using the diagnostic model of PTSD there is an implicit focus on the individual and the 'symptoms' of the individual. This can mean that relational, community and contextual issues and supports are not routinely considered. Systemic family therapy and Narrative therapy in particular have significant history and expertise in working effectively with trauma, involving the family or community as a way to witness the responses people have made to trauma which help them move away from a story of victimhood into one	Thank you for your comment and for drawing our attention to Beaudoin (2005), Coulter (2013), Lock (2016), Marshall et al. (2009), McFarlane (2010), Mendenhall & Berge (2010), Ncube (2006), Wilson (2007), Yuen (2007), and Zala (2012) citations. Neuner et al. (2004) is included in Evidence report D. The guideline used a class approach for analysis and Narrative Exposure Technique (NET) is

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				as a survivor which resonates in meaningful ways with the experiences and values of family, community and individuals to enhance identity and connection, which may have been eroded by traumatic experiences. An individualistic model also does not allow space for cultural understandings, such as power, privilege and experience differences between therapist and person seeking therapy which may impact upon therapy outcomes; it also promotes recovery based on western individualistic ideas about symptom-resolution, where this may not be always be in alignment with a person's cultural, spiritual and other values, and may not reflect cultural differences in expression, communication and collective responses to trauma. Stephen Coulter (2013) Systemic psychotherapy as an intervention for post-traumatic stress responses: an introduction, theoretical rationale and overview of developments in an emerging field of interest Journal of Family Therapy Volume35, Issue 4 November pp. 381-406 https://doi.org/10.1111/j.1467-6427.2011.00570.x Ncube, N. (2006). The Tree of Life Project: Using narrative ideas in work with vulnerable children in Southern Africa. International Journal of Narrative Therapy and Community Work, 1, 3–16.	included within the trauma-focused CBT class. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. We have also made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and examples of specific interventions (in the glossary) have been added to the recommendation. The guideline included family therapy and couple interventions, however, the evidence was very limited and the committee did not think that a recommendation was warranted for any of these interventions. The guideline includes recommendations that interventions are offered in a way that is culturally and linguistically appropriate for service users, and that interpreters and/or offering a choice of therapists are considered where language or culture differences present challenges to the use of psychological interventions. There is also a

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				Beaudoin, M-N. (2005) Agency and choice in the face of trauma: A narrative therapy map. Journal of Systemic Therapies, Vol. 24, No. 4, 2005, pp. 32–50 Lock, S. (2016) The Tree of Life: A review of the collective narrative approach EDUCATIONAL PSYCHOLOGY RESEARCH AND PRACTICE Vol. 2, No. 1. March 2016. pp. 2–20 Yuen, Angel (2007) Discovering Children's Responses to Trauma: A Response-based Narrative Practice [online]. International Journal of Narrative Therapy & Community Work, No. 4, 2007: 3-18. https://search.informit.com.au/documentSummary;dn=059632175830395;res=IELIND> ISSN: 1446-5019 Zala, S. (2012). Complex Couples: Multi-Theoretical Couples Counselling with Traumatised Adults Who have a History of Child Sexual Abuse. Australian and New Zealand Journal of Family Therapy, 33(3), 219-231. doi:10.1017/aft.2012.27 TJ Mendenhall, JM Berge (2010) Family therapists in trauma-response teams: bringing systems thinking into interdisciplinary fieldwork. Journal of Family Therapy, 32: 43-57.	recommendation on promoting access to services for people with PTSD that includes offering a choice of therapist that takes into account the person's traumatic experience. The guideline focused on the effectiveness of different interventions to treat PTSD. Therapist effects were not an area that was prioritised for inclusion in the guideline, therefore the evidence on this has not been reviewed and we are not able to make any recommendations on this issue.

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				Neuner, Frank,Schauer, Margarete,Klaschik, Christine,Karunakara, Unni,Elbert, Thomas (2004) A Comparison of Narrative Exposure Therapy, Supportive Counseling, and Psychoeducation for Treating Posttraumatic Stress Disorder in an African Refugee Settlement. Journal of Consulting and Clinical Psychology, Vol 72(4), Aug 2004, 579-587. Marshall, G. N., Schell, T. L., & Miles, J. N. V. (2009). Ethnic differences in posttraumatic distress: Hispanics' symptoms differ in kind and degree. Journal of Consulting and Clinical Psychology, 77, 1169-1178. doi: 10.1037/a0017721McFarlane,A.C. (2010). The long-term costs of traumatic stress: intertwined physical and psychological consequences. World Psychiatry, 9, 3-10. Wilson, J. P. (2007). The Lens of Culture: Theoretical and Conceptual Perspectives in the Assessment of Psychological Trauma and PTSD. In J. P. Wilson & C. S. Tang (Eds.), Cross-Cultural Assessment of Psychological Trauma and PTSD (pp. 3-31). New York, NY: Springer Science + Business Media, LLC.	
Association for Rewind Trauma Therapy	Guideline	General	General	**Purpose of this response** If a trauma focused therapy could be reduced to two to three sessions with a 90% **closure** rate then its use would increase dramatically, the costs to the country would fall both in terms of drug prescriptions, welfare costs,	Thank you for your comment. Rewind intervention was not excluded from the guideline review but no eligible evidence was identified. On this basis, the

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				turnover and adequate man power. The Rewind Trauma Focused Therapy provides such an alternative. It would consequently seem to be cost effective, efficacious and ethical for NICE to recommend use of the Rewind should all other trauma focused therapies let down both clients and therapists. Ethical because it does not involve the client disclosing any details of the traumatic event.. The purpose of this note is to ask NICE for careful examination of this treatment. **Factual Background** **NHS England r**eported that 4.4% of the population screened positive for PTSD**.** Around half of those who did (50.9%) were currently receiving treatment for a mental or emotional problem. The most common form of treatment was psychotropic (mental health) medication, either on its own (26.9% of those who screened positive for PTSD), or in combination with psychological therapy (16.7%). **Psychological therapy without medication was the least common form of treatment (7.3%).** Four in ten participants who screened positive for PTSD (43.6%) were currently taking psychotropic medication. The most common types were those primarily used for the treatment of depression (39.8%) or anxiety (36.0%). In addition, 8.7% were taking medication used in the treatment of substance misuse disorders. **Claire Murdoch,** NHS England's National Director for Mental Health has written to say that the analysis of	committee did not consider a recommendation to be appropriate. The reconsolidation of traumatic memories (RTM) intervention involves 'rewinding' techniques. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new RCTs were identified through stakeholder comments and were integrated into the pairwise analyses. The committee considered this new evidence for RTM, and agreed that although there was limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. The committee were also concerned about the generalisability of this evidence given that both studies were on US military veterans. Furthermore, this evidence could not be included in the guideline NMA and, subsequently, in the guideline economic modelling, because the comparator in both studies was treatment as usual, rather than waitlist, and therefore the two studies could not be connected to the evidence network. Please note, however, that the fact that RTM was not considered in the guideline economic analysis had no impact on recommendations, as the clinical evidence itself

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				mental health services, compiled by NHS Digital, inter alia shows that of the 567,000 people finishing a course of NHS talking therapy in 2016/2017:... recovery rates improved to an average of **49 per cent over the course of the year**...	was too limited to warrant a recommendation for RTM.
Association for Rewind Trauma Therapy	Guideline	General	Recommendations	"**The duration of trauma-focused psychological treatment for CBT and EMDR should normally be 8–12 sessions when the PTSD results from a single event."** **PTSD therapies compared** Treatment is principally through prescribing antidepressants and psychotherapy. The NHS currently reaches just 25% of sufferers with talking therapies due partly to client concerns but mainly because multiple session trauma treatment therapy one-on-one delivery is expensive and the time to closure long. CBT and EMDR successful therapy outcomes are described as "significant symptom improvement". *The Rewind* instead addresses the traumatic event itself rather than the avoidance behaviour etc., aiming to get patients to "file the traumatic event". What this means in everyday practice is that **involuntary** recall of the traumatic event is brought under **voluntary** recall. **Unlike CBT and EMDR, *Rewind Trauma Focused Therapy* usually needs just two treatment sessions.** The first comprises psychoeducation, completion of a PTSD self assessment questionnaire such as the Impact	Thank you for your comment. Rewind intervention was not excluded from the guideline review but no eligible evidence was identified. On this basis, the committee did not consider a recommendation to be appropriate. The reconsolidation of traumatic memories (RTM) intervention involves 'rewinding' techniques. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new RCTs were identified through stakeholder comments and were integrated into the pairwise analyses. The committee considered this new evidence for RTM, and agreed that although there was limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. The committee were also concerned about the generalisability of this evidence given that both studies were on US military veterans. Furthermore, this evidence could not be included in the guideline NMA and, subsequently, in the guideline economic

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				of Events Scale (IES) or the PTSD Check- list 5 (PCL 5) and a succession of two minute duration treatments. The purpose of the second session is to confirm the outcome: closure**.** In those few cases where the outcome is not positive, i.e. the IES or PCL 5 score has not altered, a third session is undertaken. If still unsuccessful, Rewind is not attempted further. Other advantages offered in addition to closure in just a few sessions are: ● CBT and EMDR have a subject drop out rate of around 15%, *The Rewind* dropout is extremely rare, because subjects do not have to disclose the details of their trauma and there are fewer sessions, ● The £100-£200 one day training cost for a Rewind Counsellor compares very favourably with what is required for CBT and EMDR counsellors(respectively(approximate figures) £3800 and £3000) ● Rewind is effective from the age of four. ● Compared with CBT and EMDR, *The Rewind*'s hugely reduced trauma course duration, low dropout and 2x success rate gives it a significant cost-benefit *single* client advantage. ● Burn-out arising from compassion fatigue is avoided with *The Rewind* as no details of the causal event are disclosed to the therapist. **Conclusion**	modelling, because the comparator in both studies was treatment as usual, rather than waitlist, and therefore the two studies could not be connected to the evidence network. Please note, however, that the fact that RTM was not considered in the guideline economic analysis had no impact on recommendations, as the clinical evidence itself was too limited to warrant a recommendation for RTM.

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				The Rewind is applicable to single and multiple life-threatening traumas, is ethical and enjoys a single individual 90% - 95% success rate. Group-conducted Rewind (3) has successfully treated 18 out of 21 patients in a single session and is consequently a potentially efficacious and cost-effective transformative alternative to current NHS NICE-approved practice.	
Association for Rewind Trauma Therapy	Guideline	General	Recommendations	**"The committee noted how encouraging the evidence is for psychological treatments such as trauma-focused CBT for treating PTSD. However, they agreed that there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms. It is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and physical health."** **ARTT comment** NICE rightly highlighted the dilemma facing therapists as to what to do next to treat or manage PTSD symptoms when these therapies fail. We would like to suggest that NICE recommend use of the Rewind as an affordable alternative should all other trauma focused therapies fail. The following national organisations and charities are currently trained and using the Rewind.Clearly, this shows that these	Thank you for your comment. Rewind intervention was not excluded from the guideline review but no eligible evidence was identified. On this basis, the committee did not consider a recommendation to be appropriate. The reconsolidation of traumatic memories (RTM) intervention involves 'rewinding' techniques. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new RCTs were identified through stakeholder comments and were integrated into the pairwise analyses. The committee considered this new evidence for RTM, and agreed that although there was limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. The committee were also concerned about the generalisability of this evidence given that both

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				organisations are already embracing a therapy which, contrary to the currently renewed NICE CBT and EMDR guidelines, meets their needs to deal with the lengthy waiting lists, costs and human benefits . 500 new mental health therapists have been trained this year and a further 500 are booked to be trained by IARTT by the end of 2018 and 4000 more by 2020. London Fire Brigade, Derbyshire Alcohol Advice Service Sheffield Rape and Sexual Abuse Centre QCCS, Ashwood House, Birmingham Women's & Children's NHS Foundation Trust, Birmingham Women's and Children's Hospital, Bower House,Christian Counselling, Market Harborough, CARITAS, CRASAC, CRUSE BEREAVEMENT CARE Dragonfly Therapy Ltd, Gofal, Harmonious Counselling, Hereward College, HMP(Her Majesties Prison) Whatton, IAPTS NHS Insight Healthcare,InspirePowerUK, Journeys Journeys Cardiff; Cardiff Concern, Listening 2 U Medway Talking Therapies, Insight Health, NHS CAMHS Oxleas Trust,PACT (MH) UK, Parents and Carers Together, PSS PSS (Spinning World), QUAL Consultancy, Safeline, HMP Onley,Reclaim Life RELATE,ROAD VICTIMS TRUST, St Elizabeths Catholic Primary School, TEWV NHS Trust, Thanet Counselling, The Light House Coventry. The Old SurgeryCounselling Centre, Touchstones Child	studies were on US military veterans. Furthermore, this evidence could not be included in the guideline NMA and, subsequently, in the guideline economic modelling, because the comparator in both studies was treatment as usual, rather than waitlist, and therefore the two studies could not be connected to the evidence network. Please note, however, that the fact that RTM was not considered in the guideline economic analysis had no impact on recommendations, as the clinical evidence itself was too limited to warrant a recommendation for RTM.

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				Bereavement, Winston's Wish, Worcestershire Acute NHS Trust, Tommy Atkins Centre for Veterans Worcester Solace (Leeds), Beck (Leeds), Mind (Basildon) Nottingham Counsellors Group,Mind (Wales), East London Foundation NHS trust (Bedfordshire area),Manchester "Counselling Northwest", Birmingham/Solihull Sexual violence and Sexual Abuse. Becky Willoughby at Willow Therapy in Tring, Sue Ryder hospice in Moggerhanger Bedfordshire, Cardiff and Vale and Cwm Taf NHS, Coventry Haven and Safeline, CRASAC (RAPE CRISIS AND SEXUAL ABUSE) Carmarthenshire counselling services, Chai Cancer Care, Derbyshire Alcohol Advice Service (which is a charity) based in Chesterfield. We provide Drug & Alcohol counselling	
Association for Rewind Trauma Therapy	Guideline	General	Recommendations	"The committee noted how encouraging the evidence is for psychological treatments such as traumafocused CBT for treating PTSD. **However, they agreed that there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms. It is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and**	Thank you for your comment. Rewind intervention was not excluded from the guideline review but no eligible evidence was identified. On this basis, the committee did not consider a recommendation to be appropriate. The reconsolidation of traumatic memories (RTM) intervention involves 'rewinding' techniques. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new RCTs were

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				physical health." **ARTT above comment continues** **The list of organisations and Charities adopting the Rewind.** Coventry Mind. Edward's Trust (EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST) EAP providers including critical incident Families First Bedfordshire , Charity "Jenkins Centre - FreeVA" Leicester, Headstrong Wellbeing CIC Leicester, Mind NorthStaffs Stoke-on-Trent, North Warwickshire Counselling Service.Mind in Milton Keynes, S.H.E UK, provide support for survivors of childhood sexual abuse, sexual violence and rape. RASA.Merseyside , Birmingham St. Mary's Hospice, The Student Counselling Centre University of Leeds Rape and Sexual Abuse Support Centres trained to date in the UK Worcestershire ,Coventry, Essex,Wolverhampton,Liverpool,Sheffield,Aylesbury,Peterborough,Bristol Birmingham/Solihull	identified through stakeholder comments and were integrated into the pairwise analyses. The committee considered this new evidence for RTM, and agreed that although there was limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. The committee were also concerned about the generalisability of this evidence given that both studies were on US military veterans. Furthermore, this evidence could not be included in the guideline NMA and, subsequently, in the guideline economic modelling, because the comparator in both studies was treatment as usual, rather than waitlist, and therefore the two studies could not be connected to the evidence network. Please note, however, that the fact that RTM was not considered in the guideline economic analysis had no impact on recommendations, as the clinical evidence itself was too limited to warrant a recommendation for RTM.
Birth trauma Association	Guideline	General	General	• Paragraphs 1.6.20 and 1.6.21 recommends specific drug treatments for PTSD but does not mention that some of these drugs are contra-indicated for breastfeeding women. This is important to mention because approximately 20,000	Thank you for your comment. As specified in the review protocols, this guideline does not cover women with antenatal or postnatal PTSD as there is existing NICE guidance, 'Antenatal and postnatal mental health: clinical management and service

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				women a year experience postnatal PTSD and some of these will be breastfeeding. • Paragraph 1.6.19 advises against psychologically-focused debriefing. However, it would have been useful to mention that a medically-focused debriefing can be helpful for women with postnatal PTSD. Further, trials on psychological debriefing have failed to show significant effect. However, these trials did not offer the service when women who have experienced traumatic birth felt they needed it. Rather, they delivered a debriefing intervention in the timescales set out in the research methodology. Thus, we have no robust evidence on psychological debriefing delivered in a manner and timescale that women find acceptable. We do know however that women complain of lack of acknowledgement of traumatic birth, so it seems that no debriefing is possibly harmful. We therefore request that Nice put out a research recommendation for further research in patient-led debriefing • In section 1.1.1, the guideline mentions that people with PTSD may present with a range of symptoms associated with functional impairment, including "anger and irritability" and "negative alterations in mood and thinking". It fails to consider the impact these symptoms may have on a woman who is also caring for a new baby – a time that is	guidance' which includes recommendations for this group. Please see CG45 https://www.nice.org.uk/Guidance/CG45

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				recognised as particularly difficult and stressful even for parents without mental health problems. • Although there are several references to avoidance as a symptom of PTSD, the guideline does not consider the fact that for women with postnatal PTSD, avoidance can take the form of staying away from contact with health professionals or with the hospital where they gave birth, making it harder to identify these women and treat them. Postnatal PTSD can also make it hard for women to bond with their baby and make them less likely to seek help because they fear the baby being taken away. The guideline should therefore address the problem of making sure women are able to access the help they need. • Trials on psychological debriefing have failed to show significant effect. However, these trials did not offer the service when women felt they need ed it rather they delivered a debriefing intervention in the timescales set out in the research methodology. Thus, we have no robust evidence on psychological debriefing delivered in a manner and timescale that women find acceptable. We do know however that women complain of lack of acknowledgement of traumatic birth, so it seems that no debriefing is possibly harmful. Would therefore request that Nice put out a research recommendation for further research in woman or patient led debriefing.	

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				• Within the guidelines very little is referred to how to support healthcare professionals to recognise PTSD in individuals and particularly related to women where a traumatic birth accounts for 200,000 women a year which is a large amount. How would this be reflected in the guidelines.	
British Association for Behavioural and Cognitive Psychotherapies	Guideline	6	18	1.2.2 Removal of "conducted by competent individuals" makes sense in context of this being a general NHS requirement.	Thank you for your comment.
British Association for Behavioural and Cognitive Psychotherapies	Guideline	8	16	1.3.2 We agree that it is important not to delay treatment because of litigation. In terms of the implications of this, it may be helpful to highlight that work is needed with the Crown Prosecution Service and legal bodies to think about whether clinical notes can be requested and work with clinicians to think through the level of detail to include in notes for these cases. Currently clinicians often feel they need to warn patients that notes can be requested, and this tends to put people off having therapy.	Thank you for your comment. A cross-reference to the relevant CPS guidance has now been added to this recommendation.
British Association for Behavioural and Cognitive Psychotherapies	Guideline	9	14	1.4.4 In relation to: "Be aware of the risk of continued exposure to trauma-inducing environments or triggers for people with PTSD, and minimise exposure to triggers that could risk exacerbating symptoms." We note that this may be difficult, for example in situations of enduring inter-group conflict so it will be important early in therapy to break the link between triggers and trauma memories.	Thank you for your comment. The committee recognise these potential difficulties and the recommendation on adaptations that may be required for people with PTSD and additional needs includes the guidance to take into account the safety and stability of the person's personal

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					circumstances and how this might impact on engagement with and success of treatment.
British Association for Behavioural and Cognitive Psychotherapies	Guideline	9	19	1.4.5 In "Ivolving and supporting families and carers" and the following section 1.4.6 We welcome the more specific details of types of family involvement that may be helpful	Thank you for your comment.
British Association for Behavioural and Cognitive Psychotherapies	Guideline	12	4	1.6.4 The recommendation for either active monitoring or individual trauma focussed CBT is confusing especially in the context of previous guidelines which recommended waiting for 1 month post-traumatic incident. Whilst we welcome early intervention, having a clearer rationale for this change within the guideline document itself would be helpful.	Thank you for your comment. The rationale for all recommendations should be included in the 'Rationale and impact' section towards the end of the guideline document. However, you are correct that this has been missed for this recommendation, many thanks for drawing our attention to this omission. The rationale for this recommendation included in the evidence report has now been added to the guideline document. The committee discussed the absence of evidence for individual trauma-focused CBT within 1 month of trauma. There was also insufficient evidence for any other intervention for children and young people within the first month of trauma exposure. Based on their clinical experience the committee did not believe that there would be significant risks associated with offering trauma-focused CBT to children and young people in this early phase and did not believe that there were any strong reasons

					why it would not work in this phase. With this in mind, the committee decided to draw on stronger evidence showing individual trauma-focused CBT to be effective for children and young people more than 1 month after a traumatic event, and the evidence from adults showing benefits within 1 month of trauma, and based on consensus opinion agreed that individual trauma-focused CBT should be considered for children and young people with clinically important PTSD symptoms or acute stress disorder. Drawing on their clinical experience, the committee were mindful that intervention within the first month would not be appropriate for all children and young people. For example, where children and young people and their caregivers are interested in managing their symptoms on their own, are unsure about whether to commence a psychological therapy like trauma-focused CBT or there are practical difficulties in commencing an active treatment (e.g. someone in the family unit is still recovering from their injuries, the family has had to be relocated). For these individuals, a period of active monitoring may be of clinical utility in allowing a child or young person the opportunity to understand more about their symptoms. Furthermore, it was felt this recommendation conveyed an important non-stigmatising message around the normality of PTSD symptoms, which may in turn help to reduce distress. The committee were also aware of a meta-analytic review

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					suggesting that there is an important degree of natural recovery of PTSD symptoms in the first weeks and months following a trauma in children and young people. For these reasons the committee agreed that active monitoring should be considered alongside individual trauma-focused CBT and a choice between these two options should be based on clinical judgement.
British Association for Behavioural and Cognitive Psychotherapies	Guideline	12	21	1.6.9 We welcome the inclusions of "booster sessions" in the guideline. We would suggest the guideline of 6-12 sessions should say "but could take more and this should be based on individual patient need," as many patients need more than 6-12 sessions.	Thank you for your comment. In response to your, and other stakeholder's comments, this recommendation has been amended to *'typically be provided over 6 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas'*.
British Association for Behavioural and Cognitive Psychotherapies	Guideline	12	21	1.6.9 Trauma-focused CBT for children and young people should include … We recognise the importance of these sections that lists the specific elements of Trauma Focussed Cognitive Behavioural Therapy (TFCBT) to help ensure that patients know what to expect and what they should be receiving	Thank you for your comment.
British Association for Behavioural and Cognitive Psychotherapies	Guideline	14	6	1.6.14 Trauma-focused CBT for adults should include… We recognise the importance of these sections that lists the specific elements of TFCBT to help ensure that patients know what to expect and what they should be receiving	Thank you for your comment.
British Association for	Guideline	15	12	1.6.17 We welcome the recommendation of supported trauma-focused computerised CBT for adults with a	Thank you for your comment.

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Behavioural and Cognitive Psychotherapies				diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event who do not want or have not been able to engage in face-to-face, trauma-focused CBT or EMDR. [2018] This recommendation also helps to facilitate trauma-focused treatment for adults with PTSD who may live in remote areas who are unable to easily access services regularly, who may be unable to take time off work for treatment, or who hold negative beliefs about accessing services for weekly treatment. Some people may find it easier to disclose details of their trauma online, rather than face-to-face, because of feelings of shame or stigma.	
British Association for Behavioural and Cognitive Psychotherapies	Guideline	15	24	1.6.19 We welcome the clarity over not using psychological debriefing in adults for PTSD prevention.	Thank you for your comment.
British Association for Behavioural and Cognitive Psychotherapies	Guideline	19	7	Under the section - Recommendations for research "As part of the 2018 update, the guideline committee removed the 2005 research recommendations and replaced them with the recommendations below." Comment – As ICD 11 will have a specific diagnostic category on prolonged grief disorder and DSM5 contains a research category of prolonged complex grief disorder – an important new area of research is how to understand the phenomenology of complex grief and differentiate Complex	Thank you for your comment. The committee did not make a research recommendation in this area as other areas were assessed to be of greater importance.

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				grief from PTSD related to traumatic death and develop effective treatments for this trauma reacted disorder	
British Association of Art Therapists	General	General	General	I am writing on behalf of the three professional arts therapies bodies. We are all HCPC regulated professions who belong to the Allied Health Professions and represent more than 4000 practitioners, many of whom work with people with PTSD, including veterans. It is with great dismay that we read that for art therapy, NICE found only two art therapy studies to consider both of which were excluded (Schouten et al.; Uttley): "Two studies were reviewed at full text and excluded from this review because they were systematic reviews with no new useable data and any meta-analysis results were not appropriate to extract.". Despite some indication that NICE would be more inclusive of qualitative evidence, once again NICE's approach seems to favour a medical model and RCTs whilst ignoring other types of evidence. As you will be no doubt aware, research has found up to 30% of service-users with PTSD to be unresponsive to evidence-based treatments (Wisco, Marx, & Keane, 2012). These service users are left with no other psychological therapies provisions if these are limited to the usual provision of CBT, etc. Furthermore, a recent meta-analysis showed high drop-out rates of 36% for PTSD psychotherapies (Goetter et al.,	Thank you for your comment and for drawing our attention to Goetter et al. (2015), Lab et al. (2008) and Wisco et al. (2012) citations. Arts therapies were not excluded. However, very limited eligible evidence was identified. Namely, a single study of art therapy for children (Lyshak-Stelzer 2007). Although this study was suggestive of potential benefits of art therapy (in addition to treatment as usual) on clinician-rated PTSD symptoms, the committee did not consider that a single study with 29 participants and only one outcome was sufficient evidence on which to base a recommendation. The committee also noted that the intervention in that study, Trauma-focused expressive art therapy, shared many features of trauma-focused CBT, and thus applicability or generalisability to non-directive art therapy was uncertain. For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs)

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				2015), suggesting that many service users did not engage with treatment. Narrow use of NICE recommended treatment options often did not lead to recovery. (Lab, Santos & DeZuleta, 2008) We feel very strongly that excluding arts therapies (art therapy, music therapy and dramatherapy) from the evidence for this draft guideline will be detrimental to service users and we would like to ask you urgently to reconsider your decision.	and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. This guideline also included a qualitative review of service user experience (see Evidence report H), however, experience of arts therapies (positive or negative) did not emerge as a theme. The committee recognise that there can be difficulties in keeping people with PTSD engaged in treatment and in response to this drafted recommendations in the 'Planning treatment and supporting engagement' section of the guideline. In response to your, and other stakeholder's comments, arts therapies have now been added as an example intervention to the research recommendation about sequencing and further line treatment in Appendix L of Evidence report D.
British Association of Art Therapists	Guideline	13	9-13	We recommend considering art therapy for children who have not responded to or engaged with trauma-focused CBT. Some children find it difficult to engage in verbal therapy, especially very young children (Malchiodi & Crenshaw, 2017).[1] Although trauma-focused CBT may incorporate art therapy and play therapy, Malchiodi (2015)[2] explains specifically the theoretical and limited empirical basis for art therapy and play therapy for children who have experienced trauma. We note that the evidence on trauma-	Thank you for your comment and for drawing our attention to the Chapman (2014), Klorer (2005), Malchiodi (2015), Malchiodi & Crenshaw (2017), and Wamser-Nanney & Steinzor (2017) citations. Art therapy and play therapy were included in the review. However, as highlighted in your response, the evidence for these interventions was very

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				focused CBT on which this guideline is based was mainly for children over 7. Research has reported between 33 and 77% attrition from trauma-focused CBT for children (Wamser-Nanney & Steinzor, 2017[3]). We have a concern that a guide that aims to restrict practice to trauma-focused CBT may lead to children who have difficulty engaging with trauma-focused CBT missing out on potentially helpful art therapy and/or play therapy. Similar considerations may be relevant to young people, where there is some evidence that art therapy can also be helpful (Lyshak-Stelzer et al. 2007)[3]. [1] Malchiodi, C.A. & Crenshaw, D.A. [Eds]. (2017). What to do when children clam up in psychotherapy: Interventions to facilitate communication. (pp. 3-17). New York, NY, US: Guilford Press; US. [2] Malchiodi, C.A. [Ed]. (2015). Creative interventions with traumatized children, 2nd ed. (pp. 258-278). New York, NY, US: Guilford Press; US [3] Wamser-Nanney, R. & Steinzor, C.E. (2017). Factors related to attrition from trauma-focused cognitive behavioral therapy. *Child Abuse and Neglect,* 66, 73-83. http://dx.doi.org/10.1016/j.chiabu.2016.11.031 [4] Lyshak-Stelzer, F., Singer, P., St. John, P. & Chemtob, C. (2007). Art therapy for adolescents with Post Traumatic Stress Disorder symptoms: A pilot study. *Art Therapy: Journal of the American Art Therapy Association,* 24(4),163-169.	limited and the committee did not consider it appropriate to recommend either intervention. The evidence suggested that trauma-focused CBT was effective for children both over and under 7 years. Most of the evidence came from older children, so the committee could not recommend it with the same certainty for under 7s but agreed it should be thought of as an option for them. The committee discussed the evidence that showed a trend for a higher rate of discontinuation with trauma-focused CBT relative to waitlist, treatment as usual or no treatment, and agreed that, given that this effect was not statistically significant and the comparison against supportive counselling showed a trend in favour of trauma-focused CBT for lower discontinuation, the benefits of trauma-focused CBT outweighed any potential harm. The committee also drafted recommendations in the 'Planning treatment and supporting engagement' section of the guideline that attempted to address some of the potential reasons for early discontinuation. In response to your, and other stakeholder's comments, arts therapies have now been added as an example intervention to the research

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				Further literature on mechanisms of art therapy with children: Chapman, L. (2014). *Neurobiologically informed trauma therapy with children and adolescents: Understanding mechanisms of change*. New York: W. W. Norton. Klorer, P. (2005). Expressive therapy with severely maltreated children: neuroscience contributions. *Art Therapy: Journal of the American Art Therapy Association*, *22*(4), 213-220. **Studies on art therapy with children** Chapman, L., Morabito, D.,Ladakakos, C., Schreier, H. & Knudson, M. (2001). The effectiveness of art therapy interventions in reducing Post Traumatic Stress Disorder (PTSD) symptoms in pediatric trauma patients. *Art Therapy: Journal of the American Art Therapy Association, 18*(2), 100-104. Pifalo, T. (2002). Pulling out the thorns: Art therapy with sexually abused children and adolescents. *Art Therapy: Journal of the American Art Therapy Association*, 19(1), 12-22.	recommendation about sequencing and further line treatment in Appendix L of Evidence report D. Please see below for details on the inclusion/exclusion of each of the references you cite: • Lyshak-Stelzer et al. (2007) is included in the review for Evidence report B • Chapman 2001 is included in the excluded studies (Appendix K) in Evidence report A because efficacy or safety data could not be extracted (data in figures) • Pifalo (2002) has not been included in the guideline as it does not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs)
British Association of Art Therapists	Guideline	15	12-15	We recommend adding a further option of offering art therapy, either group or individual, for people who have not engaged with, or not been able to benefit from face to face trauma-focused CBT. Research has found up to 20% of people with PTSD to drop out of CBT for PTSD (Bryant et al., 2007)[1]. Moreover in their own study Bryant et al. (2007) reported that those who dropped out were, among	Thank you for your comment and for drawing our attention to the Bryant et al. (2007) and Lobban (2018) citations. Very limited eligible evidence was identified for art therapy, namely a single study in children (Lyshak-Stelzer 2007). Although this study was suggestive

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				other things, more prone to avoid reminders of their trauma. Art therapy can help people approach it less directly and in such a way that they feel more in control (Lobban, 2018)[2]. There needs to be more choice available for PTSD. [1] Bryant, R.A., Moulds, M.L., Mastrodomenico, J., Hopwood, S., Felmingham, K., & Nixon, R.D.V. (2007). Who drops out of treatment for post-traumatic stress disorder? *Clinical Psychologist,* 11, 13-15. DOI: 10.1080/13284200601178128 [2] Lobban, J. (2018). Bypassing the sentinel. In J. Lobban (Ed.), Art therapy with military veterans: Trauma and the image (pp. 152–166). London: Routledge.	of potential benefits of art therapy (in addition to treatment as usual) on clinician-rated PTSD symptoms, the committee did not consider that a single study with 29 participants and only one outcome was sufficient evidence on which to base a recommendation. The committee also noted that the intervention in that study, Trauma-focused expressive art therapy, shared many features of trauma-focused CBT, and thus applicability or generalisability to non-directive art therapy was uncertain. The committee recognise that there can be difficulties in keeping people with PTSD engaged in treatment. Although the evidence for trauma-focused CBT was overwhelmingly positive, the committee discussed the evidence suggesting a significantly higher rate of drop-out relative to waitlist, and a small but still statistically significant higher drop-out where trauma-focused CBT augmented treatment as usual or medication (relative to treatment as usual/medication-only). The committee discussed potential reasons for this higher rate of discontinuation, and speculated that trauma-focused CBT may be less acceptable to people who are not ready to directly confront traumatic memories, are not able to engage due to functional impairment from associated symptoms,

					and/or have difficulties in building a trusting therapeutic relationship. As existing recommendations for non-trauma-focused symptom-specific CBT interventions, modifications of trauma-focused therapies for those with additional needs (including complex PTSD), and engagement strategies for those with difficulties in building trust in the therapeutic relationship (based on the qualitative evidence [see evidence review H]) have the potential to address some of these reasons for discontinuation, the committee agreed that the potential for benefit was greater than the potential for harm. The committee also noted that effects on discontinuation only reached the threshold for clinical importance for the comparison against waitlist where there may be an additional incentive for waitlist participants not to drop-out, given that access to the intervention is contingent upon continuing in the trial. Furthermore, offering EMDR as an option for those with non-combat-related PTSD, or supported computerised trauma-focused CBT as an alternative lower intensity intervention, allows people who may not find trauma-focused CBT acceptable to access another psychological intervention if they prefer. In response to your, and other stakeholder's comments, arts therapies have now been added as an example intervention to the research

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					recommendation about sequencing and further line treatment in Appendix L of Evidence report D.
British Association of Art Therapists	Guideline	16	4-6	We are concerned that the advice is to consider an SSRI even though evidence for their effectiveness is not strong. In addition there is evidence of 'discontinuation effects' for SSRIs, and this may lead later on to the person experiencing difficulty stopping the drugs, leading to on-going costs that may not have been incurred had the person received appropriate therapy from the outset. If they ask for drug treatment they should be given accurate information about the superior evidence for psychological therapy, and told about 'discontinuation effects' of SSRIs. Furthermore, art therapy has long been recognised in both the USA and UK as helpful within multi-disciplinary approaches to PTSD in military and ex-military personnel, and we suggest offering it should continue to be recommended either as part of a package of treatment or an alternative to trauma-focused CBT, particularly where people's reluctance to enter a talking therapy is based on difficulty talking about their trauma. Visual representation (a) can make it possible to approach trauma from a non-verbal and less direct angle, therefore can feel safer, (b) lends itself to the sensory-cognitive integration important for healing (Brewin et al., 2010[1]; Collie et al. 2006[2]), and (c) may enable people to overcome initial avoidance and thereafter engage in trauma-focused CBT or EMDR. Many art therapists are working within the Herman (1992)[3] phased model of approaching trauma, establishing	Thank you for your comment and for drawing our attention to the Americans for The Arts (2013), Avrahami (2005), Brewin et al. (2010), Collie et al. (2006), Gantt & Tinnin (2009), Herman (1992), Konopka (2016), Lobban (2017a, 2017b, 2017c, 2017d, 2017e), Lobban & Ellis (2017), Lobban & Murphy (2017), Lusebrink & Hinz (2016), Smith & Lobban (2017), Talwar (2007), Tinnin & Gantt (2014), Tripp (2007), and Van der Kolk (2014) citations. The recommendation concerning SSRIs states that they should only be considered where the person has a preference for drug treatment. The committee considered the short and long-term harms associated with the side effects of medication and took these into account when developing the recommendation. However, the committee were also mindful of the negative consequences of prolonged PTSD and associated symptoms, the potential to ameliorate functional impairment, and the need to facilitate patient choice where there is a clear preference for medication over psychological interventions. It is made clear in the rationale and impact section of Evidence report F that SSRIs should not be considered as a first-line treatment

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				grounding before moving on to working with traumatic material, and there is preliminary research evidence of effectiveness and high acceptability for military people with PTSD (Jones et al. 2018[4]; Walker, 2017[5]). Lobban's (2012[6]; 2016[7]) small scale evaluations of art therapy for veterans within a multi-disciplinary treatment programme are also promising. Other evidence also supports the use of art therapy in conjunction with cognitive therapies (Campbell et al., 2016[8]; Murphy et al. (2015).[9] [1] Brewin, C. R., Gregory, J. D., Lipton, M., & Burgess, N. (2010). Intrusive images in psychological disorders: Characteristics, neural mechanisms, and treatment implications. Psychological Review, 117, 210-232. DOI: 10.1037/a0018113 [2] Collie, K., Backos, A., Malchiodi, C.A., & Spiegel, D. (2006). Art therapy for combat-related PTSD: Recommendations for research and practice. *Art Therapy,* 23, 157-64. https://doi.org/10.1080/07421656.2006.10129335 [3] Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress, 5,* 377-391. https://doi.org/10.1002/jts.2490050305 [4] Jones, J.P., Walker, M.S., Drass, J.M., & Kaimal, G. (2018). Art therapy interventions for active duty military service members with post-traumatic stress disorder and traumatic brain injury. *International Journal of Art Therapy,* 23, 70-85. https://doi.org/10.1080/17454832.2017.1388263	for PTSD (except where a person expresses a preference for drug treatment) due to concern about side effects of SSRIs, evidence from the guideline NMA that suggests relatively larger effect sizes for all psychological interventions recommended relative to SSRIs (trauma-focused CBT, EMDR, non-trauma-focused CBT and self-help with support), and evidence from the guideline economic modelling that suggests that SSRIs are less cost-effective than EMDR, brief individual trauma-focused CBT or self-help with support. Very limited eligible evidence was identified for art therapy, namely a single study in children (Lyshak-Stelzer 2007). Although this study was suggestive of potential benefits of art therapy (in addition to treatment as usual) on clinician-rated PTSD symptoms, the committee did not consider that a single study with 29 participants and only one outcome was sufficient evidence on which to base a recommendation. The committee also noted that the intervention in that study, Trauma-focused expressive art therapy, shared many features of trauma-focused CBT, and thus applicability or generalisability to non-directive art therapy was uncertain.

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				[5] Walker, M.S. (2017). Art therapy approaches within the National Intrepid Center of Excellence at Walter Reed National Military Medical Center. In P. Howie (Ed.), *Art Therapy with Military Populations: History, Innovation and Applications* (pp. 111-123). London: Routledge. [6] Lobban, J. (2012). The invisible wound: Vetarans' art therapy. *International Journal of Art Therapy,* 19, 3-18. https://doi.org/10.1080/17454832.2012.725547 [7] Lobban, J. (2016). Factors that influence engagement in an inpatient art therapy group for veterans with post traumatic stress disorder. *International Journal of Art Therapy,* 21, 15-22. https://doi.org/10.1080/17454832.2015.1124899 [8] Campbell, M., Decker, K.P., Kruk, K. & Deaver, S. (2016). Art therapy and cognitive processing therapy for combat-related PTSD: A randomized controlled trial. *Art Therapy*, 33, 169-177. https://doi.org/10.1080/07421656.2016.1226643 [9] Murphy, D., Hodgman, G., Carson, C., Spencer-Harper, L., Hinton, M., Wessely, S., & Busuttil, W. (2015). Mental health and functional impairment outcomes following a six-week intensive treatment programme for UK military veterans with post-traumatic stress disorder (PTSD): A naturalistic study to explore dropout and health outcomes at follow-up. *BMJ Open.* 2015;5:e007051. http://dx.doi.org/10.1136/bmjopen-2014-007051 **Further literature on hypothesised mechanisms of art therapy, based on practice and neuropsychology:**	In response to your, and other stakeholder's comments, arts therapies have now been added as an example intervention to the research recommendation about sequencing and further line treatment in Appendix L of Evidence report D. Please see below for details on the inclusion/exclusion of each of the references you cite: • Jones et al. (2018) is not included as the population is outside scope (trials of soldiers on active service). • Foa et al. (2009), Johnson et al. (1997), Lobban (2012), Lobban (2016a, 2016b), Murphy et al. (2015), Nanda et al. (2010), Rademaker et al. (2009) and Walker (2017) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Campbell et al. (2016) does not meet the sample size inclusion criterion of at least 10 participants per arm for analysis • Palmer et al. (2017) is included in the excluded studies (Appendix K) of Evidence report H as outcomes were outside protocol (experiences of disorder or care with no explicit implications for management, planning and/or delivery of care)

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				Americans for The Arts. (2013). *Arts, Health and Well-Being across the Military Continuum.* Washington, DC: Author. https://www.issuelab.org/resource/arts-health-and-well-being-across-the-military-continuum-white-paper-and-framing-a-national-plan-for-action.html Avrahami, D. (2005). Visual art therapy's unique contribution in the treatment of Post-Traumatic Stress Disorder. *Journal of Trauma and Dissociation, 6*(4), 5-38. Gantt, L. & Tinnin, L. (2009). Support for a neurobiological view of trauma with implications for art therapy. *The Arts in Psychotherapy, 36*, 148-153. Konopka , L. (2016). Neuroscience concepts in clinical practice . In J. L. King (ed.), *Art therapy, trauma and neuroscience: Theoretical and practical perspectives* (pp. 11 – 41). New York, NY : Routledge . Lobban, J. (Ed.). (2017). *Art therapy with military veterans: Trauma and the image.* London, Routledge. Lobban, J. (2017). The development and practice of art therapy with military veterans. In Lobban, J. (Ed.). (2017). *Art therapy with military veterans: Trauma and the image.* (pp. 9-25). London, Routledge. Lobban, J. (2017). In two minds. In Lobban, J. (Ed.). (2017). *Art therapy with military veterans: Trauma and the image* (pp. 126-139). London, Routledge. Lobban, J. (2017). Bypassing the sentinel. In Lobban, J. (Ed.). (2017). *Art therapy with military veterans:*	

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				Trauma and the image (pp. 152-166). London, Routledge. Lobban, J. & Ellis, L. (2017). Cultural collaborations. In Lobban, J. (Ed.). (2017). *Art therapy with military veterans: Trauma and the image* (pp. 183-201). London, Routledge. Lobban, J., Mackay, K., Redgrave, M., & Rajagopal, S. (2017). An adaptive art therapy model for working with traumatised veterans. In J. Lobban (Ed.), *Art therapy with military veterans: Trauma and the image* (pp. 103–125). London: Routledge. Lobban, J. & Murphy, D. (2017). Using art therapy to overcome avoidance in veterans with chronic post-traumatic stress disorder. *International Journal of Art Therapy.* https://doi.org/10.1080/17454832.2017.1397036 Lusebrink , V. B. & Hinz , L. D. (2016). The Expressive Therapies Continuum as a framework in the treatment of trauma . In J. L. King (ed.), *Art therapy, trauma and neuroscience: Theoretical and practical perspectives* (pp. 42 – 66). New York, NY : Routledge . Smith, A. & Lobban, J. (2017). Research and evaluation. In Lobban, J. (Ed.). (2017). Art therapy with military veterans: Trauma and the image (pp. 167-179). London, Routledge. Smith, A. & Lobban, J. (2017). Research and evaluation. In Lobban, J. (Ed.). (2017). Art therapy with military	

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				veterans: Trauma and the image (pp. 167-179). London, Routledge. Talwar, S. (2007). Accessing traumatic memory through art making: an art therapy trauma protocol (ATTP). *The Arts in Psychotherapy*, *34*, 22-35. Tinnin, L. & Gantt, L. (2014). *The instinctual trauma response and dual-brain dynamics: A guide for trauma therapy*. Morgantown, W. V. Gargoyle Press. Tripp, T. (2007). A short term therapy approach to processing trauma: art therapy and bilateral stimulation. *Art Therapy: Journal of the American Art Therapy Association*, *24*(4), 176-183. Van der Kolk, B. (2014).*The body keeps the score: Brain, mind and body in the healing of trauma*. New York: Viking Penguin. **Further studies and reviews:** Foa, E. B., Keane, T. M., Friedman, M. J. & Cohen, J.A. (eds). (2009). Effective Treatments for PTSD, Second Edition: Practice Guidelines from the International Society for Traumatic Stress Studies. New York. The Guilford Press. Johnson, D., Lubin, H., Miller, J. & Hale, K. (1997). Single Session Effects of Treatment Components Within a Specialized Inpatient Post Traumatic Stress Disorder Program. *Journal of Traumatic Stress,* 10(3), 377-390.	

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				Lobban, J. (2016). *Art therapy for military veterans with PTSD: A transatlantic study*. Retrieved from www.wcmt.org.uk/fellows/reports/art-therapy-military-veteransptsd-transatlantic-study#downloads. Nanda U., Gaydos, L., Hathorn, K. & Watkins, N. (2010). Art and Posttraumatic Stress: A review of the empirical artwork for veterans with Posttraumatic Stress Disorder. *Environment and Behaviour*, 42(3), 376-389. Palmer, E., Hill, K., Lobban, J. & Murphy. D. (2017). Veterans' perspectives on the acceptability of art therapy: a mixed-methods study. International Journal of Art Therapy, 22(3), 132-135. Rademaker, A., Vermetten, E., and Kleber, R. (2009). Multimodal exposure-based group treatment for peacekeepers with PSTD: A preliminary evaluation. *Military Psychology*, 21, 482-496.	
British Association of Art Therapists	Guideline	16	7-9	We can see potential significant disadvantages to recommending antipsychotics, given that the evidence for effectiveness of antipsychotics is even weaker than that for SSRIs, and that antipsychotics can carry significant risk of harm to people's physical health. Their increased prescription because of this recommendation would be likely to incur further health costs on top of the cost of the drug and on top of the cost of secondary care (recommended by this guideline if people are to be prescribed these drugs). Furthermore, PTSD would be	Thank you for your comment. In response to your and other stakeholder's comments, the antipsychotic recommendation has been amended so that antipsychotics should only be considered as an adjunct to psychological therapies and only if the person's symptoms have not responded to other drug or psychological treatments and they have disabling symptoms and behaviours (for example,

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				unlikely to be substantially addressed and would itself incur further health care costs and costs in terms of the person's on-going difficulties re-engaging with work and community involvement and contribution.	severe hyperarousal symptoms, or psychotic symptoms). The committee expressed the view that the recommendation on antipsychotics is expected to reduce variation in the way antipsychotics are used in current practice. Additional costs associated with the use of antipsychotics, such as drug acquisition costs, costs of regular reviews and those associated with the management of side effects are acknowledged, however, the committee's opinion was that these costs were not substantial (given that the recommendation is relevant to a sub-group of people with PTSD) and benefits are expected to outweigh costs.
Chroma Therapies Ltd	Evidence (B)	124	General	Chroma and our partners in the healthcare and social care sectors feel very strongly that excluding the Allied Health Professions collective known as the Arts Therapies (art therapy, music therapy and dramatherapy) from the evidence for this draft guideline will be detrimental to children with PTSD and we would like to ask you urgently to reconsider your decision. Although our work with 100s of children who have experienced significant early life trauma (sexual abuse, violence, severe neglect etc) is not captured within an RCT model of evidence (which is a very poor and narrow lens for judging the arts therapies), we	Thank you for your comment. Arts therapies were not excluded. However, very limited evidence was identified. Namely, a single study of art therapy for children (Lyshak-Stelzer 2007). Although this study was suggestive of potential benefits of art therapy (in addition to treatment as usual) on clinician-rated PTSD symptoms, the committee did not consider that a single study with 29 participants and only one outcome was sufficient evidence on which to base a recommendation. The committee also noted that the intervention in that study, Trauma-focused expressive art therapy, shared many features of trauma-focused CBT, and thus applicability or

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				understand how the arts therapies have clinical utility within this population. Our commissioners (more than 40+ local authorities in the UK) continue to choose the Arts Therapies over CBT or psychodynamic interventions to support children with PTSD because they also experience these approaches working in the every-day clinical setting. Chroma urges NICE tro consider the following studies/articles in their new guidelines for the treatment of PTSD in children: **Music Therapy** • Borczon, R. M. (2015). Music Therapy for Survivors of Traumatic Events. In B. Wheeler (Ed.), Music Therapy Handbook (pp. 379-389). New York; London: Guilford Press. • Bower, J., Catroppa, C., Grocke, D., & Shoemark, H. (2014). Music therapy for early cognitive rehabilitation post- childhood TBI: An intrinsic mixed methods case study. Developmental neurorehabilitation, 17(5), 339-346. • Bower, J., & Shoemark, H. (2012). Music therapy for the pediatric patient experiencing agitation during posttraumatic amnesia constructing a	generalisability to non-directive art therapy was uncertain. For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. This guideline also included a qualitative review of service user experience, however, experience of arts therapies (positive or negative) did not emerge as a theme. The committee do not consider routine datasets to be better or equivalent to RCT data as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading. Please see below for details on the inclusion/exclusion of each of the references you cite: • Borczon (2015), Bower et al. (2014), Bower & Shoemark (2014), Brooke (2007), Felsenstein (2012), James & Johnson (1996), Landy (2010), Ng (2005), Osborne (2012), Robarts (2003), Robarts (2006), Robarts (2009), Robarts (2014), Sutton (2002a), Sutton (2002b), Sutton (2011), Swart

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				Linda Chapman MA, ATR-BC, Diane Morabito RN, MPH, Chris Ladakakos PhD, Herbert Schreier MD & M. Margaret Knudson MD (2001) The Effectiveness of Art Therapy Interventions in Reducing Post Traumatic Stress Disorder (PTSD) Symptoms in Pediatric Trauma Patients, Art Therapy, 18:2, 100-104, DOI: 10.1080/07421656.2001.10129750	
Chroma Therapies Ltd	Evidence (D)	General	General	Chroma is concerned that despite some indication NICE would be more inclusive of qualitative evidence, having read the consultation documents, NICE's approach seems to favour a medical model and RCTs whilst ignoring other types of evidence. I would urge NICE to reconsider this stance to support patients' best interests. As you will be no doubt aware, research has found up to 30% of service-users with PTSD to be unresponsive to commonly provided treatments (Wisco, Marx, & Keane, 2012). These service users are left with no other psychological therapies provisions if these are limited to the usual provision of CBT. Indeed in some of our medico-legal work, solicitors themselves feel that CBT is deeply inappropriate, as stated in a recent article (Partners in Cost, Summer 2018, retrieved from: http://www.pic.legal/PartnersInCostsMagazine/#p=18) "In his 2008 paper, "Cognitive-Behavioral Therapies: Achievements and Challenges" Brandon Gaudiano states "the CBT therapist helps the patient to identify, evaluate,	Thank you for your comment and for drawing our attention to the Wisco et al. (2012), Partners in Cost (2018) and Gaudiano (2008) citations. A qualitative review of service user experience was included in the guideline (see Evidence report H). For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. However, the qualitative review (in Evidence report H) was used to both reword existing recommendations in order to more accurately reflect the needs of service users, and as a basis for new recommendations. For instance, in the absence of evidence for clinical efficacy and on the basis of the qualitative meta-synthesis, the guideline recommends that access to peer support groups should be facilitated for those who may

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				and then modify distorted cognitions to produce more realistic and adaptive evaluations. This is typically first accomplished through rational disputation techniques introduced by the therapist during sessions, followed by behavioral experiments designed to test out the validity of the patient's assumptions and predictions." A patient experiencing trauma or of being traumatised as a result of an accident or medical negligence is not due to "distorted cognitions" as Gaudiano suggests; these feelings are a normal response to abnormal events. Treating the psychological impact of a trauma through "rational disputation techniques introduced by the therapist" (Gaudiano 2008) is potentially highly inappropriate and may further traumatise them due to the therapist having all the control; control is exactly what the patient lost at the moment of the injury, and is so desperate to have again, especially in the rehabilitation process. Rehabilitation approaches that place the locus of control back onto the patient while working simultaneously on functional and trauma-based psychological issues may be much more clinically and economically effective. " In the treatment of adults with PTSD, we would urge NICE to consider these studies and articles in the new guidelines; **Literature Reviews**	benefit as the thematic analysis highlighted potential benefits including facilitating access to services and helping individuals at risk of social isolation to integrate with others with shared experiences. Please see below for details on the inclusion/exclusion of each of the references you cite: • Baker et al. (2017) systematic review has been checked for any relevant references and no additional studies that meet the inclusion criteria were identified • Bensimon et al. (2008), Bensimon et al. (2012), Borczon (2015), Brooke (2007), James & Johnson (1996), Landy (2010), Miller & Teramoto (2015), Ng (2005), Osborne (2012), Spiegel et al. (2006), Sutton (2002a), Sutton (2002b), Sutton (2011), Swart (2014), van Eck (2014), Walker et al. (2016), Walsh (2002), and Wellman & Pinkerton (2015) do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Blanaru et al. (2012) and Carr et al. (2012) do not meet the sample size inclusion criterion of at least 10 participants per arm for analysis

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				• David Spiegel MD, Cathy Malchiodi MA, ATR-BC, Amy Backos MA, ATR-BC & Kate Collie PhD, MFA, ATR (2006) Art Therapy for Combat-Related PTSD: Recommendations for Research and Practice, Art Therapy, 23:4, 157-164, DOI: 10.1080/07421656.2006.10129335 • Melissa S. Walker, Girija Kaimal, Robert Koffman, Thomas J. DeGraba, Art therapy for PTSD and TBI: A senior active duty military service member's therapeutic journey, The Arts in Psychotherapy, Volume 49, 2016, Pages 10-18, ISSN 0197-4556, https://doi.org/10.1016/j.aip.2016.05.015. (http://www.sciencedirect.com/science/article/pii/S0197455616300636)	
Chroma Therapies Ltd	Evidence (G)	General	General	Chroma is concerned that despite some indication NICE would be more inclusive of qualitative evidence, having read the consultation documents, NICE's approach seems to favour a medical model and RCTs whilst ignoring other types of evidence. I would urge NICE to reconsider this stance to support patients' best interests. As you will be no doubt aware, research has found up to 30% of service-users with PTSD to be unresponsive tocommonly provided treatments (Wisco, Marx, & Keane, 2012). These service users are left with no other psychological therapies	Thank you for your comment and for drawing our attention to the Wisco et al. (2012) citation. A qualitative review of service user experience was included in the guideline (see Evidence report H). For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual

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				provisions if these are limited to the usual provision of CBT, etc The lack of treatments will also have a huge impact on family members.	and was pre-specified in the review protocols. However, the qualitative review (in Evidence report H) was used to both reword existing recommendations in order to more accurately reflect the needs of service users, and as a basis for new recommendations. For instance, in the absence of evidence for clinical efficacy and on the basis of the qualitative meta-synthesis, the guideline recommends that access to peer support groups should be facilitated for those who may benefit as the thematic analysis highlighted potential benefits including facilitating access to services and helping individuals at risk of social isolation to integrate with others with shared experiences. The committee noted that there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms if there is no response to treatment. The committee agreed that it is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and physical health. Therefore they prioritised this area as one for further research.
Chroma Therapies Ltd	Evidence (G)	General	General	Chroma work in partnership with organisations across the Health, Education and Social Care sectors including private	Thank you for your comment. Unfortunately, no references are included within this comment so we

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				and NHS hospitals, education establishments, legal and case management firms representing both ex-military personnel and people living with life-changing traumatic brain injuries, and more than 40 local authorities supporting 100s of adopted children, many of whom have experienced severe neglect, trauma and abuse at an early stage in their lives. The majority of our work is with people who live with diagnosed or un-diagnosed PTSD, as a result of a traumatic and unexpected event. I would like to bring the following studies and papers to the attention of the consultation team, given indications that NICE would be more inclusive of qualitative evidence, rather than just favouring a medical model and RCTs whilst ignoring other types of evidence. Please include the following in your deliberations;	are unable to respond directly to the studies cited. However, if these have been provided elsewhere (in another comment), then please see the relevant response for details on the inclusion/exclusion of each of the references you cite. A qualitative review of service user experience was included in the guideline (see Evidence report H). For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. However, the qualitative review (in Evidence report H) was used to both reword existing recommendations in order to more accurately reflect the needs of service users, and as a basis for new recommendations. For instance, in the absence of evidence for clinical efficacy and on the basis of the qualitative meta-synthesis, the guideline recommends that access to peer support groups should be facilitated for those who may benefit as the thematic analysis highlighted potential benefits including facilitating access to services and helping individuals at risk of social isolation to integrate with others with shared experiences.

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				• Sutton, J. (Ed.). (2002). *Music, Music Therapy and Trauma*. London: Jessica Kingsley. • Sutton, J. (2002). Trauma in Context. In J. Sutton (Ed.), *Music, Music Therapy and Trauma* (pp. 21-40). London: Jessica Kingsley. • Sutton, J. (2011). A Flash of the Obvious: Music Therapy and Trauma. In A. Meadows (Ed.), *Developments in Music Therapy Practice: Case Study Perspectives* (pp. 268-284). Gilsum, NH: Barcelona. • Swart, I. (2014). From trauma to well-being: How music and trauma can transform us. *The Journal for Transdisciplinary Research in Southern Africa, 10*(2), 193-207. • van Eck, F. (2014). The role of the musician working with traumatized people in a war-affected area: Let the music happen. *Journal of Applied Arts & Health*, *4*(3), 301-311. doi: 10.1386/jaah.4.3.301_1 • Walsh, R. (2002). See Me, Hear Me, Play With Me: Working with the Trauma of Early Abandonment and Deprivation in Psychodynamic Music Therapy.	

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				In J. Sutton (Ed.), *Music, Music Therapy and Trauma* (pp. 133-152). London: Jessica Kingsley. **Dramatherapy** • James, M., & Johnson, D. R. (1996). Drama therapy for the treatment of affective expression in posttraumatic stress disorder. In D. L. Nathanson (Ed.), *Knowing feeling: Affect, script, and psychotherapy* (pp. 303-326). New York, NY, US: W W Norton & Co. • Landy, R.J. (2010). Drama as a means of preventing post-traumatic stress following trauma within a community. *Journal of Applied Arts and Health, 1*(1), 7-18. **Art Therapy** • David Spiegel MD, Cathy Malchiodi MA, ATR-BC, Amy Backos MA, ATR-BC & Kate Collie PhD, MFA, ATR (2006) Art Therapy for Combat-Related PTSD: Recommendations for Research and Practice, Art Therapy, 23:4, 157-164, DOI: 10.1080/07421656.2006.10129335	

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Chroma Therapies Ltd	Evidence (G)	General	General	Regarding families and those supporting people with PTSD, a recent meta-analysis showed high drop-out rates of 36% for PTSD psychotherapies (Goetter et al., 2015), suggesting that many service users did not engage with treatment. Narrow use of NICE recommended treatment options often did not lead to recovery. (Lab, Santos & DeZuleta, 2008). Chroma and our partners in the healthcare and social care sectors feel very strongly that excluding the Allied Health Professions collective known as the Arts Therapies (art therapy, music therapy and dramatherapy) from the evidence for this draft guideline will be detrimental to service users and we would like to ask you urgently to reconsider your decision.	Thank you for your comment and for drawing our attention to the Goetter et al. (2015) and Lab et al. (2008) citations. Arts therapies were not excluded. However, very limited evidence was identified. Namely, a single study of art therapy for children (Lyshak-Stelzer 2007). Although this study was suggestive of potential benefits of art therapy (in addition to treatment as usual) on clinician-rated PTSD symptoms, the committee did not consider that a single study with 29 participants and only one outcome was sufficient evidence on which to base a recommendation. The committee also noted that the intervention in that study, Trauma-focused expressive art therapy, shared many features of trauma-focused CBT, and thus applicability or generalisability to non-directive art therapy was uncertain. The committee recognise that there can be difficulties in keeping people with PTSD engaged in treatment and in response to this drafted recommendations in the 'Planning treatment and supporting engagement' section of the guideline. In response to your, and other stakeholder's comments, arts therapies have now been added as

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					an example intervention to the research recommendation about sequencing and further line treatment in Appendix L of Evidence report D.
College of Policing	Evidence Review C General	General	General	The PICO table for Evidence Review C include a range of psychological, psychosocial and other interventions which are described as preventative interventions to be implemented during the first month post traumatic exposure. This is very important in policing where there is a need to reduce the incidence of mental health issues in the workplace. **Comment:** Police forces are working to develop wellbeing programmes, including peer support programmes, to help to improve the mental health of officers and staff. It may be impractical or inappropriate to provide clinical treatments in the first month following a traumatic exposure. Forces may provide crisis management, demobilising, defusing and debriefing during the first month. In emergency services the current approach has been to provide early interventions which are tailored to the needs of the individuals It is in the first month following a disaster when interventions such as crisis management, demobilisation, defusing and debriefing are commonly employed in emergency services.	Thank you for your comment. The references you cite (Braddon et al. 1993; Brewin & Copas 2010; British Psychological Society 2002, 2015, 2018; College of Policing 2018; Cox et al. 1993; Levan & McManamly 2003; Luce et al. 2003; Mitchell et al. 2000; Orner et al. 1997; Rick et al. 1998, 2006) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs). For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. We do not consider routine datasets to be better or equivalent to RCT data as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading. In the guideline systematic review of RCTs for psychologically-focused debriefing there was single-study evidence at 1-year follow-up showing a

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				There have been many evaluations of organisational responses to crisis, disasters and trauma including: Cox et al. (1993); Braddon et al. (1993), Orner et al (1997), Rick et al. (1998 & 2006) Mitchell et al. (2000) British Psychological Society (2002, 2015, 2018) Luce et al (2003), Levan & McManamly (2003); Brewin & Copas, (2010) College of Policing (2018). None of these have been considered by the NICE committee. **Questions:** • Is NICE in the best position to provide guidance on dealing with the early responses to Crisis, Disasters and Trauma in policing or other emergency services? • Should NICE restrict itself to dealing with the management of clinical treatments? • Should NICE recognise and provide guidance on the potential for vicarious trauma in some policing roles e.g. online child abuse investigations?	clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects were at best non-significant. On this basis the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits. The recommendation to not offer psychologically-focused debriefing is not a recommendation against early intervention. The guideline recommends that an individual trauma-focused CBT intervention should be offered to adults who have acute stress disorder or clinically important symptoms of PTSD and have been exposed to 1 or more traumatic events within the last month. The guideline is for those treating PTSD in the NHS and NHS funded services. Other related services may choose to use the guideline to inform their practice. The guideline can therefore inform the policy and practice of police forces in relation to the

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					assessment and treatment of PTSD but it does not offer guidance to occupational health services. In the recognition section of the guideline there is a recommendation that users of the guideline should be aware that work-related exposure to trauma, including remote exposure, can be associated with the development of PTSD. All recommendations in the guideline apply to those with PTSD whether exposure resulted from direct experience of the traumatic event, witnessing the traumatic event, learning that the traumatic event occurred to a close family member or close friend, or experience of first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related). However, where a staff member does not have, or is not at risk of PTSD (as defined by the review protocol), then they are outside the scope of this guideline.
College of Policing	Evidence Review G General	General	General	Evidence G looks at the impact of trauma on family members and carers. In policing there is a high risk of secondary trauma and compassion fatigue in officers and staff dealing with victims of trauma. These roles include Family Liaison, Dealing with On-line child abuse images, Scene of Crimes, Body Recovery, Negotiators, Undercover officers and Counter Terrorism.	Thank you for your comment. In the recognition section of the guideline there is a recommendation that users of the guideline should be aware that work-related exposure to trauma, including remote exposure, can be associated with the development of PTSD. All recommendations in the guideline apply to those with PTSD whether exposure resulted from direct experience of the traumatic

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				Comment It is recognised that policing is not the only organisation where employees are frequently faced with dealing with secondary traumatisation, however, it is an important risk and is covered in DSM 5 as a falling within the scope of PTSD. **Questions** • Will NICE be looking at the needs of emergency service personnel affected by traumatic exposures experienced as part of their work? • What guidance might NICE give to emergency services on protecting the wellbeing of their employees?	event, witnessing the traumatic event, learning that the traumatic event occurred to a close family member or close friend, or experience of first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related). However, where a staff member does not have, or is not at risk of PTSD (as defined by the review protocol), then they are outside the scope of this guideline.
College of Policing	Guidelines	1	7	Who is the NICE guidance on PTSD for? As a recent stakeholder in the review process the College of Policing recognises that any decisions made by the NICE committee can have a significant impact on the way that PTSD is managed in policing and other law enforcement organisations. The committee needs to be mindful of the potential impact that decisions can have on the operation of organisations where there is a constant exposure to direct and indirect traumatic hazards (Foley & Massey, 2018; Tehrani, 2017; Fragkaki et al 2016).	Thank you for your comment and for drawing our attention to the Foley & Massey (2018), Fragkaki et al. (2016), and Tehrani (2017) citations. The guideline is for those treating PTSD in the NHS and NHS funded services. Other related services may choose to use the guideline to inform their practice. The guideline can therefore inform the policy and practice of the College in relation to the assessment and treatment of PTSD but it does not

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				The College of Policing was established in 2012 as the professional body for everyone who works for the police service in England and Wales. The purpose of the College is to provide those working in policing with the skills and knowledge necessary to prevent crime, protect the public, and secure public trust. The College undertakes three complementary functions: ▪ **Knowledge** – we develop the research and infrastructure for improving evidence of 'what works'. Over time, this will ensure that policing practice and standards are based on knowledge, rather than custom and convention. ▪ **Education** – we support the development of individual members of the profession. We set educational requirements to assure the public of the quality and consistency of policing skills and we facilitate the academic accreditation and recognition of our members' expertise. ▪ **Standards** – we draw on the best available evidence of 'what works' to set standards in policing for forces and individuals. Examples include our Authorised Professional Practice (APP) and peer reviews. The College has the mandate to set standards in professional development, including codes of practice and regulations, to ensure consistency across the 43 forces in England and Wales. We also have a remit to set standards	offer guidance to occupational health services or on medical retirement.

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				for the police service on training, development, skills and qualifications, and we will provide maximum support to help the service implement these standards. A fundamental development within the College is the use of knowledge and research to develop an evidence-based approach to policing. We are hosting the What Works Centre for Crime Reduction, which involves collaboration with academics and a university consortium. We will also take a coordinating role across the country, commissioning research and setting up regional networks, so that universities, further education colleges and police forces can work together to learn from best practice. The British model of policing by consent is admired across the world. We will help to create the best conditions to sustain and enhance that model. **Health, Safety and Welfare** The College of Policing provides support and advice for police forces and other related stakeholders, however the responsibility for the health, safety and welfare of police officers and staff remains with the Chief Police Officer at the relevant force. The College is involved in: ▪ Conducting and facilitating research relating to occupational health, safety and welfare in the police service	

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				▪ Providing support to the national Health, Safety and Welfare Strategic Group and supporting the ongoing work of the related sub groups ▪ Supporting clinical and health and safety professionals working with the police service, including at development events ▪ Issuing guidance for national use by forces ▪ Supporting the Home Office and the police service develop consistent approaches **Comments:** • The College of Policing is aware that traumatic stress is a major hazard for officers and staff • There is a need to ensure that police officers get the best possible help and assistance • There is a legal duty of care to protect the mental health of officers and staff • Medical retirements due to PTSD is expensive • Police Forces use Occupational Health **Question:** To what extent will or should the NICE guidance cover these occupational and legal issues?	

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Department of Health and Social Care	General	General	General	Thank you for the opportunity to comment on the draft for the above guideline. I wish to confirm that the Department of Health and Social Care has no substantive comments to make, regarding this consultation	Thank you for your comment.
Devon County Council	General	General	General	I am seeking advice re: the generalisability of evidence contained in NICE Evidence review supporting the new PTSD guidelines currently out to consultation. I am in the initial stages of a needs assessment regarding trauma amongst adults who have experienced complex lives. The needs assessment is particularly focused on those who may be considered sub threshold for mental health service intervention and/or would not meet the ICD-10 criteria for PTSD as are not displaying sufficient symptoms but nevertheless have been affected by trauma. As such I have been reviewing the relevant NICE guidelines and have thus far found only guidelines regarding PTSD specifically rather than any wider definition or experience of trauma. The question I wanted your and/or the committee's view on is, to what extent can the evidence regarding effective interventions for PTSD be generalised to other manifestations of trauma (including sub-threshold)? My assumption was that it should be generalisable as my (non-clinical) understanding is they share the same cause	Thank you for your comment. The reviews on the prevention of PTSD include the delayed treatment of people with non-significant PTSD symptoms which may be comparable to your group of interest but any further advice is outside the scope of this guideline.

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				(experience of trauma), if not the full spectrum of symptoms required for a PTSD diagnosis. I also note that many of the studies included in the evidence review use an inclusion criterion wider than ICD10- (i.e. clinically important symptoms) and thus their participants may be representative of a wider group who have experienced trauma. I would be very grateful for your views on this matter and your views on the transferability of the evidence and NICE recommendations.	
Devon County Council	Guideline Scoping Document Evidence Review D	4 2 278 General	Recommendations box 1.1 33-35	The text states that the 'recommendations in this guideline relate to everyone who has PTSD.' However the scoping document under 1.1 states the groups that will be covered include those 'at risk of PTSD'. The evidence review (page 278 line 33-35) states "Previous treatment recommendations were made for adults with PTSD, whereas current recommendations are relevant to adults with a diagnosis of PTSD or with clinically important symptoms of PTSD". Please clarify if and how the guidance and treatment recommendations are relevant to those 'at risk' and with 'clinically important symptoms of PTSD' as well as those who meet the ICD-10 criteria.	Thank you for your comment. The recommendations box has been amended in the short guideline document to clarify that the recommendations apply to those at risk of and who have PTSD. The prevention recommendations in the guideline apply to those at risk of PTSD. The treatment recommendations specify who they are relevant to, e.g. if they are limited to those with a diagnosis of PTSD (as for the adult drug treatment recommendations) or for those with both clinically important symptoms and a diagnosis of

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					PTSD (as in the psychological treatment recommendations).
EMDR UK & Ireland Association	General	General	General	On behalf of the EMDR UK & Ireland Association , EMDR Europe Association and the wider international EMDR Therapy Community), we would like to thank the National Institute for Health and Care Excellence **[NICE]** for its guidance, advice and important information with regards to Post-Traumatic Stress Disorder [PTSD]. This up-date **[June 2018]** is both timely and necessary – particularly as the global burden of psychological trauma continues unabated. Although EMDR UK & Ireland Association is a registered stakeholder to NICE, the feedback provided to GID-NG10013 [PTSD] also includes comments from the broader EMDR Therapy International Community – including EMDR Europe. The intention of this feedback is to highlight areas of consensus, but importantly, from an EMDR Therapy	Thank you for your comment and for drawing our attention to the Barkham & Mellor-Clark (2003), Bongaerts et al. (2017), Bromet et al. (2018), Brewin et al. (2017), Calancie et al. (2018), the Department of Veterans Affairs and the Department of Defence guidelines, González et al. (2017), Hase et al. (2017), Pagani et al. (2017), Shapiro et al. (2017), Shapiro (2001), UNHCR, US Military Guideline (2016), Wagenmans et al. (2018) and World Health Organization. (2013, 2015) citations. In response to references cited for RCTs of EMDR in children, please note that Diehle et al. (2015) and De Roos et al. (2017) are included in Evidence report B. De Roos et al. (2011) is included in Evidence report A as baseline scores are below the clinical threshold for PTSD. The committee considered the evidence for EMDR in the treatment of children with PTSD and noted the limited evidence base, in terms of the number of studies/participants, the number of different comparisons, the breadth of outcomes reported, and the availability of long-term follow-up. The committee observed that the benefits of EMDR were not statistically significant relative to waitlist or treatment as usual, and the head-to-head

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				perspective, areas where there is clear disagreement with the current guidance for PTSD GID-NG10013. For the purpose of context - Eye Movement Desensitization & Reprocessing [EMDR] Therapy is a form of psychotherapy/ psychological treatment, that has been extensively researched and proven effective for the treatment of the effects due to exposure to adverse life events – mainly PTSD and Complex PTSD[1] [2]. Its theoretical construct is that of Adaptive Information Processing (AIP), which holds that the primary source of psychopathology is the presence of memories of adverse life experiences that have been insufficiently processed [3] [4].	comparisons against trauma-focused CBT (although suggestive of no significant difference) were not sufficiently powered to detect non-inferiority (single-study analyses). The committee also took into account the results of the NMA and economic base-case analysis which both suggested that EMDR was less clinically effective and cost-effective than all individual trauma-focused CBT interventions. On the basis of the clinical and cost-effectiveness and these additional considerations, the committee agreed that EMDR should only be considered for children and young people if they do not respond to or engage with trauma-focused CBT. Thank you for drawing our attention to the Gil-Jardiné et al. (2018) and Yurtsever et al. (2018) references. These studies have now been added to

[1] Bromet E, Karam E, Koenen K, Stein D, editors. Trauma and Posttraumatic Stress Disorder: Global Perspectives from the WHO World Mental Health Surveys. Cambridge University Press; 2018 Aug 31.
[2] Brewin CR, Cloitre M, Hyland P, Shevlin M, Maercker A, Bryant RA, Humayun A, Jones LM, Kagee A, Rousseau C, Somasundaram D. A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. Clinical Psychology Review. 2017 Sep 6.
[3] Shapiro F, Wesselmann D, Mevissen L. Eye Movement Desensitization and Reprocessing Therapy (EMDR). In Evidence-Based Treatments for Trauma Related Disorders in Children and Adolescents 2017 (pp. 273-297). Springer, Cham.
[4] Shapiro F. Eye Movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols and procedures.

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				Since 2013, EMDR Therapy has been included in the recommendation issued by the World Health Organization [5], as one of two elective therapies for treating PTSD in children, adolescents and adults. To date, this WHO meta-analysis offered the most comprehensive review of treatment interventions for stress – including PTSD. The World Health Organization and the UN Refugee Agency [UNHCR] – Mental Health GAP Humanitarian Intervention Guide (mhGAP-HIG), further supported this: Clinical management of mental, neurological and substance use conditions in humanitarian emergencies[6]. Furthermore, the Department of Veterans Affairs and the Department of Defence guidelines describes the strength of research	the review (to evidence reports C and D respectively). The committee considered the new evidence for EMDR in the first month following trauma in adults (Gil-Jardiné 2018). However, the committee did not consider that it was appropriate to make a recommendation in this time period as evidence was limited to a small single study (N=71) that only reported on one clinical outcome of interest and the effect on the number of participants with PTSD at 3-month follow-up was not statistically significant. In response to references cited for RCTs of EMDR in adults, please note that Nijdam et al. (2012) and Rothbaum et al. (2005) are included in Evidence report D. In considering the cost-effectiveness of EMDR for the treatment of PTSD in adults, the committee noted that EMDR was offered in 6 sessions in economic modelling, based on the average resource use reported in the trials that informed the

[5] World Health Organization. (2013). *Guidelines for the management of conditions that are specifically related to stress*. World Health Organization.

[6] World Health Organization and United Nations High Commissioner for Refugees. mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: WHO, 2015.

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				evidence underpinning EMDR Therapy – for PTSD, as '***Strong***'[7]. Consequently, there appears to be some divergence between the WHO (2013), UNHCR [8], VA/Department of Defence Clinical Practice Guideline for the Management of Post-traumatic Stress Disorder and Acute Stress disorder, NICE PTSD Guideline [CG26 – published March, 2005], and this proposed NICE PTSD Guideline [GID-NG10013]. As figure 1 highlights, by the end of 2017, there were some 38 controlled studies dealing with the treatment of severe trauma and Post-traumatic stress disorders. The body of EMDR Therapy Publications [9] [10] include the following	NMA and economic analysis. Nevertheless, the committee tested also 10 sessions of EMDR in the economic model and noted that its relative cost effectiveness was not substantially affected (it dropped two places in cost effectiveness ranking). Therefore, they decided to recommend 8-12 sessions of EMDR, in line with validated treatment manuals. The recommendation about the structure and content of EMDR for adults is informed by the interventions in the RCTs, and modified by the expert advice of the committee. The committee considered the evidence for EMDR in the 1-3 month period following trauma, and in response to your, and other stakeholder's comments, agreed that a new recommendation should be added to consider EMDR for adults with PTSD within 1-3 months of non-combat-related trauma. This recommendation is based on single-study evidence showing large benefits of EMDR

[7] https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGClinicianSummaryFinal.pdf
[8] https://data2.unhcr.org/en/documents/download/39722
[9] https://emdr-europe.org/research/research-studies/
[10] https://emdria.site-ym.com/page/EMDRResearch?

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				• EMDR Treatments: **452** • EMDR and PTSD: **337** • EMDR and Trauma: **212** • EMDR Reviews: **139** • EMDR and Anxiety: **136** • EMDR and Depression: **87** • EMDR Mechanisms: **75** • EMDR in Children: **72** • EMDR and Pain: **14** • EMDR and Refugees: **14** • EMDR and Addiction: **11** • Meta-Analysis: **34** ***Figure 1: Empirical Evidence Base in Support of EMDR Therapy by end of 2017*** This aptly demonstrates the increasing empiricism underpinning EMDR Therapy as a safe, effective and efficient psychological treatment intervention[11] [12] which has	relative to supportive counselling in the 1-3 month period and an extrapolation from stronger evidence for EMDR more than 3 months after trauma. This was a weaker recommendation (consider rather than offer) based on the limited direct evidence available. There was no eligible evidence identified for integrative interventions and on this basis the committee did not feel it appropriate to make any recommendations about these interventions. The committee considered and compared the evidence for discontinuation from EMDR and trauma-focused CBT interventions and found no significant differences between the two intervention types on the rate of drop-out. The committee discussed the evidence suggesting a significantly higher rate of drop-out of trauma-focused CBT relative to waitlist, and a small but still statistically significant higher drop-out where trauma-focused CBT augmented treatment as usual or medication relative to treatment as usual/medication-only. The

[11] Bongaerts H, Van Minnen A, de Jongh A. Intensive EMDR to treat patients with complex posttraumatic stress disorder: A case series. Journal of EMDR Practice and Research. 2017 May 1;11(2):84-95.
[12] Wagenmans A, Van Minnen A, Sleijpen M, De Jongh A. The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD. European journal of psychotraumatology. 2018 Jan 1;9(1):1430962.

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				also been significantly enhanced by its neurobiological underpinnings [13] [14] [15] [16]. As with the NICE guideline CG26, EMDR UK & Ireland Association acknowledges that PTSD is a global public health issue, significant in its magnitude, and potentially devastating for individuals, families, communities and society as a whole. NICE Guidance on PTSD is vital in recognizing, assessing and treating PTSD in children, young people and adults. Any recommendations that aims to raise awareness of PTSD and improve co-ordination of care, is welcomed, not just by EMDR UK & Ireland & EMDR Europe, but by the global EMDR Therapy Community.	committee discussed potential reasons for this higher rate of discontinuation, and speculated that trauma-focused CBT may be less acceptable to people who are not ready to directly confront traumatic memories, are not able to engage due to functional impairment from associated symptoms, and/or have difficulties in building a trusting therapeutic relationship. As existing recommendations for CBT interventions targeted at specific symptoms (such as sleep disturbance or anger), modifications of trauma-focused therapies for those with additional needs (including complex PTSD), and engagement strategies for those with difficulties in building trust in the therapeutic relationship (based on the qualitative evidence [see evidence review H]) have the potential to address some of these reasons for discontinuation, the committee agreed that the potential for benefit was greater than the potential for harm. The committee also noted that effects on discontinuation only

[13] Calancie OG, Khalid-Khan S, Booij L, Munoz DP. Eye movement desensitization and reprocessing as a treatment for PTSD: current neurobiological theories and a new hypothesis. Annals of the New York Academy of Sciences. 2018 Jun 21.

[14] Pagani M, Amann BL, Landin-Romero R, Carletto S. Eye movement desensitization and reprocessing and slow wave sleep: a putative mechanism of action. Frontiers in psychology. 2017 Nov 7;8:1935.

[15] González A, del Río-Casanova L, Justo-Alonso A. Integrating neurobiology of emotion regulation and trauma therapy: reflections on EMDR therapy. Reviews in the Neurosciences. 2017 May 24;28(4):431-40.

[16] Hase M, Balmaceda UM, Ostacoli L, Liebermann P, Hofmann A. The AIP model of EMDR therapy and pathogenic memories. Frontiers in psychology. 2017 Sep 21;8:1578.

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				In response to the NICE PTSD Guideline DRAFT (June 2018) – EMDR UK & Ireland Association and EMDR Europe are in ***broad agreement*** with the following sections: **1.1 Recognition of post-traumatic stress disorder** - 1.1.1 - 1.1.2 - 1.1.3 - 1.1.4 - 1.1.5 **Specific recognition issues for children** - 1.1.6 - 1.1.7 **Screening of people involved in a major disaster, refugees and asylum seekers** - 1.1.8 - 1.1.9 **1.2 Assessment and co-ordination of care** - 1.2.1 - 1.2.2 **Supporting transitions between services** - 1.2.4	reached the threshold for clinical importance for the comparison against waitlist where there may be an additional incentive for waitlist participants not to drop-out, given that access to the intervention is contingent upon continuing in the trial. Furthermore, offering EMDR as an option for those with non-combat-related PTSD, or supported computerised trauma-focused CBT as an alternative lower intensity intervention, allows people who may not find trauma-focused CBT acceptable to access another psychological intervention if they prefer. In response to your, and other stakeholder's, comments the recommendation for EMDR for adults with PTSD exposed to non-combat-related trauma more than 3 months ago, has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option to trauma-focused CBT for non-combat related trauma. The committee do not consider routine datasets to be better or equivalent to RCT data as we cannot be sure that the populations treated with various

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				- 1.2.5 - 1.2.6 **1.3 Access to Care** - 1.3.1 - 1.3.2 We particularly welcome this inclusion: *"Do not delay or withhold treatment for PTSD because of court proceedings or applications for compensation. Discuss with the person the implications of the timing of any treatment to help them make an informed decision about if and when to proceed.* **[2018])"** **1.4 Principles of care – supporting people with PTSD** - 1.4.1 - 1.4.2 **1.4.3 Peer support** **1.4.4 Maintaining safe environments** **1.4.5 Involving and supporting families and carers** 1.4.6 1.4.7	interventions are the same and to assume so would be potentially misleading. Bongaerts et al. (2017), Hoge & Chard (2018), Mevissen et al. (2017), Morgenthaler et al. (2018), Najavits (2015), Saltini et al. (2018), Steenkamp et al. (2016), Trentini et al. (2018),Van Woudenberg et al. (2018), Zepeda Méndez et al. (2018), and Zoet et al. (2018) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs). Brown et al. (2017) is listed in excluded studies (Appendix K) of Evidence report A. This systematic review could not be included in its entirety as review questions and inclusion/exclusion criteria were not sufficiently similar. This systematic review was checked for any relevant references, however, no additional studies that met inclusion criteria were identified. Verardo & Cioccolanti (2017) is listed in excluded studies (Appendix K) of Evidence report B. This systematic review could not be included in its entirety as review questions and inclusion/exclusion criteria were not sufficiently similar. This systematic review was checked for any relevant references,

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				1.4.8 **1.5 Language and culture** 1.5.1 1.5.2 1.5.3 We welcome these up-dates: **1.5.1** *"Pay particular attention to identifying people with PTSD in working or living environments where there may be cultural challenges to recognising the psychological consequences of trauma (see recommendations on avoiding stigma and promoting social inclusion in the NICE guideline on service user experience in adult mental health)".* **[2005, amended 2018]** **1.5.2** ***"****When offering interventions, ensure they are culturally and linguistically appropriate for service users."* **[2005, amended 2018]** **1.6 Management of PTSD in children, young people and adults: Planning treatment and supporting engagement** - 1.6.1 - 1.6.2 - 1.6.3 – active monitoring	however, no additional studies that met inclusion criteria were identified. Bisson (2005), Imel et al. (2013), Lee et al. (2016), Swift et al. (2014), and Steenkamp et al. (2015) are listed in excluded studies (Appendix K) of Evidence report D. These systematic reviews could not be included in their entirety as review questions and inclusion/exclusion criteria were not sufficiently similar. These systematic reviews were checked for any relevant references, however, no additional studies that met inclusion criteria were identified. Thank you for drawing our attention to the Moreno-Alcázar et al. (2017), Pfefferbaum et al. (2017), Thompson et al. (2018), and Wilson et al. (2018) systematic reviews. These have now been checked for any relevant references but no additional studies that met inclusion criteria were identified. Steinert et al. (2016) is not included as it is a preliminary report of an RCT already included (Steinert 2017). Van den Berg et al. (2015) is not included as participants were being treated for psychosis and trials of people with psychosis as a coexisting

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				- 1.6.11 – drug treatment for children and young people **1.6.19 – Psychologically focused debriefing** **1.6.20 – Drug treatment for adults** - 1.6.21 - 1.6.22 **1.7 Care for people with PTSD and complex needs** - 1.7.1 - 1.7.2 - 1.7.3 - 1.7.4 **1.8 Disaster planning** - 1.8.1 However, EMDR UK & Ireland Association and EMDR Europe **does not concur** with the guidance regarding Children & Adolescents, Adults, and Military Populations – with each area addressed separately. Regarding PTSD in	condition were listed as exclusions in the review protocols. Watts et al. (2013) could not be obtained and is listed in the excluded studies (Appendix K) of Evidence report D. Foa et al. (2018) is not included as the population is outside scope (trials of soldiers on active service). Unfortunately, footnotes 9 and 10 are missing and without provision of the specific studies to which these footnotes refer, we are unable to give a justification for inclusion or exclusion here.

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				Children and Adolescents, EMDR UK & Ireland Association and EMDR Europe does not support the following sections: **1.6 Management of PTSD in children, young people and adults: Planning treatment and supporting engagement** **Prevention for children and young people** - 1.6.4 - 1.6.5 **Treatment for children and young people** - 1.6.6 - 1.6.7 - 1.6.8 - 1.6.9 - 1.6.10 **EMDR Therapy Response to Prevention and Treatment for Children and Young People**	

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				"Consider Eye Movement Desensitization and Reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD 10 or clinically important symptoms of PTSD more than 3 months after a 11 traumatic event ***only if they do not respond to or engage with trauma-focused CBT.***" *"There was limited evidence for eye movement desensitisation and reprocessing (EMDR) suggesting possible benefits on PTSD symptoms in children aged over 16 years. Based on uncertainties in this evidence, the committee decided it* ***should be considered only if children do not respond to or engage with trauma-focused CBT,*** *an intervention that is supported by better evidence."* [Page 13 of 57] EMDR UK & Ireland Association and EMDR Europe recommends to the committee to consider three randomised control trails [RCT's] that have been published demonstrating the effectiveness of EMDR Therapy with children. These include the following:	

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				○ Diehle et al., (2015)[17] – N = 48 ○ De Roos et al., (2011)[18] – N= 52 ○ De Roos et al, (2017) – N = 103 A summary of the Diehle et al (2015) study is as follows: "To prevent adverse long-term effects, children who suffer from posttraumatic stress symptoms (PTSS) need treatment. Trauma-focused cognitive behavioral therapy (TF-CBT) is an established treatment for children with PTSS. However, alternatives are important for non-responders or if TF-CBT trained therapists are unavailable. Eye movement desensitization and reprocessing (EMDR) is a promising treatment for which sound comparative evidence is lacking. The current randomized controlled trial investigates the effectiveness and efficiency of both treatments. Forty-eight children (8–18 years) were randomly assigned to eight sessions of TF-CBT or EMDR. The primary outcome was PTSS as measured with	

[17] Diehle J, Opmeer BC, Boer F, Mannarino AP, Lindauer RJ. Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: What works in children with posttraumatic stress symptoms? A randomized controlled trial. European child & adolescent psychiatry. 2015 Feb 1;24(2):227-36.

[18] de Roos C, Greenwald R, den Hollander-Gijsman M, Noorthoorn E, van Buuren S, De Jongh A. A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster-exposed children. European Journal of Psychotraumatology. 2011 Jan 1;2(1):5694.

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				the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA). Secondary outcomes included parental report of child PTSD diagnosis status and questionnaires on comorbid problems. The Children's Revised Impact of Event Scale was administered during the course of treatment. TF-CBT and EMDR showed large reductions from pre- to post-treatment on the CAPS-CA (−20.2; 95 % CI −12.2 to −28.1 and −20.9; 95 % CI −32.7 to −9.1). The difference in reduction was small and not statistically significant (mean difference of 0.69, 95 % CI −13.4 to 14.8). Treatment duration was not significantly shorter for EMDR ($p = 0.09$). Mixed model analysis of monitored PTSS during treatment showed a significant effect for time ($p < 0.001$) but not for treatment ($p = 0.44$) or the interaction of time by treatment ($p = 0.74$). Parents of children treated with TF-CBT reported a significant reduction of comorbid depressive and hyperactive symptoms. TF-CBT and EMDR are effective and efficient in reducing PTSS in children." We highlight to the committee the following summary from the study: "***TF-CBT and EMDR are effective and efficient in reducing PTSS in children.***"	

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				In addition, there is the de Roos (2011)[19] study, which highlighted the following: "Standardised CBT and EMDR interventions can significantly improve functioning of disaster-exposed children. Both treatment approaches produced significant reduction on all measures, which were maintained at follow-up. Treatment gains of EMDR were reached in fewer sessions." EMDR UK & Ireland and EMDR Europe does not understand why the committee did not consider the RCT carried out by De Roos (2017)[20] entitled: Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioural writing therapy, and wait-list in paediatric posttraumatic stress disorder following single-incident	

[19] de Roos C, Greenwald R, den Hollander-Gijsman M, Noorthoorn E, van Buuren S, De Jongh A. A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster-exposed children. European Journal of Psychotraumatology. 2011 Jan 1;2(1):5694.

[20] - de Roos C, van der Oord S, Zijlstra B, Lucassen S, Perrin S, Emmelkamp P, de Jongh A. Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioral writing therapy, and wait-list in pediatric posttraumatic stress disorder following single-incident trauma: a multicenter randomized clinical trial. Journal of Child Psychology and Psychiatry. 2017 Nov;58(11):1219-28.

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				trauma: a multi-centre randomized clinical trial. Yet this RCT clearly met the committee's specific inclusion criteria? A summary of the study is as follows: **"BACKGROUND:** Practice guidelines for childhood posttraumatic stress disorder (PTSD) recommend trauma-focused psychotherapies, mainly cognitive behavioral therapy (CBT). Eye movement desensitization and reprocessing (EMDR) therapy is a brief trauma-focused, evidence-based treatment for PTSD in adults, but with few well-designed trials involving children and adolescents. **METHODS:** We conducted a single-blind, randomized trial with three arms (n = 103): EMDR (n = 43), Cognitive Behavior Writing Therapy (CBWT; n = 42), and wait-list (WL; n = 18). WL participants were randomly reallocated to CBWT or EMDR after 6 weeks; follow-ups were conducted at 3 and 12 months posttreatment. Participants were treatment-seeking youth (aged 8-18 years) with a DSM-IV diagnosis of PTSD (or subthreshold PTSD) tied to a single	

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				trauma, who received up to six sessions of EMDR or CBWT lasting maximally 45 min each. **RESULTS**: Both treatments were well-tolerated and relative to WL yielded large, intent-to-treat effect sizes for the primary outcomes at post-treatment: PTSD symptoms (EMDR: d = 1.27; CBWT: d = 1.24). At post-treatment 92.5% of EMDR, and 90.2% of CBWT no longer met the diagnostic criteria for PTSD. All gains were maintained at follow-up. Compared to WL, small to large (range d = 0.39-1.03) intent-to-treat effect sizes were obtained at post-treatment for negative trauma-related appraisals, anxiety, depression, and behaviour problems with these gains being maintained at follow-up. Gains were attained with significantly less therapist contact time for EMDR than CBWT (mean = 4.1 sessions/140 min vs. 5.4 sessions/227 min). **CONCLUSIONS:** EMDR and CBWT are brief, trauma-focused treatments that yielded equally large remission rates for PTSD and reductions in the severity of PTSD and comorbid difficulties in children and adolescents seeking treatment for PTSD tied to a	

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				single event. Further trials of both treatments with PTSD tied to multiple traumas are warranted." In addition, we would like to bring to the attention of the committee the following research publications relating to EMDR Therapy and children – these are also summarised: 1. **Trentini, C., Lauriola M., Giuliani, A., Maslovaric, G., Tambelli, R., Fernandez, I., Pagani, M. (2018) Dealing with the aftermath of mass disasters: A field study on the application of EMDR Integrative Group Treatment Protocol with child victims of the 2016 Italy earthquakes. *Frontiers in Psychology, doi: 10.3389/fpsyg.2018.00862*** This study explored the effects of the EMDR Integrative Group Treatment Protocol (EMDR-IGTP) on child survivors of the earthquakes that struck Italy in 2016. Three hundred and and thirty-two children from severely disrupted villages received 3 cycles of EMDR-IGTP. At T3, older children showed a reduction of distress and anger, whereas younger children reported an increase on these domains; moreover, older children reported a greater reduction of anxiety than younger ones. A	

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				greater reduction of distress, anxiety, and need for help was evidenced in females, whereas a greater improvement in depressive symptoms was evidenced in males. The effects of the EMDR-IGTP treatment on post-traumatic symptoms were particularly evident in older children, compared to younger ones, and marginally greater in females than in males; moreover, a greater improvement was found in children who had received a timelier intervention, than in those who received delayed treatment. These results provide further evidence for the utility of EMDR-IGTP in dealing with the extensive need for mental health services in mass disaster contexts. Also, these data highlight the importance of providing EMDR-IGTP in the immediate aftermath of a natural disaster, to contribute significantly in restoring adaptive psychological functioning in children, especially in older ones. 2. **R. C. Brown, A. Witt, J. M. Fegert, F. Keller, M. Rassenhofer and P. L. Plener (2017). Psychosocial interventions for children and adolescents after man-made and natural disasters: a meta-analysis and systematic review. *Psychological Medicine*, *doi:10.1017/S0033291717000496*** *Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees*	

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				In the light of increasing numbers of refugees under the age of 18 years worldwide, there is a significant need for effective treatments. This meta-analytic review investigates specific psychosocial treatments for children and adolescents after man-made and natural disasters. Treatments investigated by at least two studies were cognitive–behavioural therapy (CBT), eye movement desensitization and reprocessing (EMDR), narrative exposure therapy for children (KIDNET) and class- room-based interventions, which showed similar effect sizes. CBT, EMDR, KIDNET and classroom-based interventions can be equally recommended. **3. Verardo, A. R., & Cioccolanti, E. (2017). EMDR beyond PTSD. Traumatic experiences and EMDR in childhood and adolescence. A review of the scientific literature on efficacy studies. *Clinical Neuropsychiatry, 14(5), 313-320*** The aim of this review was to examine the efficacy of EMDR treatment on children and adolescents with post-traumatic stress disorder symptoms through comparisons with other established trauma treatment or no treatment control groups. Literature	

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				search was done concerning the effects of EMDR treatment on PTSD symptomatology in children and adolescents by analyzing digital databases like PsycINFO, MEDLINE, Google Scholar and Cochrane Library and with a traditional research method, targeting revisions and articles. Results show the efficacy of EMDR in respect of the number of sessions. Fewer EMDR sessions are associated with better outcomes. These findings support the use of EMDR for treating symptoms of PTSD in children, although further replications and comparisons are required. **4. Mevissen, L., Didden, R., Korzilius, H., & de Jongh, A. (2017). Eye movement desensitisation and reprocessing therapy for posttraumatic stress disorder in a child and an adolescent with mild to borderline intellectual disability: A multiple baseline across subjects study. *Journal of Applied Research in Intellectual Disabilities*, *30*, 34-41.** This study explored the effectiveness of eye movement desensitization and reprocessing (EMDR) therapy for post-traumatic stress disorder (PTSD) in persons with mild to borderline intellectual	

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				disability (MBID). For both participants, number of PTSD symptoms decreased in response to treatment and both no longer met PTSD criteria at post-treatment. This result was maintained at 6-week follow-up. The results of this study add further support to the notion that EMDR can be an effective treatment for PTSD in children and adolescents with MBID. **5. Moreno-Alcázar A, Treen D, Valiente-Gómez A, Sio-Eroles A, Pérez V, Amann BL. (2017) Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adolescent with Post-traumatic Stress Disorder: A Meta-Analysis of Randomized Controlled Trials. *Frontiers in Psychology 10;8:1750. doi: 10.3389/fpsyg.2017.01750.*** Post-traumatic stress disorder (PTSD) can occur in both adults and children/adolescents. Untreated PTSD can lead to negative long-term mental health conditions such as depression, anxiety, low self-concept, disruptive behaviors, and/or substance use disorders. To prevent these adverse effects, treatment of PTSD is essential, especially in young population due to their greater vulnerability. The principal aim of this meta-analysis was to examine the efficacy of eye movement desensitization and	

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				reprocessing (EMDR) therapy for PTSD symptoms in children and adolescents. Secondary objectives were to assess whether EMDR therapy was effective to improve depressive or anxious comorbid symptoms. EMDR therapy was superior to waitlist/placebo conditions and showed comparable efficacy to cognitive behavior therapy (CBT) in reducing post-traumatic and anxiety symptoms. A similar but non-statistically significant trend was observed for depressive symptoms. The obtained results suggest that EMDR therapy could be a promising psychotherapeutic approach for the treatment of PTSD and comorbid symptoms in young individuals. 1.6.10 Consider eye movement desensitisation and reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event only if they do not respond to or engage with trauma-focused CBT. **[2018]** 1.6.11 Consider eye movement desensitisation and reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event only	

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				if they do not respond to or engage with trauma-focused CBT. **[2018]** **EMDR UK & Ireland and EMDR Europe Summary:** We do not support recommendation 1.6.10 and 1.6.11 as it currently stands. The research highlighted above demonstrates the efficacy of EMDR Therapy with children and adolescents, and its equivalence with trauma focussed CBT. Consequently, we do not support using EMDR only if a child or young person does not respond to or engage with trauma focussed CBT – instead we would like to assert that children and young people be offered a 'choice' between TF-CBT and EMDR. **EMDR Therapy Response to Prevention and Treatment of Adults** Regarding PTSD in Adults, EMDR UK & Ireland Association and EMDR Europe does not support the following sections:	

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				Psychological and psychosocial interventions for the prevention and treatment of PTSD in adults 1.6.12 Treatment in adults 1.6.13 1.6.14 1.6.15 1.6.16 1.6.17 1.6.18 **EMDR UK & Ireland Association and EMDR Europe response to 1.6.12** Concerning EMDR Therapy as a treatment effect with Acute Stress Disorder, EMDR UK & Ireland Association and EMDR Europe concurs that there is a paucity of research regarding this specific disorder. However, there is increasing evidence of the effectiveness of using EMDR Therapy as an early intervention. As a result, we would like to bring the committee's attention the following references:	

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				1. Gil-Jardiné C, Evrard G, Al Joboory S, Saint Jammes JT, Masson F, Ribéreau-Gayon R, Galinski M, Salmi LR, Revel P, Régis CA, Valdenaire G. Emergency room intervention to prevent post-concussion-like symptoms and post-traumatic stress disorder. A pilot randomized controlled study of a brief eye movement desensitization and reprocessing intervention versus reassurance or usual care. *Journal of psychiatric research.* 2018 May 26. ***Summary:*** This is the first randomized controlled trial that shows that a short EMDR intervention is feasible and potentially effective in the context of the Emergency Room (ER). **2. Pfefferbaum B, Nitiéma P, Tucker P, Newman E. Early child disaster mental health interventions: a review of the empirical evidence. In Child & Youth Care Forum 2017 Oct 1 (Vol. 46, No. 5, pp. 621-642). Springer US.**	

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				Summary: This study highlights successful implementation of a range of interventions including CBT, narrative exposure, meditation relaxation, debriefing, and EMDR **3. Saltini A, Rebecchi D, Callerame C, Fernandez I, Bergonzini E, Starace F. Early Eye Movement Desensitisation and Reprocessing (EMDR) intervention in a disaster mental health care context. Psychology, health & medicine. 2018 Mar 16;23(3):285-94.** ***Summary:*** The results of this study suggest that EMDR is a viable treatment option in response to a disaster crisis and in reducing psychological distress of acutely traumatized individuals within the context of a natural disaster. **4. Trentini C, Lauriola M, Giuliani A, Maslovaric G, Tambelli R, Fernandez I, Pagani M. Dealing with the aftermath of mass disasters: A field study on the**	

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				application of EMDR Integrative Group Treatment Protocol with child victims of the 2016 Italy earthquakes. Frontiers in psychology. 2018;9:862. ***Summary:*** The effects of the EMDR-IGTP treatment on post-traumatic symptoms were particularly evident in older children, compared to younger ones, and marginally greater in females than in males; moreover, a greater improvement was found in children who had received a timelier intervention, than in those who received delayed treatment. These results provide further evidence for the utility of EMDR-IGTP in dealing with the extensive need for mental health services in mass disaster contexts. Also, these data highlight the importance of providing EMDR-IGTP in the immediate aftermath of a natural disaster, to contribute significantly in restoring adaptive	

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				psychological functioning in children, especially in older ones. **5. Yurtsever A, Konuk E, Akyüz T, Zat Z, Tükel F, Çetinkaya M, Savran C, Shapiro E. An Eye Movement Desensitization and Reprocessing (EMDR) Group Intervention for Syrian Refugees With Post-traumatic Stress Symptoms: Results of a Randomized Controlled Trial. Frontiers in psychology. 2018;9.** ***Summary:*** This study indicated that EMDR G-TEP effectively reduced PTSD symptoms among refugees living in a camp, after two treatment sessions conducted over a period of 3 days. **EMDR UK & Ireland Association and EMDR Europe response to 1.6.13 – 1.6.18** In Section 1.6.16 the committee recommends the following	

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				"Typically be provided over 8 to 12 sessions but more if clinically indicated, for example, where people have experienced multiple traumas." However, we would like to bring to the committee's attention the following study by Nijdam et al (2012)[21] As summary is as follows: **Background** Trauma-focused cognitive–behavioral therapy (CBT) and eye movement desensitization and reprocessing therapy (EMDR) are efficacious treatments for post-traumatic stress disorder (PTSD), but few studies have directly compared those using well-powered designs and few have investigated response patterns. **Aims** To compare the efficacy and response pattern of a trauma-focused CBT modality, brief eclectic psychotherapy for PTSD, with EMDR (trial registration: ISRCTN64872147).	

[21] Nijdam MJ, Gersons BP, Reitsma JB, de Jongh A, Olff M. Brief eclectic psychotherapy v. eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder: randomised controlled trial. The British Journal of Psychiatry. 2012 Mar;200(3):224-31.

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				Method Out-patients with PTSD were randomly assigned to brief eclectic psychotherapy (n = 70) or EMDR (n = 70) and assessed at all sessions on self-reported PTSD (Impact of Event Scale – Revised). Other outcomes were clinician-rated PTSD, anxiety and depression. **Results** Both treatments were equally effective in reducing PTSD symptom severity, but the response pattern indicated that EMDR led to a significantly sharper decline in PTSD symptoms than brief eclectic psychotherapy, with similar drop-out rates (EMDR: n = 20 (29%), brief eclectic psychotherapy: n = 25 (36%)). Other outcome measures confirmed this pattern of results. **Conclusions** Although both treatments are effective, EMDR results in a faster recovery compared with the more gradual improvement with brief eclectic psychotherapy. What this study clearly highlights is that 92% of the research participants lost their (single event) PTSD diagnosis after	

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				just 5 sessions of EMDR therapy, despite current guidance of between 8-12 treatment sessions. An important aspect of this particular research is that it is one of the few studies that measured the time needed to treat the condition [PTSD] rather than adhering to a fixed number of treatment sessions.[22] We would also like to bring to the attention of the committee the following reference in support of intensive treatment for adults with PTSD: ***Zepeda Méndez M, Nijdam MJ, ter Heide FJ, van der Aa N, Olff M. A five-day inpatient EMDR treatment programme for PTSD: pilot study. European journal of psychotraumatology. 2018 Jan 1;9(1):1425575.*** ***Summary:***	

[22] Bisson JI, Ehlers A, Pilling S, Dix P, Murphy A, Johnston J, Richards D, Turner S, Yule W, Jones C, King R. Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care.

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				Background: Trauma-focused psychotherapies for posttraumatic stress disorder (PTSD) have been demonstrated to be efficacious, but also have considerable non-response and dropout rates. Intensive treatment may lead to faster symptom reduction, which may contribute to treatment motivation and thereby to reduction of dropout. ***Objective***: The aim of the current study was to investigate the feasibility and preliminary effectiveness of an intensive five-day inpatient treatment with Eye Movement Desensitization and Reprocessing (EMDR) and trauma-informed yoga for patients with PTSD. ***Method:*** A non-controlled pilot study with 12 adult patients with PTSD was conducted. At baseline the PTSD diagnosis was assessed with the Clinician-Administered PTSD Scale (CAPS-5) and comorbid disorders with the Mini International Neuropsychiatric Interview (MINI). Primary outcome was self-reported PTSD symptom severity (PTSD Check List for DSM-5; PCL-5) measured at the beginning of day 1 (T1), at the end of day 5 (T2) and at follow-up on day 21 (T3). Reliable change indexes (RCI) and clinically significant changes were calculated.	

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				Results: From T1 to T3, PTSD symptoms significantly improved with a large effect size (Cohen's d = 0.91). Nine of the 11 patients who completed treatment showed reliable changes in terms of self-reported PTSD. At T3, two of the patients no longer met criteria for PTSD as measured with the PCL-5. One patient dropped out after the first day. No serious adverse events occurred. ***Conclusions:*** The majority of patients in our pilot study experienced symptom reduction consistent with reliable changes in this five-day inpatient treatment with EMDR and yoga. Randomized controlled trials – with longer follow up periods – are needed to properly determine efficacy and efficiency of intensive clinical treatments for PTSD compared to regular treatment. This is one of the first studies to show that intensive EMDR treatment is feasible and is indicative of reliable improvement in PTSD symptoms in a very short time frame. Section 1.6.16 continued: "be delivered in a phased manner and include psychoeducation about reactions to trauma;	

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				managing distressing memories and situations; identifying and treating target memories (often visual images); and 6 promoting alternative positive beliefs about the self " We found this aspect difficult to understand, and was unsure upon which research studies this assertion was based upon. Consequently, we would seek further clarification on this aspect. However, we would like to bring to the attention of the committee the following study by Steinert (2016)[23], which indicates the following: "We conclude that a treatment focusing on stabilization rather than confrontation, by establishing a secure patient/therapist relationship, applying stabilization techniques, and putting an emphasis on a patient's own resources, significantly reduced symptoms of PTSD in comparison to a waiting list."	

[23] Steinert C, Bumke PJ, Hollekamp RL, Larisch A, Leichsenring F, Mattheß H, Sisokhom S, Sodemann U, Stingl M, Thearom R, Vojtová H. Treating post-traumatic stress disorder by resource activation in Cambodia. World Psychiatry. 2016 Jun;15(2):183-5.

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				EMDR UK and Ireland Association and EMDR Europe would also like to bring attention to the emerging research in support of Adult PTSD, which focusses upon intensive treatment - utilising EMDR either as a 'stand-alone treatment' or in conjunction with other trauma-focussed treatment interventions. We are of the opinion that combined trauma treatments are insufficiently addressed, acknowledged or considered by this current guideline. The following studies are therefore recommended to the committee: 1. ***Bongaerts H, Van Minnen A, de Jongh A. Intensive EMDR to treat patients with complex posttraumatic stress disorder: A case series. Journal of EMDR Practice and Research. 2017 May 1;11(2):84-95.*** ***Summary:*** CAPS scores decreased significantly from pre- to posttreatment, and four of the seven patients lost their PTSD diagnosis as established	

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				with the CAPS. The results were maintained at 3-month follow-up. Effect sizes (Cohen's d) on the CAPS and PSS-SR were large: 3.2, 1.7 (pre/post) and 2.3, 2.1 (pre/follow-up), respectively. The results of this case series suggest that an intensive program using EMDR therapy is a potentially safe and effective treatment alternative for complex PTSD. ***2. Wagenmans A, Van Minnen A, Sleijpen M, De Jongh A. The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD. European journal of psychotraumatology. 2018 Jan 1;9(1):1430962.*** ***Summary:*** Large effect sizes were achieved for PTSD symptom reduction for all trauma groups [PE and EMDR therapy] (Cohen's d = 1.52–2.09). For the Clinical Administered PTSD Scale (CAPS) and	

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				the Impact of Event Scale (IES), no differences in treatment outcome were found between the trauma (age) groups. For the PTSD Symptom Scale Self Report (PSS-SR), there were no differences except for one small effect between CSA and NSA. **3. Zoet HA, Wagenmans A, van Minnen A, de Jongh A. Presence of the dissociative subtype of PTSD does not moderate the outcome of intensive trauma-focused treatment for PTSD. European journal of psychotraumatology. 2018 Jan 1;9(1):1468707.** **Summary:** Background: There is a widely-held belief in the trauma field that the presence of dissociative symptoms is associated with poor treatment response. However, previous research on the effect of dissociation in treatment outcomes pertained to specific patients and trauma populations. **Objective:** To test the hypothesis that the presence of the dissociative subtype of PTSD (DS) would	

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				have a detrimental effect on the outcome of an intensive trauma-focused treatment programme. **Methods:** PTSD symptom scores (Clinician Administered PTSD Scale [CAPS] and PTSD Symptom Scale Self-Report [PSS-SR]) were analysed using the data of 168 consecutive patients (70.6% female) who had been exposed to a wide variety of multiple traumas, including childhood sexual abuse, and of whom 98.2% were diagnosed with severe PTSD (CAPS > 65). Most of them suffered from multiple comorbidities and 38 (22.6%) met the criteria for DS. They took part in an intensive trauma-focused treatment programme for PTSD. Pre- and post-treatment differences were compared between patients with and without DS. **Results:** Large effect sizes were achieved for PTSD symptom reduction on CAPS and the PSS-SR, both for patients with DS and those without. Although patients with DS showed a significantly greater PTSD symptom severity at the beginning, and throughout, treatment, both groups showed equal reductions in PTSD symptoms. Of those who met the criteria for DS, 26 (68.4%) no longer fulfilled the criteria for this classification after treatment.	

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				Conclusion: The results provide no support for the notion that the presence of DS negatively impacts trauma-focused treatment outcomes. Accordingly, PTSD patients with DS should not be denied effective trauma-focused treatments. **4. Van Woudenberg, C., Voorendonk, E.M., Bongaerts, H., Zoet, H.A., Verhagen, M., Van Minnen, A., Lee, C.W., & De Jongh, A. (2018). The effectiveness of an intensive treatment programme combining prolonged exposure and EMDR for severe posttraumatic stress disorder (PTSD). European Journal of Psycho-traumatology, 9:1, https://doi.org/10.1080/20008198.2018.1487225** **Background:** There is room for improvement regarding the treatment of severe posttraumatic stress disorder (PTSD). Intensifying treatment to increase patient retention is a promising development. **Objective:** The aim of this study was to determine the effectiveness of an intensive trauma-focused	

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				treatment programme over 8 days for individuals suffering from severe PTSD. **Method:** Treatment was provided for 347 PTSD patients (70% women; mean age = 38.32 years, SD = 11.69) and consisted of daily sessions of prolonged exposure and eye movement desensitization and reprocessing (EMDR) therapy (16 sessions in total), physical activity, and psycho-education. All participants had experienced multiple traumas, including sexual abuse (74.4%), and suffered from multiple comorbidities (e.g. 87.5% had a mood disorder). Suicidal ideation was frequent (73.9%). PTSD symptom severity was assessed by both clinician-rated [Clinician Administered PTSD Scale (CAPS)] and self-report [PTSD Symptom Scale Self Report (PSS-SR) and Impact of Event Scale (IES)] inventories. For a subsample (n = 109), follow-up data at 6 months were available. **Results:** A significant decline in symptom severity was found (e.g. CAPS intention-to-treat sample Cohen's d = 1.64). At post-treatment, 82.9% showed a clinically meaningful response and 54.9% a loss of diagnosis. Dropout was very low (2.3%). **Conclusions:** Intensive trauma-focused treatment programmes including prolonged exposure, EMDR	

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				therapy, and physical activity can be effective for patients suffering from severe PTSD and are associated with low dropout rates. **5. Morgenthaler TI, Auerbach S, Casey KR, Kristo D, Maganti R, Ramar K, Zak R, Kartje R. Position paper for the treatment of nightmare disorder in adults: an American Academy of Sleep Medicine position paper. J Clin Sleep Med. 2018;14(6):1041–1055.** Position Statement: The following therapies may be used for the treatment of PTSD-associated nightmares: cognitive behavioral therapy; cognitive behavioral therapy for insomnia; ***eye movement desensitization and reprocessing***; exposure, relaxation, and rescripting therapy; the atypical antipsychotics olanzapine, risperidone and aripiprazole; clonidine; cyproheptadine; fluvoxamine; gabapentin; nabilone; phenelzine; prazosin; topiramate; trazodone; and tricyclic antidepressants.	

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				EMDR UK & Ireland and EMDR Europe Summary: We do not support recommendation 1.6.12 and 1.6.18 as it currently stands: 1.6.12 Offer individual trauma-focussed CBT to adults who have acute stress disorder or clinically important symptoms of PTSD and have been exposed to 1 or more traumatic events within the last month 1.6.18 Consider symptom specific CBT interventions (for symptoms such as sleep disturbance or anger) for adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event who:	

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				• Are unable or unwilling to engage in a trauma-focussed intervention that specifically targets PTSD or • Have residual symptoms after a trauma-focussed intervention. [2018] The research highlighted above demonstrates the efficacy of EMDR therapy with adults between 1 and 3 months, including sleep disturbance/nightmares. The committee makes an assertion that there is 'limited evidence' (both TF-CBT and EMDR) – however, the research in support of EMDR Therapy as an intervention should be considered by means of 'choice', and balance between TF-CBT ***and*** EMDR therapy. **EMDR Therapy Response to Non-Combat -Related Trauma**	

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				We refer to page 31 of 57 of the proposed guidance - Eye movement desensitisation and reprocessing (recommendations 1.6.15 and 1.6.16) "Less evidence was found on EMDR than on trauma-focused CBT, but the committee agreed that what was available justified recommending EMDR as an option. Although studies that compared EMDR directly with trauma-focused CBT did not show significant differences, there was a trend towards EMDR. This trend in favour of EMDR was also present in the cost-effectiveness results. The evidence suggested EMDR may be less effective in people with military combat-related trauma, so the committee restricted their recommendation to non-combat-related trauma." Regarding PTSD with Non-Combat-Related Trauma, EMDR UK & Ireland Association does not support the following sections: 1.6.15 - Offer eye movement desensitisation and reprocessing (EMDR) as an option for non-combat-related trauma to adults with a diagnosis of PTSD	

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				or clinically important symptoms of PTSD more than 3 months after a traumatic event. [2018] This current guidance makes a clear distinction between combat and non-combat related PTSD – EMDR UK and Ireland Association and EMDR Europe would question the rationale for this assertion. As mentioned earlier, the US Military Guideline (2016) were EMDR & TF-CBT were given equal credibility. Here is the hyperlink to the clinician summary version: https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGClinicianSummaryFinal.pdf Please refer to page 6, section B, point 11 "For patients with PTSD, we recommend individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive	

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				behavioural therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure." Please also find a hyperlink to the recent article published in Frontiers in Psychology entitled: The Use of Eye-Movement Desensitization Reprocessing (EMDR) Therapy in Treating Post-traumatic Stress Disorder—A Systematic Narrative Review https://www.frontiersin.org/articles/10.3389/fpsyg.2018.00923/full A summary is as follows: ***Results:*** Data from meta-analyses and Randomized-Controlled Trials included in this review evidence the efficacy of EMDR therapy as a treatment for PTSD. Specifically, EMDR therapy improved PTSD diagnosis, reduced PTSD symptoms, and reduced other trauma-related symptoms. EMDR therapy was evidenced as being	

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				more effective than other trauma treatments, and was shown to be an effective therapy when delivered with different cultures. However, limitations to the current evidence exist, and much current evidence relies on small sample sizes and provides limited follow-up data. The majority of trauma treatment with military populations ostensibly focusses upon Prolonged Exposure and/or Cognitive Processing Therapy. We concur with the VA/DOD recommendation that the research evidence underpinning both these trauma interventions are 'strong'. Nonetheless, we would also like to bring to the committee's attention Steenkamp et al (2015)[24] study which concluded: "In military and veteran populations, trials of the first-line trauma-focused interventions CPT and prolonged exposure have shown clinically meaningful improvements for many patients with	

[24] Steenkamp MM, Litz BT, Hoge CW, Marmar CR. Psychotherapy for military-related PTSD: a review of randomized clinical trials. Jama. 2015 Aug 4;314(5):489-500.

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				PTSD. However, nonresponse rates have been high, many patients continue to have symptoms, and trauma-focused interventions show marginally superior results compared with active control conditions. There is a need for improvement in existing PTSD treatments and for development and testing of novel evidence-based treatments, both trauma-focused and non–trauma-focused. The International EMDR Therapy community accepts that more research is needed exploring the utilization of EMDR Therapy with military PTSD clinical populations. **1.6.15.** Offer eye movement desensitisation and reprocessing (EMDR) as an option for non-combat-related trauma to adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event. **[2018]** **Response:** We do not recommend this guidance as it currently stands. The recommendation offered diverges from the VA/DOD guidelines, which states the following:	

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				"For patients with PTSD, we recommend individual, manualized trauma- focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioural therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure. - ***Strength: Strong*** (ref. Section 4, recommendations; Part 11, page 34/200; page 46/200." The VA document also states the following: The trauma-focused psychotherapies with the strongest evidence from clinical trials are PE, CPT, and EMDR. These treatments have been tested in numerous clinical trials, in patients with complex presentations and comorbidities, compared to active control conditions, have long-term follow- up, and have been validated by research teams other than the developers. Other manualized protocols that have sufficient evidence to recommend use are: specific cognitive behavioural therapies for PTSD, BEP, NET, and written narrative exposure.	

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				It also describes EMDR as the following: "EMDR incorporates imaginal exposure through narration and visualization to process the worst image, emotion, and negative cognition associated with the traumatic event, along with a more healthy cognitive reappraisal, with bilateral eye movements or other form of bilateral stimulation intended to create a dual awareness environment to facilitate processing and relaxation." EMDR is also described as part of 'Trauma-focused psychotherapies—therapies that include consciously recalling or activating the traumatic memory either as part (or all) of the presumed therapeutic mechanism or to provide material for other therapeutic techniques (e.g., cognitive restructuring, relaxation, imagery substitution) [Page 49, 158]. This is alongside PET, CPT, TF-CBT, NET, etc. Indeed, there is currently only limited evidence for the utilization of EMDR therapy involving combat-related PTSD. However, to consider this distinction – should there not be	

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				reservations also regarding other specific populations, for example intellectual learning disabilities, refugees, asylum seekers with PTSD? This paucity of evidence, with these populations, applies also to TF-CBT as much as it does to EMDR therapy. One important study to bring to the committee's attention is a systematic review/ meta-analysis by Thompson et al (2018)[25] which explored psychological interventions for PTSD in refugees and asylum seekers. It states the following: ***Abstract summary:*** There is a high prevalence of post-traumatic stress disorder (PTSD) in refugee and asylum seeker populations, which can pose distinct challenges for mental health professionals.	

[25] Thompson CT, Vidgen A, Roberts NP. Psychological interventions for post-traumatic stress disorder in refugees and asylum seekers: A systematic review and meta-analysis. Clinical Psychology Review. 2018 Jun 15.

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				This review included 16 randomised controlled trials (RCTs) with 1111 participants investigating the effect of psychological interventions on PTSD in these populations. 525 trials were reviewed, 16 were included with 15 contributed to meta-analyses. Despite the challenges of conducting research in this field, we found evidence for trauma-focused psychological interventions for PTSD in this population. Following sub-group analyses, we found evidence to support the use of EMDR and Narrative Exposure Therapy for PTSD symptoms. We considered these findings in relation to the broader PTSD treatment literature and related literature from survivors of large-scale conflict. These findings suggest that trauma focused psychological therapies can be effective in improving symptoms for refugees and asylum seekers with PTSD.	

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				Furthermore, we would like to bring to the attention of the committee a critical research study missing from the guidance: - van den Berg D.P.G., de Bont P.A.J.M., van der Vleugel B.M., De Roos C., De Jongh A., van Minnen, A. van der Gaag M. (2015). Prolonged Exposure versus Eye Movement Desensitization and Reprocessing versus Waiting List for Posttraumatic Stress Disorder in Patients With a Psychotic Disorder: A randomized Clinical Trial. JAMA Psychiatry, 72(3):259-267. https://doi.org/10.1001/jamapsychiatry.2014.2637 The conclusion from this important study indicated 'Standard PE and EMDR protocols are effective, safe, and feasible in patients with PTSD and severe psychotic disorders, including current symptoms.' In addition, we would like to bring to the committee's attention the following references in support:	

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				Lee DJ, Schnitzlein CW, Wolf JP, Vythilingam M, Rasmusson AM, Hoge CW. Psychotherapy versus pharmacotherapy for posttraumatic stress disorder: Systemic review and meta-analyses to determine first-line treatments. *Depress Anxiety.* Sep 2016;33(9):792-806. Rothbaum BO, Astin MC, Marsteller F. Prolonged exposure versus eye movement desensitization and reprocessing (EMDR) for PTSD rape victims. *J Trauma Stress.* Dec 2005;18(6):607-616. Watts BV, Schnurr PP, Mayo L, Young-Xu Y, Weeks WB, Friedman MJ. Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *J Clin Psychiatry.* Jun 2013;74(6):e541-550. Recent publications evaluating outcomes with the US VA movement which utilises PE, PCT, and CPT (TF-CBT) models as PTSD treatment interventions, have raised	

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				questions regarding the extent of their efficacy among veterans[26] [27]. Steenkamp (2016)[28] noted the following: "While beneficial to many patients, between one-third and half of veterans receiving CPT or PE do not demonstrate clinically meaningful symptom improvement" (2016, page 431). During this period EMDR therapy has held its own with more and more VA therapists being trained in EMDR. **Additional Comments from EMDR UK & Ireland Association** o Dropout rates from Trauma Treatment o Practice-Based Evidence o Integrative Approach to Trauma	

[26] Foa EB, McLean CP, Zang Y, Rosenfield D, Yadin E, Yarvis JS, Mintz J, Young-McCaughan S, Borah EV, Dondanville KA, Fina BA. Effect of prolonged exposure therapy delivered over 2 weeks vs 8 weeks vs present-centered therapy on PTSD symptom severity in military personnel: A randomized clinical trial. JAMA. 2018 Jan 23;319(4):354-64.

[27] Hoge CW, Chard KM. A Window Into the Evolution of Trauma-Focused Psychotherapies for Posttraumatic Stress Disorder. Jama. 2018 Jan 23;319(4):343-5.

[28] Steenkamp MM, Larson JL, Litz BT. Posttraumatic Stress Symptoms Across the Deployment Cycle: A Latent Transition Analysis Alyssa M. Boasso VA Boston Healthcare System, Massachusetts Veterans Epidemiology Research and Information Center.

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				Dropout Rates Hoge & Chard (2018)[29] in an editorial paper highlighted the following: "The wars in Iraq and Afghanistan sparked tremendous investment to improve the care of service members and veterans with posttraumatic stress disorder (PTSD), including enhancing screening and treatment services, updating clinical practice guidelines, and initiating multicenter randomized clinical trials (RCTs) to refine treatment approaches.1 The most recent US Department of Veterans Affairs (VA) and Department of Defense (DoD) clinical practice guideline for management of PTSD recommends trauma-focused psychotherapies as first-line treatment ahead of medications, with prolonged exposure therapy and cognitive processing therapy the most widely used therapies. Despite these efforts, however, many challenges remain, including stigma, barriers to care, and high rates of patient dropout from treatment." (page 343)	

[29] Hoge CW, Chard KM. A Window Into the Evolution of Trauma-Focused Psychotherapies for Posttraumatic Stress Disorder. Jama. 2018 Jan 23;319(4):343-5.

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Please insert each new comment in a new row</th><th>Developer's response
Please respond to each comment</th></tr>
<tr><td></td><td></td><td></td><td></td><td>Often, despite well-designed studies, including rigorous methodologies, including blinded assessment are also subject to 'loss to follow-up', which often approaches 50% at 6 months follow-up. The average dropout rate across treatments in PTSD clinical trials is approximately 20%[30].
<table>
<tr><th>Disorder</th><th>Treatment Approach</th><th>k</th><th>Dropout rate</th><th>95%</th></tr>
<tr><td>PTSD</td><td>Average</td><td>92</td><td>21.0%</td><td>18.
23.</td></tr>
<tr><td></td><td>Behavior Therapy (AR)</td><td>4</td><td>12.1%</td><td>5.5</td></tr>
<tr><td></td><td>Behaviour Therapy (exposure)</td><td>25</td><td>23.2%</td><td>19.
27.</td></tr>
<tr><td></td><td>Cognitive Therapy</td><td>8</td><td>15.2%</td><td>9.6</td></tr>
<tr><td></td><td>CPT</td><td>5</td><td>23.7%</td><td>16.
33.</td></tr>
<tr><td></td><td>EMDR</td><td>10</td><td>16.9%</td><td>10.
27.</td></tr>
<tr><td></td><td>Full CBT</td><td>27</td><td>28.5%</td><td>22.
35.</td></tr>
</table></td><td></td></tr>
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[30] Imel ZE, Laska K, Jakupcak M, Simpson TL. Meta-analysis of dropout in treatments for posttraumatic stress disorder. Journal of consulting and clinical psychology. 2013 Jun;81(3):394.

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				Integrative 4 8.8% 2.9%, 23.7% Supportive 9 15.3% 11.1%, 20.5% ***Table 1: Dropout Rates for PTSD – adapted version***[31] Results suggest that there is no significant difference between EMDR Therapy and other empirically supported treatment interventions for PTSD. Interestingly the dropout rates regarding integrative treatments are approximately (8.8%), whereas the drop-out rate for the Van Woudenberg et al (2018)[32] study was 2.3%. It is important to bring this study to the committee's attention. Consequently, this study is summarized as follows: "Treatment was provided for 347 PTSD patients (70% women; mean age = 38.32 years, SD = 11.69) and consisted of daily sessions of prolonged exposure and eye movement desensitization and	

[31] Swift JK, Greenberg RP. A treatment by disorder meta-analysis of dropout from psychotherapy. Journal of Psychotherapy Integration. 2014 Sep;24(3):193.

[32] Van Woudenberg, C., Voorendonk E., Bongaerts, H., Zoet, H.A., Verhagen, M.,Lee, C.W., Minnena, A.V., De Jongh, A. Effectiveness of an intensive treatment programme combining prolonged exposure and eye movement desensitization and reprocessing for severe post-traumatic stress disorder. EUROPEAN JOURNAL OF PSYCHOTRAUMATOLOGY 2018, VOL. 9, 1487225 https://doi.org/10.1080/20008198.2018.1487225

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				reprocessing (EMDR) therapy (16 sessions in total), physical activity, and psycho-education. All participants had experienced multiple traumas, including sexual abuse (74.4%), and suffered from multiple comorbidities (e.g. 87.5% had a mood disorder). Suicidal ideation was frequent (73.9%). PTSD symptom severity was assessed by both clinician-rated [Clinician Administered PTSD Scale (CAPS)] and self-report [PTSD Symptom Scale Self Report (PSS-SR) and Impact of Event Scale (IES)] inventories. For a subsample (n = 109), follow-up data at 6 months were available. ***Results:*** A significant decline in symptom severity was found (e.g. CAPS intention-to-treat sample Cohen's d = 1.64). At post-treatment, 82.9% showed a clinically meaningful response and 54.9% a loss of diagnosis. Dropout was very low (2.3%)." Another important article in regard to 'dropout rates is: **Najavits, L. M. (2015). The problem of dropout from "gold standard" PTSD therapies. *F1000prime Reports*, *7*, 43. doi:10.12703/P7-43** Quoting from the abstract of Najavits	

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				The two PTSD therapies most studied in relation to retention and dropout are ***Prolonged Exposure and Cognitive Processing Therapy***, which have been the subject of massive, formal, multi-year dissemination roll-outs. Both of these evidence-based treatments are defined as gold-standard therapies for PTSD and showed positive outcomes and reasonable retention of patients in randomized controlled trials (RCTs). ***But an emerging picture based on real-world practice indicates substantial dropout***. Such ***real-world studies are distinct from RCTs***, which have consistently evidenced far lower dropout rates, but under much more restricted conditions (e.g. a more selective range of patients and clinicians). In this paper, the phenomena of retention and dropout are described based on real-world studies of Prolonged Exposure and Cognitive Processing Therapy, including rates, characteristics of patients, clinicians, and programs in relation to retention and dropout, and identification of clinical issues and future research on these topics. ***It is suggested that the term "gold-standard" evidence-based treatments should be reserved for treatments that evidence both positive results in RCTs but also feasibility and strong retention in real-world settings.***	

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				on page 6 she states: "We are at a pivotal historical moment with regard to PTSD therapies. There has now been substantial investment in development of therapies, testing of them in rigorous RCTs, and dissemination of them in large-scale treatment systems. Such efforts indicate that the actual performance of the "gold standard" therapies PE and CPT consistently perform less well in real-world implementation with regard to retention and dropout than in the RCT literature. As Hoge et al.[33] recently stated in relation to the problem of PTSD patients dropping out of therapy: "Dropping out of care is clearly the most important predictor of treatment failure; therefore the most promising strategies to improve efficacy of evidence-based treatments will be those that address engagement, therapeutic rapport, and retention." **Integrative Approaches to PTSD/ Complex PTSD Treatment**	

[33] Hoge CW, Chard KM. A Window Into the Evolution of Trauma-Focused Psychotherapies for Posttraumatic Stress Disorder. Jama. 2018 Jan 23;319(4):343-5.

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				The intensive trauma treatment study mentioned earlier highlights both the benefits of intensive treatment, but also integrative approaches. The Van Woudenberg et al (2018) study indicates that intensive trauma-focused treatment programmes - including prolonged exposure, EMDR therapy, and physical activity can be effective for patients suffering from severe PTSD and are associated with low dropout rates. EMDR UK & Ireland Association and EMDR Europe considers that the committee be mindful, and cognizant with 'Modular/ Integrative Treatment', which often consider trans-diagnostic approaches (including co-morbidity factors) concerning PTSD. The Van Woudenberg et al study (2018) is a seminal work in this area. Returning to the issue of 'dropout rates' EMDR UK & Ireland Association and EMDR Europe would like to bring to the	

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				attention of the committee the following quotation from Swift & Greenburg study (2014): "After the integrative approaches, applied relaxation, cognitive therapy, supportive approaches, and EMDR were also found to have relatively lower rates of premature discontinuation (ranging from 12.1% to 16.9%) for PTSD clients. In contrast, the highest rates of premature discontinuation in PTSD were found in full cognitive– behavioral therapy (28.5%), followed by exposure (23.2%) and cognitive processing therapy (23.2%)." [Page 202] **Practice-Based Evidence and EMDR therapy** Whilst we concur that NICE primarily focusses on Evidence-Based Practice [EBP] in knowledge that since its inception during the 1980's EBP has become a primary driver of health policy within the United Kingdom. The application of EBP has had a major impact upon psychological therapies in the endeavor towards delivering rigorous, empirically supported	

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				treatment interventions that are safe, effective and efficient. Nonetheless, this also raises concerns regarding clinical relevance in 'real' clinical environments and settings. Enhancing treatment quality is driven instead by 'Practice-Based Evidence' [PBE]. Inevitably, there is a tension between the two[34]. EMDR Europe consists of a membership of over 22,000 people – all of which trained through an EMDR Europe Accredited Training Provider. It would be reasonable to state that many members of EMDR UK & Ireland Association, in particular, do not support some of the new guidance implications for the NICE [2018] PTSD. The following are several examples of important narratives – from experienced EMDR Therapists (including many who	

[34] Barkham M, Mellor-Clark J. Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice. 2003 Nov;10(6):319-27.

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				are also BABCP Accredited), in specific regard to this proposed PTSD guideline: "The NICE [2018] guideline for PTSD will lose credibility with the clinical sector if they argue for a preference over CBT for Trauma as opposed to EMDR when both are indicated to be effective." **[Therapist A]** "I am really frustrated to see how the NICE PTSD guidelines are 'downgrading' EMDR. I think a big issue that reflects EMDR v TFCBT results is that many services have very few EMDR trained clinicians. In my current service, we have a large trauma waiting list but as there are only three EMDR trained clinicians in a team of over 20 clinicians TF-CBT is always offered as a first treatment." **[Therapist B]** "As an EMDR Therapist in an IAPT service, it is very important that we offer clear choice, for our PTSD clients, between TF-CBT and EMDR. Although there are more CBT therapists in the team, recovery rates for EMDR therapy are consistently better than TF-CBT. In addition, dropout rates from EMDR therapy is much, much lower. But, getting access to	

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				the data to support this is – challenging." **[Therapist C]** "As ex-military myself, my experience, as an EMDR Europe Accredited Therapist, of working with soldiers with PTSD, is that they prefer EMDR to TF-CBT as they don't want to talk through trauma in detail." **[Therapist D]** "I am trained in all 3 trauma based interventions - EMDR, TF-CBT and NET (for refugee populations) – with a lot of experience of working with complex trauma/severe and enduring MH difficulties. EMDR is now my main model, and the outcomes are far superior to those I ever achieved with TF-CBT. With TF-CBT attrition was a problem, emotional shifts happened less quickly, high 'fear states' were more prolonged, and clients drop out of treatment more." **[Therapist E]** "My background is I qualified as a registered mental health nurse in the NHS then joined the Royal Air Force as a mental Health Nurse for 10 years treating trauma. I completed my EMDR training in 2006 and left the services in 2015 and currently work with the military veterans service in the north-west NHS. As I am not BABCP qualified in CBT I have always treated my patients with EMDR with good success.	

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				Within both the MOD and the NHS military veterans service. At assessment, patients have always been offered a choice of trauma focused CBT or EMDR." **[Therapist F]** "My view of working with military veterans and serving soldiers with EMDR is that it is more affective when working with different nationalities due to language and cultural differences as they relate very well to feelings in the body and not always content of thought." **[Therapist G]** "I also feel there is a benefit of EMDR when you take into account the average reading age of an infantry soldier is seven years old so many find reading and writing difficult. Soldiers are also "task orientated" so engage with EMDR well as they feel that something practical is happening and they can engage with it. If this change comes into effect patients will suffer with lack of choice in treatment and may suffer due to their learning needs." **[Therapist H]** These are just some examples from within the EMDR UK & Ireland Association Community – narratives that we hear repeated time, and time again. What they highlight are the following themes:	

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				○ Maximizing choice of treatment interventions ○ Paucity of access to EMDR Therapy ○ Insufficient numbers of EMDR Therapist available within current services ○ Client preference for EMDR therapy over TF-CBT ○ Distinct advantages in working with EMDR as opposed to TF-CBT ○ Language ○ Translators ○ Shame-based trauma ○ Unspoken trauma ○ Cultural appropriateness ○ Dealing with somatic trauma memories using EMDR therapy A further cogent international narrative are comments by Professor Brigadier (Retired) Mowadat H Rana, MB, FCPS, FRC Psych (UK), Former Advisor in Psychiatry to Pakistan Armed Forces (2003-2013), Patron EMDR Pakistan (2009 to date), Chair, Department of Behavioural Sciences, University of Health Sciences, Lahore, Pakistan, Chief editor, Journal of Pakistan Psychiatric Society. He states the following:	

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				"NICE guidelines are a constant resource in developing practice guidelines in psychiatry in Pakistan Armed Forces as well as for clinical practice recommendations made by Pakistan Psychiatric Society. Most mental health professionals in Pakistan draw strength and preferences for both pharmacological as well as non-pharmacological / psychotherapeutic interventions from the evidence and recommendations of NICE. Since its introduction in Pakistan through EMDR UK & Ireland, in 2007, EMDR has become the mainstay of treatment for PTSD in this part of the world. In a country challenged by natural, as much as man-made disasters, and people and its armed forces at the forefront of war on terror, Pakistan has probably experienced more psycho-trauma than any other nation in the world. With less than three hundred psychologists and almost no therapists trained in trauma focused CBT, the only two interventions available for PTSD patients in Pakistan have been medication, and EMDR. The choices of these interventions have been made based on WHO guidelines, NICE guidelines and VA recommendations. In the absence of trauma focused CBT practitioners, the current burden is being carried ***exclusively*** by a hundred odd EMDR	

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				practitioners working in military and civil health settings. The services of EMDR practitioners have consistently shown beneficial outcomes and positive responses from patients of PTSD both in military and civil. An ongoing double blind randomized controlled trial by Pakistan Armed Forces psychiatrists suffering from military trauma in war against terror, has shown response rates of as high as 90% with EMDR . Unfortunately, the permission to publish the study, or share findings of this study in scientific journals or circles has not been allowed by the concerned quarters for operational reasons. However, we continue to find reports, commentaries, and presentations made in national and international psychiatric, psychological, and EMDR conferences of the excellent outcomes in patients of PTSD treated with EMDR. While none of this is of scientific value as evidence to support the case of EMDR as a successful treatment of PTSD, it is of great significance at a qualitative and inspirational level for mental health professionals in resource constrained countries like Pakistan where there are no CBT specialists.	

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				In case EMDR is removed as a first choice intervention for PTSD in adults, children, and military trauma, from the NICE guidelines, it will do an irreparable damage to mental health services in countries like Pakistan which lack CBT facilities and practitioners. Pakistan and many countries currently in war zones in Asia especially Middle East, EMDR is currently the only psychotherapeutic resource. Once it loses credibility at the hands of NICE, the PTSD patients in military and civil settings will be well in their right to opt out of EMDR, and yet have no other credible psychotherapeutic intervention available to them. It is with these concerns in mind that NICE may reconsider the recommendations referred to earlier in the document." ***EMDR UK & Ireland Association and EMDR Europe therefore strongly recommends that the committee be mindful of Practice-Based Evidence concerning the guidance provided by NICE, in regard to PTSD, and its subsequent application into clinical practice and service delivery***	

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				Summary of EMDR UK & Ireland Association and EMDR Europe's position on NICE Guidance: Post-traumatic Stress disorder (up-date) - In development [GID-NG10013] The recommendations from EMDR UK & Ireland Association and EMDR Europe are as follows: 1. EMDR UK & Ireland Association and EMDR Europe ***support*** the following sections in their current iteration: 1.1 1.1.1 – 1.1.9 1.2 1.2.1 – 1.2.6 1.3 1.3.1 – 1.3.2 1.4 1.4.1 – 1.4.8 1.5 1.5.1 – 1.5.3 1.6 1.6.1, 1.6.2, 1.6.3, 1.6.11, 1.6.21, 1.6.22 1.7 1.7.1 – 1.7.4 1.8	

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				1.8.1 2. EMDR UK & Ireland Association and EMDR Europe ***does not support*** the following sections in their current iteration: 1.6 1.6.4 – 1.6.18 3. EMDR UK & Ireland Association and EMDR Europe considers patient choice, concerning the treatment of PTSD, to be an important imperative. As the research evidence base in support of effective treatment for PTSD demonstrates strong levels of consistency with both TF-CBT and EMDR therapy, we therefore recommend to the committee a continuation of the NICE PTSD CG26 [2005] guideline advise: o **CG26 PTSD NICE [2005]**	

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				"All PTSD sufferers should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing). These treatments should normally be provided on an individual outpatient basis." [Section 1.9.2.1] ○ **CG26 PTSD Review Recommendation Final December 2011** "Section 17: "Through the process no areas were identified which would indicate a significant change in clinical practice. There are no factors described above which would invalidate or change the direction of current guideline recommendations." [Page 5 of 49] ***4.*** EMDR UK & Ireland Association and EMDR Europe would like to direct the committee to the recommendations asserted by the WHO (2013)[35] Guidelines for the Management of Conditions Specifically Related to Stress – ***PTSD***	

[35] World Health Organization. Guidelines for the management of conditions specifically related to stress. Geneva: WHO, 2013.

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				recommendations for children, adolescents and adults o "Recommendation 14: Individual or group cognitive-behavioural therapy (CBT) with a trauma focus, eye movement desensitization and reprocessing (EMDR) or stress management should be considered for adults with posttraumatic stress disorder (PTSD)." [Page 8] o "Recommendation 15: Individual or group cognitive-behavioural therapy (CBT) with a trauma focus or eye movement desensitization and reprocessing (EMDR) should be considered for children and adolescents with posttraumatic stress disorder (PTSD)." [Page 9] We therefore consider that the up-dated NICE Guidance for PTSD should be more closely aligned with the WHO (2013) recommendation for treating children, adolescents and adults diagnosed with PTSD	

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				5. EMDR UK & Ireland Association and EMDR Europe does not support the distinction between combat and non-combat related trauma – in specific regard to the current empirical evidence. Consequently, we would strongly recommend alignment with the VA/DOD (2017) recommendation: o "The trauma-focused psychotherapies with the strongest evidence from clinical trials are PE, CPT, and EMDR. These treatments have been tested in numerous clinical trials, in patients with complex presentations and comorbidities, compared to active control conditions, have long-term follow- up, and have been validated by research teams other than the developers." 6. EMDR UK & Ireland Association and EMDR Europe acknowledges that offering 'patient choice' in treatment interventions for PTSD does have financial and resource implications for service provision with regards to validated/ accredited training in TF-CBT and EMDR therapy and appropriate, robust clinical supervision. Nonetheless, as the is '***strong evidence***' in support of both TF-CBT and EMDR therapy service provision should maximize choice between the main treatment	

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				modalities for children, adolescents and adults diagnosed with PTSD. **In conclusion** – EMDR UK & Ireland Association and EMDR Europe is committed to evidence-based practice and the continued need for high quality research and development for those traumatized by adverse life experiences. As a critical stakeholder of NICE concerning PTSD, we trust you find our feedback useful. We therefore look forward to a detailed reply to our recommendations.	
Expert Peer Reviewer	Evidence review F	General	General	I have reviewed the evidence reviews for pharmacological interventions for the prevention and treatment of PTSD in adults, including the methodology chapter, and have the following comments to make: - I found the systematic review and quality appraisal of the studies rigorous and transparent. - Very comprehensive coverage of drug types. - The range of outcomes extracted was very helpful when comparing studies including both PTSD symptoms (self and clinician rated), wider	Thank you for your comment. Both self-reported and clinician-reported PTSD symptomatology were included in the clinical review as the committee were aware that there are potential issues with both respondents in terms of blinding and because this provided the opportunity for triangulation but in almost all cases the findings

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				associated symptoms/diagnoses, measures of functioning and QoL, attrition and discontinuation secondary to adverse events. - Discussion of the review panels' consideration of clinical benefits and harms of various medications vs potential harms of persistent PTSD symptoms when weighing up the evidence is good and helpful. - I'm not sure I agree with the prioritisation of self-rated PTSD symptoms over clinician rated, especially given the poor blinding of patients in many studies, though I'm not sure this made much difference to the recommendations ultimately. - Based on the limited evidence available I agree with the 'consider' rather than 'offer' wording in the recommendation. - I would suggest however that the broad recommendation for SSRIs is limited to the ones which are mentioned in the evidence review, i.e. Paroxetine, Fluoxetine and Sertraline, as has been done for antipsychotics (Risperidone, Quetiapine and Olanzapine). Otherwise other SSRIs could be prescribed for which evidence is lacking, e.g. citalopram. - I understand that though there is emerging evidence for some medications there is not yet sufficient evidence to support a recommendation. It is helpful, however, that this evidence review will	from self-reported and clinician-reported scales agreed. The committee considered the evidence on the effectiveness of different SSRIs and found no evidence for significant differential efficacy of specific SSRIs (sertraline, fluoxetine and paroxetine), so the committee did not consider it appropriate to restrict the recommendation to certain SSRIs in order to allow individual prescribers to decide which SSRI to use. However, in recognition of differences in side effects and to bring this recommendation more in line with the antipsychotics recommendation, the committee decided to amend this recommendation to include one example of a specific drug (sertraline), this drug is one of two that are licensed in the UK for this indication and paroxetine, the other drug that is licensed, is more likely to be associated with discontinuation symptoms. The committee did not consider pharmacological interventions only for those with complex PTSD as there was not a specific review question to address this and the NMA and economic modelling were not restricted to a specific sub-population. The review

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				be available for clinicians to use should they want to discuss with treatment resistant patients the use of other potentially helpful medications which have not been formally recommended. - As a clinician I appreciated the subgroup analyses comparing the efficacy of drugs in single vs multiple trauma, especially important given the new ICD 11 diagnosis of complex PTSD, even though there was no apparent difference in effect for any medication, but some increased drop out for adults with multiple trauma. - However, I also wonder if the panel reviewed any evidence for pharmacological treatment of complex PTSD, rather than just considering intervention studies for multiple or single event traumas? - The recommendation that antipsychotics are only considered in a secondary care setting is likely to restrict some adults access to effective treatment as most with PTSD do not cross the threshold for local secondary care services such as CMHTs or equivalent. Some consideration/mention of the lack of generalizability of the limited available evidence to clinical populations beyond those in the mostly western country based studies.	used the multiple trauma subgroup as a proxy for complexity. The reference to secondary care has been removed from the antipsychotic recommendation. However, due to concerns around the tolerability of these drugs the committee agreed that these should only be prescribed in a specialist setting or after consultation with a specialist. When making recommendations, the committee interpret RCT evidence in light of their knowledge of the clinical context so that the 'reality' for people experiencing PTSD is taken into consideration and recommendations can be made that are relevant to the populations that clinicians typically encounter. Recommendations in the language and culture section also provide guidance about linguistic or cultural adaptations that may be needed.
Expert Peer Reviewer	Guideline	5	22-25	This is a very important recommendation as we have experienced that clinicians often feel more comfortable asking parents about child symptoms than the child. Probably because they do not want to upset children. Since	Thank you for your comment. We agree that this is an important change to the recommendation. The committee did not consider it appropriate to limit this recommendation to those aged 6 years and

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				many studies show that parents underreport internalizing symptoms this is extremely important. Also parents may, for different reasons, want to deny trauma related symptoms in their child. I think the recommendation should be stated even clearer: "All children 6 years and above (and younger children when developmentally appropriate) should be asked directly and separately about trauma exposure and symptoms." We have data on 15,000 children referred to clinical services where they were asked whether they became upset after being asked about trauma exposure. Very few said they became upset. This is in line with other studies in non-clinical populations. Children rarely disclose abuse it they are not asked, and there is a concern that children therefore are treated for other disorders because trauma exposure is not identified. Therefore I think the guidelines should state that routine screening in child mental health clinics is recommended. Now this is only recommended after major disasters. .	older as for some 4 and 5 year olds this may also be appropriate. On this basis, the committee considered it more appropriate to leave the decision about when this might be developmentally appropriate to clinical judgement. The committee were not able to make a recommendation about routine screening in child mental health clinics as the recognition and assessment sections from the 2005 guideline were not included in this update (as outlined in the scope) and the evidence on recognition and assessment has not been reviewed. This means that the only changes we are able to make are those that are necessary in order to clarify meaning and this new proposed recommendation goes beyond this scope.
Expert Peer Reviewer	Guideline	General	General	Main comments Little change since 2005 guideline - disappointing. Criteria looking at RCTs is too rigid and not true to real clinical practice. Criteria should be relaxed and other lower powered evidence included and stated as such. Guideline remains rigid and not true to real life clinical practice and this can be misleading in cases of chronic	Thank you for your comment. A qualitative review of service user experience was included in the guideline (see Evidence report H). For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs)

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		Page 17	Para 1.7.3 & 1.7.4	complicated presentations; pure PTSD presentations are rare and co-morbidity is the norm. Nice should advise on training of all mental health staff engaged in treating psychological trauma cases. Nice should advise on multidisciplinary working across the mental health specialties in working with populations suffering from PTSD. Re PTSDand depression guideline Co morbidity and ComplexPTSD I think you have covered this in main guideline but to reiterate: Exclude risk to self and others. This will influence decision to treat depression aggressively first. In those who are severely depressed who also suffer PTSDit is essential to treat depression first. Advice must include and consider those who are severely depressed and who can have psychotic presentations - which will be alleviated if depression is treated aggressively with medication. Important to train staff to take a trauma history routinely.	and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. However, the qualitative review (in Evidence report H) was used to both reword existing recommendations in order to more accurately reflect the needs of service users, and as a basis for new recommendations. For instance, in the absence of evidence for clinical efficacy and on the basis of the qualitative meta-synthesis, the guideline recommends that access to peer support groups should be facilitated for those who may benefit as the thematic analysis highlighted potential benefits including facilitating access to services and helping individuals at risk of social isolation to integrate with others with shared experiences. Furthermore, when making recommendations, the committee interpret RCT evidence in light of their knowledge of the clinical context so that the 'reality' for people experiencing PTSD is taken into consideration and recommendations can be made that are relevant to the populations that clinicians typically encounter. The committee did not consider it appropriate to recommend a multidisciplinary approach, integrated approach, or phasic treatment model as specific

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				Important to include a guidance section on training of nhs (and all) staff re Post Traumatic Stress related to all uniformed services, veterans, refugees, and in disaster planning, and for those who are going to treat ptsd using trauma focussed interventions; as well as those who prescribe GPs and Psychiatrists as their knowledge and training is grossly lacking. General point re prescribing opiates for chronic pain which interferes with trauma focussed therapy and emotional processing. Education if medical staff essential. The culture of the uniformed services needs to be understood and incorporated into training of all relevant staff. Manualisation of psychological treatments may be useful for treating simple ptsd but not so useful in those with multiple trauma who dissociate and who are real life cases who do not neatly fit into the ideal rct based subject. See Page 12 management of ptsd section Point 5 re litigation court hearings - this point needs to be expanded and explained better page 13 Those with dual diagnosis should have their substance misuse disorders under control otherwise their trauma focussed therapy will fail.	service delivery models as the evidence for these models was not assessed. In response to your and other stakeholder's comments, the recommendations about the structure and content of psychological interventions have been amended to include the guidance that they should *'be delivered by trained practitioners with ongoing supervision*'. In response to your and other stakeholder's comments, the coexisting depression and PTSD recommendation has been amended so the guidance is *'treat the depression first if the severity of depression might make psychological treatment of the PTSD difficult, or there is a risk of harm to self or others*'. We agree that training and education on PTSD, including the taking of trauma histories, is important but these are matters for implementation. The committee did not consider it appropriate to make a specific recommendation about opiates (for chronic pain) and their potential to interfere with trauma-focused therapies, or to be more prescriptive in terms of medication recommendations, for instance, outlining

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				It's essential that substance misuse services and traumatic stress services work closely to ensure case management and supervision of patients who need to access both specialist areas of intervention. Joint training of clinical staff (pts and addictions staff) is also essential to ensure that patients' access processes to both services encourages engagement and not serve as a discouragement to engage or be excluded page 15.	medication choices where a patient is obese, diabetic with cardiac disorders and other physical illness, as these are matters for clinical judgement. However, in the 'Planning treatment and supporting engagement' section there is guidance about the need to take into account any previous treatment and coexisting conditions when discussing treatment options with a person with PTSD.
		General Page 16	General Para 1.6.20	Here is no clear reference to Judith Herman's trauma phasic treatment model for PTSD that I can see related to phasic treatment approaches. Medication section is interesting but guidance is unclear in relation to treating multi trauma complex PTSD with complicated presentations. Medication studies summarised do not reflect true to life cases Eg No studies related to comorbid chronic pain and co morbid depression and ptsd No guidance related to medication choices where patient is obese, diabetic with cardiac disorders and other physical illness etc No guidance as to which medications are useful to treat dissociation eg mood stabilisers. RCTs do not reflect true clinical cases. This should be CLEARLY stated!	The committee wanted to ensure that the interventions recommended in the guideline are provided in routine care. One way to do this was to advise practitioners to follow the treatment as set out in the treatment manuals. The committee agreed to do this as there is evidence that treatments inappropriately applied can be harmful. However, there is a recommendation concerning the adaptations that may be necessary to psychological interventions for people with PTSD and additional needs, including complex PTSD. The committee also drafted the recommendations about the content and structure of psychological interventions in a way that allowed enough flexibility for the clinician to modify treatment to the individual,

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				I would expect that medical doctor experts on panel would have first-hand experience treating such complicated cases; and inclusion of comment should be included and disadvantages of only including highly selected research studies should be clearly stated. The guidelines are therefore at risk of being misleading rather than informative in some such cases! Nice should consider including medication algorithms to advise on practical Medication choices and decision making.- this is very badly needed. Consider need for a funded Delphi study. Clear advice about treating sleep in ptsd sufferers is badly needed. e.g. use of trazodone, melatonin vs sedative antidepressants. Treatment using medication and cbt interventions related to specific ptsd symptoms would be helpful E.g. nightmares, sleep, anxiety, panic attacks, dissociation etc Engagement in treatment using art therapy should be reviewed. Even if RCTs do not exist there should be reference to this and similar useful stabilisation interventions	but enough specificity to ensure a minimum standard is set. In response to stakeholder's comments about the court proceedings recommendation, a cross-reference to Crown Prosecution Service guidance has been added to this recommendation, in order to provide further information and greater clarity. In response to your, and other stakeholder's, comments changes have been made to the recommendations for those with coexisting PTSD and substance misuse to reflect that for some people substance misuse may need to be addressed to enable engagement with trauma-focused intervention. The previous recommendation has been amended as follows: 'Do not exclude people with PTSD from treatment based *solely* on comorbid drug or alcohol misuse', and the recommendation for adaptations that may be needed for people with additional needs has been amended to recommend that people are helped to manage any issues, including substance misuse, that might be a barrier to engaging with trauma-focused therapies.
			Para 1.7.4		There was insufficient evidence in terms of benefits or harms of mood stabilisers for the treatment of

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		Page 17 Page 19	line 11	Para 1.7.4 of guideline needs to be clearer re dbt related interventions Examples should include using the stairs model (Cloitre) and use of Dialectic Behaviour Therapy where overlaps with borderline behaviours exist Stepped care for ptsd sufferers The risk of putting patients off as they have to repeat their trauma story as they are referred further up the stair model is a real risk of encouraging non engagement and dropouts The secret is through training of staff and a triage system with experienced clinicians at the front end of a whole service with access to all tiers of treatment	dissociative symptoms in PTSD and the committee did not consider a recommendation appropriate. The guideline included a recommendation for CBT interventions targeted at specific symptoms such as sleep when the person is unable or unwilling to engage in a trauma-focused intervention that specifically targets PTSD or has residual symptoms after a trauma-focused intervention. There was insufficient evidence to make a recommendation for the use of trazodone, melatonin, or sedative antidepressants on sleeping difficulties in people with PTSD. There was insufficient evidence to make a recommendation about the use of combined psychological and pharmacological interventions. There is only a single study of combined trauma-focused CBT and SSRIs relative to waitlist, and results of this single study are inconclusive. There was very limited eligible evidence identified for arts therapies. Namely, a single study of art therapy for children (Lyshak-Stelzer 2007). Although this study was suggestive of potential benefits of art therapy (in addition to treatment as usual) on clinician-rated PTSD symptoms, the committee did not consider that a single study with

					29 participants and only one outcome was sufficient evidence on which to base a recommendation. The committee also noted that the intervention in that study, Trauma-focused expressive art therapy, shared many features of trauma-focused CBT, and thus applicability or generalisability to non-directive art therapy was uncertain. In response to your, and other stakeholder's comments, arts therapies have now been added as an example intervention to the research recommendation about sequencing and further line treatment in Appendix L of Evidence report D. The recommendation about supporting engagement with treatment has been amended in order to make users of the guideline aware that *'people with PTSD may be apprehensive, anxious, or ashamed and may avoid treatment, believe that PTSD is untreatable, or have difficulty developing trust*'. There are also techniques to address these difficulties built into the recommendations about the structure and content of psychological interventions, and in the recommendation about adaptations that may be necessary to psychological interventions for those with PTSD and additional needs, including complex PTSD. The guideline used a class approach for analysis and dialectical behaviour therapy (DBT) is included

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					within the Trauma-focused CBT class. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term. We have also made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions. The guideline review did not find evidence for a stepped care approach and this is not what is recommended.
Expert Peer Reviewer	Guideline and Evidence	General	General	This is a major and very impressive piece of work; my congratulations and thanks go to those who have been involved. My comments, naturally, focus on areas I have some concerns about but should be read in the knowledge that I do not have concerns about the majority of the text. Due to time limitations, I have, unfortunately, not been able to go through every single study and meta-analysis in detail but have taken a closer look at some areas I am most familiar with. My comments are also informed by familiarity with the results of the meta-analyses being used to inform the development of the next iteration of the International Society for Traumatic Stress Studies (ISTSS) Treatment Guidelines. (I would be happy to share the ISTSS meta-analyses if that would be helpful.)	Thank you for your comment. In response to your, and other stakeholder's comments and the publication of ICD-11 we have amended the recognition recommendation to include specific reference to complex PTSD, and the symptoms of complex PTSD have been added to the bullet-pointed list. In response to your and other stakeholder's comments, the peer support recommendation has been amended to reflect that these might not be appropriate for everyone but access should be facilitated where they may be of benefit. Further

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				1. In paragraph 1.1.1, and elsewhere, there is no real mention of ICD 11 PTSD and Complex PTSD. Indeed, the document comes across as being DSM-oriented. Given the fact that ICD is the official classification system for the United Kingdom, I recommend a section is inserted to address this, not least as the inclusion of Complex PTSD as a diagnosis in ICD-11 is a very important advance and likely to influence the development of (better) new and existing treatments for PTSD and Complex PTSD in the future. 2. Paragraph 1.4.3 recommends access to peer support groups is provided wherever possible. I note the caveats that it should be ensured there is no risk of re-traumatisation and that such groups should be facilitated by people with training and supervision. I welcome the caveats but surely any discussion of distressing traumatic events "risks" re-traumatisation and how should the caveats be established by NHS clinicians? I agree that good peer support groups can be very useful to some PTSD sufferers but have seen a lot of individuals who have been re-traumatised, at times, and would recommend a more cautious statement. For example, given the evidence, would informing individuals of the potential benefits but also of potential risks, especially if not facilitated by individuals with training and supervision, be more appropriate?	changes have been made to specify that facilitators should have mental health training, and the 'risk of re-traumatisation' phrase has been removed and replaced with 'risk of exacerbating symptoms' which may be more amenable to assessment by NHS clinicians. Group trauma-focused CBT was not recommended for the delayed treatment (>3 months) of adults as the NMA found group TF-CBT to be less clinically effective than most other active interventions and not statistically significant relative to waitlist. The committee also considered the economic modelling results and group TF-CBT did not appear to be cost-effective relative to other active interventions assessed, ranking in the bottom 5 places among active interventions. The guideline used a class approach for analysis. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The committee agreed that although some interventions within the Trauma-focused CBT class place an emphasis on exposure and others place an emphasis on cognitive techniques, there is considerable overlap in techniques and mechanisms. The definition of trauma-focused CBT

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				3. In the section on treatment of adults, group trauma focused cognitive behaviour therapy is not recommended despite apparent good evidence for this. I note this appears to be as a result of a network meta-analysis but find this a strange decision given the increase for evidence for group TFCBT in recent years. 4. I am not a big fan of grouping all TFCBTs together. There is great heterogeneity between different TFCBT approaches and, interestingly (and not surprisingly in my view), heterogeneity in outcomes. I appreciate there are some issues with respect to the number of studies for some TFCBTs but recommend consideration is given to looking more specifically at distinct TFCBT interventions and recommending most strongly those TFCBTs with the best evidence. 5. Overall, I felt the guideline came across as more in favour of TFCBT than EMDR. I appreciate there are more TFCBT trials but, as stated above, they cover a heterogeneous group of interventions and the head to heads suggest EMDR is as effective. I appreciate there is often a judgment call and that this is often based on some (often limited) evidence but was surprised with the caveat for EMDR in the treatment of combat related PTSD. This is a very standard treatment for combat related PTSD and given the evidence for EMDR in various traumatised	in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. However, in response to stakeholder's comments, we have now made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and added the examples of named therapies that are in the glossary to the recommendation. Trauma-focused CBT and EMDR are offered as equivalent options for adults with PTSD who have been exposed to non-combat-related trauma more than 3 months ago. In response to stakeholder's comments the EMDR recommendation has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option to trauma-focused CBT for adults exposed to non-combat related trauma. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically

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				populations I think it is difficult to argue that combat related PTSD should be excluded when considering the evidence as a whole. 6. The recommendation regarding supported computer based TFCBT is restricted to those individuals who do not want to or have not been able to engage in face-to-face TFCBT or EMDR. I agree that the evidence is not as strong as for these interventions but I strongly suspect that the majority of those not able to engage in face-to-face therapy will not engage in computer based TFCBT. I would argue that a better approach would be to discuss the weaker evidence and offer individuals with milder forms of PTSD the opportunity to make an informed choice about treatment. The true place for supported computerised TFCBT is likely to be as part of a stepped/stratified approach with it being first line and provided by facilitators in or very close to primary care. There are major issues with accessibility to treatment for PTSD sufferers and I encourage NICE to take into account the long waiting lists many individuals find themselves on for face-to-face TFPT at present. (This also applies to the prescription of medication.) 7. The recommendation against psychologically focused debriefing to adults for prevention is very strong, given the evidence available. I think this can be argued for individual PD but not for group PD, especially when the groups are of	important and statistically significant benefits were observed. The committee agreed that the supported computerised trauma-focused CBT recommendation needed re-drafting as it was open to unintended interpretations. The re-drafted recommendation clarifies that supported trauma-focused computerised CBT should be considered for adults with established PTSD where the person has a preference relative to face-to-face trauma-focused CBT or EMDR, and if the person does not have severe PTSD symptoms in particular dissociative symptoms and are not at risk of harm to themselves or others. An additional recommendation has also been added to clarify what this intervention should include. The guideline review did not find evidence for a stepped care approach. In the guideline systematic review of RCTs for psychologically-focused debriefing, effects are fairly consistent across studies (whether the intervention is delivered individually or as the intervention was originally conceived as a group intervention for teams of emergency workers who are used to working together) and suggest non-significant effects of debriefing at best, and some suggestion

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				individuals who work together. The evidence for this (although not significant in the ISTSS meta-analyses) is better than it was and there does not appear to be evidence of potential harm as with individual PD. 8. Why are SSRIs grouped together? There is some evidence that not all SSRIs do perform as well and I feel those with evidence of a true, albeit low, effect (i.e. fluoxetine, paroxetine sertraline) should be recommended above others. 9. The recommendation to consider antipsychotic drugs seems fair but the naming of three specific drugs is inconsistent with the approach taken for SSRIs. I was surprised to see olanzapine included as a monotherapy as it comes out as neutral in the ISTSS work. On closer scrutiny, this is because studies with less than 10 participants per arm were excluded by NICE. This means the Butterfield 2001 study of 15 individuals is excluded and the recommendation relies solely on the Carey study of 28. It seems wrong to me not to increase the number of individuals by over 50% in the final meta-analysis, especially for a drug of the nature of olanzapine. 10. I was also somewhat concerned that anti-psychotic prescribing was recommended in secondary (as opposed to) primary care. From my knowledge of working in secondary care in the NHS, this is likely to be very difficult	of a trend in favour of no treatment. On this basis the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits. The committee considered the evidence on the effectiveness of different SSRIs and found no evidence for significant differential efficacy of specific SSRIs (sertraline, fluoxetine and paroxetine), so the committee did not consider it appropriate to restrict the recommendation to certain SSRIs in order to allow individual prescribers to decide which SSRI to use. However, in recognition of differences in side effects and to bring this recommendation more in line with the antipsychotics recommendation, the committee decided to amend this recommendation to include one example of a specific drug (sertraline), this drug is one of two that are licensed in the UK for this indication and paroxetine, the other drug that is licensed, is more likely to be associated with discontinuation symptoms. In response to your and other stakeholder's comments, the antipsychotic recommendation has now been revised to make it more consistent with

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				to deliver, especially if follow-up monitoring is expected in secondary care. In my experience, antipsychotic drugs are commonly prescribed and monitored by general practitioners and I fear making a strong statement re secondary care could prevent some PTSD sufferers having timely access to treatments that may help them. I would favour mention of necessary competencies. 10. I was also surprised there was no mention of other drugs, in particular prazosin, which the ISTSS analyses found evidence of having a low but positive effect for augmentation. I suspect that this is due to different inclusion and exclusion criteria but recommend the data used are compared. 11. I felt the section on page 18 that mentions Complex PTSD was quite weak and, in line with my point above, could be strengthened with more reference to ICD-11 and the increasing amount of research being undertaken in this area. There are many unanswered questions and I certainly think that research into appropriate treatment for ICD-11 complex PTSD would be a good research recommendation to consider in addition to the research questions already included (which appear sensible). 12. On page 34 the guideline seems to pull back from recommending increasing the number of sessions for some	the class approach taken for SSRIs, and only a single example has been left in (risperidone, based on the fact that we have more evidence for risperidone in terms of number of participants). The reference to secondary care has also been removed. However, due to concerns around the tolerability of these drugs the committee agreed that these should only be prescribed in a specialist setting or after consultation with a specialist. The committee considered the evidence for augmentation of routine medications with prazosin, and agreed that although there is limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. In response to your, and other stakeholder's comments, the recommendation about adaptations that may need to be made to psychological interventions for people with PTSD and additional needs, including those with complex PTSD, has been amended and now includes ICD-11 symptoms in the list of issues that that might be a barrier to engaging with trauma-focused therapies and a person might need help in managing. The committee agreed that further research into

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				individuals because the provision of more than 12 sessions is variable. This seems a strange reason to give and felt inconsistent with other recommendations which seem more purely based on research evidence than on service provision. In fact, as demonstrated by my comments on antipsychotic drugs and computerised TFCBT above, I have some sympathy for a degree of pragmatism that takes into account service provision within the NHS, although can see it both ways. Whatever the final decision is, there should be consistency throughout the guideline. 13. Building on my points re service provision, I wondered if more could be written about service provision of care from the PTSD sufferer perspective? It strikes me that it would be easy to advocate an evidence-based care pathway that facilitates informed choice and allows individuals to receive care as close to home as possible. This will, inevitably but positively, result in training and supervision implications, e.g. ensuring GPs, especially those in areas most likely to see traumatised individuals, are competent to prescribe the drugs that are recommended.	interventions for those with complex PTSD was necessary and was the justification for prioritising the following research recommendation: 'What is the clinical and cost effectiveness of interventions to deliver stabilisation and reintegration for people with complex PTSD?' The committee agreed that for some people more than 12 sessions may be necessary and added this proviso to the recommendations for the structure and content of trauma-focused CBT and EMDR, e.g. 'typically be provided over 8–12 sessions but more if clinically indicated, for example where people have experienced multiple traumas' and in the adaptations to psychological interventions for people with PTSD and additional needs recommendation ('increase the number of trauma-focused therapy sessions according to the person's needs'). The rationale and impact sections have now been amended to make this clearer. A qualitative review of service user experience was included in the guideline (see Evidence report H). This qualitative review was used to both reword existing recommendations in order to more accurately reflect the needs of service users, and as a basis for new recommendations. Providing access to the assessment, management and care

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					recommended in this guideline, including appropriate training and supervision, will be a matter for implementation of the guideline.
Fair Treatment for the Women of Wales (FTWW)	Review C	General	General	We are concerned that the recommendation for CBT therapies only may imply that other therapies continue to remain excluded / not included, with the view they are not as effective. Whilst it is easier to implement studies on CBT due to their structured framework, many patients presenting with PTSD have an emotional response to triggers which challenges the success rate of purely behavioural therapies. Some models like Foa, and Ehlers & Clark for example suggest using some stabilisation techniques at the beginning of therapy. However, we would suggest that the time spent on this is not enough to create a strong enough foundation to build upon when processing traumatic memories. Some services connected to the NHS in England are currently implementing compassion focussed therapy (CFT) prior to using CBT, with excellent results. CFT is now being used to treat the aftermath of trauma and PTSD, particularly where shame, (an emotional	Thank you for your comment. The guideline did not identify any evidence that met inclusion criteria for Compassion Focused Therapy and on this basis the committee did not think that a recommendation was warranted. The guideline does include a recommendation for people with additional needs, including complex PTSD, that there is adequate time for the person to establish trust included in treatment.

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				response) is experienced by the patient. It integrates proven research-based techniques such as CBT with mindfulness concepts, together with current research on human development and neuroscience. Many people experiencing PTSD feel disconnected from themselves, others around them and their environment. The traumatised mind has become 'stuck'; the grief process hasn't been completed and anger, fear, and sadness can be over-riding emotions. Shame, if experienced, is the disconnector, and connectedness is at the heart of recovery. Compassionate minds are empathic, strong, wise, knowledgeable and understanding, none of which can be felt when somebody is disconnected. Integrating CFT together with CBT in the treatment of PTSD, by teaching compassion to self and others in a group format would, we believe, give a more holistic, stable, complete set of skills to patients, enabling them to process their trauma without fear in one-to-one CBT therapy. Whilst it is clear that CBT appears to be the more popular evidence-based treatment, CFT also has a very strong evidence base which can be seen through the	

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				studies of Professor Paul Gilbert, world-renowned for his work on depression, shame and self-criticism, and whose work has successfully been adapted by Dr Deborah Lee in the use of treating shame based trauma and PTSD. As an integrative therapist myself, who works with both models depending on the patient's requirements, I would very much like to see CFT encouraged, so that we can see improvement rates higher than the 50% requirement of the NHS trust in which I have experience of working.	
Grenfell Health and Wellbeing Service	Guideline	General	General	Approaches for children with PTSD and Autism/ Learning Disabilities: we would welcome guidance on how treatment may need to be altered, or adapted for children with PTSD and learning disability or Autism. Clinically, we have identified a proportionally high number of children with both PTSD and Autism and have been using an adapted TF-CBT approach. It would be useful to have some specific guidance on this.	Thank you for your comment. There are existing recommendations in the *'Autism spectrum disorder in adults: diagnosis and management'* and *'Autism spectrum disorder in under 19s: support and management'* NICE guidelines that recommend that, where necessary, adaptations are made to recommended psychological interventions and examples are given of autism-specific adaptations of CBT interventions. Please see CG170 https://www.nice.org.uk/Guidance/CG170 The existing NICE guidance on *'Mental health problems in people with learning disabilities: prevention, assessment and management'* also includes principles for adapting recommended psychological interventions for people with learning disabilities. Please see NG54 https://www.nice.org.uk/guidance/ng54

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Grenfell Health and Wellbeing Service	Guideline	General	General	It would be useful to have guidance on the recommended approaches for working with families where parents and children are each experiencing clinically important symptoms of PTSD related to the same event: more specifically, whether trauma-focused CBT should be offered to family members separately or as a family. Clinically, we have been offering individual based CBT for adults and children separately, but with some elements (e.g. psychoeducation, stabilisation and review sessions) offered to families together on some occasions.	Thank you for your comment. In response to your and other stakeholder's comments, a new recommendation has been added for members of a family who have experienced the same traumatic event and have PTSD that recommends that users of the guideline think about what aspects of treatment might be usefully provided together, such as psychoeducation, while still providing the recommended treatments for individuals.
Grenfell Health and Wellbeing Service	Guideline	8	1	We welcome the fact that the guidelines are as inclusive as possible for ensuring access to asylum seekers and refugees who have historically been excluded from services offering trauma-focussed therapy as they are considered to not have the safety required to engage with therapy whilst awaiting immigration proceeding decisions which is often not the case.	Thank you for your comment.
Grenfell Health and Wellbeing Service	Guideline	8	16	The stronger recommendation of not delaying or withholding treatment due to court proceedings is very welcome as this is in line with the nationally led work stream for updating the 2001 CPS pre-trial therapy guidelines. We have been working with the national CPS policy department, the police, NHS England and the voluntary sector on this. The final draft is being reviewed by the CPS and the revised guidance will then be approved with the relevant lead representatives for the CPS. The main premise is that the provision of trauma-focussed	Thank you for your comment. We agree that this recommendation is important and have now added a cross-reference to the relevant CPS guidance, in order to provide further information and greater clarity.

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				therapy (in particular) should be provided with the victim's best interests being paramount.	
Grenfell Health and Wellbeing Service	Guideline	9	18	Laying out explicitly what is helpful and supportive to whole family and community systems is particularly helpful about the psychological impact of trauma. This is especially when considering that multiple family members have been exposed to the same traumatic event as at GHWS. We request that this includes children and not just carers. It would be very helpful to be more explicit about how the traumatic event affects the relationships between family members. This is particularly relevant where PTSD presentations may contribute to risky or harmful behaviours to the person or others.	Thank you for your comment. In response to your and other stakeholder's comments, a new recommendation has been added for members of a family who have experienced the same traumatic event and have PTSD that recommends that users of the guideline think about what aspects of treatment might be usefully provided together, such as psychoeducation, while still providing the recommended treatments for individuals. In response to your comment, family members (in addition to carers) has also been added to the recommendation about discussing how they are being affected by the person's PTSD.
Grenfell Health and Wellbeing Service	Guideline	11	16	The use of the term 'active monitoring' as opposed to 'watchful waiting' for those who show symptoms of the disorder, is more helpful and meaningful terminology as often clinicians have misinterpreted watchful waiting as meaning they should not take any action in the first month, when the evidence demonstrates that meaningful support during this time has a significant impact on reducing the development of PTSD.	Thank you for your comment.

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Grenfell Health and Wellbeing Service	Guideline	12	12	TF-CBT for children under the age of 7 years: it would be useful to clarify whether there is a lower age limit for this. We are aware that there are manualised approaches available for children aged 3 years and above (e.g. Scheeringa, 2016). However, we would welcome clarity on approaches for children under the age of 3. Clinically, we have been using a combination of psychoeducation, carer support and attunement-based approaches.	Thank you for your comment and for drawing our attention to the Scheeringa (2016) citation. In response to your, and other stakeholder's comments, this recommendation has been amended to include a lower age limit of 5 years based on the youngest children included in the studies that are in our evidence review. Given the lack of clear evidence or clear consensus the committee did not consider it was appropriate to make recommendations for adaptations that may be required for very young children.
Grenfell Health and Wellbeing Service	Guideline	12	8	Group TF-CBT for children within one month of the trauma: it would be useful to clarify whether the group programme should be based on a particular manualised approach and also whether it should include an element of group- based elaboration and processing of the trauma memories. We are aware that some Group based TF-CBT approaches do not include this element.	Thank you for your comment. In response to your and other stakeholder's comments, a new recommendation has been made about the structure and content of the group trauma-focused CBT interventions for children and young people who have been exposed to large scale trauma within the last month. The recommendation includes the guidance that such interventions should be based on a validated manual and involve elaboration and processing of the trauma memories.
Grenfell Health and Wellbeing Service	Guideline	13	9	EMDR for children – please could you clarify why this is recommended only after TF-CBT has been tried for 3 months? Clinically, we have been offering either TF-CBT or EMDR to children based on patient choice and have found	Thank you for your comment. No eligible evidence was identified for the use of EMDR with children and young people within 3 months of trauma, and on this basis the committee

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				that some children prefer EMDR as there is less emphasis upon verbal description of the trauma narrative.	did not consider it appropriate to recommend EMDR as an early intervention for children and young people. The committee considered the evidence for EMDR in the delayed treatment of children with PTSD (more than 3 months after trauma) and noted the limited evidence base, in terms of the number of studies/participants, the number of different comparisons, the breadth of outcomes reported, and the availability of long-term follow-up. The committee observed that the benefits of EMDR were not statistically significant relative to waitlist or treatment as usual, and the head-to-head comparisons against trauma-focused CBT (although suggestive of no significant difference) were not sufficiently powered to detect non-inferiority (single-study analyses). The committee also took into account the results of the NMA and economic base-case analysis which both suggested that EMDR was less clinically effective and cost-effective than all individual trauma-focused CBT interventions. On the basis of the clinical and cost-effectiveness and these additional considerations, the committee agreed that EMDR should only be considered for children and young people if they do not respond to or engage with trauma-focused CBT.

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Grenfell Health and Wellbeing Service	Guideline	14	20	Could you please provide clarity as to why EMDR should only be offered after 3 months? Clinically we have implemented EMDR at the same time frame as TF-CBT with good effect, so would request that the evidence and rationale for delaying EMDR is made explicit please.	Thank you for your comment. In the consultation version of the guideline, there was no evidence for EMDR within 1 month of trauma. Through stakeholder comments, one additional new study was identified and added to the analysis. The committee considered the new evidence for EMDR in the first month following trauma in adults (Gil-Jardiné 2018). However, the committee did not agree that it was appropriate to make a recommendation in this time period as evidence was limited to a small single study (N=71) that only reported on one clinical outcome of interest and the effect on the number of participants with PTSD at 3-month follow-up was not statistically significant. The committee considered the evidence for EMDR in the 1-3 month period following trauma, and in response to stakeholder's comments, agreed that a new recommendation should be added to consider EMDR for adults with PTSD within 1-3 months of non-combat-related trauma. This recommendation is based on single-study evidence showing large benefits of EMDR relative to supportive counselling in the 1-3 month period and an extrapolation from stronger evidence for EMDR more than 3 months after trauma. This was a weaker recommendation

Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
					(consider rather than offer) based on the limited direct evidence available. The rationale behind recommendations of psychological interventions for adults at risk or with PTSD, including the above considerations, is provided in the 'Rationale and Impact' sections of the PTSD guideline evidence reports C and D respectively.
Grenfell Health and Wellbeing Service	Guideline	15	11	We would like to recommend that self-soothing techniques are not only for use in session, but that in teaching these the person is able to utilise these resources to manage their symptoms more effectively between sessions.	Thank you for your comment. In response to your and other stakeholder's comments, this recommendation has been amended to include the teaching of self-calming techniques for use within *and between sessions*.
Grenfell Health and Wellbeing Service	Guideline	17	22	We are aware that the scoping exercise for identifying the relevant evidence for these updated guidelines was completed prior to the major incidents that occurred in the UK last year. However, we have been operating a very different major incident model of response at GHWS. Although we acknowledge that this has yet to be published and that the response is unique to date in the UK due to it affecting a whole community, not a dispersed population, we would welcome NICE in supporting the development of future additional strategic policy publications. This would also facilitate sharing the learning from both GHWS the NHSE major incident responses to the terror attacks to strongly inform that all services working with psychological	Thank you for your comment. As specified in the scope, the disaster planning section from the 2005 guideline was not included in this update. In line with NICE processes, the 2005 content has been carried across to this updated guideline. However, the evidence on disaster planning has not been reviewed and we are not able to make any changes to this section (except where they are necessary in order to clarify meaning).

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				trauma have robust disaster plans in place to respond quickly and effectively.	
Grenfell Health and Wellbeing Service	Guideline	17	3	We welcome the recognition that substance misuse is often a coping strategy for manging PTSD related symptoms especially with complex PTSD where emotion regulation difficulties are present and that this needs to be managed during the course of therapy, not that trauma-focussed therapy cannot be provided. However, if there is evidence as to which substances are contraindicated as inhibitors of processing traumatic memories, such as benzodiazepines, advice regarding this would be particularly helpful. Where chaotic substance misuse is identified we would recommend the inclusion of a robust joint management strategy between psychological therapies and substance misuse services is put in place.	Thank you for your comment. In response to your and other stakeholder's comments, changes have been made to recommendations to reflect that for some people substance misuse may need to be addressed to enable engagement with trauma-focused intervention. The previous recommendation has been amended as follows: 'Do not exclude people with PTSD from treatment based *solely* on comorbid drug or alcohol misuse', and the recommendation for adaptations to psychological interventions that may be needed for people with PTSD and additional needs has been amended to recommend that people are helped to manage any issues, including substance misuse, that might be a barrier to engaging with trauma-focused therapies.
Grenfell Health and Wellbeing Service	Guideline	17	8	We welcome the improved definition of complex PTSD and its inclusion in the guidance, however this definition does not include the additional areas of impairment related to: sustaining relationships and the sense of self as diminished, defeated or worthless, which has been published by Maercker et al., (2013) and the UK Psychological Trauma Society guidance on the provision of services for complex PTSD (2017). This inclusion would help clarify why stabilisation and reintegration are important in the provision of therapy. We recognise that the recommendations are hindered by the current lack of RCTs	Thank you for your comment and for drawing our attention to the Maercker et al. (2013) and UK Psychological Trauma Society (2017) citations. In response to your and other stakeholder's comments, and the publication of ICD-11 we have amended the recognition recommendation to include explicit reference to complex PTSD and the symptoms of complex PTSD have been added to

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				for complex PTSD, but the guidance could still be more explicit in the descriptions of the points which relate to phased based therapy.	this recognition recommendation as additional bullet points. Furthermore, the existing recommendation on adaptations that may be needed to psychological interventions for people with PTSD and additional issues, including complex PTSD, has been expanded to include: helping people manage other issues (including dissociation, emotional regulation, interpersonal difficulties or negative self-perception) that may be a barrier to engaging with trauma-focused therapies; building in extra time to develop trust with the person (by increasing the duration or the number of therapy sessions according to the person's needs); planning any ongoing support the person needs. The recommendations concerning the structure and content of trauma-focused CBT interventions have also been amended to include 'the processing of trauma-related emotions, including shame, guilt, loss and anger'.
Grenfell Health and Wellbeing Service	Guideline	32	7	Supported trauma focussed computerised CBT- could this be clarified as to which programmes this refers to please? Is this guided self-help programmes supported by sessions with a therapist or on-line programmes. Our understanding is that there is an emerging evidence base for guided self-help through the RAPID trial, but this is much more	Thank you for your comment. The committee agreed that greater clarity was needed about the structure and content of supported computerised trauma-focused CBT and added a new recommendation that specifies the content and structure of the recommended intervention in such

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				interactive than on-line therapy and requires more resources for services.	a way that allows enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set.
Human Givens Institute	Review B and D (treatment in children and adults)	General	General	We are concerned that 'Rewind', a trauma-focussed CBT technique, was not mentioned at all in the guidelines for treatment in spite of informing the review and sending copies and links of relevant articles. Rewind is a trauma-focussed graded exposure technique using imaginal exposure, and as such belongs in the trauma-focussed CBT category. There are three versions of Rewind, which is based on an NLP technique called visual-kinesthetic dissociation (VKD). One in the USA is called Reconsolidation of Traumatic Memories (RTM) and in the UK there is the David Muss version of Rewind and the Human Givens (HG) version of Rewind. Detailed descriptions of the two Rewind protocols are in the process of being published, and are available on request from XX. The Veterans Association in the USA uses Reconsolidation of Traumatic Memories (RTM) in some of their trauma centres. Published evidence includes 3 RCTs and one pre-post treatment study. For more information on papers on RTM, contact XX. Gray, R. & Liotta, R. (2012). PTSD: Extinction, Reconsolidation and the Visual-Kinesthetic Dissociation Protocol. Traumatology, 18(2), 3-16. DOI 10.1177/1534765611431835.	Thank you for your comment and for drawing our attention to the Gray & Liotta (2012) citation. Rewind intervention was not excluded from the guideline review but no eligible evidence was identified. On this basis the committee did not consider a recommendation to be appropriate. The reconsolidation of traumatic memories (RTM) intervention involves 'rewinding' techniques. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new RCTs were identified through stakeholder comments and were integrated into the pairwise analyses. The committee considered this new evidence for RTM, and agreed that although there was limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. The committee were also concerned about the generalisability of this evidence given that both studies were on US military veterans. Furthermore, this evidence could not be included in the guideline NMA and, subsequently, in the guideline economic

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				Gray, R., & Bourke, F. (2015). Remediation of intrusive symptoms of PTSD in fewer than five sessions: A 30-person pre-pilot study of the RTM Protocol. Journal of Military, Veteran and Family Health, 1(2), 85-92. doi:10.3138/jmvfh.3119 Gray, R., Budden-Potts, D., & Bourke, F. (2016). The Reconsolidation of Traumatic Protocol (RTM) for the treatment of PTSD: A randomized waitlist study of 30 female veterans. Submitted Manuscript. Lee, J. L. C., Nader, K., & Schiller, D. An Update on Memory Reconsolidation Updating. Trends in Cognitive Sciences, 21(7), 531-545. doi: 10.1016/j.tics.2017.04.006 Tylee, D., Gray, R., Glatt, S. & Bourke, F. (2017). Evaluation of the reconsolidation of traumatic memories protocol for the treatment of PTSD: A randomized, waitlist controlled trial. Journal of Military, Veteran and Family Health, 3(1) doi:10.3138/jmvfh.4120 Rewind is used widely in the UK in a variety of organisations, including the police and fire service, victim support services, maternity units, specialist trauma treatment centres in the UK and northern Ireland (e.g. PTSD Resolution treating war veterans, the Red Poppy Company, Barnado), with studies in the grey literature on	modelling, because the comparator in both studies was treatment as usual, rather than waitlist, and therefore the two studies could not be connected to the evidence network. Please note, however, that the fact that RTM was not considered in the guideline economic analysis had no impact on recommendations, as the clinical evidence itself was too limited to warrant a recommendation for RTM. Please see below for details on the inclusion/exclusion of each of the references you cite: • Tylee et al. (2017) has now been added to the review in evidence report D • Gray & Bourke (2015) and Lee et al. (2017) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Adams (2017) is not included as dissertations were not included (as outlined in the review protocols)

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				the efficacy of treatment. There is also a pilot study of a successful Rewind clinic in the NHS (Adams, 2017, service evaluation). Much of the research is currently in the grey literature and in various stages of preparation for peer reviewed publication. We note that the guidelines do reference unpublished papers, e.g. Guideline D, page 297, lines 1-7. We did provide links to a PsyD dissertation with the University of Leicester including a systematic review and meta-analysis of Rewind (did not include RTM) which passed the university peer review process. The link for this dissertation is (Adams, 2017) http://hdl.handle.net/2381/39978. While the systematic review included grey literature, (24 studies and 4,995 participants), 13 studies met the inclusion criteria for the meta-analysis of Rewind (including the Muss and HG versions). Raw data from the meta-analysis of Rewind is available on request and some is already uploaded onto the Mendeley database website. Other papers, accepted for publication, currently under review, and in preparation for publication are available on request too. Contact XX Adams, S. (2017). *Human Givens Rewind Treatment for PTSD and Sub-threshold Trauma*. University of Leicester, U.K. Retrieved from http://hdl.handle.net/2381/39978 **It would be a serious omission to have no mention of Rewind or RTM in these guidelines.**	

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Human Givens Institute	Review B (children)	11	General	Rewind and Reconsolidation of Traumatic Memories (RTM) should be included in a section under trauma-focussed CBT: Clinical evidence. Results, including no results found, should still be reported (see comment 6 below).	Thank you for your comment. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new RCTs were identified through stakeholder comments and were integrated into the pairwise analyses. The committee considered this new evidence for RTM, and agreed that although there was limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. The committee were also concerned about the generalisability of this evidence given that both studies were on US military veterans. Furthermore, this evidence could not be included in the guideline NMA and, subsequently, in the guideline economic modelling, because the comparator in both studies was treatment as usual, rather than waitlist, and therefore the two studies could not be connected to the evidence network. Please note, however, that the fact that RTM was not considered in the guideline economic analysis had no impact on recommendations, as the clinical evidence itself was too limited to warrant a recommendation for RTM.
Human Givens Institute	Review B and D (treatments	9 (for review B)	Table 1 Interventions	The Table 1 has an incomplete list of interventions used by a many organisations.	Thank you for your comment. Table 1 provides a summary of the review protocol that was pre-specified at the beginning of the review process. The list of included interventions is illustrative rather

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	for children and adults)	11 (for review D)		Rewind and Reconsolidation of Traumatic Memories (RTM) should be included under trauma-focussed CBT interventions. Human Givens should still be listed separately as an intervention. (Like prolonged exposure (PE) is a trauma-focussed CBT treatment, but CBT also can include non-trauma-focussed interventions, Rewind is a trauma-focussed exposure technique is a stand alone technique that is separate from HG therapy but may be included in it.)	than exhaustive and Rewind and Reconsolidation of Traumatic Memories (RTM) interventions were not excluded, although limited evidence was identified.
Human Givens Institute	Review B (children)	82	1	We found an omission in that there were no comments on Humans Givens (HG) therapy: Clinical evidence in Review B, even though HG was included in the list of interventions and in the search. There is one case reporting case studies on adolescents using HG therapy and Rewind. This study would have been excluded because it has fewer than 10 participants, but this should have been reported and the study should be included in Appendix K. Yates, Y., & Atkinson, C. (2011). Using Human Givens therapy to support the well-being of adolescents: a case example. *Pastoral Care in Education*, *29*(1), 35-50. http://dx.doi.org/10.1080/02643944.2010.548395	Thank you for your comment. No studies were identified for full-text review for Humans Givens therapy. As acknowledged in your comment, Yates & Atkinson (2011) could not be included as it does not meet the sample size inclusion criterion of at least 10 participants per arm for analysis. This was not included in Appendix K because it was excluded at the title/abstract stage. The list of excluded studies (Appendix K) lists only those studies excluded at the full-text review stage.
Human Givens Institute	Review B (children)	115	37	There is insufficient evidence to make recommendations about Human Givens therapy on PTSD symptoms in children and young people.	Thank you for your comment. The committee agreed and this is why no recommendation was made for Human Givens therapy

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Human Givens Institute	Review D (Adults)	13	General	Rewind and Reconsolidation of Traumatic Memories (RTM) should be included in a section under trauma-focussed CBT: Clinical evidence. The following are studies that should be mentioned in the review of Rewind and RTM and either included or excluded and put into Appendix K: • Gray, R. & Liotta, R. (2012). PTSD: Extinction, Reconsolidation and the Visual-Kinesthetic Dissociation Protocol. Traumatology, 18(2), 3-16. DOI 10.1177/1534765611431835. • Gray, R., & Bourke, F. (2015). Remediation of intrusive symptoms of PTSD in fewer than five sessions: A 30- person pre-pilot study of the RTM Protocol. Journal of Military, Veteran and Family Health, 1(2), 85-92. doi:10.3138/jmvfh.3119 • Gray, R., Budden-Potts, D., & Bourke, F. (2016). The Reconsolidation of Traumatic Protocol (RTM) for the treatment of PTSD: A randomized waitlist study of 30 female veterans. Submitted Manuscript. • Lee, J. L. C., Nader, K., & Schiller, D. An Update on Memory Reconsolidation Updating. Trends in Cognitive Sciences, 21(7), 531-545. doi: 10.1016/j.tics.2017.04.006 • Tylee, D., Gray, R., Glatt, S. & Bourke, F. (2017). Evaluation of the reconsolidation of traumatic	Thank you for your comment and for drawing our attention to the Gray & Liotta (2012) citation. No studies were identified for full-text review for Humans Givens therapy. The list of excluded studies (Appendix K) lists only those studies excluded at the full-text review stage (studies excluded at title/abstract are not listed in the guideline). In response to your and other stakeholders' comments, 2 RCTs (Gray 2017; Tylee 2017) have been added to the cognitive therapies section of Evidence report D. These studies were considered in pairwise meta-analyses but could not be included in the network meta-analysis (NMA) or economic analysis as they are compared with treatment as usual (and a waitlist network was used). The committee reviewed the evidence from these trials and agreed that although there is limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are

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				memories protocol for the treatment of PTSD: A randomized, waitlist controlled trial. Journal of Military, Veteran and Family Health, 3(1) doi:10.3138/jmvfh.4120 In Press. The following are peer reviewed published evidence for the Muss version of Rewind that is published in peer reviewed papers, but do not include an RCT. They are included in the Adams (2017) review: • Adams, S., & Allan, S. (accepted for publication). Muss' Rewind treatment for trauma: Description and multi-site pilot study. *Journal of Mental Health.* https://doi.org/10.1080/09638237.2018.1487539 • Muss, D. C. (1991b). A new technique for treating Posttraumatic Stress Disorder. *British Journal of Clinical Psychology, 30*, 91-92. • Utuza, A. J., Joseph, S. & Muss, D. C. (2012). Treating traumatic memories in Rwanda with the rewind technique: Two-week follow-up after a single group session. *Traumatology, 18(1),* 17-78. doi:10.1177/1534765611412795 The following meta-analysis of Rewind should be mentioned even though it is not yet published in a peer-reviewed journal. It has been through the university peer review process for a doctorate. The grey literature is in the process of being published and much of it is available on	true effects and thus a recommendation could not be supported. Please see below for details on the inclusion/exclusion of each of the references you cite: • Tylee et al. (2017) has now been added to the review in evidence report D • Adams & Allan (in press), Gray & Bourke (2015), Lee et al. (2017), Muss (1991), and Utuza et al. (2012) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Gray et al. (2016) could not be included as it is unpublished and was not identified by the search • Adams (2017) is not included as dissertations were not included (as outlined in the review protocols)

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				the Mendeley database and is available on request from XX. Results for the 13 studies (*N*=642) included in the meta-analysis of Rewind include a quality assessment using a practice-based tool (Cahill *et al.,* 2010), sampling method, inclusion and exclusion criteria, data capture rates, drop-out rates, and a pre-post effect size, recovery rates, and reliable improvement and reliable deterioration (using reliable change indices for the standardised questionnaires used in the studies) and equivalent CBT benchmarks. While it is important to note that in this meta-analysis of Rewind studies there were no RCTs and that some of the studies have not yet been published in peer-reviewed journals, the results should nonetheless be reported or summarised given the number of studies and participants. • Adams, S. (2017). *Human Givens Rewind Treatment for PTSD and Sub-threshold Trauma*, pp 1-50. University of Leicester, U.K. Retrieved from http://hdl.handle.net/2381/39978	
Human Givens Institute	Review D (adults)	212	General	Human Givens (HG) therapy is mentioned in the interventions but is not specifically reported on in this section. At the very least, the systematic review on HG therapy and rewind (24 studies and 4,995 participants) should be mentioned. Other HG studies that are published in peer reviewed journals should be mentioned and put in Appendix K if they are excluded.	Thank you for your comment. No studies were identified for full-text review for Humans Givens therapy. The list of excluded studies (Appendix K) lists only those studies excluded at the full-text

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				• Adams, S. (2017). *Human Givens Rewind Treatment for PTSD and Sub-threshold Trauma*, pp 1-50. University of Leicester, U.K. Retrieved from http://hdl.handle.net/2381/39978 • Andrews, W., Twigg, E., Minami, T., & Johnson, G. (2011). Piloting a practice research network: A 12-month evaluation of the Human Givens approach in primary care at a general medical practice. *Psychology and Psychotherapy: Theory, Research and Practice, 84*(4), 389-405. http://dx.doi.org/10.1111/j.2044-8341.2010.02004. • Andrews, W., Wislocki, A., Short, F., Chow, D., & Minami, T. (2013). A five-year evaluation of the Human Givens therapy using a practice research network. *Mental Health Review Journal*, *18*(3), 165-176. http://dx.doi.org/10.1108/MHRJ-04-2013-0011 • Guy, K., & Guy, N. (2009). Psychological trauma. *Counselling at Work*, 19-22. Retrieved March 5, 2015, from http://www.bacp.co.uk/admin/structure/files/pdf/4222_a.pdf • Tsaroucha, A., Kingston, P., Stewart, T., Walton, I., & Corp, N. (2012b). Assessing the effectiveness of the "human givens" approach in treating depression: A quasi experimental study in primary care. *Mental Health Review Journal*, *17*(2), 90-103.	review stage (studies excluded at title/abstract are not listed in the guideline). Please see below for details on the inclusion/exclusion of each of the references you cite: • Andrews et al. (2011), Andrews et al. (2013), and Guy & Guy (2009) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Adams (2017) is not included as dissertations were not included (as outlined in the review protocols) • Tsaroucha et al. (2012) includes participanyts with depression (rather than PTSD) and does not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs)

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Human Givens Institute	Review D (adults)	252	General	Economic evidence. Evidence for Rewind and RTM in comment 2 could be considered in this section.	Thank you for your comment. No clinical or economic evidence was identified for Rewind. Regarding RTM, 2 RCTs were identified through stakeholder comments and were integrated into the pairwise analyses; no published economic evidence was identified. The committee considered this new evidence for RTM, and agreed that although there was limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. The committee were also concerned about the generalisability of this evidence given that both studies were on US military veterans. Furthermore, this evidence could not be included in the guideline NMA and, subsequently, in the guideline economic modelling, because the comparator in both studies was treatment as usual (as controls had been receiving drug treatment), rather than waitlist, and therefore the two studies could not be connected to the evidence network. Please note, however, that the fact that RTM was not considered in the guideline economic analysis had no impact on recommendations, as the clinical evidence itself was too limited to warrant a recommendation for RTM.

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Human Givens Institute	Review D (adults)	262	General	Specific statements should be made about the clinical evidence for a. Rewind and RTM Human Givens therapy	Thank you for your comment. Reference to human givens therapy is already included in the introduction section of Evidence report D where it is clarified that evidence for human givens therapy was searched for but none was found. Specific reference to Rewind was not considered appropriate as this intervention was not pre-specified in the review protocol as an intervention of interest. However, the list of interventions in the review protocol is illustrative rather than exhaustive and Rewind was not excluded, although no eligible evidence was identified. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new RCTs were identified through stakeholder comments and were integrated into the pairwise analyses in Evidence report D.
Human Givens Institute	Review D (adults)	275	General	Recommendations on the above should also be included in this section	Thank you for your comment. No eligible evidence was identified for Rewind or human givens therapy and on this basis did not consider it appropriate to make a recommendation for either of these interventions. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new

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11/06/2018 to 23/07/2018

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					RCTs were identified through stakeholder comments and were integrated into the pairwise analyses. The committee considered this new evidence for RTM, and agreed that although there was limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. The committee were also concerned about the generalisability of this evidence given that both studies were on US military veterans. Furthermore, this evidence could not be included in the guideline NMA and, subsequently, in the guideline economic modelling, because the comparator in both studies was treatment as usual, rather than waitlist, and therefore the two studies could not be connected to the evidence network. Please note, however, that the fact that RTM was not considered in the guideline economic analysis had no impact on recommendations, as the clinical evidence itself was too limited to warrant a recommendation for RTM.
Human Givens Institute	Review D (adults)	288	General	References for included studies should be made	Thank you for your comment. No eligible evidence was identified for Rewind or Human Givens therapy. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new

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					RCTs were identified through stakeholder comments and were integrated into the pairwise analyses in Evidence report D, including references for these studies.
Human Givens Institute	Review D (adults)	1338	General	For each of the three questions, a category should be added to include **'patient' feedback** on the treatment, asking those who have received the treatment about what they thought of the treatment and what they consider to be important outcome measures to them and considerations for treatment of choice. 1. 'Patients' who have experienced several treatments should be asked about their treatment of choice and what they think should be first and second line treatments/outcomes, etc. 2. Specific subgroups (like refugees, asylum seekers, veterans, people with shame-based traumas) should be asked about their opinions of treatments, what issues related to treatment are important to them, etc. 3. People with complex trauma should be asked for their opinion of what treatment they prefer, what aspects of treatment are important to them and what are helpful in their recovery, as well as what they feel outcome measures should include, etc.	Thank you for your comment. The committee did not agree that the issues you raise should be addressed by amending the research recommendations, although the committee agreed that experience of previous treatment and patient preference are important factors in treatment decisions. In response to your and other stakeholder's comments, an amendment has been made to the recommendation about planning treatment that makes more explicit the importance of patient preference.
Human Givens Institute	Review D (adults)	Appendix K	General	References related to Rewind, RTM and Human Givens therapy that are excluded should be included in this section.	Thank you for your comment. No studies were identified for full-text review for Rewind or Human Givens therapy. The list of excluded studies

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					(Appendix K) lists only those studies excluded at the full-text review stage. No RTM studies were reviewed at full-text and excluded from the review.
Human Givens Institute	Review H (principles of care)	General	General	Consider the evidence in the following studies that asked service users their opinions of HG therapy and Rewind. For more information on any of these studies, including the original university dissertations, please contact XX • Adams, S. (2017). *Human Givens Rewind Treatment for PTSD and Sub-threshold Trauma*, (Service evaluation, pp. 121-149, pp180-196). University of Leicester, U.K. Retrieved from http://hdl.handle.net/2381/39978 • Adams, S. (2017). *Human Givens Rewind Treatment for PTSD and Sub-threshold Trauma*, (Main study includes acceptability of treatment, pp. 51-107). University of Leicester, U.K. Retrieved from http://hdl.handle.net/2381/39978 • Dale, A. (2012). Post Trauma Stress: Identifying What Works In Therapy. (Unpublished dissertation). Nottingham Trent University, Nottingham, UK. Summarised in How Human Givens therapy is helping war veterans, Human Givens, 19(2), 14-19. • Gofton, Z. (2011). How effective is the rewind technique in reducing symptoms of individuals	Thank you for your comment. Please see below for details on the inclusion/exclusion of each of the references you cite: • Adams (2017), Dale (2012), Gofton (2011), and Murphy (2007) are not included as dissertations were not included (as outlined in the review protocols) • Guy & Guy (2003), and Guy & Guy (2009) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs)

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				suffering from Post-traumatic stress disorder (PTSD). (Unpublished dissertation). University of Plymouth, Plymouth, UK. • Guy, K., & Guy, N. (2003). The fast cure for phobia and trauma: Evidence that it works [Electronic Version]. Chalvington, East Sussex: Human Givens Publishing. Retrieved from http://www.hgi.org.uk/archive/rewindevidence.htm • Guy, K., & Guy, N. (2009). Psychological Trauma, Counselling at Work, Spring, 19-22. Retrieved from http://www.bacp.co.uk/admin/structure/files/pdf/4222_a.pdf • Murphy, M. (2007). An Effectiveness Study of the Use of Visual Kinaesthetic Dissociation in the Treatment of Posttraumatic Stress Reactions. (Unpublished dissertation). University of Ulster, Ireland. Summarised in: Testing treatment for trauma: Qualitative research providing evidence of effectiveness of the rewind technique for trauma. Human Givens, 14(4), 37-42.	
Human Givens Institute	Views on question 2	General	General	Question 2 There is evidence that Rewind, RTM and HG therapy can be completed in fewer sessions than is recommended by NICE, which has cost implications. In the Adams (2017, pp 19-23, pp 40) systematic review of Rewind and HG therapy (24 studies that included the grey	Thank you for your comment. No eligible evidence was identified for human givens therapy or rewind. On this basis the committee did not consider

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				literature), the number of sessions for Rewind and HG therapy were extracted. The mean number of treatment sessions ranged from 1-6.5 (range 1-24 sessions). Eleven studies reported results of a single Rewind session. While none of these studies included an RCT and no comparisons can be made to other treatments, this evidence should still be acknowledged. Adams, S. (2017). *Human Givens Rewind Treatment for PTSD and Sub-threshold Trauma*. University of Leicester, U.K. Retrieved from http://hdl.handle.net/2381/39978 The following are published evidence for the Muss version of Rewind that is published in peer reviewed papers, but do not include an RCT. They are included in the Adams (2017) review. Adams, S., & Allan, S. (accepted for publication). Muss' Rewind treatment for trauma: Description and multi-site pilot study. *Journal of Mental Health.* https://doi.org/10.1080/09638237.2018.1487539 Muss, D. C. (1991b). A new technique for treating Posttraumatic Stress Disorder. *British Journal of Clinical Psychology, 30*, 91-92. Utuza, A. J., Joseph, S. & Muss, D. C. (2012). Treating traumatic memories in Rwanda with the rewind technique:	recommendations for these interventions to be appropriate. In the consultation version of the guideline, no evidence was identified for RTM. However, 2 new RCTs were identified through stakeholder comments and were integrated into the pairwise analyses. The committee considered this new evidence for RTM, and agreed that although there was limited evidence for efficacy, the evidence base was considered too small to be confident that the benefits observed are true effects and thus a recommendation could not be supported. The committee were also concerned about the generalisability of this evidence given that both studies were on US military veterans. Furthermore, this evidence could not be included in the guideline NMA and, subsequently, in the guideline economic modelling, because the comparator in both studies was treatment as usual, rather than waitlist, and therefore the two studies could not be connected to the evidence network. Please note, however, that the fact that RTM was not considered in the guideline economic analysis had no impact on recommendations, as the clinical evidence itself

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				Two-week follow-up after a single group session. *Traumatology, 18(1),* 17-78. doi:10.1177/1534765611412795 In addition, an RCT with 74 war veterans evaluated three 120 sessions of RTM versus a waiting list control. See Gray and Liotta (2012). Reconsolidation of Traumatic Memories for PTSD: A randomized controlled trial of 74 male veterans. Retrieved from http://www.randrproject.org/pdf/2017/75person-NYstudy17.pdf Excluding Rewind or RTM from the review may mean that some people will not have access to treatment that is potentially cost effective. It would be appropriate to evaluate Rewind as part of this review and if this is too late, at least to document that Rewind and RTM were not included in this review and therefore no conclusions can be drawn about its efficacy, but that they warrant further investigation. The above references should also be included in Review D (treatment for adults).	was too limited to warrant a recommendation for RTM. Please see below for details on the inclusion/exclusion of each of the references you cite: • Gray et al. (2017) which we believe is the study being referred to by your Gray and Liotta 2012 citation in the comment has now been added to the review in evidence report D • Adams & Allan (in press), Muss (1991), and Utuza et al. (2012) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Adams (2017) is not included as dissertations were not included (as outlined in the review protocols).

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Human Givens Institute	Views on question 7	General	General	Question 7. Shame can be a barrier to accessing treatment. It has been proposed that embarrassment or distrust in some cultures and in some refugee populations may lead to people not reporting rape or sexual abuse (e.g., Tankink & Richters, 2007; ter Heide *et al.,* 2011). Shame can be based on cultural factors or related to the interpersonal nature of the trauma (e.g. rape, abuse by a close family member). There is small evidence (Adams, 2017, p136-137, pp193-195) that some people were willing to access trauma-focussed exposure treatment if they knew that they did not have to discuss the details of the trauma, as is the case with Rewind. Further research is needed to evaluate the treatment of choice for service users for shame-based traumas, and research should include Rewind. It is estimated that as many as 30–60% who have been exposed to trauma either do not seek help, or refuse CBT approaches, or drop out of treatment, or are not significantly helped by treatment (e.g., Bradley *et al.,* 2005; Schottenbauer *et al.*, 2008). Effective treatments that were not included in the NICE (2005) guildelines should therefore also be considered. There is evidence from the meta-analysis on Rewind that included 13 studies, all with consecutive sampling and data capture rates of 80% and above, nine studies reported drop out rates of 0% with the highest drop out rate being 12%. (Adams, 2017, pp 18-23). The low attrition rates and reduction of symptoms in the	Thank you for your comment and for drawing our attention to Bradley et al. (2005), Schottenbauer et al. (2008), Tankink & Richters (2007), ter Heide et al. (2011) citations. Adams (2017) is not included in the guideline as dissertations were not included (as outlined in the review protocols). In response to your and other stakeholder's comments, the supporting engagement recommendation has been amended to include guidance that users of the guideline should be aware that people with PTSD may be ashamed. In addition, the recommendations about the structure and content of trauma-focused CBT have been amended to include the processing of trauma-related emotions, including shame, guilt, loss and anger. The committee did not make a research recommendation in this area as other areas were assessed to be of greater importance.

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				meta-analysis on Rewind suggests that Rewind in its different versions may be an acceptable and effective treatment, although an RCT is now needed. Adams, S. (2017). *Human Givens Rewind Treatment for PTSD and Sub-threshold Trauma*. University of Leicester, U.K. Retrieved from http://hdl.handle.net/2381/39978	
International Society of Interpersonal Psychotherapy	Evidence review D	General	General	Interpersonal psychotherapy (IPT) takes a very different approach from cognitive and behavioral exposure regimens, focusing on the affective flattening and severe interpersonal consequences of PTSD rather than on re-exposure to trauma reminders and narrative. This non-exposure approach has limited but growing empirical support. Your literature search seems to have omitted some of that research, including secondary analyses of a key study. In describing our randomized controlled trial (RCT) for unmedicated patients with chronic PTSD, in which manualized individual IPT was non-inferior to Prolonged Exposure delivered by seasoned PE therapists,[1] IPT showed advantages over exposure for patients with comorbid major depression (half of all PTSD patients)[1] and for patients with sexual trauma as the source of their disorder[2] [this paper uncited]. Patients preferred it to PE, doubtless largely because they were not required to expose themselves to trauma reminders[3] [uncited]. Gains were generally maintained at three-month follow-up[4]	Thank you for your comment. RCT studies of IPT were searched for. However, limited eligible evidence was identified and the committee did not consider the evidence sufficient to justify a recommendation for IPT. Please see below for details on the inclusion/exclusion of each of the references you cite: • Markowitz et al. (2015) and Krupnick et al. (2008) are included in the review (as acknowledged in your comment) • Markowitz et al. (2018) could not be included as follow-up data was only available for responders to initial treatment (not relevant to the review question) • Markowitz et al. (2017) is listed in the excluded studies (Appendix K) of Evidence report D. This study is excluded on the basis that it is a subgroup/secondary analysis of an RCT that has already been included. Secondary/subgroup

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				[uncited]. You do cite a second RCT of group IPT showing superior outcomes to a waiting list for a difficult to treat population of non-treatment seeking, multiply abused, socially deprived minority women recruited from medical clinics.[5] But you have not noted that IPT has also shown benefits for PTSD in an open trial for US military veterans[6] and as an augmentation of pharmacotherapy for Brazilian civilians with PTSD.[7] Based on these studies, IPT is now included in the most recent, 2017 United States Veterans Administration/Department of Defense PTSD guidelines.[8] IPT deserves greater consideration in the NICE guidelines, if only as a fallback for exposure refusers and non-responders. **References** 1. Markowitz JC, Petkova E, Neria Y, Van Meter P, Zhao Y, Hembree E, Lovell K, Biyanova T, Marshall RD: Is exposure necessary? A randomized clinical trial of interpersonal psychotherapy for PTSD. Am J Psychiatry 2015;172;430-440 2. Markowitz JC, Neria Y, Lovell K, Van Meter PE, Petkova E: History of sexual trauma moderates psychotherapy outcome for posttraumatic stress disorder. Depress Anxiety 2017;34:692-700 3. Markowitz JC, Meehan KB, Petkova E, Zhao Y, Van Meter PE, Neria Y, Pessin H, Nazia Y: Treatment preferences of psychotherapy patients with chronic PTSD. J Clin Psychiatry 2016;77:363-370	analyses were outside protocol for the review as it is not possible to integrate them across studies. Planned subgroup analyses were conducted (where there was sufficient data) in order to address sub-questions, such as differential efficacy associated with different trauma types • Markowitz et al. (2016) does not meet inclusion criteria as the comparison of preferred treatment condition relative to unwanted treatment condition does not match the review protocol. Patient preference, choice and the principles of shared decision making were considered by the committee during the interpretation of evidence and making the recommendations • Campanini et al. (2010) and Krupnick et al. (2016) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs)

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				4. Markowitz JC, Choo T, Neria Y: Stability of improvement after psychotherapy of posttraumatic stress disorder. Canadian Journal of Psychiatry/La Revue canadienne de psychiatrie 2018;63:37-43 5. Krupnick JL, Green BL, Stockton P, Miranda J, Krause E, Mete M: Group interpersonal psychotherapy for low-income women with posttraumatic stress disorder. Psychother Res 2008; 18:497-50 6. Krupnick JL, Melnikoff E, Reinhard M: A pilot study of interpersonal psychotherapy for PTSD in women veterans. Psychiatry 2016;79:56-69 7. Campanini RF, Schoedl AF, Pupo MC, Costa AC, Krupnick JL, Mello MF: Efficacy of interpersonal therapy-group format adapted to post-traumatic stress disorder: an open-label add-on trial. Depress Anxiety 2010;27:72-77 8. https://www.healthquality.va.gov/guidelines/MH/ptsd/	
International Society of Interpersonal Psychotherapy	Evidence review D, Recom-mendations	365	General	The proposed NICE guidelines emphasize exposure therapies as first line treatment for posttraumatic stress disorder (PTSD), as they should. Exposure therapies have by far the most empirical support as PTSD treatments. Yet they also have limited efficacy for many patients; and still more refuse to face their trauma reminders or, having entered, drop out of treatment – exposure therapy attrition is remarkably high, exceeding 30% and reaching 50% in some trials. Pharmacotherapy with serotonin reuptake	Thank you for your comment. The committee discussed the evidence suggesting a potential harm of trauma-focused CBT in terms of a significantly higher rate of drop-out relative to waitlist, and a small but still statistically significant higher drop-out where trauma-focused CBT augmented treatment as usual or medication relative to treatment as usual/medication-only. The committee discussed potential reasons for this

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				inhibitors and other medications lowers PTSD symptoms but rarely brings about remission. In view of the less than complete response of much PTSD to standard treatments, the NICE guidelines should also consider alternative psychotherapeutic approaches to exposure for PTSD. What to do when the first treatment fails, or the patient refuses it? Yet your recommendations are: 1) CBT, 2) EMDR, 3) trauma-focused computerised CBT. What alternatives does that leave for patients who refuse or do not respond to CBT? We are concerned that your recommendations are partisan rather than fully objective. It is no secret that schools of psychotherapy have historically competed rather than cooperated. And there is both room and need for more than one approach.	higher rate of discontinuation, and speculated that trauma-focused CBT may be less acceptable to people who are not ready to directly confront traumatic memories, are not able to engage due to functional impairment from associated symptoms, and/or have difficulties in building a trusting therapeutic relationship. As existing recommendations for non-trauma-focused symptom-specific CBT interventions, modifications of trauma-focused therapies for those with additional needs (including complex PTSD), and engagement strategies for those with difficulties in building trust in the therapeutic relationship (based on the qualitative evidence [see evidence review H]) have the potential to address some of these reasons for discontinuation, the committee agreed that the potential for benefit was greater than the potential for harm. The committee also noted that effects on discontinuation only reached the threshold for clinical importance for the comparison against waitlist where there may be an additional incentive for waitlist participants not to drop-out, given that access to the intervention is contingent upon continuing in the trial. Furthermore, offering EMDR as an option for those with non-combat-related PTSD, or supported computerised trauma-focused CBT as an alternative lower intensity intervention, allows people who may not find

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					trauma-focused CBT acceptable to access another psychological intervention if they prefer. The committee noted that there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms if there is no response to treatment. The committee agreed that it is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and physical health. Therefore, they prioritised this area as one for further research.
IPTUK	Evidence Review D	197	11-12	Interpersonal Psychotherapy was inconsistently listed in the interventions and the search terms used for psychological and psychosocial interventions and other non-pharmacological interventions for the treatment of PTSD in adults, raising doubts about the comprehensiveness of the literature review**.** Two relevant studies were not cited: Campanini, Schoedl, Pupo, MSc.,Costa, BSc., Krupnick, and Mello (2010) Efficacy of interpersonal therapy-group format adapted to post-traumatic stress disorder: an open-label add-on trial. Depression and Anxiety 27: 72–77.	Thank you for your comment. The list of interventions in the review protocols are intended to be illustrative rather than exhaustive (as stated, 'psychological interventions listed below are examples of interventions'). Please see Appendix B of Evidence report D for search strategies for the psychological treatment of PTSD in adults review. Campanini et al. (2010) and Krupnick et al. (2016) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs)

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				Krupnick, Melnikoff & Reinhard (2016) A Pilot Study of Interpersonal Psychotherapy for PTSD in Women Veterans, Psychiatry, 79:1, 56-69, DOI: 10.1080/00332747.2015.1129873	
IPTUK	Guideline	19-20	17-23 4-10	The guideline offers only two recommendations for treatment following an individual declining or demonstrating non-response to TF-CBT or EMDR, both of which involve additional CBT. We therefore welcome the recommendation for research on sequencing and further line treatment and personalised care and risk markers, which are inadequately addressed in the currently evidence base. (Draft, p 19, line 17-23 and p 20, line 4-10 line).	Thank you for your comment. The committee noted that there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms if there is no response to treatment. The committee agreed that it is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and physical health. Therefore, they prioritised this area as one for further research.
IPTUK	Guideline Evidence Review D	284 284	33-49 13-18	The draft provides very limited evidence-based guidance on managing the implications of high drop-out rates for TF-CBT. The committee speculate on the reasons why this might occur and suggesting only that recommended modifications for some groups have potential to address some of these reasons for discontinuation. This trust in potential, but as yet insufficiently evidenced, benefits related to a significant implementation issue for TF-CBT, is in direct contrast to the conclusion drawn on other psychosocial interventions, with some evidence of efficacy. It was argued that, "Given the considerable	Thank you for your comment. There is no RCT evidence on how you would manage high drop-out so it is not possible for this advice to be evidence-based. However, the committee were aware that high rates of discontinuation are an issue for people with PTSD from psychological interventions in general, and trauma-focused therapies in particular. Based on their clinical knowledge and experience, the committee speculated on the reasons for this high drop-out and provided guidance that sought to address these issues, for instance, reassuring people that PTSD is a treatable condition, providing

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				evidence for trauma-focused CBT, EMDR, self-help and non-trauma-focused symptom-specific CBT, the committee considered it appropriate to set a relatively high bar for other interventions." The logic of setting a "high bar" rather than a fair, transparent and consistent standard is unclear and undermines the impression of the committee's impartiality. It appears a perverse disincentive to implementing evidence based practice to preclude cautious and informed consideration of approaches with limited evidence, in the absence of clear data on sequencing treatments, because one intervention has a substantial evidence base, albeit that, "With the exception of less than a handful of outcomes of moderate quality, all the evidence reviewed was of low or very low quality, reflecting the high risk of bias associated with the studies." This impression of bias undermines the credibility of guideline, and it is essential the committee is seen to make fair and transparent recommendations across all treatment options.	detailed information about interventions that includes the likelihood of improvement and recovering, what to expect during the intervention (including that symptoms can seem to get worse temporality), and that recovery is more likely if they stay engaged with treatment, offering flexible modes of delivery, making sure that people are not treated in trauma-inducing environments, making sure that interventions are culturally and linguistically appropriate, and allowing for more sessions if clinically indicated (for example for multiple trauma). Given the large quantity of evidence suggesting large benefits of trauma-focused therapies, and the consensus-based recommendations that aimed to address some of the difficulties there may be in keeping people with PTSD engaged in treatment, the committee agreed the potential benefits outweighed the harms. GRADE considers quality of evidence, but also considers four other domains in making recommendations, namely, balance between desirable and undesirable effects, values and preferences, and whether the intervention represents a wise use of resources. The committee refute the claim of a bias towards CBT. The intervention recommendations were

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					evidence-based, and given that there was good evidence for a number of interventions, the committee did not consider it appropriate to make recommendations based on very limited and uncertain evidence in other areas. This is entirely in keeping with the NICE guidelines manual. Patient choice is a central element of the provision of effective healthcare. We have made recommendations in the 'planning treatment and supporting engagement' section which require those providing treatment and support for people with PTSD to set out the benefits and harms, and the requirements of individual interventions so as to enable people to make an informed choice. NICE guidelines make recommendations for interventions where there is evidence that they are clinically and cost effective. The purpose of recommending the interventions that we have is not to remove patient choice, but rather to provide people with a choice from those interventions that have the greatest likelihood of being effective.
Lancashire Care NHS Foundation Trust	Guideline	General	General	Treatment in adults - the information in this section could helpfully state clearly that the guidance is for simple trauma	Thank you for your comment. It is not the case that the 'Treatment in adults' section is only for 'simple' trauma. Although the evidence was limited on interventions for people who have complex PTSD, the evidence suggested that trauma-focused

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					therapies could also benefit this group. Based on their experience, the committee proposed ways of modifying interventions to address the barriers people with complex PTSD might have to engaging in treatment, like offering more sessions and avoiding an abrupt end to treatment by planning ongoing support.
Lancashire Care NHS Foundation Trust	Guideline	General	General	In relation to drug treatments - there is no mention of the fact that this might be the patient's preferred approach rather than psychological treatment – in terms of patient choice and consent – this could be seen as important	Thank you for your comment. The recommendation for SSRIs or venlafaxine states that these drugs should be considered where an adult with PTSD has a preference for drug treatment.
Lancashire Care NHS Foundation Trust	Guideline	General	General	Good to see the requirement not to exclude people with comorbid drug and alcohol misuse - but what about comorbid psychosis?	Thank you for your comment. No guidance is offered on those with coexisting psychosis as trials of people with psychosis as a coexisting condition were excluded from the guideline as pre-specified in the review protocols.
Lancashire Care NHS Foundation Trust	Guideline	General	General	Good to see taking adequate time to build trust is included as part of the treatment and the need to increase the number of therapy sessions	Thank you for your comment.
Lancashire Care NHS Foundation Trust	Guideline	General	General	good to see that the guidelines refer to setting the treatment of PTSD in the context of an holistic approach to planning and delivering treatment – as more interventions might be needed in addition to processing the memory	Thank you for your comment.
Lancashire Care NHS Foundation Trust	Guideline	General	General	There is a suggestion of a distinction between "adults with a diagnosis of PTSD or with clinically important symptoms of PTSD". This could helpfully elaborated. The criterion event A for a diagnosis of PTSD in line with DSM5 are	Thank you for your comment. As pre-specified in the review protocols 'at risk of PTSD' is defined in accordance with DSM and the definition of a traumatic event maps on to criterion A. As evidence

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				quite "tight" - there are many individuals who present with a broad range of difficulties who have experienced traumatic events that would not meet criterion for A especially where for example an adult trauma event makes a connection with childhood experiences. It might be helpful if there is reference to the importance of considering the meaning of the event to the person	has not been considered for events that do not meet this definition the committee did not consider I it appropriate to make changes to recommendations.
Lancashire Care NHS Foundation Trust	Guideline	General	General	Sleep disturbance and anger are core features of the presentation of `PTSD. It is not clear why these are being seen as " associated symptoms"	Thank you for your comment. Sleep disturbance and anger are not seen as 'associated symptoms' and that term is not used in the recommendation. In response to yours and other stakeholder's, comments this recommendation has been amended in an attempt to avoid unintended interpretations. The term '*symptom-specific CBT interventions*' has been replaced with '*CBT interventions targeted at specific symptoms such as sleep disturbance or anger*', and the recommendation about when you would consider this has been made stronger so that you would *only* consider such interventions when the person is unable or unwilling to engage in a trauma-focused intervention or has residual symptoms after a trauma-focused intervention.
Lancashire Care NHS Foundation Trust	Guideline	General	General	There are a broader range of activities involved in working with complex trauma than the delivery of evidence based treatments that assist in the processing of trauma memories – it would be helpful if this broader context was referenced – as it is the reality of work for many services working with complex trauma	Thank you for your comment. The recommendation for people with additional needs, including complex PTSD, recommends ways of modifying interventions to address the barriers people with complex PTSD might have to engaging in treatment, like offering more sessions and avoiding

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					an abrupt end to treatment by planning ongoing support. This recommendation also includes other considerations and adaptations that may be required when working with people with additional needs including: helping the person manage any issues (such as substance misuse, dissociation or emotional dysregulation) that might be a barrier to engaging with trauma-focused therapies; ensuring extra time is built in to develop trust with the person; taking into account the safety and stability of the person's personal circumstances (for example their housing situation) and how this might impact on engagement with and success of treatment.
Lancashire Care NHS Foundation Trust	Guideline	4	11	- why only mention substance misuse - alcohol misuse can equally lead to functional impairment - as can a range of other risk taking behaviours	Thank you for your comment. The committee agreed that it was inappropriate to focus on substance misuse over and above other coexisting conditions. In response to stakeholder's comments and after review of the recommendation, the committee questioned the appropriateness of including a list of commonly occurring coexisting conditions to a recommendation on symptoms that are included in the diagnostic criteria for PTSD. On this basis, the reference to substance misuse was removed from this recommendation.
Lancashire Care NHS Foundation Trust	Guideline	9	8	it would be good to state who might have the role of facilitating peer support groups	Thank you for your comment. In response to yourand other stakeholder's, comments this recommendation has been amended to include the guidance that peer support groups should *'be*

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					facilitated by people with mental health training and supervision'.
Lancashire Care NHS Foundation Trust	Guideline	11	4	It might be helpful to talk explicitly about trauma informed care	Thank you for your comment. Most of the recommendations are trauma-informed, however, the committee did not consider it appropriate to recommend trauma-informed care as a specific service delivery model as no eligible evidence for this model was identified. The committee agreed that this is an important priority for further research and have made a research recommendation about the clinical and cost effectiveness of trauma-informed care or trauma-informed approaches.
Lancashire Care NHS Foundation Trust	Guideline	13	20	In recommendation 1.6.12 perhaps there is scope to consider the benefits of psychoeducational initiatives for individuals with "less significant symptoms"	Thank you for your comment. The committee considered the evidence for psychoeducation in the prevention of PTSD in adults and although limited evidence suggests that a single psychoeducational session may be effective at improving anxiety symptoms, the committee concluded that non-significant effects on PTSD symptomatology, PTSD caseness, and depression symptoms did not warrant a recommendation for psychoeducation.
Leeds & York Partnership NHS Foundation Trust	Guideline	17	3	Do not exclude people with PTSD from treatment based on comorbid drug or alcohol misuse. I get the idea of not excluding people but given the treatment recommended (i.e. CBT including processing work) I wonder how realistic it is depending on the extent of the misuse. Usually significant dependence on substances to control feelings is a counter-indicator for trauma	Thank you for your comment. In response to your and other stakeholders' comments changes have been made to recommendations to reflect that for some people substance misuse may need to be addressed to enable engagement with trauma-focused intervention. The previous recommendation has been amended as follows: 'Do not exclude

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				processing work. I'm not sure what the evidence is for this recommendation.	people with PTSD from treatment based *solely* on comorbid drug or alcohol misuse', and the recommendation for adaptations that may be needed o psychological interventions for people with PTSD and additional needs has been amended to recommend that people are helped to manage any issues, including substance misuse, that might be a barrier to engaging with trauma-focused therapies.
Leeds & York Partnership NHS Foundation Trust	Guideline	18.	19 Comple x PTSD	This distinction is helpful but the description sounds an awful lot like what is sometimes described as EUPD (.Emotionally Unstable Personality Disorder). There is evidence for different psychological approaches for EUPD. CAT (Cognitive Analytical Therapy) is starting to gather evidence for its use with this kind of problem. I wonder how NICE would distinguish between the two diagnoses.	Thank you for your comment. This definition has been amended slightly to reflect minor changes in the now published ICD-11. No eligible evidence was identified for Cognitive Analytical Therapy in the treatment of PTSD. It is not possible for this guideline to make any recommendations about differential diagnosis as the recognition and assessment sections from the 2005 guideline were not included in this update (as outlined in the scope). As the evidence on recognition and assessment has not been reviewed, we are not able to make any changes to this section (except where they are necessary in order to clarify meaning).
Manchester Metropolitan University	Guideline	7	22	In line with Comment 3, section 1.4 does not consider the complexities in working via TIs. The reader is referred to recommendations in the NICE guidelines on service user experience in adult mental health and patient experience in adult NHS services	Thank you for your comment. Recommendations in section 1.5 (language and culture) address additional support needs, including the use of interpreters that may be needed for non-English-language speakers. The committee did not consider

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				(https://www.nice.org.uk/guidance/CG136/chapter/1-Guidance#assessment) which also include no consideration of this eventuality.	that it was appropriate to provide greater specificity in this area as needs are likely to be specific and best left to clinical judgement
Manchester Metropolitan University	NICE Guidelines Draft	8	1	In line with Comment 3, reference to the special needs of non-English speaking refugees and asylum seekers is too general / vague / inadequate.	Thank you for your comment. The committee did not think that it was appropriate to be more prescriptive in this recommendation and agreed that this was best left to clinical judgement and based on the individual needs of the person with PTSD.
Manchester Metropolitan University	NICE Guidelines Draft	8	25	Among the issues covered in section 1.42. "*Give information and support to people with PTSD (and their family members or carers as appropriate) covering*: …" information to parents and pregnant women with PTSD about the effects on parenting behaviour and impact on their children should be added (please, refer to comment 8 for more information regarding the effects of PTSD on parenting and child development)	Thank you for your comment. As specified in the review protocols, this guideline does not cover women with antenatal or postnatal PTSD as there is existing NICE guidance, 'Antenatal and postnatal mental health: clinical management and service guidance' which includes recommendations for this group. Please see CG45 https://www.nice.org.uk/Guidance/CG45
Manchester Metropolitan University	NICE Guidelines Draft	9	18	This section should contain two specific subsections referring to the effects of PTSD on i) parenting behaviour (especially mothers, or primary care givers) of little children, as it could have a huge impact on the developing children (e.g., see Schechter et al., 2017a, 2017b; Cordero et al., 2017), and ii) on pregnant women, as hormonal alteration related to PTSD disorder could impact the developing foetus, and affect postnatal maternal behaviour (e.g., see Cai et al., 2017; References:	Thank you for your comment and for drawing our attention to the Cai et al. (2017), Cordero et al. (2017), Habersaat et al. (2014), Moss et al. (2017), and Schechter et al. (2017a, 2017b) citations. As specified in the review protocols, this guideline does not cover women with antenatal or postnatal PTSD as there is existing NICE guidance, 'Antenatal and postnatal mental health: clinical management and service guidance' which includes recommendations for this group. Please see CG45 https://www.nice.org.uk/Guidance/CG45

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				Cai D, Zhu Z, Sun H, Qi Y, Xing L, Zhao X, Wan Q, Su Q, Li H (2017) Maternal PTSD following Exposure to the Wenchuan Earthquake Is Associated with Impaired Mental Development of Children. PLoS One 12:e0168747. Cordero MI, Moser DA, Manini A, Suardi F, Sancho-Rossignol A, Torrisi R, Rossier MF, Ansermet F, Dayer AG, Rusconi-Serpa S, Schechter DS (2017) Effects of interpersonal violence-related post-traumatic stress disorder (PTSD) on mother and child diurnal cortisol rhythm and cortisol reactivity to a laboratory stressor involving separation. Horm Behav 90:15-24. Habersaat S, Borghini A, Nessi J, Forcada-Guex M, Muller-Nix C, Pierrehumbert B, Ansermet F (2014) Effects of perinatal stress and maternal traumatic stress on the cortisol regulation of preterm infants. J Trauma Stress 27:488-491. Moss KM, Simcock G, Cobham V, Kildea S, Elgbeili G, Laplante DP, King S (2017) A potential psychological mechanism linking disaster-related prenatal maternal stress with child cognitive and motor development at 16 months: The QF2011 Queensland Flood Study. Dev Psychol 53:629-641. Schechter DS, Moser DA, Aue T, Gex-Fabry M, Pointet VC, Cordero MI, Suardi F, Manini A,	

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				Vital M, Sancho Rossignol A, Rothenberg M, Dayer AG, Ansermet F, Rusconi Serpa S (2017a) Maternal PTSD and corresponding neural activity mediate effects of child exposure to violence on child PTSD symptoms. PLoS One 12:e0181066. Schechter DS, Moser DA, Pointet VC, Aue T, Stenz L, Paoloni-Giacobino A, Adouan W, Manini A, Suardi F, Vital M, Sancho Rossignol A, Cordero MI, Rothenberg M, Ansermet F, Rusconi Serpa S, Dayer AG (2017b) The association of serotonin receptor 3A methylation with maternal violence exposure, neural activity, and child aggression. Behav Brain Res 325:268-277. .	
Manchester Metropolitan University	NICE Guidelines Draft	16	1	Drug treatment for adults should add "except for pregnant women", e.g., the use of serotonin reuptake inhibitor (SSRI) could affect foetal development (Lugo-Candelas et al., 2018) References: Lugo-Candelas C, Cha J, Hong S, Bastidas V, Weissman M, Fifer WP, Myers M, Talati A, Bansal R, Peterson BS, Monk C, Gingrich JA, Posner J (2018) Associations Between Brain Structure and Connectivity in Infants and Exposure to Selective Serotonin Reuptake	Thank you for your comment and for drawing our attention to the Lugo-Candelas et al. (2018) citation. As specified in the review protocols, this guideline does not cover women with antenatal or postnatal PTSD as there is existing NICE guidance, 'Antenatal and postnatal mental health: clinical management and service guidance' which includes recommendations for this group. Please see CG45 https://www.nice.org.uk/Guidance/CG45

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				Inhibitors During Pregnancy. JAMA pediatrics 172:525-533.	
Manchester Metropolitan University	NICE Guidelines Draft	18	13-16	As above, in the definition of 'clinically important': Need to be specific; when referring to the DSM or ICD diagnosis of PTSD, need to state the exact version of DSM or ICD.	Thank you for your comment. The diagnostic classification system will vary by study and this was recorded, however, all were eligible in terms of inclusion criteria.
Manchester Metropolitan University	NICE Guidelines Draft	40	23	Compared to other re-experiencing symptoms, flashbacks are less frequently reported by survivors (and they tend to be associated with more severe exposure to trauma). Intrusive memories or images of the trauma and related nightmares are more frequent symptoms. So, considering the aims of the guidelines, if flashbacks are to be mentioned here, it is important to also mention 'dreams related to the event'.	Thank you for your comment. In response to your comment, nightmares have been added to the context section.
Manchester Metropolitan University	B	9	10 (TABLE 1)	The phrase "defined by a diagnosis of PTSD according to DSM, ICD…": The diagnosis of PTSD has evolved over time and this is reflected on the different versions of DSM and ICD. It is important to be clear and state whether this refers to the most recent versions of these documents or not.	Thank you for your comment. This is a summary of the review protocol and defines the population we were interested in. The diagnostic classification system will vary by study and this was recorded, however, all were eligible in terms of inclusion criteria.
Manchester Metropolitan University	H	20	General	Although the guidelines repeatedly refer generically to the specific needs of refugees and asylum seekers in promoting equitable access to services, more consideration is needed of specific needs when considering assessment and treatment. In addition, the involvement of translators and interpreters (TIs) in the care of asylum-seekers and refugees needs to be taken into consideration throughout the different	Thank you for your comment. Recommendations in section 1.5 (language and culture) address additional support needs, including the use of interpreters that may be needed for refugees and asylum seekers. The committee did not think that it was appropriate to provide greater specificity in this

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				documents, making the reader more aware of some of the risks involved. For example, TIs and service-users may speak the same language, but belong to different ethnic, religious, or political groups. The service-user may feel threatened or uncomfortable in the presence of a person who –in their eyes- is associated with the perpetrator(s) of their trauma (e.g., belongs to the 'other side' in the context of a civil war, or belongs to the same political party as those who persecuted or tortured the service-user, etc.). Apart from the risks to the service users, the recommendations need to reflect the understanding that listening to narrations of traumatic events often has an emotional impact on the listener. TIs may be from the same ethnic, religious or political groups with the service users and may sympathise more with them, thus increasing the risk of becoming emotionally distressed (or even developing symptoms of secondary traumatic stress). A better review of these issues and the inclusion of brief recommendations would be very helpful.	area as needs are likely to be specific and best left to clinical judgement.
Manchester Metropolitan University	I	43	34	In line with Comment 3, the statement "*ensuring that methods of access to services take into account the needs of specific populations of people with PTSD, including migrants and asylum seekers*" is too vague thus inadequate.	Thank you for your comment. The committee did not consider that it was appropriate to be more prescriptive in this recommendation and agreed that this was best left to clinical judgement and based on the individual needs of the person with PTSD.

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Mindfulness Orkney	Guideline	General	1.6.16	The EMDR should be given by a clinician trained by an accredited provider. EMDR Europe in cooperation with the EMDR UK & Ireland Association adopts a rigorous policy of regularly accrediting and monitoring the standards of all EMDR trainers and training courses. Accreditation as an EMDR trainer is the highest standard that the EMDR Europe association can award and is only granted to the most experienced and skilled clinicians with proven ability to teach. Only EMDR Europe accredited trainers are allowed to teach the seven day basic EMDR course. All accredited trainers must also regularly submit themselves and their training courses for reaccreditation.	Thank you for your comment. In response to your, and other stakeholder's, comments this recommendation (and other recommendations about the structure and content of psychological interventions) has been amended to include the guidance that interventions should *'be delivered by trained practitioners with ongoing supervision'*. The committee did not consider it appropriate to include accreditation in this recommendation.
Mindfulness Orkney	Guideline	47	1.6.10	I am concerned that the recommendations suggest that EMDR should only be considered if CBT does not work. The evidence shows that EMDR works quicker than CBT thus patient gets better faster and also less expensively	Thank you for your comment. The committee considered the evidence for EMDR in treatment of children with PTSD and noted the limited evidence base, in terms of the number of studies/participants, the number of different comparisons, the breadth of outcomes reported, and the availability of long-term follow-up. The committee observed that the benefits of EMDR were not statistically significant relative to waitlist or treatment as usual, and the head-to-head comparisons against trauma-focused CBT (although suggestive of no significant difference) were not sufficiently powered to detect non-inferiority (single-study analyses). The committee also took into account the results of the NMA and economic base-case analysis which both suggested that EMDR was less clinically effective and cost-

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					effective than all individual trauma-focused CBT interventions. On the basis of the clinical and cost-effectiveness and these additional considerations, the committee agreed that EMDR should only be considered for children and young people if they do not respond to or engage with trauma-focused CBT.
Mindfulness Orkney	Guideline	54	1.1.2	Along with the list of factors the inclusion of bullying should be considered as this can present patients with the same characteristics for a diagnosis of PTSD	Thank you for your comment. The committee did not consider it appropriate to include bullying in this list as bullying does not meet the diagnostic definition of a criterion A traumatic event unless it involves serious danger, in which case it would be covered by the categories included.
NHS England	General	General	General	**Clinically important symptoms** We do not feel this term is very clear and could be easily confused with sub-threshold trauma reactions. We suggest referring to people with a diagnosis of PTSD or those who have a positive screen on a validated screening measure. (CR)	Thank you for your comment. The definition of clinically important symptoms is included in the glossary and is defined as those with a diagnosis of PTSD according to DSM, ICD or similar criteria or those who are assessed as having PTSD on a validated scale as indicated by baseline scores above clinical threshold.
NHS England	guideline	1.9.5.6	General	We welcome the proposed research recommendations relating to the clinical and cost effectiveness of sequencing and further line treatment IN PTSD. We would like to see more explicit reference to arts therapies in this, as both the 2005 guideline and draft guideline update were unable to make recommendations on Art Therapy due to limitations and uncertainties in the evidence. Strengthening the evidence base for the 14 Allied Health Professions,	Thank you for your comment. Arts therapies have been added as one of the intervention examples for the research recommendation about sequencing and further line treatment in Appendix L of Evidence report D.

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				including Arts, Music and drama Therapies is a national priority for NHS England (SC)	
NHS England	Guideline	5	5	It is excellent to see the inclusion of birth trauma here as an example of a traumatic event. We would welcome this to be expanded to include **"traumatic birth, miscarriage, stillbirth or neonatal death"** which are the perinatal examples listed in Antenatal and postnatal mental health: clinical management and service guidance. It is important these are included and named to ensure that miscarriage, stillbirth or neonatal death are listed as key examples of traumatic incidents and women effectively picked up in relation to the recommendations in section 1.1.4 and 1.1.5 (CR)	Thank you for your comment. This has been amended to *'trauma related to serious health conditions such as, but not limited to, traumatic neonatal death or intensive care admission'* to reflect the committee discussion that traumatic birth, miscarriage, stillbirth and neonatal death can be traumatic but they do not necessarily always meet the diagnostic definition of a criterion A traumatic event, and the fact that other health-related events can be but are not necessarily traumatic.
NHS England	Guideline – research recommendations	19	10	We would strongly encourage additional research recommendations that address the research gaps in screening, assessing and treating PTSD that arises in the maternity and perinatal context. This would include: - identifying the most reliable, valid and acceptable screening tools for PTSD following traumatic birth, miscarriage, stillbirth or neonatal death understanding the clinical and cost effectiveness of interventions that specifically treat PTSD following traumatic birth, miscarriage, stillbirth or neonatal death (CR)	Thank you for your comment. As specified in the review protocols, this guideline does not cover women with antenatal or postnatal PTSD as there is existing NICE guidance, 'Antenatal and postnatal mental health: clinical management and service guidance' which includes recommendations for this group. Please see CG45 https://www.nice.org.uk/Guidance/CG45
NHS England	Guideline	24	1	We welcome the inclusion of holistic approaches to care for people with a PTSD (SC)	Thank you for your comment.

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NHS England	Guideline	45	General	We welcome the points raised about people needing to be supported to plan ongoing support, return to everyday activities (SC)	Thank you for your comment.
NHS England	Guideline	48	General	We welcome the inclusion within the guideline of people with PTSD requiring support in re-establishing a healthy lifestyle, work and social relationships (SC)	Thank you for your comment.
NHS England National IAPT team	General	General	General	The NHS England teams are grateful to the guideline development group for their hard work and the production of an impressive document. Various stakeholders within IAPT and the Veterans and Health and Justice teams were sent a draft guideline. Their comments are collated below. The comments do not necessarily reflect an official NHS England view but we would be grateful if the NICE team could consider them as a reflection of the range of responses that the draft document has elicited among stakeholders.	Thank you for your comment.
NHS England National IAPT team	General	General	General	It would be helpful if the recommendations were more detailed on the issue of treatment duration in complex post-traumatic stress disorder, particularly where multiple traumatic episodes mean that the person may need more than 20 sessions.	Thank you for the comment. The recommendations on structure and content of trauma-focused CBT and EMDR interventions recommend that more sessions may be required '*if clinically indicated, for example if they have experienced multiple traumas*'. In addition, the recommendation for people with additional needs, including complex PTSD, recommends that extra time is built in to develop trust with the person, by increasing the duration or the number of therapy sessions according to the

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					person's needs. However, the committee did not agree that any greater specificity should be provided as it was worded in this way to allow clinical flexibility.
NHS England National IAPT team	Guideline	General	General	There has been a change from the 2005 guidance which previously put TF-CBT and EMDR on a par as first line treatment for people with PTSD (after 3 months). Is this draft guidance suggesting that TFCBT is a first line treatment, and EMDR a second line treatment given the way the documentation is set out? We are concerned about the impact this will have on people with PTSD symptoms in practice in terms of treatment choice, wait for treatment and recovery rates. Within our IAPT service, EMDR is an established and successful treatment for people presenting with PTSD. We would welcome some clarity on this issue.	Thank you for your comment. Trauma-focused CBT and EMDR are offered as equivalent options for adults with PTSD who have been exposed to non-combat-related trauma more than 3 months ago. In response to your, and other stakeholder's, comments the EMDR recommendation has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option to trauma-focused CBT for adults exposed to non-combat related trauma. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed.
NHS England National IAPT team	Guideline	General	General	There is little specific reference to the military community in the guidelines but they were frequently discussed in the meetings and a sizeable number of the studies that were considered were from a military setting. There are few mentions in the draft guidelines of the following word/groups:	Thank you for your comment. Serving military are outside the scope of the guideline, as is the CPA and the recovery model. However, studies on military veterans were included in most of the reviews, and with the exception of the EMDR recommendation, recommendations apply equally to those who have been exposed to combat-related

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				1. Veteran(s), 2. Armed forces, (serving or otherwise) 3. Emergency services 4. Care Programme Approach 5. Recovery model 6. Combat/Military only related to claims of not a good evidence from EMDR for this type of PTSD	trauma as those who have been exposed to any other type of trauma. The guideline does not make explicit reference to any specific trauma type and the committee did not consider it was appropriate to single out military combat trauma unless there was good evidence to suggest that treatment of PTSD should be different in this group.
NHS England National IAPT team	Guideline	General	General	The guideline is light on social interventions. It would be helpful if an explanation of this was included (perhaps an absence of good quality studies?).	Thank you for your comment. The evidence reports provide full details of all interventions that were searched for and studies that were reviewed at full-text. A number of studies were searched for that might be classified as 'social interventions' including practical support and peer support. Furthermore, this list is illustrative rather than exhaustive so if there had been social intervention studies that met our inclusion criteria they should have been identified by our search but were not, confirming your suggestion that this represents an absence of high quality studies.
NHS England National IAPT team	Guideline	General	General	It would be helpful if the guideline included more detail about how services should work together to address alcohol issues in people presenting with PTSD. Many psychological therapy services that offer NICE recommended treatments for PTSD are happy to work with	Thank you for your comment. The committee considered that many of the issues raised in your comment could be addressed by the general

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				clients by providing psychoeducation about the problems with using alcohol or drugs to deal with PTSD and to help individuals who are not seriously dependent to reduce their intake. However, the services do not have the expertise or capacity for formal detoxification programmes. These need to be provided elsewhere but is obviously in patients interests if the two types of intervention can be coordinated and included in a coherent treatment plan.	principles recommended for supporting transitions between services. The committee did, however, agree that changes were needed to recommendations to reflect that for some people substance misuse may need to be addressed to enable engagement with trauma-focused intervention. The previous recommendation has been amended as follows: 'Do not exclude people with PTSD from treatment based solely on comorbid drug or alcohol misuse', and the recommendation for adaptations that may be needed to psychological interventions for people with PTSD and additional needs has been amended to recommend that people are helped to manage any issues, including substance misuse, that might be a barrier to engaging with trauma-focused therapies.
NHS England National IAPT team	Guideline	General	General	There is no mention of trauma informed interventions	Thank you for your comment. Evidence for trauma-informed care as a service delivery model was searched for, however, no eligible evidence was identified. Most of the recommendations are trauma-informed, however, the committee did not consider it appropriate to recommend trauma-informed care as a specific service delivery model given the lack of eligible evidence. The committee agree that this is an important priority for further research and have made a research

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					recommendation about the clinical and cost effectiveness of trauma-informed care or trauma-informed approaches.
NHS England National IAPT team	Guideline	General	General	It would be helpful if the guideline could more formally acknowledge the need for empathy, cultural competence and a good therapeutic relationship during the delivery of trauma focused interventions. As such interventions often involve some form of reliving after the trauma, it is easy for the patient to feel victimised again during the therapy process. To counteract this, therapists need to be extra attentive to providing a safe, supportive, and trusted therapeutic environment. DSM-5 has a whole section of culture and the different needs according to gender (which gets a small mention here), ethnicity, religion, national culture, etc.	Thank you for your comment. The committee agreed that these are important but considered that these needs were not specific to trauma-focused CBT and were captured by existing recommendations in the NICE 'Service user experience in adult mental health' guideline. Furthermore, a specific recommendation in the 'language and culture' section of this guideline provides guidance about the use of interpreters and/or offering a choice of therapist where language or culture differences present challenges to the use of psychological interventions in PTSD. The recommendation for adaptations to psychological interventions that may be required for people with PTSD and additional needs, including complex PTSD, also includes the guidance that adequate time should be included in treatment for the person to establish trust.
NHS England National IAPT team	Guideline	General	General	There is not a specific mention of the relationship of the therapist to the trauma experienced, the exception is mention of male therapists for rape victims.	Thank you for your comment. The committee did not review the evidence for therapist factors as they were outside the scope of this review, and therefore the committee did not consider it was appropriate to provide guidance on this.

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11/06/2018 to 23/07/2018

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NHS England National IAPT team	Guideline	General	General	Demonstrate the recovery is not just the absence of symptoms which is suggested in at the beginning but elsewhere reduction in functional impairment is also mention.	Thank you for your comment. As outlined in 'The committee's discussion of the evidence' sections in the evidence reports, critical outcomes were measures of PTSD symptom improvement on a validated scale, remission, response and discontinuation. The committee considered dissociative symptoms, personal/social/occupational functioning (including global functioning/functional impairment, sleeping or relationship difficulties, and quality of life), and symptoms of a coexisting condition (including anxiety, depression and substance use disorder symptoms) as important but not critical outcomes. This distinction was based on the primacy of targeting the core PTSD symptoms. However, the committee reviewed the evidence for all outcomes and evidence of wider benefits impacted on decision-making about the broader efficacy of a given intervention and whether a recommendation should be made and the strength of that recommendation.
NHS England National IAPT team	Guideline	General	General	Migrant and asylum seekers are referenced as a special (but not a "protected") group but not refugees, rape victims, armed forces, veterans, prisoners, peacekeepers, emergency services, etc.	Thank you for your comment. The guideline considered inequalities relating to gender, sexual orientation, gender reassignment, age, homelessness, refugees and asylum seekers, illegal immigrants, undocumented workers and failed asylum seekers, people with neurodevelopmental disorders, people with

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					coexisting conditions, and people who are critically ill. This list was expanded from the original one that was submitted during scope consultation, and so stakeholders have contributed to shaping how the guideline would look at inequalities during recommendation development.
NHS England National IAPT team	Guideline	General	General	Would the guideline development group consider including a section on lessons learnt from post Omagh/ London/ Tunisia/Manchester Terrorist attacks? There are a number of published studies that outline how successful interventions were organised and evaluated.	Thank you for your comment. For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. We do not consider routine datasets as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading.
NHS England National IAPT team	Guideline	General	General	Some stakeholders have indicated that they would like to see further discussion of the importance of social/welfare support.	Thank you for your comment but this is outside the scope of this guideline.
NHS England National IAPT team	Guideline	General	General	The optimal time for intervention described as between one and 3 months after trauma, would mean the majority of the prison population would be out of scope for the optimal period for intervention.	Thank you for your comment. Mental health care of adults in contact with the criminal justice system (not solely as a result of being a witness) is outside the scope of this guideline as there is an existing NICE guideline on 'Mental health of adults in contact with the criminal justice system'. Please see NG66 https://www.nice.org.uk/guidance/ng66

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NHS England National IAPT team	Guideline	General	General	The guidelines look to be focused on community based services so would not apply to those in the secure and detained settings.	Thank you for your comment. Mental health care of adults in contact with the criminal justice system (not solely as a result of being a witness) is outside the scope of this guideline as there is an existing NICE guideline on 'Mental health of adults in contact with the criminal justice system'. Please see NG66 https://www.nice.org.uk/guidance/ng66
NHS England National IAPT team	Guideline	5	5	We welcome the addition of traumatic birth to the list of traumatic events associated with the development of PTSD as we see a number of women and on some occasions, their partners presenting to services in this context following a traumatic birth.	Thank you for your comment. This has been amended to *'trauma related to serious health conditions such as, but not limited to, traumatic neonatal death or intensive care admission*' to reflect the committee discussion that traumatic birth, miscarriage, stillbirth and neonatal death can be traumatic but they do not necessarily always meet the diagnostic definition of a criterion A traumatic event, and the fact that other health-related events can be but are not necessarily traumatic.
NHS England National IAPT team	Guideline	7	17	The addition to the guideline on supporting people transitioning between services, ie that the referring team should not discharge the service user before another team has accepted the referral is very welcome. However, a stakeholder has commented that clearer guidance is needed about the level of the NHS where treatment should occur. At the moment there is significant discussion between primary and secondary teams. Does the guideline group think that more explicit guidance could save time and ensure a smoother referral process? This is also relevant	Thank you for your comment. Treatment for PTSD is offered in a range of services including specialist PTSD services and also in IAPT where the greater number of people with PTSD are treated. The committee did not consider it helpful to make a primary/secondary care distinction.

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				to guideline 1.7.4. We recognise that there is considerable variability in local offers at primary and secondary care level and this may preclude further guidance.	
NHS England National IAPT team	Guideline	8	1	This is helpful in outlining access to care and taking into consideration the needs of specific populations. It would be useful to consider the needs of certain groups such as travellers, or asylum seekers who may not have a fixed abode, not be registered with a GP for example as this is often the barrier to accessing services whose entry criteria is based on post codes or GP registration. Lack of having safe and suitable accommodation to live in, or threats of deportation may also create an environment that could potentially render trauma focussed psychological interventions less effective and the guideline needs to consider if this needs to be made more explicit.	Thank you for your comment. Migrants and asylum seekers were already included in this recommendation, however, in response to your comment this recommendation has been amended to add people who are homeless or not registered with a GP to the list of groups who may have specific needs in terms of access.
NHS England National IAPT team	Guideline	8	16	The recommendation of not withholding treatment due to court proceedings is welcome as this is often the point when services receive referrals of people in distress and it seems unethical to withhold treatment. What would be welcome is to make more explicit what is the legal position and when is it appropriate to not consider trauma focussed treatments if there is a risk of jeopardising legal proceedings as there is a lot of misinformation about this issue.	Thank you for your comment. A cross-reference to the relevant Crown Prosecution Service guidance has now been added to this recommendation, in order to provide further information and greater clarity.
NHS England National IAPT team	Guideline	8	16-19	While this is a welcome recommendation, it goes against guidance by the CPS and needs further unpacking, as I understand it current guidance is that witnesses in criminal prosecution should have their treatment delayed because	Thank you for your comment. This recommendation does not contradict CPS guidance, but you are correct in that there are additional considerations around whether therapy can affect the actual or

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				of the impact on the perceived reliability of their evidence. Guideline producers need to confirm that their guidance conforms with the recommendations from the Crown Prosecution Service.	perceived reliability of witness evidence. A cross-reference to the relevant Crown Prosecution Service guidance has now been added to this recommendation, in order to provide further information and greater clarity.
NHS England National IAPT team	Guideline	9	13	This is on maintaining safe environments and about not exposing the individual to trauma inducing environments that might trigger PTSD, and this is at times difficult in actual practice, for instance people who experience PTSD following a traumatic event where they live, but have to continue to live there and be faced with reminders of the trauma, for instance meeting perpetrators of the event on a daily basis.	Thank you for your comment. The committee recognise these potential difficulties and the recommendation on adaptations that may be required for people with PTSD and additional needs includes the guidance to take into account the safety and stability of the person's personal circumstances (for example their housing situation) and how this might impact on engagement with and success of treatment.
NHS England National IAPT team	Guideline	9	19	Laying out explicitly what is helpful and supportive for family members and carers is particularly helpful, especially when considering that multiple family members may have been exposed to the same traumatic event and may require support around PTSD themselves.	Thank you for your comment.
NHS England National IAPT team	Guideline	11	16	The use of 'active monitoring' as opposed to 'watchful waiting' for those who show mild symptoms of the disorder, is welcomed as individuals may present with no symptoms in the immediate aftermath of a traumatic event and may appear to be coping, only to experience distress later and may often be missed.	Thank you for your comment.
NHS England National IAPT team	Guideline	11 13	16-19 19-22	We have detected considerable confusion among health providers about the active monitoring recommendation. This confusion is similar to the confusion that already exists	Thank you for your comment. Your reading of the guideline is correct and active monitoring is recommended for those without clinically important

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	Treatment in Adults	278 281	16 9	about the 2005 'watchful waiting' recommendation. We read the recommendation as saying that active monitoring should be instituted in the first month after a trauma for adults who are exposed to trauma and do not have symptoms or only have relatively mild symptoms. For individuals who have acute stress disorder or clinically important symptoms of PTSD within the first month individual trauma focused CBT should be offered. However, this isn't how everyone has interpreted the guidance, perhaps because the sections on active monitoring are separate from the sections on prevention of PTSD during the first month. Some health providers are interpreting the guidance as meaning that you shouldn't do anything other than active monitoring with any trauma victims during the first month. Greater clarity in the wording of the guidance would be much appreciated.	PTSD symptoms/acute stress disorder and trauma-focused psychological intervention for adults with a diagnosis of acute stress disorder or clinically important symptoms of PTSD. The committee carefully considered where to place the active monitoring recommendation and agreed that it should form its own section prior to the prevention or treatment sections. This decision was made on the basis that the recommendation applies to both adults and children and young people, and the structure also helps to highlight the distinction that the recommendation is for those with non-significant symptoms.
NHS England National IAPT team	Guideline	13 14	19-22 1	There are specific EMDR protocols for acute stress disorder. It would be helpful to know why these are not recommended in addition to trauma focused CBT at this point. Is it because of a lack of appropriate evidence for EMDR in acute stress disorder populations?	Thank you for your comment. In response to your question, EMDR is not recommended for acute stress disorder due to insufficient evidence. In the consultation version of the guideline, there was no evidence for EMDR within 1 month of trauma. Through stakeholder comments, one additional new study was identified and added to the analysis. The committee considered the new evidence for EMDR in the first month following trauma in adults (Gil-Jardiné 2018). However, the committee did not consider that it was appropriate to make a

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					recommendation in this time period as evidence was limited to a small single study (N=71) that only reported on one clinical outcome of interest and the effect on the number of participants with PTSD at 3-month follow-up was not statistically significant.
NHS England National IAPT team	Guideline	14	20	We are concerned that the evidence to support the recommendation to offer EMDR for non-combat related trauma only is not representative of clinical presentations in current practice. The studies included (Evidence D) seem to be largely based on historical combat trauma e.g. Vietnam veterans, whereas in current practice patients present with a more recent onset of symptoms, typically within 5-15 years. This evidence does not seem sufficiently strong or credible to support this recommendation. Currently, veterans whose mental health is related to their military service are prioritised for treatment in our service. If only one treatment (TF CBT) is being offered, this will inevitably impact and delay access to care and treatment for those experiencing combat related PTSD due to increased demand for CBT. This will also negatively impact on the waiting times for CBT for patients with other common mental health problems. We know that patient choice and patient expectancy are clinically significant predictors for treatment outcomes. We are concerned that by limiting the treatment for combat related PTSD to TF CBT only will have a negative impact on patient engagement, clinical outcomes and recovery rates. Numerous veterans have benefitted from accessing	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. The committee considered whether veteran populations in the EMDR studies were significantly different from veteran populations in trauma-focused CBT studies and concluded that they were similar so it is not possible to account for differential efficacy in this population by differences in the trial populations. When making recommendations, the committee interpret the evidence in light of their knowledge of the clinical context so that the 'reality' for people experiencing PTSD is taken into consideration and recommendations can be made that are relevant to the populations that clinicians typically encounter. However, in the case of EMDR for military veterans the committee did not consider a recommendation to be appropriate. Providing access to individual

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				EMDR therapy over recent years within our IAPT service which in the future would be denied to them with the current draft recommendations. Also we are concerned that the divide being made between combat and non- combat trauma is an artificial one, as it is our experience that the vast majority of veterans present with multiple trauma events both combat and non-combat related, including other adult traumas but often childhood trauma.	trauma-focused CBT will be a matter for implementation of the guideline.
NHS England National IAPT team	Guideline	14	20-23	One stakeholder commented that it was not clear from the guideline why EMDR is only recommended if PTSD has persisted for more than three months whereas trauma focused CBT is recommended after a shorter period. It is also not clear why EMDR is only recommended for non-combat-related trauma.	Thank you for your comment. In the consultation version of the guideline, there was no evidence for EMDR within 1 month of trauma. Through stakeholder comments, one additional new study was identified and added to the analysis. The committee considered the new evidence for EMDR in the first month following trauma in adults (Gil-Jardiné 2018). However, the committee did not consider that it was appropriate to make a recommendation in this time period as evidence was limited to a small single study (N=71) that only reported on one clinical outcome of interest and the effect on the number of participants with PTSD at 3-month follow-up was not statistically significant. The committee discussed the strength and breadth of the evidence for trauma-focused CBT within the first month of trauma, with benefits observed on

					both clinician-rated and self-rated measures of PTSD symptomatology, the rate of PTSD caseness at endpoint and follow-up, and on some other outcomes including depression and anxiety symptoms. Taken together with evidence suggesting that benefits are potentially long-lasting, the committee agreed that trauma-focused CBT should be offered to adults with clinically important PTSD symptoms or acute stress disorder within 1-month of the traumatic event in order to prevent the later development of PTSD. The committee considered the evidence for EMDR in the 1-3 month period following trauma, and in response to stakeholder's comments, agreed that a new recommendation should be added to consider EMDR for adults with PTSD within 1-3 months of non-combat-related trauma. This recommendation is based on single-study evidence showing large benefits of EMDR relative to supportive counselling in the 1-3 month period and an extrapolation from stronger evidence for EMDR more than 3 months after trauma. This was a weaker recommendation (consider rather than offer) based on the limited direct evidence available. The evidence for trauma-focused CBT in the 1-3 month time period was also limited, however, the committee extrapolated from the limited evidence showing benefits between 1 and 3 months after

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					trauma, and the broader evidence base that showed benefits within the first month and more than 3 months after trauma. Given that the committee thought it was unlikely that effects would be different in this 2-month time period, they recommended that trauma-focused CBT should be offered to adults with PTSD more than 1 month after trauma. EMDR is only recommended for non-combat-related trauma because the evidence shows a lack of efficacy in veteran populations, and this was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. The rationale behind recommendations of psychological interventions for adults at risk or with PTSD, including the above considerations, is provided in the 'Rationale and Impact' sections of the PTSD guideline evidence reports C and D respectively.
NHS England National IAPT team	Guideline	14	24	A stakeholder commented as follows: "With the growing evidence base for EMDR, we see value in this decision. Feedback from clients within our services that implement this approach has been that it is useful in some instances. Are there any adaptations to the approach which would make it more suitable for combat-related trauma?"	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically

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					important and statistically significant benefits were observed. The committee did not consider adaptations to EMDR that might make it more suitable to combat-related trauma as these would be untested and there was evidence for an effective intervention in this population, namely individual trauma-focused CBT.
NHS England National IAPT team	Guideline Treatment in Adults	15 276/7	16 6.& 36	The guideline recommends that clinicians "Consider symptom-specific CBT interventions (for symptoms such as sleep disturbance and anger) for adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than three months after a traumatic event". Greater clarity is required about what the committee means by "symptom specific CBT interventions in this context. We have noted that a few IAPT services have already interpreted this draft recommendation as an indication that it is fine to include people with PTSD in large scale general wellbeing groups that are being offered in some IAPT services. We assume that is not the guideline group's intention but it is likely to become common practice if the guideline does not clarify what it intends, especially as this is a significant change from the 2005 guideline. So, more detail please and also a clearer statement about the evidence base.	Thank you for your comment. In response to your and other stakeholder's comments, this recommendation has been amended in an attempt to avoid unintended interpretations. The term '*symptom-specific CBT interventions*' has been replaced with '*CBT interventions targeted at specific symptoms such as sleep disturbance or anger*', and the recommendation about when you would consider this has been made stronger so that you would *only* consider such interventions when the person is unable or unwilling to engage in a trauma-focused intervention or has residual symptoms after a trauma-focused intervention. The rationale behind recommendations of psychological interventions for adults with PTSD, including a statement about the evidence base, is provided in full in the 'Rationale and Impact' section of the PTSD guideline evidence report D and summarised at the end of the short guideline.

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NHS England National IAPT team	Guideline	17	1	Treatment of PTSD and comorbid depression and treating the depression first if severe is important, as service users may be too depressed and behaviourally withdrawn and unable to engage in PTSD treatment. It is helpful to make this explicit. It would also be useful to explicitly state that severe depression and suicidality is often found in complex PTSD, along with self harm and that this needs to be managed as a priority so that safety is established prior to commencing trauma focussed treatment. This is mentioned in line 5 of page 17 but needs to be made clearer perhaps?	Thank you for your comment. In response to your and other stakeholder's comments, the recommendation for people with PTSD and coexisting depression has been amended to include the guidance to treat the depression first if it is severe enough to make psychological treatment of the PTSD difficult, or if there is a risk of the person harming themselves or others. The committee did not consider it appropriate to make changes to the recommendation for the adaptations that may be required to psychological interventions for people with PTSD and additional needs, including complex PTSD, as they felt that the need for safety to be established prior to commencing trauma-focused therapy was adequately covered by the existing recommendation.
NHS England National IAPT team	Guideline	17	3	Recommendations are made around the management of comorbid substance misuse and that this should not be a barrier to treating PTSD. A number of service users with PTSD are dependent on alcohol and/or other substances. This can add further risk to their clinical presentation and can interfere with the psychological treatment of PTSD, for instance attending sessions, or lead to service users using this as an avoidance strategy which can interfere with interventions such as reliving. In primary care settings, the usual practice when working with clients referred with PTSD and significant comorbid substance misuse, would be to work alongside other services who would help	Thank you for your comment. In response to your and other stakeholder's comments, changes have been made to recommendations to reflect that for some people substance misuse may need to be addressed to enable engagement with trauma-focused intervention. The previous recommendation has been amended as follows: 'Do not exclude people with PTSD from treatment based *solely* on comorbid drug or alcohol misuse', and the recommendation for adaptations that may be needed to psychological interventions for people with PTSD and additional needs has been

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				manage any serious substance dependence. See also comment 5.	amended to recommend that people are helped to manage any issues, including substance misuse, that might be a barrier to engaging with trauma-focused therapies.
NHS England National IAPT team	Guideline	30	7	We are concerned that the evidence used is biased towards TF CBT for early intervention of less than one month. Three RCT's were included (Evidence D), one study compared EMDR to another active treatment (supportive counselling), whereas the two RCT's for TF CBT was compared to non-active treatment (No treatment and Waiting List). This is not a like for like comparison and it would be expected that TF CBT is shown to be effective versus no treatment, as TF CBT is known to be effective in the treatment of PTSD symptoms.	Thank you for your comment. The evidence you refer to in your comment is for the early treatment (1-3 months post-trauma) rather than early prevention (<1 month). The early prevention evidence is presented in Evidence report C. In the consultation version of the guideline, there was no evidence for EMDR within 1 month of trauma. Through stakeholder comments, one additional new study was identified and added to the analysis. The committee considered the new evidence for EMDR in the first month following trauma in adults (Gil-Jardiné 2018). However, the committee did not consider that it was appropriate to make a recommendation in this time period as evidence was limited to a small single study (N=71) that only reported on one clinical outcome of interest and the effect on the number of participants with PTSD at 3-month follow-up was not statistically significant. The committee discussed the strength and breadth of the evidence for trauma-focused CBT within the first month of trauma, with benefits observed on

					both clinician-rated and self-rated measures of PTSD symptomatology, the rate of PTSD caseness at endpoint and follow-up, and on some other outcomes including depression and anxiety symptoms. Taken together with evidence suggesting that benefits are potentially long-lasting, the committee agreed that trauma-focused CBT should be offered to adults with clinically important PTSD symptoms or acute stress disorder within 1-month of the traumatic event in order to prevent the later development of PTSD. The committee considered the evidence for EMDR in the 1-3 month period following trauma, and in response to stakeholder's comments, agreed that a new recommendation should be added to consider EMDR for adults with PTSD within 1-3 months of non-combat-related trauma. This recommendation is based on single-study evidence showing large benefits of EMDR relative to supportive counselling in the 1-3 month period and an extrapolation from stronger evidence for EMDR more than 3 months after trauma. This was a weaker recommendation (consider rather than offer) based on the limited direct evidence available. The evidence for trauma-focused CBT in the 1-3 month time period was also limited, however, the committee extrapolated from the limited evidence showing benefits between 1 and 3 months after

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					trauma, and the broader evidence base that showed benefits within the first month and more than 3 months after trauma. Given that the committee thought it was unlikely that effects would be different in this 2-month time period, they recommended that trauma-focused CBT should be offered to adults with PTSD more than 1 month after trauma.
NHS England National IAPT team	Guideline	32	7-19	Supported trauma focussed computerised CBT- it would be helpful to include how many sessions are recommended or found to be effective.	Thank you for your comment. The committee agreed that greater clarity was needed about the structure and content of supported computerised trauma-focused CBT and added a new recommendation that specifies the content and structure of the recommended intervention, including the typical number of sessions.
NHS England National IAPT team	Guideline	34	18	We consider that there will be barriers to accessing cCBT in a public place, such as, a library due to symptoms of PTSD including hypervigilance and avoidance. We are also concerned that people accessing cCBT treatment in isolation are at potential risk of experiencing harmful symptoms, such as, abreaction and dissociation, which likely lead to future barriers in accessing effective treatments such as TF CBT and EMDR due to disengagement and loss of hope and confidence. It is also common in our experience that people presenting with PTSD also fit the diagnostic criteria for depression and therefore can lack the motivation to access cCBT and may lead to higher drop- out rates.	Thank you for your comment. The committee recognise the potential difficulties in accessing computerised CBT, however, one of the roles of the facilitating practitioner would be to consider access to a computer and where appropriate facilitate this. In response to your, and other stakeholder's, comments the supported trauma-focused computerised CBT intervention recommendation has been amended so that such interventions should only be considered if people do not have severe PTSD symptoms in particular dissociative symptoms and they are not at risk of harm to

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					themselves or others. The committee agreed that restricting this recommendation to a more clearly defined sub-population of people with PTSD should help to prevent this intervention being offered inappropriately and as a result avoid disengagement and loss of hope. Moreover, this recommendation is restricted to those who have a preference relative to face-to-face trauma-focused CBT or EMDR so it could help to facilitate access for those who may be avoidant of face-to-face trauma-focused therapy. The evidence for computerised CBT for people with depression is good and the discontinuation rates in our data for people with PTSD are broadly similar to the discontinuation rates observed with face-to-face trauma-focused CBT.
NHS England National IAPT team	Guideline	37	20-21 5	This recommendation will mean that some patients will need a link therapist with the drug and alcohol miss use service. The service user may require additional resources, longer treatments, and will need increased monitoring. Therapists will require additional training in working with clients who present with addictions. Business case needed to provide additional treatment lengths. See also comments 5 and 27.	Thank you for your comment. The committee thought that the recommendation for adaptations to psychological interventions for people with PTSD and additional needs applied to adaptations that may be needed for people with coexisting substance misuse, including: helping the person manage any issues (including substance misuse) that might be a barrier to engaging with trauma-focused therapies; increasing the number of trauma-focused therapy sessions according to the person's needs; planning any ongoing support the

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					person needs including the management of co-morbidity symptoms after the end of therapy.
NHS England National IAPT team	Treatment in Adults	257	38	Clarification needed as to whether cCBT is delivered at step 2 or 3 of the care pathway.	Thank you for your comment. The committee did not consider the evidence sufficient to recommend a stepped care model for the delivery of PTSD interventions. For supported trauma-focused computerised CBT interventions the committee developed a recommendation which is intended to indicate in which circumstances and for which sub-population of people with PTSD such interventions would most appropriately be offered.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	General	General	It is fairly clear how we could operationalise the recommendations. This would require some resource reallocation and additional training. Greater scoping on the most suitable computerised CBT packages would also be needed. More resources in CAMHs would almost certainly be required.	Thank you for your comment. These issues are considered by NICE when developing resource impact / implementation tools to support implementation of the guideline. It is outside the scope of the NICE guideline to mention scoping of specific tools and it would not be appropriate for us to recommend commercial products.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	General	General	In Adult services the biggest impact on practice and challenge would be to introduce adequate EMDR provision and access to computerised CBT. Finding additional resources for CAMHs may also prove challenging.	Thank you for your comment. Providing access to the interventions recommended will be a matter for implementation of the guideline. However, we will bring your comment to the attention of the NICE cost impact team.
North West Boroughs	Guideline	4	6	Inclusion of 'dissociative difficulties' e.g. derealisation, depersonalisation would seem to be relevant. They can be	Thank you for your comment. In response to your and other stakeholder's comments, and in response

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Healthcare NHS Foundation Trust				present after one incident, often go unidentified and cause considerable distress/confusion.	to the recent publication of ICD-11 and the complex PTSD diagnosis, dissociation has now been added to recommendations 1.1.1 and 1.1.3 for the recognition and assessment of PTSD.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	5	17	For individuals with unexplained physical symptoms the assessment of dissociation is particularly important.	Thank you for your comment. The committee did not consider it appropriate to add dissociation to this recommendation as it is a single symptom of PTSD. If there is no trauma then PTSD symptoms do not need to be covered and if people have experienced trauma the recommendation 1.1.4 applies and they should be asked about PTSD symptoms as listed in 1.1.1 which includes dissociation.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	5	26	It is helpful to 'normalise' the presence of some of these symptoms in the first few weeks as they can manifest but diminish as part of 'natural' recovery.	Thank you for your comment. In response to your, and other stakeholder's comments, this recommendation has now been amended to include the guidance that emergency staff should explain to parents or carers about *the normal responses to trauma* and the possibility of PTSD developing.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	5	8	Assessment of dissociative symptoms also required at this point.	Thank you for your comment. In response to your and other stakeholder's comments, and in response to the recent publication of ICD-11 and the complex PTSD diagnosis, dissociation has now been added to this recommendation.
North West Boroughs Healthcare	Guideline	8	16	Agree with this particularly important recommendation.	Thank you for your comment.

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NHS Foundation Trust					
North West Boroughs Healthcare NHS Foundation Trust	Guideline	9	10	Adequate supervision and monitoring of Peer support groups does have significant resource implications. Greater consideration needed of who should provide this. Support groups have the potential to go badly wrong if they don't stick to clear parameters.	Thank you for your comment. Peer support groups are not routinely offered everywhere but they are in fairly widespread use. The committee noted that facilitating access to these groups should not involve major resource implications. Any costs would be offset by potential savings associated with promoting earlier access to support that will help to prevent people from developing more severe problems.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	9	13	Providing a suitable environment, such as avoiding a 'noisy inpatient ward' can be very difficult to achieve and has resource implications.	Thank you for your comment. The committee agree that this may be challenging but the aim of this recommendation is also to ensure that people get adequate physical health care. We expect that the adjustment will be considered in the ward environment, for example the use of a side room.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	10	19	Interpreters may require debriefing to avoid secondary traumatisation. Thereis a duty of care for their wellbeing.	Thank you for your comment. The needs of interpreters are outside the scope of the guideline unless they meet the criteria of having PTSD or being at risk of PTSD (as defined in the review protocols), and if so the recommendations in the guideline apply to those who have developed PTSD in response to work-related exposure to trauma (including remote exposure).
North West Boroughs	Guideline	11	General	The phrase 'Clinically Important Symptoms' is clear and comprehensible.	Thank you for your comment.

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Healthcare NHS Foundation Trust					
North West Boroughs Healthcare NHS Foundation Trust	Guideline	13	1	Include psychoeducation on grounding techniques to manage dissociation.	Thank you for your comment. The committee did not consider it appropriate to make specific reference to grounding techniques in this recommendation as we do not have evidence that grounding techniques are better than other techniques such as mindful or controlled breathing. With this in mind, the committee amended the recommendation to include strategies for managing flashbacks.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	13	4	Include the processing/resolution of difficult emotions such as blame, guilt, loss and anger.	Thank you for your comment. In response to your, and other stakeholder's, comments this recommendation has been amended to include *'processing trauma-related emotions, including shame, guilt, loss and anger*'.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	14	13	Include the processing/resolution of difficult emotions such as blame, guilt, loss and anger.	Thank you for your comment. In response to your, and other stakeholder's, comments this recommendation has been amended to include *'processing trauma-related emotions, including shame, guilt, loss and anger*'.
North West Boroughs Healthcare	Guideline	14	9	Include psychoeducation on grounding techniques to manage dissociation.	Thank you for your comment. The committee did not consider it appropriate to make specific reference to grounding techniques in this

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NHS Foundation Trust					recommendation as we do not have evidence that grounding techniques are better than other techniques such as mindful or controlled breathing. With this in mind, the committee amended the recommendation to include strategies for managing flashbacks.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	14	General	The resource implications of offering EMDR in CAMHs are significant and would require further investment. Currently there are not enough trained staff in the Trust. Equipment such a light boxes would also have to be purchased.	Thank you for your comment. Implementation issues are considered by NICE when developing resource impact / implementation tools. We acknowledge that some recommendations entail initial implementation costs, however, EMDR (as well as other recommended interventions) was found to be cost-effective for adults in the guideline economic analysis and therefore implementation of the respective recommendation ensures efficient use of resources.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	14	General	Resource implications for offering EMDR for adults in primary and secondary care are significant and would require further investment. Currently there are not enough adequately trained staff in the Trust. Equipment such a light boxes would also have to be purchased.	Thank you for your comment. Implementation issues are considered by NICE when developing resource impact / implementation tools. We acknowledge that some recommendations entail initial implementation costs, however, EMDR (as well as other recommended interventions) was found to be cost-effective for adults in the guideline economic analysis and therefore implementation of the respective recommendation ensures efficient use of resources.

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North West Boroughs Healthcare NHS Foundation Trust	Guideline	15	General	Recommendation for computerised CBT is welcome. However this would require initial investment until the cost benefits are realised.	Thank you for your comment. Implementation issues are considered by NICE when developing resource impact / implementation tools. We acknowledge that some recommendations entail initial investment, however, computerised CBT was found to be a cost-effective intervention in the guideline economic analysis and therefore implementation of the relevant recommendation ensures efficient use of resources.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	16	General	Section 1.7 – recommendations for PTSD and Complex needs requires much more development. Greater specificity with regard to assessment and treatment needed. No mention of working with individuals with a comorbid personality disorder, complex dissociative disorders, psychosis etc. which make up the majority of clients in secondary care.	Thank you for your comment. In response to your, and other stakeholder's comments and the publication of ICD-11 we have amended the recognition recommendation to include explicit reference to complex PTSD and the symptoms of complex PTSD have been added to the recommendation as additional bullet points. The recommendation for people with additional needs includes those with complex PTSD, as well as those with a comorbid personality disorder and recommends adaptations that may be needed to treatment, including: helping people manage other issues (including dissociation, emotional regulation, interpersonal difficulties or negative self-perception) that may be a barrier to engaging with trauma-focused therapies; ensuring extra time to develop trust is built in (by increasing the duration or the number of therapy sessions according to the person's needs); planning any ongoing support the

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					person needs. The committee did not agree that any greater specificity should be provided as it was worded in this way to allow clinical flexibility. No guidance is offered on those with coexisting psychosis as trials of people with psychosis as a coexisting condition were excluded from the guideline as pre-specified in the review protocols.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	16	General	Clinicians working with this group will require a higher degree of training and expertise.	Thank you for your comment. The committee thought that the recommendations about the structure and content of psychological interventions already specify that interventions should be delivered by trained practitioners with ongoing supervision.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	16	General	Therapists working with this group will also require greater levels of supervision due to case complexity and to avoid secondary traumatisation.	Thank you for your comment. The committee thought that the recommendations about the structure and content of psychological interventions already specify that interventions should be delivered by trained practitioners with ongoing supervision.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	17	15	Requires greater emphasis that the individual's safety needs to be ensured before work takes place.	Thank you for your comment. The committee agrees that this is very important but consider that it is addressed by the recommendation for people with additional needs, including complex PTSD, which includes the recommendation to take into account the safety and stability of the person's personal circumstances (for example their housing

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					situation) and how this might impact on engagement with and success of treatment.
North West Boroughs Healthcare NHS Foundation Trust	Guideline	17	17	Very vague on time frame for treatment. Recognition that this work may take a long period or require several episodes of treatment would be helpful. Services should ensure they have the capacity to do this work.	Thank you for your comment. The recommendations on the structure and content of trauma-focused CBT and EMDR include the proviso that more sessions may be required *'if clinically indicated, for example where people have experienced multiple traumas'*. The recommendation on adaptations that may be required to psychological interventions for people with PTSD and additional needs, including complex PTSD, also recommends that extra time is built in to develop trust with the person (by increasing the duration or the number of therapy sessions according to the person's needs). However, the committee did not agree that any greater specificity should be provided as it was worded in this way to allow clinical flexibility. The committee agreed that some people may need to have several episodes of treatment and were aware that prior treatment can sometimes be a barrier to accessing further treatment. On this basis the committee amended the recommendation on promoting access to services to include the recommendation that the need for further treatment or support should be assessed for people who have

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					not benefited fully from treatment or who have relapsed.
North West Boroughs Healthcare NHS Foundation Trust	Terms used	18	20	The term 'Complex PTSD' is also well established in the literature and has been used in research publications for many years.	Thank you for your comment. The term complex PTSD is used in the guideline and the definition has been amended slightly to accurately reflect the now published ICD-11 definition.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	8	16	Clinicians may need pointing to guidance in order to inform this decision (e.g. guidance documents about witnesses and therapy from CPS.gov.uk)	Thank you for your comment. A cross-reference to the relevant CPS guidance has now been added to this recommendation.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	9	14	Should suitable provision of therapy environments be specified here? If we are asking people to work on their trauma in individual or group therapy then the environment in which that happens is a very important factor in not re-triggering people – it is not just ward based.	Thank you for your comment. In response to your, and other stakeholder's, comments the maintaining safe environments recommendation has been amended to include the guidance that users of the guideline should *'avoid exposing people to triggers that could worsen their symptoms or stop them from engaging with treatment, for example, assessing or treating people in noisy or restricted environments...*'
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	13	20	EMDR has been successfully active worldwide in first response. In addition in practice singular event traumas are rare including amongst those that have acute stress disorder or clinically important symptoms of PTSD . Also patients are unable to move forward as an earlier traumatic event (which also might have made them more vulnerable	Thank you for your comment. In the consultation version of the guideline, there was no evidence for EMDR within 1 month of trauma. Through stakeholder comments, one additional new study was identified and added to the analysis. The committee considered the new evidence for EMDR

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				to PTSD) is unprocessed. There is an ethical debate here if we should offer CBT for the presenting trauma in these situations, or rather EMDR which would allow for a full memory network to be processed.	in the first month following trauma in adults (Gil-Jardiné 2018). However, the committee did not consider that it was appropriate to make a recommendation in this time period as evidence was limited to a small single study (N=71) that only reported on one clinical outcome of interest and the effect on the number of participants with PTSD at 3-month follow-up was not statistically significant.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	14	20	This also applies to the wording (as an option?) , and the idea EMDR is not efficient after one month of trauma. A more useful distinction could be that if there is an earlier onset trauma (regardless of it being one or three months post trauma	Thank you for your comment. In response to your and other stakeholder's comments, the EMDR recommendation has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option to trauma-focused CBT for adults exposed to non-combat related trauma. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. The committee considered the evidence for EMDR in the 1-3 month period following trauma, and in response to stakeholder's comments, agreed that a new recommendation should be added to consider EMDR for adults with PTSD within 1-3 months of

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					non-combat-related trauma. This recommendation is based on single-study evidence showing large benefits of EMDR relative to supportive counselling in the 1-3 month period and an extrapolation from stronger evidence for EMDR more than 3 months after trauma. This was a weaker recommendation (consider rather than offer) based on the limited direct evidence available.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	14	24	Your own evidence suggests the same? An example of this for instance is a substantial body of research that shows that adverse life experiences which contribute to both psychological and biomedical pathology. Eye movement desensitization and reprocessing (EMDR) therapy is an empirically validated treatment for trauma, including such negative life experiences as commonly present in medical practice. The positive therapeutic outcomes rapidly achieved without homework or detailed description of the disturbing event offer the medical community an efficient treatment approach with a wide range of applications. Furthermore the distinctive role of eye movement desensitization and reprocessing (EMDR) therapy. Similarly to NET (Narrative Exposure Therapy) being used to evidence CBT, Eye movements (EM's) are an important	Thank you for your comment. EMDR is recommended as an option for adults with non-combat-related PTSD more than 1 month after a traumatic event.

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				component of EMDR with evidence of its effects on memory processing.	
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	14	24	Why is the same not the case for CBT? There should be an acknowledgement throughout the guidelines there that multiple or complex trauma may need more sessions	Thank you for your comment. In response to your and other stakeholder's, comments the trauma-focused CBT recommendation has been amended to *'typically be provided over 8 to 12 sessions but more if clinically indicated, for example if they have experienced multiple traumas'*.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	14	6	Where has the 8 to 12 sessions come from? What is the evidence for this? My clinical experience is this is fine for working on a single event trauma but not complex or multiple traumas If they are specifying a manual based therapy they should provide the reference for the manual	Thank you for your comment. The recommendations about the structure and content of psychological interventions are informed by the interventions in the RCTs, and modified by the expert advice of the committee. In response to your and other stakeholder's comments, the trauma-focused CBT and EMDR recommendations have been amended to *'typically be provided over 8 to 12 sessions but more if clinically indicated, for example if they have experienced multiple traumas'*. The committee did not think that it was appropriate to specify a specific manual, particularly as the trauma-focused CBT recommendation is for a class of interventions that includes a number of specific interventions. The committee drafted the recommendations about the content and structure of psychological interventions in a way that allowed

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					enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	15	16	EMDR is an 8 phase therapy which has the building of resources, broadening support systems and stabilisation of the patient as part of its treatment protocol (phase2)the efficacy which all can be found in the research . In addition the aim is to engage a patient in the trauma processing hence this is a collaborative decision to proceed to phase 3 at this stage. The therapeutic relationship still being in place to either proceed or for the patient to return to when then ready to engage in the trauma processing. EMDR is effective in reducing trauma related stress, anxiety, and depression symptoms among children and adults of different racial and ethnic backgrounds, including veterans.1,2 Data on the efficacy of EMDR have been established through 30 randomized clinical trials, with published findings showing immediate improvements; **some have shown maintenance of reduction of symptoms (e.g., anxiety, fear, depression) at followup**.1–4 EMDR has been evaluated through meta-analytic procedures in six reviews. Findings from one of these reviews suggest that EMDR therapy and trauma-focused cognitive behavioural therapy provide the best evidence of efficacy for those suffering from PTSD.1 Another review noted that EMDR had incremental efficacy compared to other established cognitive behavioural	Thank you for your comment. Unfortunately, the footnote numbers appear to be embedded within the comments, but we are unable to identify any reference and therefore are unable to respond directly to the studies cited. The committee considered the evidence for EMDR in treatment of children with PTSD and noted the limited evidence base, in terms of the number of studies/participants, the number of different comparisons, the breadth of outcomes reported, and the availability of long-term follow-up. The committee observed that the benefits of EMDR were not statistically significant relative to waitlist or treatment as usual, and the head-to-head comparisons against trauma-focused CBT (although suggestive of no significant difference) were not sufficiently powered to detect non-inferiority (single-study analyses). The committee also took into account the results of the NMA and economic base-case analysis which both suggested that EMDR was less clinically effective and cost-effective than all individual trauma-focused CBT interventions. On the basis of the clinical and cost-

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				treatments in treating children with PTSD.5 While other reviews found EMDR therapy to be as effective as exposure therapies for reducing PTSD symptoms, **the length of EMDR treatment is more advantageous in reducing clinical symptoms in a shorter period of time. 3, 4**	effectiveness and these additional considerations, the committee agreed that EMDR should only be considered for children and young people if they do not respond to or engage with trauma-focused CBT. The committee also considered the evidence for EMDR for the treatment of adults and agreed that although it may be considered an equivalent option for the treatment of adults with PTSD who had been exposed to non-combat-related trauma more than 3 months ago. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	15	16	Where is the evidence for this, and would it be more helpful to distinguish severity of the trauma presentation?	Thank you for your comment. The committee did not consider it more helpful to limit this recommendation to people with particular symptom severity. However, in response to stakeholder's comments, changes have been made to this recommendation. For instance, the recommendation about when you would consider this has been made stronger so that you would *only* consider such interventions when the person is unable or unwilling to engage in a trauma-focused

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					intervention or has residual symptoms after a trauma-focused intervention. The rationale behind recommendations of psychological interventions for adults with PTSD, including a statement about the evidence base, is provided in full in the 'Rationale and Impact' section of the PTSD guideline evidence report D and summarised at the end of the short guideline.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline (rationale)	15	16	(Although EMDR uses the same broad approach, the committee was concerned that psychological interventions are not always delivered in a consistent way, so they used their experience to agree a specific structure and content in this guideline) - It is not clear if you are alluding to therapist drift which would need to cover both CBT and EMDR in that case	Thank you for your comment. There are recommendations about the structure and content of both EMDR and trauma-informed CBT. These recommendations are informed by the interventions in the RCTs, and modified by the expert advice of the committee. The recommendations are drafted in a way that allows enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	31	18	This is unclear as it seems to be suggesting that psyched is as effective as intervention??	Thank you for your comment. The evidence from the NMA and economic analysis does suggest that psychoeducation is as effective as psychological interventions. However, given that the evidence base for psychoeducation is very limited and uncertain the committee interpreted this evidence with caution and did not consider it sufficient to warrant a recommendation for psychoeducation on its own.

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Nottinghamshire Healthcare NHS Foundation Trust	Guideline	31	26	If the comparison studies between CBT and EMDR showed a trend in favour of EMDR then surely EMDR should at least be recommended as an equal option to CBT, if not as possibly recommended over CBT. As it stands at the moment the guidelines recommend CBT first which doesn't seem to match with what is stated here.	Thank you for your comment. Trauma-focused CBT and EMDR are offered as equivalent options for adults with PTSD who have been exposed to non-combat-related trauma more than 3 months ago. In response to your, and other stakeholder's, comments the EMDR recommendation has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option to trauma-focused CBT for adults exposed to non-combat related trauma. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	32	1	From my clinical experience in Step 4 Psychology, EMDR can be highly effective for people with military combat related trauma and tends to be my preferred model of choice over CBT for people where there are multiple traumas which are inter-related such as in military experiences. Does the evidence for CBT with military veterans outweigh evidence for EMDR? It is concerning that this guidance would potentially remove access for veterans to a therapy which can potentially be very helpful and life transforming.	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. For questions about intervention efficacy the committee considered the most appropriate study

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					design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. We do not consider routine datasets as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	32	18	This is very concerning. In my experience people with complex PTSD and dissociation need many more than 12 sessions to work on stabilisation, reducing symptoms and working through their trauma experiences. I think the distinction between single event trauma and complex or multiple trauma needs to be much clearer throughout.	Thank you for your comment. The recommendation for people with additional needs, including complex PTSD, recommends that extra time is built in to develop trust with the person (by increasing the duration or the number of therapy sessions according to the person's needs). The recommendations concerning the content and structure of the trauma-focused psychological interventions have also been amended so that the typical number of sessions is followed by *'but more if clinically indicated, for example where people have experienced multiple traumas*'.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	32	8	*Was the evidence specifically for computerised self help based on people who find it difficult to engage in face to face trauma focused therapy?* Were the people in these studies people with PTSD and or complex PTSD? Clinically I would be concerned about recommending this for people with severe or complex PTSD	Thank you for your comment. The evidence for computerised self-help was not specifically from people who find it difficult to engage in face-to-face trauma-focused therapy and/or people with complex PTSD, although there was evidence for efficacy from studies that included people who had been exposed to multiple incident trauma and studies where inclusion criteria were restricted to those with a diagnosis of PTSD (and not only studies that used

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				Dissociation is mentioned in a very limited way, and in the context of "some support might be needed to managed these". In my clinical experience, dissociation is severe and disabling and needs significant input to enable stabilisation before any trauma focused work can be attempted.	a potentially broader definition of clinically important PTSD symptoms). However, the committee agreed that this recommendation needed re-drafting as it was open to unintended interpretations. The re-drafted recommendation clarifies that supported trauma-focused computerised CBT should be considered for adults with established PTSD where the person has a preference relative to face-to-face trauma-focused CBT or EMDR, and if the person does not have severe PTSD symptoms in particular dissociative symptoms and are not at risk of harm to themselves or others.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	37	20	What would the guidelines be therefore about how the substance misuse should be managed as people using substances would find it difficult to engage in therapy at the same time? This is also a change in practice from the previous guideline. This was reflected in the previous guideline v1.8.2.4 For PTSD sufferers with drug or alcohol dependence or in whom alcohol or drug use may significantly interfere with effective treatment, healthcare professionals should treat the drug or alcohol problem first. But is now being deleted – why?	Thank you for your comment. In response to your and other stakeholder's comments, changes have been made to recommendations to reflect that for some people substance misuse may need to be addressed to enable engagement with trauma-focused intervention. The previous recommendation has been amended as follows: 'Do not exclude people with PTSD from treatment based *solely* on comorbid drug or alcohol misuse', and the recommendation for adaptations that may be needed to psychological interventions for people with PTSD and additional needs has been amended to recommend that people are helped to manage any issues, including substance misuse, that might be a barrier to engaging with trauma-focused therapies.

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Nottinghamshire Healthcare NHS Foundation Trust	Guideline	37	22	Vague and unhelpful in practice – what would ongoing support be and who would offer this/ where?	Thank you for your comment. The committee amended the term 'ongoing symptom management' in this recommendation as they agreed that it was unclear and replaced with 'the management of any residual PTSD or co-morbidity symptoms after the end of therapy'. The committee did not consider that greater specificity was appropriate and agreed that given the lack of clear evidence or clear consensus it was not possible to be more prescriptive.
Nottinghamshire Healthcare NHS Foundation Trust	Guideline	38	2	I think they should be clear throughout that they are not addressing complex trauma here. The previous guidelines specified: 1.8.2.5 When offering trauma-focused psychological interventions to PTSD sufferers with comorbid personality disorder, healthcare professionals should consider extending the duration of treatment. But this is now being deleted, as is the following 1.9.2.4 Healthcare professionals should consider extending the duration of treatment beyond 12 sessions if several problems need to be addressed in the treatment of PTSD sufferers, particularly after multiple traumatic events, traumatic bereavement, or where chronic disability resulting from the trauma, significant comorbid disorders or	Thank you for your comment. It is not the case that the 'Treatment in adults' section is only for 'simple' trauma. Although the evidence was limited on interventions for people who have complex PTSD, the evidence suggested that trauma-focused therapies could also benefit this group. Based on their experience, the committee proposed ways of modifying interventions to address the barriers people with complex PTSD might have to engaging in treatment, like offering more sessions and avoiding an abrupt end to treatment by planning ongoing support. Moreover, in response to stakeholder comments and the publication of ICD-11 we have amended the recognition recommendation to include explicit reference to complex PTSD and the symptoms of

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				social problems are present. Trauma-focused treatment needs to be integrated into an overall plan of care.	complex PTSD have been added to the recommendation as additional bullet points. The recommendation for people with additional needs includes those with complex PTSD, as well as those with a comorbid personality disorder and recommends adaptations that may be needed to treatment, including: helping people manage other issues (including dissociation, emotional regulation, interpersonal difficulties or negative self-perception) that may be a barrier to engaging with trauma-focused therapies; ensuring extra time to develop trust is built in (by increasing the duration or the number of therapy sessions according to the person's needs); planning any ongoing support the person needs. The recommendations about the structure and content of trauma-focused CBT and EMDR also include that more sessions should be provided where clinically indicated. The recommendations from the previous guideline that you have referred to in your comment have been addressed by new recommendations in this guideline, predominantly by the recommendation about adaptations to psychological interventions that may be required for people with additional needs.
				This is also being deleted 1.9.2.5 For some PTSD sufferers, it may initially be very difficult and overwhelming to disclose details of their traumatic events. In these cases, healthcare professionals should consider devoting several sessions to establishing a trusting therapeutic relationship and emotional stabilisation before addressing the traumatic event.	
				I think these previous guidelines made it much clearer that for some people additional input may be needed, and I am not sure that any evidence would suggest this is not the case still now. *The balance of emdr and cbt was clearer in the previous guidelines which are now being deleted*	
				1.9.2.1 All PTSD sufferers should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing). These treatments should normally be provided on an individual outpatient basis.	

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				These are being deleted – why? There are many other forms of therapy for trauma which have not yet developed the evidence base for them. But for people who have perhaps tried CBT and EMDR, alternatives need to be able to be offered. 1.9.2.7 For PTSD sufferers who have no or only limited improvement with a specific trauma-focused psychological treatment, healthcare professionals should consider the following options: □ an alternative form of trauma-focused psychological treatment □ the augmentation of trauma-focused psychological treatment with a course of pharmacological treatment. 1.9.2.8 When PTSD sufferers request other forms of psychological treatment (for example, supportive therapy/non-directive therapy, hypnotherapy, psychodynamic therapy or systemic psychotherapy), they should be informed that there is as yet no convincing evidence for a clinically important effect of these treatments on PTSD.	
Nottinghamshire Healthcare NHS Foundation Trust	Evidence (D)	277	10	The response of the EMDR practitioners in the service is that their experience is that Veterans come in when they have tried everything else. And that in addition, due the often multiple presentations of their traumatic memories, EMDR then offered a viable therapy. Our service saw 139	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast

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				Veterans in the last year. This is a typical feedback from an EMDR practitioner I saw this patient back in 2010 when they were presenting with PTSD linked to a trauma whilst serving abroad in the 80's. I used a CBT approach to treat the PTSD but the patient was unable to engage. He felt unable to commit to the listening of his trauma recording and was unable to tolerate the distress that his "homework" provoked. The patient then sought support from Combat Stress and was treated with EMDR therapy. Last year the patient presented with symptoms of PTSD linked to another trauma event that occurred whilst serving in the army. I believe he had accessed our service because Combat Stress were no longer able to offer EMDR therapy and the way they offered their support had changed (patient's had to commit to a 6 week programme). The patient was unable to do this because he is working full time. He also did not wish to receive CBT treatment. EMDR therapy was used to treat the trauma event successfully and I discharged the patient last week.	to all other included trauma types where clinically important and statistically significant benefits were observed. The committee noted that there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms if there is no response to treatment. The committee agreed that it is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and physical health. Therefore they prioritised this area as one for further research.
Pennine Care NHS Foundation Trust	Guidance	General	General	We are pleased that there is a shift away from Primary care to staff in all care settings. The term active monitoring is much more helpful for clients and staff than watchful waiting.	Thank you for your comment.
Pennine Care NHS	Guidance	General	General	Question 4: The addition of clinically important symptoms of PTSD as a descriptor is an improvement	Thank you for your comment.

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Foundation Trust					
Pennine Care NHS Foundation Trust	Guidance	General	General	Question 4: The addition of clinically important symptoms of PTSD as a descriptor is an improvement	Thank you for your comment.
Pennine Care NHS Foundation Trust	Guidance	General	General	We are pleased that there is a shift away from Primary care to staff in all care settings. The term active monitoring is much more helpful for clients and staff than watchful waiting.	Thank you for your comment.
Pennine Care NHS Foundation Trust	Guidance	General	General	Question 7: The Manchester Resilience Hub has spoken to many people who have not been referred to mental health services because of a perceived lack of availability and therefore welcome that care models should describe what interventions are offered rather than why services cannot be accessed.	Thank you for your comment.
Pennine Care NHS Foundation Trust	Guidance	General	General	Good to specifically name anniversaries as a time point for booster therapy sessions	Thank you for your comment.
Pennine Care NHS Foundation Trust	Guidance	General	General	The acknowledgment that treatment for PTS can be anxiety provoking and the importance of engagement strategies is good.	Thank you for your comment.
Pennine Care NHS	Guideline	General	General	Could there be more emphasis on choice? Many combat veterans have specifically asked for EMDR as this therapy has been recommended to them by their friends and fellow	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma

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Foundation Trust				ex-military colleagues. Veterans report they have shared experiences with fellow soldiers so value their opinion and trust them enough to try and engage in another/different treatment.	given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. Patient choice is a central element of the provision of effective healthcare. We have made recommendations in the 'planning treatment and supporting engagement' section which require those providing treatment and support for people with PTSD to set out the benefits and harms, and the requirements of individual interventions so as to enable people to make an informed choice. NICE guidelines make recommendations for interventions where there is evidence that they are clinically and cost effective. The purpose of recommending the interventions that we have for military veteran populations is not to remove patient choice, but rather to provide people with a choice from those interventions that have the greatest likelihood of being effective.
Pennine Care NHS Foundation Trust	Guideline	General	General	Question 4: We believe the addition of 'clinically important symptoms' of PTSD as a descriptor is an improvement	Thank you for your comment.

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Pennine Care NHS Foundation Trust	Guideline	General	General	Question 7: Our experience over the last 7-years, has highlighted that for some ex-armed forces personnel, access to appropriate trauma intervention can be difficult. Sometimes the barriers may exist within the individual client, and involve issues of shame, guilt, deservedness, myths perpetuated within some areas of the armed forces community of trauma being 'untreatable', and beliefs that civilians will not understand. Some barriers exist within services, such as low tolerance to comorbid substance misuse issues, or anger and aggression. Perhaps adding a few lines or paragraph to dovetail this guidance with the 2 health pledges outlined in the 2011 Armed Forces Covenant would be helpful. Those individuals with military-related trauma can expect to access a service that has an understanding of military culture; and where their condition is attributable to their military service they can expect priority treatment subject to clinical need.	Thank you for your comment. Serving military are outside the scope of the guideline but there are specific veterans' services in the NHS. We believe that we have addressed these important access issues (which also apply to other groups of people with PTSD) in a number of the recommendations. For instance, the guidance: to reassure people that PTSD is treatable; to be aware that people with PTSD may be apprehensive, anxious, or ashamed and may avoid treatment, believe that PTSD is untreatable, or have difficulty developing trust; that people with PTSD should not be excluded from treatment based solely on comorbid drug or alcohol misuse; and that people should be helped in managing any issues that might be a barrier to engaging with trauma-focused therapies (including substance misuse and emotional dysregulation).
Pennine Care NHS Foundation Trust	Guideline	General	General	Question 5: The guidelines regarding not using EMDR for combat-related trauma will have significant implications in operationalising and adherence to these proposed changes.	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. Providing access to individual trauma-focused CBT for adults with PTSD in response to military combat trauma will be a matter for implementation of the guideline.

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Pennine Care NHS Foundation Trust	Guidance	5	28	'Parents or carers about the possibility of PTSD developing' suggest instead "Parents or carers about the normal responses to trauma and the possibility of PTSD developing" This would alert CYP and their parents/carers that initial changes to emotions and behaviour and functioning are to be expected.	Thank you for your comment. In response to your and other stakeholder's comments, the suggested change has been made to the recommendation.
Pennine Care NHS Foundation Trust	Guidance	5	8	'When assessing for PTSD ask adults specific questions' suggest instead "When assessing for PTSD ask people specific questions" This would ensure that CYP were also asked specifically about their symptoms	Thank you for your comment. In response to your and other stakeholder's comments, the suggested change has been made to the recommendation.
Pennine Care NHS Foundation Trust	Guidance	9	10	'Be facilitated by people with training and supervision' suggest instead "Be facilitated by people with mental health training and supervision" The Manchester Resilience Hub has run events for those affected by the Manchester arena Attack and reducing social isolation and the value in meeting others has been highlighted by those who attended. From our experience those running the groups need to have a mental health training to manage the risks/safeguarding that could present. We fully agree that meeting others and sharing stories could increase uptake into services.	Thank you for your comment. In response to your and other stakeholder's comments, the suggested change to the recommendation has been made.
Pennine Care NHS	Guidance	12	4 & 8	It seems confusing to services to recommend group CBT within a month of the trauma but individual CBT if the	Thank you for your comment. The committee did not consider these recommendations to be

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Foundation Trust				traumatic event was more than a month ago. We are not sure, especially with data sharing laws how group CBT but only in the first 4 weeks is achievable for large-scale shared trauma	conflicting as group trauma-focused CBT was recommended for children and young people who had been exposed to an event within the last month leading to *large scale shared trauma, irrespective of initial symptom severity*. Whereas, individual trauma-focused CBT is recommended for children and young people exposed to *any trauma* more than 1 month ago, but only where children and young people have a *diagnosis of PTSD or clinically important symptoms*. The timescales in the treatment recommendations also refer to when people are presenting, they are not about sequencing and amendments have been made to the treatment recommendations to make this clearer. Provision of trauma-focused CBT for children and young people, in line with what is recommended in the guideline will be a matter for local implementation. There is a specific recommendation about the screening of people at high risk of PTSD following a major disaster which should facilitate access to the group trauma-focused CBT intervention, without any infringement of data sharing laws.
Pennine Care NHS Foundation Trust	Guidance	12	22	'Be based on a validated manual' suggest instead be based on a "validated model" We do not believe all useful trauma focused interventions are manualised.	Thank you for your comment. The committee wanted to ensure the interventions recommended in the guideline are provided in routine care. One way to do this was to advise practitioners to follow the treatment as set out in the treatment manuals. The

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					committee agreed to do this as there is evidence that treatments inappropriately applied can be harmful. The recommendations about the structure and content of recommended interventions are, however, written in such a way as to allow enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set.
Pennine Care NHS Foundation Trust	Guidance	13	9	Question 1: In our clinical experience at the Manchester Resilience Hub and in discussions with CAMHS services nationally, there is a wide geographical variation in access to EMDR for CYP. However, for those services who have got that resource and are offered the choice of trauma-focused Cognitive Behaviour Therapy (tCBT) and EMDR they have often chosen EMDR and there have been very positive clinical changes. So making EMDR secondary to tCBT will be problematic to operationalise as some CYP services offer EMDR but not tCBT	Thank you for your comment. The committee considered the evidence for EMDR in the treatment of children with PTSD and noted the limited evidence base, in terms of the number of studies/participants, the number of different comparisons, the breadth of outcomes reported, and the availability of long-term follow-up. The committee observed that the benefits of EMDR were not statistically significant relative to waitlist or treatment as usual, and the head-to-head comparisons against trauma-focused CBT (although suggestive of no significant difference) were not sufficiently powered to detect non-inferiority (single-study analyses). The committee also took into account the results of the NMA and economic base-case analysis which both suggested that EMDR was less clinically effective and cost-effective than all individual trauma-focused CBT interventions. On the basis of the clinical and cost-effectiveness and these additional considerations,

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					the committee agreed that EMDR should only be considered for children and young people if they do not respond to or engage with trauma-focused CBT. Provision of trauma-focused CBT for children and young people, in line with what is recommended in the guideline will be a matter for local implementation.
Pennine Care NHS Foundation Trust	Guideline	14	20	Could 'combat-related trauma' be better defined? Does it just refer to military combat? Employment role and/or on the receiving end? What about deployment-related trauma, of which combat is one subsection.	Thank you for your comment. As you suggest, combat-related trauma has now been defined and added to the glossary of the short guideline in order to provide greater clarity.
Pennine Care NHS Foundation Trust	Guideline	14	20	Question 1. Using the current NICE guidelines for PTS the Military Veterans' Service (MVS) has routinely offered a choice of trauma-focused Cognitive behavioural therapy (tCBT) (incorporating Prolonged Exposure) or EMDR to military veterans and serving soldiers where they present with military-related trauma. Bearing in mind that many of the clients have already accessed and 'failed' to improve from the mainstream offer (NHS & MOD), some of them do not want or consent to 'more of the same'. Typically, they will have often already had trauma-focused Cognitive Behavioural Therapy (tCBT) from the NHS and veteran charities, and many will have had EMDR from the MOD. Thus they may typically receive the intervention not yet attempted. We are aware that the majority of military veteran specific services in the UK, and trauma services supporting ex-armed forces personnel have always offered EMDR as an	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. The committee noted that there is very little evidence to help professionals decide what to do next to treat or manage PTSD symptoms if there is no response to treatment. The committee agreed that it is essential to provide effective support to people who have not responded well to a first-line treatment, especially given the damaging effect of persistent PTSD on quality of life and mental and

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				equal intervention to tCBT, with seemingly comparable results. Thus this recommendation will have a significant impact nationally on this client group, who for some, already believe their difficulties are untreatable. The reliving work and PE involved in tCBT is frequently experienced as aversive to this cohort and drop-out rates can be high. The expectation of between session work (homework) is also aversive to those whose cognitive, and literacy skills are limited. We have found EMDR useful for combat related trauma where there is high levels of physiological arousal, comorbidity of cognitive, developmental, and mTBI factors. We would not support to recommendation that EMDR be only used for non-combat related trauma.	physical health. Therefore they prioritised this area as one for further research.
Pennine Care NHS Foundation Trust	Guideline & Evidence	14	20	Question 1: The new guidelines appear to imply that EMDR not be offered where combat-related trauma is present. We wish to challenge the proposal to NOT recommend EMDR for combat veterans. As clinical professionals we too have reservations regarding aspects of interventions offered. Notably some evidential issues regarding the hypothesised mechanisms by which EMDR works, and the minimal level of qualification required to train in this procedure. However, all 9 psychological therapists who offer EMDR within the MVS have postgraduate training in psychological therapy, and in their hands EMDR is a valuable tool for assisting combat veterans overcome their PTS symptoms and regain their functioning.	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. We

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				As you will be aware, the lack of evidence is not the same as evidence of a lack of. From a practice-based evidence perspective, the reviewing of data over the last 3-4years, we find that the MVS has provided 171 unique military veterans with EMDR therapy for PTS. Of which: 114 (73%) were in clinical recovery on at least one clinical measure at the end of their EMDR intervention. N=101 (65%) achieved reliable improvement on IES-R (greater than or equal to a 9 point reduction for trauma) N=96 (62%) achieved reliable improvement on GAD7 (greater than or equal to 4 point reduction for anxiety) N=88 (56%) achieved reliable improvement on PHQ-9 (greater than or equal to 6 point reduction for depression) 90% achieved reliable improvement on at least one validated clinical measure. 17 did not achieve reliable improvement on clinical measures through the use of EMDR. 156 of these 171 cases were combat-related trauma. As previously stated, none of these are straight forward military trauma cases, by definition the clients accessing the MVS were requiring a specialist service. I would like to	do not consider routine datasets as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading.

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				think that the more clinically straight forward cases would achieve even better outcomes in mainstream offers of EMDR. We do not believe there is adequate evidence that the application of EMDR for combat veterans should be avoided.	
Pennine Care NHS Foundation Trust	Guideline	14	20	Question 3: Sometimes when engaging in EMDR with a client for a civilian trauma it connects to an earlier military (combat-related) trauma that needs addressing. We feel it inappropriate not to continue with EMDR in these circumstances. Perhaps a solution for this (and other issues outlined above) would be to include a line in the guidance such as "EMDR for combat related trauma can be offered by services and individuals specialising in the treatment of combat-related trauma"	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. Recommendations are based on what we know about which treatments might be effective for which groups, however, in treating an individual decisions may be made as to whether to adjust the intervention offered.
Pennine Care NHS Foundation Trust	Guidance	15	24	'Do not offer psychologically focused debriefing to adults' suggest instead "Do not offer psychologically focused debriefing to people", as presumably also not helpful for Children & Young People (CYP)?	Thank you for your comment. In response to your, and other stakeholder's, comments this change to the recommendation has been made and the recommendation has been moved to its own sub-section under the 'Management of post-traumatic stress disorder in children, young people and adults' section heading.
Pennine Care NHS Foundation Trust	Guidance	22	17	The guidelines on disaster planning (emergency preparedness) are very short. Based on recent experiences following the Manchester Arena Attack (which is currently being evaluated) we would like consideration	Thank you for your comment. As specified in the scope, the disaster planning section from the 2005 guideline was not included in this update. In line with NICE processes, the 2005 content has been

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				being given to: A single point of access for the psychosocial response Considering the use of psychological screening to assist in planning the assessment capacity. Consideration of the needs of those effected in a work capacity (first responders)	carried across to this updated guideline. However, the evidence on disaster planning has not been reviewed and we are not able to make any changes to this section (except where they are necessary in order to clarify meaning).
PTSD UK	Guidelines	General	General	We are concerned that timescales for interventions are only discussed in context of 'time since the trauma occurred'. For those who have been 'managing their condition', or have developed symptoms some time after their trauma occurred, the timescales before treatment begins are an important factor to recognise to ensure that is it accessible as quickly as possible. We would look to have specific timescales included e.g. after diagnosis (and assuming it's been more than 3 months since the trauma), treatment should be offered no later than 1 month later.	Thank you for your comment. The timescales relate to the evidence for the effectiveness of treatment and are not indicative of any wait time for treatment. Determination of wait times is not a specific focus of NICE guidelines and is a matter for local implementation.
PTSD UK	Guidelines	General	General	Peer support groups seem to be very rare in the UK and many of the people who reach out to us are looking for such facilities. As the only charity in the UK to support everyone in the UK affected by PTSD, people look to us for this type of support. Our concern here is that more and more people will be directed to us, and without the means to offer this support, more people will feel let down by 'the system'. We'd be keen to understand more about the peer support services on offer before this is included in the publication to know there are already provisions in place to offer this service nationally.	Thank you for your comment. The committee considered that although PTSD-specific peer support groups may be required for some people with PTSD, this is not necessarily the case for all. The committee were aware that although peer support groups are not routinely offered everywhere, they are in fairly widespread use. The committee noted that facilitating access to these groups should not involve major resource implications. Any costs would be offset by potential savings associated with promoting earlier access to

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					support that will help to prevent people from developing more severe problems.
PTSD UK	Question	General	General	In answer to question 3: It's vital that across the UK, the general public are educated on the causes, symptoms and treatments available for PTSD. As a charity, we began to do just that – however, a national initiative is required to ensure that not only medical professionals know what to look out for, but that they understand what can cause it too. Anyone involved with those at high risk of PTSD should have the information available: knowledge on who is vulnerable, what symptoms to look out for, and ultimately what treatment is available.	Thank you for your comment. We agree that education about PTSD is important and is part of the pre- and/or post- qualification training of all healthcare professional groups.
PTSD UK	Question	General	General	In answer to Question 4: Yes, we acknowledge that 'clinically important symptoms' is a useful phrase when discussing PTSD, and it's clear to us what this means. There are a variety of symptoms, which can help identify PTSD, and can distinguish it from other, similar conditions. However, we note that the guidelines don't have a list of what this full, or at least more comprehensive list, of symptoms may include? We'd request that a fuller list of symptoms is noted for medical professionals (and those in contact with high risk communities) to be aware of, and to help diagnose.	Thank you for your comment. The definition of clinically important symptoms is included in the glossary and is defined as those with a diagnosis of PTSD according to DSM, ICD or similar criteria or those who are assessed as having PTSD on a validated scale as indicated by baseline scores above clinical threshold. A list of symptoms that people with PTSD may present with is included in recommendation 1.1.1. In response to stakeholder's comments and the publication of ICD-11 we have also amended this recognition recommendation to include explicit reference to complex PTSD and the symptoms of complex PTSD have been added as additional bullet points to this recommendation.

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PTSD UK	Guidelines	4	8	There is evidence that 'hypervigilance' is a key symptom of PTSD, and this may require it's own entry into the recognition notes here, or be included in the 'hyperarousal' context as an example alongside anger and irritability.	Thank you for your comment. In response to your and other stakeholder's, comments recommendation 1.1.1 has been amended and hypervigilance has been included as an example of hyperarousal alongside anger and irritability.
PTSD UK	Guidelines	9	10	We are concerned that the term 'training and supervision' is a very open term, and support groups need to be carefully facilitated. Could this be clarified further?	Thank you for your comment. In response to your and other stakeholder's comments, this recommendation has been amended to include the guidance that peer support groups should 'be facilitated by people with *mental health* training and supervision'.
PTSD UK	Guidelines	11	13	We deal with many people who feel that PTSD isn't treatable – and as such, don't engage with treatments. This is another blocker to treatment, and so we feel this should be noted here.	Thank you for your comment. The committee agreed that it was important that a more hopeful and optimistic picture of the treatment of PTSD was presented and amended the promoting access recommendation to include *'emphasising that PTSD is a treatable condition'*. The recommendation about engagement strategies has also been amended to include guidance that users of the guideline should be aware that people with PTSD may *'avoid treatment, believe that PTSD is untreatable or have difficulty developing trust*' and engagement strategies could include following up when people miss appointments and allowing flexibility in service attendance policies.
PTSD UK	Guidelines	11	6	We feel it would be wise to standardise the format of the information given to people with PTSD (and their family members or carers) – verbal information can be	Thank you for your comment. We agree that information should be provided in written, as well as, verbal format and this is addressed by

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				overwhelming, so we would propose that a written format would be more easily digested and understood form of communication.	recommendation 1.4.1 (*'Provide information in both verbal and written format and in line with recommendations in the NICE guidelines on service user experience in adult mental health and patient experience in adult NHS services*.')
PTSD UK	Guidelines	17	12	There is evidence that for some, time is required to establish the specific trauma that caused their PTSD (particularly if they've had multiple traumas in their life), so adequate time may also be required to identify the main trauma which has caused PTSD to allow it to be effectively treated.	Thank you for your comment. The committee considered that such factors are taken into account in the recommendations for the assessment of PTSD in this guideline.
RCGP	Guideline	General	General	As far as recommendations concerning treatment are concerned, these are in line with the evidence supplied. However, the recommendation regarding EMDR (1.6.15) is not backed by any very firm evidence (p31, l14 '…did not show significant differences, there was a *trend* towards …') However, where the earlier recommendations concern diagnosis, a number of statements are of concern, particularly those that deal with early intervention. These include, for instance, 1.1.7, 1.1.8 and1.1.9. Can it be ensured that such approaches would not lead to a degree of overdiagnosis, with risks of harms outweighing benefits?	Thank you for your comment. Trauma-focused CBT and EMDR are offered as equivalent options for adults with PTSD who have been exposed to non-combat-related trauma more than 3 months ago. In response to stakeholder's comments the EMDR recommendation has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option to trauma-focused CBT for adults exposed to non-combat related trauma. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically

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					important and statistically significant benefits were observed. As specified in the scope, the recognition and assessment sections from the 2005 guideline were not included in this update. In line with NICE processes, the 2005 content has been carried across to this updated guideline. However, the evidence on recognition and assessment has not been reviewed and we are not able to make any changes to this section (except where they are necessary in order to clarify meaning).
RCGP	Guideline	4	L17	1.1.5. This is a surprising recommendation. Unexplained physical symptoms presented repeated are much more likely to be symptoms of anxiety (or other mental health problems). The recommendation could potentially lead professionals in the wrong direction.	Thank you for your comment. PTSD used to be classified as an anxiety disorder and multiple attendance at GPs or unusual presentations can indeed be related to undisclosed trauma. The committee considered that adding this question to any initial assessment does not incur significant costs in terms of time or resources but has the potential to provide a useful diagnostic clue as to the reasons for presentation. On this basis, the committee did not consider it appropriate to make changes to this recommendation.
Royal College of Psychiatrists	General	General	General	**Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. Would implementation of any of the draft recommendations have significant cost implications?**	Thank you for your comment. Implementation issues are being considered by NICE when developing resource impact / implementation tools. As you note, both recommended interventions were found to be cost-effective in the guideline economic

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				Scaling up the delivery of recommended interventions (trauma-focused CBT, EMDR) will likely require training of staff and supervision, which will have some cost implications. However, economic modelling included in the draft documents clarifies that treatment delivery will be not only effective but also cost-effective	analysis and therefore implementation of respective recommendations ensures efficient use of resources.
Royal College of Psychiatrists	General	General	General	**Query regarding the use of the phrase 'clinically important symptoms'**. This phrase can be clarified when used first, to indicate that 'clinically important symptoms' are defined based on subjective distress by CYP or their functional impairment (e.g., relationship with family members, engagement with peers, school attendance, educational achievement)	Thank you for your comment. The definition of clinically important symptoms is included in the glossary and is defined as those with a diagnosis of PTSD according to DSM, ICD or similar criteria or those who are assessed as having PTSD on a validated scale as indicated by baseline scores above clinical threshold.
Royal College of Psychiatrists	General	General	General	**Are there any barriers to access experienced by particular groups which you think we should be specific about in the guideline? If so, why do you think this?** The detection and treatment of PTSD has been traditionally more challenging in younger children (e.g., pre-schoolers) and in CYP with neurodevelopmental problems. Furthermore, there are populations (e.g., young offenders) where a PTSD diagnosis may be masked by its behavioural manifestations, with important treatment implications.	Thank you for your comment. In response to your comment the promoting access recommendation has been amended to add preschool-aged children to the list of groups who may have specific needs in terms of access. The committee did not think that it was appropriate to add neurodevelopmental disorders to this list as the recommendation for people with additional needs applied to adaptations that may be needed for people with ADHD as it recommends that people are helped with managing any issues including emotional dysregulation that might be a barrier to

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					engaging with trauma-focused therapies. While additional needs for those with autism or learning disabilities are covered by existing NICE guidance ('Autism spectrum disorder in adults: diagnosis and management', 'Autism spectrum disorder in under 19s: support and management', and 'Mental health problems in people with learning disabilities: prevention, assessment and management') which include principles for adapting recommended psychological interventions for people with autism or learning disabilities. The committee did not consider evidence for differential diagnosis as recognition and assessment were outside the scope of this update. Therefore, the committee did not consider it appropriate to make a recommendation about diagnostic overshadowing.
Royal College of Psychiatrists	Evidence reviews for pharmacological interventions for the prevention and treatment of	7	7	Should SSRI be included in Table 1 / Intervention? Can the text in the review briefly clarify why carbamazepine, clonidine, and propranolol were selected for the search (e.g., evidence from adults)?	Thank you for your comment. Table 1 provides a summary of the review protocol that was pre-specified at the beginning of the review process. The list of included interventions is illustrative rather than exhaustive and SSRIs were not pre-specified as an intervention of interest although eligible evidence was considered for SSRIs. These drugs were selected on the advice of the committee but as previously outlined this list was illustrative rather than exhaustive and relevant eligible evidence on

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	PTSD in children				other pharmacological interventions was considered in the review.
Royal College of Psychiatrists	Evidence reviews for psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in children	10	1	The Berkowitz, 2011 study included CYP 'exposed to a potentially traumatic event who endorsed at least one new and distressing symptom of PTSD' (see page 678 of the paper). Therefore, the paper should not be included in the 'early prevention (intervention initiated within 1 month of traumatic event)' category but rather in the 'early treatment (1-3 months) of non-significant PTSD symptoms' category.	Thank you for your comment. It is not possible to meet diagnostic criteria for PTSD within the first month of trauma so trials where the intervention was initiated within the first month (as in Berkowitz 2011) are classified as early prevention even where participants have clinically important symptoms of PTSD (as in Berkowitz 2011) or a diagnosis of acute stress disorder.
Royal College of Psychiatrists	Evidence reviews on care pathways for adults, children and young people with PTSD	10	18	The College agree that it is important to minimise 'the need for transition…'. Equally, it is important to think about how therapeutic effect should be judged and how services can capitalise on their tiered system and specialist expertise elsewhere if treatment is not effective.	Thank you for your comment. We envisage that a significant proportion of people with PTSD will already be treated in specialist services which have an appropriate level of multidisciplinary expertise. We did not have any evidence to support tiered service.
Royal College of Psychiatrists	Evidence reviews on care	10	30	To ensure that the advice is taken up by services, the guideline should give more background on working within	Thank you for your comment. This level of detail is outside the scope of this guideline. However, a cross-reference to the relevant Crown Prosecution

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	pathways for adults, children and young people with PTSD			the legal framework and examples of good and bad practice.	Service guidance has now been added to the recommendation, in order to provide further information and greater clarity.
Royal College of Psychiatrists	Evidence reviews on care pathways for adults, children and young people with PTSD	11	19	In addition to depression, there are several other coexisting conditions that should be discussed. Crucially, it would be helpful to clarify a position regarding ADHD, given the effective treatments available and the impact of the diagnosis on emotion regulation and, consequently, on engagement in treatment. The guidelines should clarify that CYP with learning disabilities, autistic spectrum disorder, and other neurodevelopmental disorders should not be excluded from PTSD treatment.	Thank you for your comment. The committee agreed that the recommendation for people with additional needs applied to adaptations that may be needed for people with ADHD as it recommends that people are helped with managing any issues, including emotional dysregulation that might be a barrier to engaging with trauma-focused therapies. The committee did not agree that it was necessary to add a recommendation that people with neurodevelopmental disorders should not be excluded from PTSD treatment. The committee recognised the importance that this group received appropriate treatment, but considered that this was covered by existing guidance ('*Autism spectrum disorder in adults: diagnosis and management*', '*Autism spectrum disorder in under 19s: support and management*', and '*Mental health problems in people with learning disabilities: prevention, assessment and management*') which include principles for adapting recommended psychological

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					interventions for people with autism or learning disabilities.
Royal College of Psychiatrists	Evidence reviews for pharmacological interventions for the prevention and treatment of PTSD in children	13	8	Should SSRI be included in Table 4 / Intervention? Can the text in the review briefly clarify why carbamazepine, clonidine, and propranolol were selected for the search (e.g., evidence from adults)?	Thank you for your comment. Table 4 provides a summary of the review protocol that was pre-specified at the beginning of the review process. The list of included interventions is illustrative rather than exhaustive and SSRIs were not pre-specified as an intervention of interest although eligible evidence was considered for SSRIs. These drugs were selected on the advice of the committee but as previously outlined this list was illustrative rather than exhaustive and relevant eligible evidence on other pharmacological interventions was considered in the review.
Royal College of Psychiatrists	Evidence reviews on care pathways for adults, children and young people with PTSD	13	19	Can the guidelines provide examples of valid resources, e.g., https://mindedforfamilies.org.uk/Content/trauma_and_coping/#/id/59e1004665803a4b6b51446b	Thank you for your comment. The committee did not consider it appropriate to provide links to existing resources as links invariably become broken and/or out-of-date. However, the recommendation outlines what information and support should include and the committee considered that this was sufficiently detailed to enable implementation.
Royal College of Psychiatrists	Evidence reviews on care pathways for adults,	13	29	The guideline should clarify that it is important to involve family members or careers in risk management to maximise success. This may include discussion around likely triggers, crisis management, and accompanying	Thank you for your comment. In response to your and other stakeholders' comments, the recommendation about people with PTSD whose assessment identifies a significant risk of harm to self or others that is in the 'Care for people with

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	children and young people with PTSD			children and young people (CYP) to sessions involving trauma-focused work. The care pathways should consider the impact of mental illness of family members or carer in treatment planning (this is particularly important when they were involved in the same traumatic experience and / or have PTSD). The guideline should recommend that family members or carers should be advised to seek treatment for themselves. Ideally the treatment for family units should have some joint work across CRP and family members or carers. This is in line with the recommendation given for intervention of family members of people at risk of PTSD.	post-traumatic stress disorder and complex needs' section has been amended to include that establishing a risk management and safety plan should involve family members and carers where appropriate. In response to your and other stakeholder's comments, a new recommendation has been added for members of a family who have experienced the same traumatic event and have PTSD that recommends that users of the guideline think about what aspects of treatment might be usefully provided together, such as psychoeducation, while still providing the recommended treatments for individuals.
Royal College of Psychiatrists	Guideline	18	12-18	The clinically important symptoms of PTSD is useful although it could be adjusted just a little to: Clinically important symptoms of PTSD refer to those with a diagnosis of PTSD according to DSM, ICD or similar criteria or those with clinically significant PTSD symptoms as indicated by baseline scores above clinical threshold on a validated scale OR THAT ARE EVIDENT AT A CLINICAL INTERVIEW. These are typically referred to or seen in studies that have not used a clinical interview to arrive at a formal diagnosis of PTSD and instead have only used self report measures of PTSD symptoms.	Thank you for your comment. The committee did not consider that it was appropriate to make the suggested change as they felt it was already covered by the text as a scale can be administered via self-report or clinical interview, and a clinical interview would often lead to a diagnosis.

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Royal College of Psychiatrists	Evidence reviews for pharmacological interventions for the prevention and treatment of PTSD in children	23	18	The Collegeagree with the recommendation by the panel. However, because coexisting psychopathology in CYP with PTSD is often neither recognised nor treated, the College suggests that the explanatory text for this recommendation should be expanded to include the following reminder. PTSD in CYP is often accompanied by other psychiatric diagnoses that should be carefully assessed and treated (including with pharmacotherapy) according to relevant NICE guidelines.	Thank you for your comment. The committee did not consider it was appropriate to make the suggested amendment to the recommendation as this guideline is concerned with the treatment of PTSD, rather than coexisting conditions, and the recommendation makes clear that drug treatments should not be offered to children and young people for the prevention or treatment *of* PTSD.
Royal College of Psychiatrists	Evidence reviews for psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in children	35	6	'Three studies of eye movement desensitisation and reprocessing (EMDR) for the 6 prevention of PTSD in adults were identified for full-text review.' Is 'adult' a typo or should these studies be excluded?	Thank you for your comment. It is a typo. Thank you for bringing this to our attention and the error has now been corrected in Evidence report A.

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Royal College of Psychiatrists	Evidence reviews for psychological, psychosocial and other non-pharmacological interventions for the prevention of PTSD in children	57	7	Based in the experience in screening CYP after mass traumas (e.g., Gobin, M., Rubin, G.J., Albert, I., Beck, A., Danese, A., Greenberg, N., Grey, N., Smith, P., Oliver, I. Outcomes of a mental health screening programme for UK Nationals affected by the 2015 and 2016 terrorist attacks in Tunisia, Paris and Brussels. *J Trauma Stress*, in press), the recommendation of active monitoring should be accompanied by a clearer statement on how active monitoring should be implemented. Because parents can be biased in their reports of their children's health (e.g., under-reported linked to stigma or normalisation of symptoms), active monitoring should include direct assessment of children rather than simply relying on parental report.	Thank you for your comment and for drawing our attention to the Gobin et al. (in press) citation. Active monitoring is defined in further detail in the glossary. However, the committee did not consider it appropriate to be more specific in terms of implementation as it was agreed that this was best left to clinical judgement.
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	General	General	A large amount of the guidance (p19 – 57) has not changed in 13 years – despite therapy for PTSD has moved on significantly. Guidance limited to CBT and EMDR despite many practitioners using several other models such as psychodynamic (Caroline Garland), CFT (Deborah Lee), CAT etc. in particular for complex, repeated trauma.	Thank you for your comment. There was very limited evidence for psychodynamic therapies that met inclusion criteria for the guideline, and no eligible evidence for CFT or CAT. The committee did not consider that there was sufficient evidence to warrant recommendations for these interventions.
Sheffield Teaching Hospitals NHS Foundation Trust	Research	General	General	As above, in the research recommendations there is no suggestion that other forms of psychological therapy should be researched in relation to PTSD. This limits the scope for psychotherapy for PTSD to evolve beyond CBT / EMDR.	Thank you for your comment. The list of research recommendations reflect the areas assessed by the committee to be of greatest importance. However, it should be noted that these research recommendations are not restricted to CBT and EMDR, for example, the research recommendation for sequencing and further-line treatment in PTSD

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					includes drug treatment, further or different psychological therapy, therapy with a more qualified therapist, and combination treatments (i.e. medication plus psychological therapy) under interventions of interest.
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	5	1.1.6	This would assume that a) the clinician in question has received specific training in speaking to children and young people about traumatic incidents, and b) that they are clinically skilled enough to determine developmental suitability for such discussions.	Thank you for your comment. The committee would expect people working with children to be aware of the core symptoms of PTSD and to be able to undertake an initial assessment as appropriate.
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	5	1.1.7	We are concerned that this might risk traumatising parents and children unnecessarily. It does not quantify the level of traumatic event, or reaction to it, so might apply to nearly all children admitted to A&E. It would be impractical and unnecessary to go through all the symptoms of PTSD with every child's parents/carers.	Thank you for your comment. As specified in the scope, the recognition and assessment sections from the 2005 guideline were not included in this update. In line with NICE processes, the 2005 content has been carried across to this updated guideline. However, the evidence on recognition and assessment has not been reviewed and we are not able to make any changes to this section (except where they are necessary in order to clarify meaning).
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	6	1.1.8	This is a good idea but again implies a level of preparedness and training for those coordinating and facilitating the screening measures.	Thank you for your comment. We agree that preparedness and training are important but this is a matter for implementation.
Sheffield Teaching Hospitals NHS	Guideline	6	1.1.9	This is a good idea but again implies a level of preparedness and training for those coordinating and facilitating the screening measures.	Thank you for your comment. We agree that preparedness and training are important but this is a matter for implementation.

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Foundation Trust					
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	7	1.2.6	The recommendation that people are not discharged from one place of care till they are established in another service is potentially very problematic in a general hospital setting. If we cannot get another service to accept the referral (e.g. IAPT / CMHT), but the person is being discharged by the medical team, psychology within the acute hospital setting cannot always manage their ongoing psychological care.	Thank you for your comment. This recommendation specifically concerns the treatment of the PTSD so unlikely to be in a general hospital setting.
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	8	1.3.2	We feel this is a change from previous advice and might necessitate further guidelines on how this work can be conducted without negatively impacting on any such court proceedings / compensation claim. In particular given the advice to *"Discuss with the person the implications of the timing of any treatment to help them make an informed decision about if and when to proceed."*	Thank you for your comment. This recommendation is in line with the recommendation in the previous PTSD guideline. A cross-reference to the relevant Crown Prosecution Service guidance has now been added to this recommendation, in order to provide further information and greater clarity.
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	11	1.6.2	There is an issue around following up on missed appointments which may often directly contravene the access / appointment cancellation policy in NHS services.	Thank you for your comment. In response to your and others stakeholder's comments, this recommendation has now been amended to include *'and allowing flexibility in service attendance policies*'.
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	14-15	1.6.13 to 1.6.18	We are concerned that this focuses on CBT, and more specifically using "a validated manual" – we recognise that there has been a review of the evidence available, and in order to research psychotherapy you need consistency of approach, which is most easily done via a manual. However, that does not mean that only manualised treatments work. We risk a situation where only IAPT /	Thank you for your comment. The committee wanted to ensure the interventions recommended in the guideline are provided in routine care. One way to do this was to advise practitioners to follow the treatment as set out in the treatment manuals. The committee agreed to do this as there is evidence that treatments inappropriately applied can be

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				CBT therapists can offer treatment or CBT therapists, as they are likely to be using specific manuals. Specialised hospital-based clinical psychology services that are more flexible and work in a more patient-focused, adaptable way would not be adhering to the guidance.	harmful. The recommendations about the structure and content of recommended interventions are, however, written in such a way as to allow enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set.
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	15	1.6.19	It would be helpful to consider how this contradicts recent examples of good practice applying debriefing (e.g. NHS Improvement, Wrightington, Wigan and Leigh NHS Foundation Trust, June 2017, *"Supporting staff wellbeing with stress management, mindfulness and trauma-debriefing"*)	Thank you for your comment and for drawing our attention to the NHS Improvement June 2017 citation. For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. We do not consider routine datasets to be better or equivalent to RCT data as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading. In the guideline systematic review of RCTs for psychologically-focused debriefing there was single-study evidence at 1-year follow-up showing a clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects were at best non-significant. On this

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					basis the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.
Sheffield Teaching Hospitals NHS Foundation Trust	Guideline	17	1.7.2	We feel this happens routinely in primary care and specialist psychotherapy services, so we are concerned that this advice may not be adhered to.	Thank you for your comment. The committee share your concern that this currently happens in routine clinical practice and this was one of the reasons why the committee agreed that it was important to make this recommendation. Ensuring that this recommendation is followed will be a matter for local implementation.
Social Support Systems CIC	Psychological Interventions for the prevention of PTSD in adults	General	General	Prior NICE membership As a member of the 2013 Evidence Update Group I brought to the committee's attention an ecologically-valid randomised control trial (RCT) of critical incident stress debriefing (CISD)[36] I sought to justify its removal from *Do Not Do* and to argue for its inclusion as a supportive early intervention promising reliable reduction posttraumatic stress in specific populations. Prior to taking my place on the Group I had informed NICE of the existence of an	Thank you for your comment. Tuckey & Scott (2014, which we think is the published paper of the online version that you cite) is included in Evidence report C. Valentine & Smith (2001) is not included in the guideline because 'trials of adults in contact with the criminal justice system (not solely as a result of being a witness or victim)' are excluded (as outlined

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				earlier RCT of Traumatic Incident Reduction (TIR)[37] assuming it had been overlooked. It had, I was informed, been excluded on grounds that I discovered were not applied across the board. Since then however, both TIR and CISD have been granted evidence-based status with the Substance Abuse and Mental Health Services Administration (SAMHSA), the mental health arm of the US government's Department of Health and Human Services. NICE had overlooked TIR and ignored CISD and seemingly continue to do so as neither appear in the proposed Guidelines here being considered. Implementation of both would have enormous economic benefits due to the speed of training and delivery through both peer-support and clinical expertise. Tuckey & Scott (2013 online version) [2] Valentine & Smith (2001)	in the review protocols) as there is an existing NICE guideline on *'Mental health of adults in contact with the criminal justice system*'. Please see NG66 https://www.nice.org.uk/guidance/ng66 In the guideline systematic review of RCTs for psychologically-focused debriefing, effects are fairly consistent across studies (whether the intervention is delivered individually or as the intervention was originally conceived as a group intervention for teams of emergency workers who are used to working together) and suggest non-significant effects of debriefing at best, and some suggestion of a trend in favour of no treatment. On this basis the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.
Social Support Systems CIC	Psychological Interventions	General	General	Efficacy and Effectiveness The ethical and potentially legal implications of ignoring an evidence-based approach showing effectiveness as well as efficacy will be apparent. Effectiveness will be clear from	Thank you for your comment. For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with

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	for the prevention of PTSD in adults			the use of both interventions in the aftermath of the terrorist attacks in London and the Grenfell Tower fire. A team trained in TIR and CISD led individual and group interventions at the Metropolitan Police Service (MPS) and, as their trainer, I supervised the team. Around 80 officers were seen including those most closely involved and heavily affected and all returned to work the following duty day. No sickness absence was reported and attributed to those incidents and all offers of ongoing support and counselling were rejected on the basis they were not needed. Positive feedback has continued and MPS is considering how to use the same in future mass-fatality incidents. No PTSD has been reported in the 12 months since those incidents occurred while no such evidence is likely from the studies being used to justify the NICE Guidelines. To ignore the empirical basis of TIR and CISD given the scrutiny (six months and 12 months respectively) SAMHSA exercised over each case and the real-world impact both have had in events expected to have near combat-levels of PTSD is to take a large professional risk and worse, threaten the lives of survivors.	the NICE guidelines manual and was pre-specified in the review protocols. We do not consider routine datasets to be better or equivalent to RCT data as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading. In the guideline systematic review of RCTs for psychologically-focused debriefing there was single-study evidence at 1-year follow-up showing a clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects were at best non-significant. On this basis the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits.

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Social Support Systems CIC	Psychological Interventions for the prevention of PTSD in adults	General	General	Harm? Or not? The side effects of drugs for posttraumatic stress disorder (PTSD) can be found online in a number of places. The list I produced for the 2013 Triage Panel meeting is presented below is available on request What has not been established is whether the side effects of the drugs are discernible from those of PTSD symptoms where they are common to both. If so it would assure NHS staff and patients that this is the case, and then how they can be discerned and reported. If the side effects listed are harmful, given that harm is warned of throughout the NICE 2005 PTSD (CG26) Guidelines, it is questionable whether the harms associated with psychological debriefing are of a different quality or magnitude. Debriefing is warned against due to potential harm. The side effects of PTSD medication give examples of actual harm and are recorded as such. The exposure of one type of harm as harmful but not the other demands some justification. If side effects are indeed harmful, they should be warned of with remedies appended.	Thank you for your comment. In the guideline systematic review of RCTs for psychologically-focused debriefing there was single-study evidence at 1-year follow-up showing a clinically important and statistically significant effect in favour of no treatment. Admittedly this evidence is limited to a single study, however, across the board effects were at best non-significant. On this basis, the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits. We are aware of the side effects that may be associated with the drug treatments recommended, and this is one of the reasons why drug treatments are not recommended as first-line treatment (except where the person has a preference for drug treatment) and regular review of drug treatment is recommended.
Sussex Partnership NHS	Evidence	31	28	We suggest that more research is commissioned by NIHR and other research funding bodies to evaluate EMDR. International studies show that where EMDR is used more	Thank you for your comment. The committee did not consider further research on EMDR to be a priority given that a strong recommendation is made for EMDR in adults. In response to your and other

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Foundation Trust				routinely, such as in the Netherlands, suggest no difference between EMDR and trauma-focused CBT.	stakeholder's comments, the EMDR recommendation has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option to trauma-focused CBT for non-combat related trauma. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed.
Sussex Partnership NHS Foundation Trust	General	General	General	Thank you for giving us the opportunity to consult on the draft guideline. The comments below are collated following a consultation in Sussex Partnership NHS Foundation Trust with experienced therapists and researchers who have expertise in PTSD, EMDR and trauma focused CBT, working in varied settings including primary care (IAPT) and secondary care services. The comments draw on the research evidence and on a wealth of practice-based evidence and clinical experience. We have raised a number of points and suggestions below and we hope that the committee find these helpful.	Thank you for your comment.
Sussex Partnership NHS Foundation Trust	General	General	General	The phrase 'clinically important symptoms' is welcome as it is clinically useful. In many services and settings, formal diagnoses are not given so it is more relevant to think in terms of "clinically important symptoms." Clinically, in our experience, there is not much difference in terms	Thank you for your comment.

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				treatments that should be offered etc. between those who would meet the diagnostic criteria and those who would fall just below it. In reality, in our experience, most clinicians think in terms of "clinically important symptoms" rather than formal diagnoses and so it should not impact too much on practice but rather reflect what is already happening. Where people without a formal diagnosis but with clinically important symptoms of PTSD are currently being excluded from therapy, this guideline would have a positive impact and the treatments would thus be opened to these patients who would benefit who might currently be excluded.	
Sussex Partnership NHS Foundation Trust	General	General	General	There were some recommendations that we suggest are missing from the current guideline that could be added. The guideline could explicitly discourage non-trauma focussed interventions for PTSD. We also suggest that the guideline should make recommendations about the need for ongoing supervision, CPD and reflective practice for EMDR and trauma focused CBT therapists to ensure these approaches are delivered safely and effectively. We also suggest that the need for staff self-care could also be highlighted in the guideline and recognising that there may be staff in services who have experienced traumas and may themselves find this work challenging or require support to undertake it.	Thank you for your comment. The committee considered the evidence for non-trauma-focused CBT interventions for adults. There was some evidence that non-trauma-focused CBT is beneficial when targeted at associated symptoms such as sleep disturbance or anger, and also leads to improvements in PTSD symptoms, but it was not clear how long these benefits would be maintained. Non-trauma-focused CBT was less cost-effective than individual trauma-focused CBT, EMDR and self-help, but more cost-effective than other interventions such as interpersonal psychotherapy (IPT), present-centred therapy, group trauma-focused CBT, combined individual trauma-focused CBT and SSRIs, counselling and no treatment. The committee agreed the potential benefits of non-

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					trauma-focused CBT were important, but that symptom-specific interventions should not be seen as an alternative to a trauma-focused first-line treatment. Instead, they could be an option when people are not ready to directly confront memories of the trauma and could promote uptake and engagement with a trauma-focused intervention that specifically targets PTSD. In response to stakeholder's comments this recommendation has been amended in an attempt to avoid unintended interpretations. The term '*symptom-specific CBT interventions*' has been replaced with '*CBT interventions targeted at specific symptoms such as sleep disturbance or anger*', and the recommendation about when you would consider this has been made stronger so that you would *only* consider such interventions when the person is unable or unwilling to engage in a trauma-focused intervention or has residual symptoms after a trauma-focused intervention. In response to your, and other stakeholder's, comments the recommendations about the structure and content of trauma-focused CBT and EMDR have been amended to include the guidance

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					that they should '*be delivered by trained practitioners with ongoing supervision*'. In the recognition section of the guideline there is a recommendation that users of the guideline should be aware that work-related exposure to trauma, including remote exposure, can be associated with the development of PTSD. All recommendations in the guideline apply to those with PTSD whether exposure resulted from direct experience of the traumatic event, witnessing the traumatic event, learning that the traumatic event occurred to a close family member or close friend, or experience of first-hand repeated or extreme exposure to aversive details of the traumatic event (not through media, pictures, television or movies unless work-related). However, where a staff member does not have, or is not at risk of PTSD (as defined by the review protocol), then they are outside the scope of this guideline.
Sussex Partnership NHS Foundation Trust	Guideline	7	17	1.2.6 Transitions between services. We agree people should be kept open until accepted by another service, however in our experience there are often times when people are accepted by another service and put on a long waiting list for treatment than might mean waiting for treatment for a year or even longer. We suggest it would be better to recommend that a service / clinician	Thank you for your comment. In response to yourand other stakeholder's comments, this recommendation has been amended to *'the referring team should not discharge the person before there is an agreed care plan in the new service*' in order to convey that the new service should be engaged.

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				keeps a person open until they are accepted by another service who are in a position to offer some treatment within acceptable time scales or until the person is stable enough to wait on a waiting list with provisions made for crisis support or interim support as needed.	
Sussex Partnership NHS Foundation Trust	Guideline	8	8	We agree with more flexible access and use of non-clinical settings such as schools or offices. In our experience interventions can also be offered in non-clinical settings at times, this can help with engagement, such as engaging refugees and asylum seekers in therapy. We have colleagues who have run peer support and stabilisation groups in garden and city farm settings to good effect.	Thank you for your comment.
Sussex Partnership NHS Foundation Trust	Guideline	9 and 10	28	We wholly support involving family members/carers in interventions and providing them support in their own right, and think this is well reflected in the guideline generally which we welcome. However, it may be worth elaborating what "appropriate" consists of in terms of their involvement in interventions. For example, in trauma focused CBT, educating the carer about the PTSD model and benefits of exposure could enable them support homework tasks, and encourage the patient to face anxiety. However, we would not consider it appropriate for family members/carers to sit in on for example re-living sessions. Given the evidence on vicarious traumatisation it may be worth specifying which aspects of treatment family members/carers should and should not be involved in.	Thank you for your comment. The committee did not consider it was appropriate to include this level of specificity in the guideline as this is best left to clinical judgement and based on the individual person with PTSD. The committee did, however, agree with stakeholder comments that a new recommendation should be added for members of a family who have experienced the same traumatic event and have PTSD and this new recommendation suggests that users of the guideline should think about what aspects of treatment might be usefully provided together, such as psychoeducation, while still providing the recommended treatments for individuals.

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Sussex Partnership NHS Foundation Trust	Guideline	10	17	Refugees and asylum seekers may find letters threatening if they are reminded of home office letters / forms of interrogation or being spied upon in their home country by institutions, especially if their understanding of written English is limited. This may mean that patients do not attend appointments and are inappropriately discharged. We suggest that a recommendation should be made to translate appointment and other letters if the person's understanding of written English is limited. There will be people who have limited literacy skills in their first language and so we suggest that literacy skills (in English and the person's first language) should be ascertained and communication adjusted accordingly (e.g. offering phone calls to confirm appointments where reading skills are limited).	Thank you for your comment. The committee agreed that these considerations are important but agreed that they are covered by recommendations in the NICE *'Service user experience in adult mental health*' guideline (CG136). For further details, please see https://www.nice.org.uk/Guidance/CG136
Sussex Partnership NHS Foundation Trust	Guideline	14	20	This section states, "Offer EMDR as an option" which may imply that it is treatment inferior to CBT. On page 31, it is stated "Less evidence was found on EMDR than on Trauma focused CBT. […] there was a trend in favour of EMDR. This trend in favour of EMDR was also present in the cost-effectiveness studies." This indicates that EMDR is likely to be equivalent (and potentially superior) to trauma focused CBT so it should not be treated as a secondary option.	Thank you for your comment. In response to your, and other stakeholder's, comments the EMDR recommendation has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option to trauma-focused CBT for adults exposed to non-combat related trauma. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran

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				In terms of practice-based evidence, EMDR is an effective treatment for PTSD. For example, in our IAPT services recovery rates from EMDR appear at least as good as for trauma focused CBT. One of our experienced EMDR supervisors has supervised in our IAPT services for several years. Her feedback was that in these services, EMDR rather than CBT tends to be offered to patients with a history of multiple traumas and with complex PTSD. This is because many IAPT trained CBT therapists do not feel equipped to these with these presentations using a CBT model as their training only covered trauma focused CBT for single traumas. Despite the more severe presentations, EMDR outcomes in our IAPT services appear at least as good as for trauma focused CBT.	populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed.
Sussex Partnership NHS Foundation Trust	Guideline	14	21	This section states that EMDR should not be offered for combat-trauma. From a theoretical perspective, both EMDR and trauma focused CBT do not distinguish between different types of trauma and there appears little in the way of a theoretical rationale in the guideline for making this distinction. We therefore suggest that the evidence for EMDR should be assumed to extend to the range of possible traumas, including combat trauma, unless there is a sound theoretical or empirical rationale to state otherwise. It is also the case in our experience that many veterans have traumas other than combat traumas. It	Thank you for your comment. The committee did not consider it appropriate to extend the EMDR recommendation to military combat-related trauma given the evidence showing lack of efficacy in veteran populations, which was in marked contrast to all other included trauma types where clinically important and statistically significant benefits were observed. For questions about intervention efficacy the committee considered the most appropriate study

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				makes little sense that they could have EMDR to treat the trauma symptoms relating to childhood abuse or domestic violence or a road traffic accident (even occurring during a tour of duty) but not for specific combat trauma. By stating that combat trauma should not be treated with EMDR, the guideline is being unintentionally discriminatory in our view by excluding this important clinical group from an effective treatment. In terms of practice-based evidence, in our services many therapists offer EMDR to ex-forces personnel in our IAPT and other services and the outcomes are very good and clients really value the intervention. One benefit we find of EMDR (in comparison to trauma focused CBT) is that the patient does not have to verbally describe the traumas, which can make EMDR more tolerable for the patient (many of whom do not want to or are not allowed to disclose confidential details). This can also make offering the therapy more tolerable for the therapist as well. In our clinical experience, many veterans prefer EMDR in comparison to trauma focused CBT and they should have the right to choose from these two effective interventions.	design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. We do not consider routine datasets as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading. The rationale behind recommendations of psychological interventions for adults with PTSD, including the above considerations, is provided in the 'Rationale and Impact' sections of the PTSD guideline evidence report D.
Sussex Partnership NHS Foundation Trust	Guideline	14	22	This section that states that EMDR should only be used three months post trauma does not take into account emerging evidence that EMDR can be effectively used much sooner post-trauma. For example, a case series showed that EMDR offered in the early weeks post trauma	Thank you for your comment and for drawing our attention to the Shapiro (2012) citation. In the consultation version of the guideline, there was no evidence for EMDR within 1 month of

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				was associated with symptom alleviation (Buydens et al., 2014). Specific protocols for offering EMDR during the first 3 months following the trauma have been developed (e.g. Shapiro, 2012) both on an individual and a group basis and are being used effectively in routine clinical practice as well as post conflict and post disaster situations world-wide, including the US. The benefits of using EMDR or trauma focused CBT in these early stages for people that are really struggling are very important, in terms of reducing distress, improving functioning and potentially preventing a worsening of symptoms. Therefore, we suggest that the recommendation for offering trauma focused CBT within the first three months following the trauma (which has limited evidence, as noted in the guideline), should be extended to EMDR.	trauma. Through stakeholder comments, one additional new study was identified and added to the analysis. The committee considered the new evidence for EMDR in the first month following trauma in adults (Gil-Jardiné 2018). However, the committee did not consider that it was appropriate to make a recommendation in this time period as evidence was limited to a small single study (N=71) that only reported on one clinical outcome of interest and the effect on the number of participants with PTSD at 3-month follow-up was not statistically significant. The committee considered the evidence for EMDR in the 1-3 month period following trauma, and in response to stakeholder's comments, agreed that a new recommendation should be added to consider EMDR for adults with PTSD within 1-3 months of non-combat-related trauma. This recommendation is based on single-study evidence showing large benefits of EMDR relative to supportive counselling in the 1-3 month period and an extrapolation from stronger evidence for EMDR more than 3 months after trauma. This was a weaker recommendation

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					(consider rather than offer) based on the limited direct evidence available. The committee did not consider routine datasets as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading. Buydens et al. (2014) has not been included in the guideline as it does not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs)
Sussex Partnership NHS Foundation Trust	Guideline	14	3	We are concerned that this recommendation "Offer individual trauma focused CBT to adults diagnosed with PTSD" may imply that CBT is a superior treatment to EMDR. We suggest that the recommendation should read "Offer individual trauma focused CBT or EMDR to adults diagnosed with PTSD". It could then go on to detail trauma focused CBT and EMDR in turn.	Thank you for your comment. It was not possible to combine EMDR and trauma-focused CBT within a single recommendation as the trauma-focused CBT recommendation is a strong recommendation for adults with PTSD more than 1 month after any trauma. Whereas for EMDR, there is a weaker recommendation for the 1-3 month time period based on very limited direct evidence, and the strong recommendation for EMDR for adults exposed to trauma more than 3 months ago is limited to non-combat-related trauma. However, in response to your and other stakeholder's comments, the EMDR recommendation has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option

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					to trauma-focused CBT for adults exposed to non-combat related trauma more than 3 months ago.
Sussex Partnership NHS Foundation Trust	Guideline	14	4	This rationale implies that there is evidence for the efficacy of trauma focused CBT in the 1-3 month period post trauma whereas there does not appear to be much evidence to support this, as described on page 33 line 9 "where the committee extrapolated from limited evidence…" If the committee is extrapolating from limited evidence, then we suggest that it can do the same for EMDR within the first three months post trauma (see below).	Thank you for your comment. In the consultation version of the guideline, there was no evidence for EMDR within 1 month of trauma. Through stakeholder comments, one additional new study was identified and added to the analysis. The committee considered the new evidence for EMDR in the first month following trauma in adults (Gil-Jardiné 2018). However, the committee did not consider that it was appropriate to make a recommendation in this time period as evidence was limited to a small single study (N=71) that only reported on one clinical outcome of interest and the effect on the number of participants with PTSD at 3-month follow-up was not statistically significant. The committee discussed the strength and breadth of the evidence for trauma-focused CBT within the first month of trauma, with benefits observed on both clinician-rated and self-rated measures of PTSD symptomatology, the rate of PTSD caseness at endpoint and follow-up, and on some other outcomes including depression and anxiety symptoms. Taken together with evidence suggesting that benefits are potentially long-lasting,

					the committee agreed that trauma-focused CBT should be offered to adults with clinically important PTSD symptoms or acute stress disorder within 1-month of the traumatic event in order to prevent the later development of PTSD. The committee considered the evidence for EMDR in the 1-3 month period following trauma, and in response to stakeholder's comments, agreed that a new recommendation should be added to consider EMDR for adults with PTSD within 1-3 months of non-combat-related trauma. This recommendation is based on single-study evidence showing large benefits of EMDR relative to supportive counselling in the 1-3 month period and an extrapolation from stronger evidence for EMDR more than 3 months after trauma. This was a weaker recommendation (consider rather than offer) based on the limited direct evidence available. The evidence for trauma-focused CBT in the 1-3 month time period was also limited, however, the committee extrapolated from the limited evidence showing benefits between 1 and 3 months after trauma, and the broader evidence base that showed benefits within the first month and more than 3 months after trauma. Given that the committee thought it was unlikely that effects would be different in this 2-month time period, they recommended that trauma-focused CBT should be

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					offered to adults with PTSD more than 1 month after trauma. The rationale behind recommendations of psychological interventions for adults at risk or with PTSD, including the above considerations, is provided in the 'Rationale and Impact' sections of the PTSD guideline evidence reports C and D respectively.
Sussex Partnership NHS Foundation Trust	Guideline	14	8	We have received practice-based evidence feedback on this section. Feedback from primary care is that delivering trauma focused CBT in 8-12 sessions can be beneficial for people with single event traumas who are functioning relatively well, have a support system and few comorbid difficulties. In secondary care, working with individuals who usually have experienced multiple traumas (often years of chronic abuse in child and/or adulthood), who may have experienced poor functioning for years, have limited support network and multiple comorbid difficulties (e.g. a diagnosis of personality disorder or psychosis) and high levels of dissociation (e.g. losing hours/days at a time/dissociating at beginning of therapy), therapists do not find it possible usually to complete this work within 12 sessions. We would suggest this recommendation could remain at 8-12 sessions, but with an explicit statement	Thank you for your comment. In response to your and other stakeholders' comments, the trauma-focused CBT and EMDR recommendations have been amended to *'typically be provided over 8 to 12 sessions but more if clinically indicated, for example if they have experienced multiple traumas'*. The recommendation on adaptations that might be required to psychological interventions for people with PTSD and additional needs, including complex PTSD, also includes the guidance that: extra time should be built in to develop trust with the person (by increasing the duration or the number of therapy sessions according to the person's needs); and that the person should be helped to manage any issues that might be a barrier to engaging with trauma-focused therapies, such as substance misuse, dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception.

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				added that more sessions are likely to be required where there are multiple traumas, comorbidity with complex mental health problems, poor social support networks or a strong tendency towards dissociation and that number of sessions should be determined by patient need.	
Sussex Partnership NHS Foundation Trust	Guideline	15	8	We agree with the suggestions of what should be included in EMDR. It may also may be worth noting that EMDR eye movements seem to have the most evidence for effectiveness and usually tried as a first line approach when using EMDR. There are also approaches such as Jim Knipe which can be used with more complex and dissociative presentations.	Thank you for your comment. In response to your, and other stakeholder's comments, the section of the recommendation that applies to bilateral stimulation has been amended to *'use repeated in-session bilateral stimulation (normally with eye movements)*' with a footnote added that '*Other methods of bilateral stimulation, including taps and tones, could be used if these are preferred or more appropriate (such as for people who are visually impaired)*'.
Sussex Partnership NHS Foundation Trust	Guideline	15	12	If guided computerised CBT is offered to those who are not able to engage with face to face treatment, we need to be aware of reasons why the person was not able to engage with the face to face treatment as this may indicate a more complex presentation and a need of more and not less clinician engagement.	Thank you for your comment. The committee agreed that this recommendation needed re-drafting as it was open to unintended interpretations. The re-drafted recommendation clarifies that supported trauma-focused computerised CBT should be considered for adults with established PTSD where the person has a preference relative to face-to-face trauma-focused CBT or EMDR and if the person does not have severe PTSD symptoms in particular dissociative symptoms and is not at risk of harm to themselves or others.

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Sussex Partnership NHS Foundation Trust	Guideline	17	14	Working with people who have complex PTSD and have stabilisation needs such as housing, immigration or health. These issues can be therapy interfering at times, though hugely important to address, where there are these needs a team approach with multi-disciplinary support is likely to enhance the effectiveness of therapy and cost effectiveness if therapy can proceed in a focussed way. We suggest that the guideline should recommend a multidisciplinary approach in these circumstances to maximise the chance of good outcomes.	Thank you for your comment. The committee did not consider it appropriate to recommend a multidisciplinary approach as a specific service delivery model as the evidence for this model was not assessed. However, the committee agrees that it is important to consider needs such as housing in order to promote access and engagement with therapy and think that this is addressed by the recommendation for people with additional needs, including complex PTSD, which includes the recommendation to take into account the safety and stability of the person's personal circumstances (for example their housing situation) and how this might impact on engagement with and success of treatment.
Sussex Partnership NHS Foundation Trust	Guideline	17	3	We are concerned that this recommendation might imply that substance misuse should not be taken into account when considering treatment options. It is true that substance misuse should not preclude trauma therapy and people with PTSD who commonly self-medicate to help with symptoms can benefit from trauma therapy. However, clients with dependency or chaotic and severe use do better if the substance abuse is treated first and a period of stabilisation achieved (and alternative coping strategies developed) before embarking on trauma therapy. We suggest that this recommendation is amended to say that substance abuse should be treated first and stabilisation achieved before starting trauma therapy.	Thank you for your comment. In response to your and other stakeholders' comments changes have been made to recommendations to reflect that for some people substance misuse may need to be addressed to enable engagement with trauma-focused intervention. The previous recommendation has been amended as follows: 'Do not exclude people with PTSD from treatment based *solely* on comorbid drug or alcohol misuse', and the recommendation for adaptations that may be needed to psychological interventions for people with PTSD and additional needs has been amended to recommend that people are helped to

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					manage any issues, including substance misuse, that might be a barrier to engaging with trauma-focused therapies.
The British Psychological Society	Evidence Reviews A,B,C,D,E	General	General	***Use of RCTs*** The only evidence included in the evaluation of PTSD interventions is from Random Controlled Trials. The NICE committee rejected all other evidence although this approach to RCTs is not consistently applied across NICE. In health research it has been recognised that some problems are too complex to be fully explored using quantitative tools alone. A paper published by O'Catgain et al (2014) which can be found on the NICE website describes how the use of triangulation can enrich the quality of the findings. O'Catgain undertook a study with combined quantitative research and random controlled trials in health research. Dealing with psychological trauma is not easy particularly when it also involves significant physical, psychological, social and cultural elements. It would be appropriate for the NICE committee to include the possibility of using a wider range of research tools including qualitative research and triangulation of results. Regarding the evidence from studies on the basis of which recommendations are based, the procedure for recognising studies seems far too complex in as far as the vast majority	Thank you for your comment and for drawing our attention to the Bradley et al. (2005), Byrne (2013), Forbes et al. (2010), Hough (2010), MRC (2014) guidelines, and O'Catgain et al. (2014) citations. A qualitative review of service user experience was included in the guideline (see Evidence report H). For questions about intervention efficacy the committee considered the most appropriate study design to be RCTs (or systematic reviews of RCTs) and this is in line with the NICE guidelines manual and was pre-specified in the review protocols. However, the qualitative review (in Evidence report H) was used to both reword existing recommendations in order to more accurately reflect the needs of service users, and as a basis for new recommendations. For instance, in the absence of evidence for clinical efficacy and on the basis of the qualitative meta-synthesis, the guideline recommends that access to peer support groups should be facilitated for those who may benefit as the thematic analysis highlighted potential benefits including facilitating access to services and helping individuals at risk of social

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				of studies are rejected. This may indeed reflect the reprehensible under-funding of research into socially important issues. However, the guideline has pushed together a variety of different approaches to treatment and called them all TF-CBT. This disguises the variation in outcomes and may ignore which approaches are most worthy of pursuing (e.g. it is surprising that KidNET does not figure more strongly as a referred treatment). Echoing and amplifying some of the themes outlined above, it has been suggested by several authors that RCTs have sometimes been prone to limited generalisability (external validity) because of questionable practices in relation to inclusion and exclusion criteria (internal validity), control groups and follow- up data (e.g. Bradley et al, 2005). Whilst the studies used in preparing the current guidelines will no doubt have been selected with an eye to avoiding clear shortcomings, there may nonetheless be a mismatch in between for example the exclusion criteria of RCTs and the extensive comorbidity encountered in clinical practice; this can mean the difference between 'efficacy' and 'effectiveness' (Forbes et al, 2010). RCTs have little to say about context, process, or individual variation (Hough, 2010). Indeed it has been suggested that neglect of the complex interactions to which health- related interventions are typically subject can render RCTs "effectively useless" (Byrne, 2013). RCTs have a clear place in putting to the test what we think we know but they are much less relevant	isolation to integrate with others with shared experiences. Furthermore, when making recommendations, the committee interpret RCT evidence in light of their knowledge of the clinical context so that the 'reality' for people experiencing PTSD is taken into consideration and recommendations can be made that are relevant to the populations that clinicians typically encounter. The guideline used a class approach for analysis and Narrative Exposure Technique (NET)/KidNET is included within the trauma-focused CBT class. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The committee discussed the categorisation of NET at great length and agreed that this intervention belonged in the trauma-focused CBT class, due to the considerable overlap in techniques and mechanisms. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. In response to stakeholder's comments, we have made some changes to the wording of the trauma-

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				to development up to this point, particularly at the stage where initial exploratory work, including of a qualitative nature, is required. Sometimes, too, interventions are relatively new so have had little chance to build up a substantial body of evaluative research. As Forbes et al (2010) commented in their 'Guide to Guidelines': "Absence of evidence does not equate to evidence of the absence of a treatment effect" (p. 552). It is presumed that recommended evaluation research will be consistent with the MRC (2014) guidelines on process evaluation of complex interventions.	focused CBT recommendations to make clear that we are referring to a class of interventions and added the examples of specific interventions (from the glossary) to the recommendation. For new interventions that look promising but there is insufficient evidence to currently recommend, the committee can prioritise these areas for further research, as is the case for trauma-informed care/approaches and interventions for complex PTSD.
The British Psychological Society	General	General	General	**References** Adler, A. D., Bliese, P. D., McGurk, D., Hoge, C. W., & Castro, C. A. (2009). Battlemind debriefing and battlemind training as early interventions with soldiers returning from Iraq: Randomization by platoon. *Journal of Consulting and Clinical Psychology*, 77, 928–940. Ashforth, B.E. (2001). *Role transitions in organizational life: An identity-based perspective*. New Jersey, NJ: Lawrence Erlbaum Associates.	Thank you for your comment. Please see below for details on the inclusion/exclusion of each of the references you cite: • Adler et al. (2009) is listed in excluded studies (Appendix K) of Evidence report C and is excluded on the basis that the population is outside scope (trials of soldiers on active service) • Ashforth (2001), Bacharach et al. (2008), Baranyi et al. (2018), Beck et al. (2004), Benight & Bandura (2004), Blair et al. (2005), Braddon & Tait (1993), Brinn & Auerbach (2015), British Psychological Society (2002), Budden (2009), Byrne (2013), Charuvastra & Cloitre (2008), College of Policing

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				Bacharach, S. B., Bamberger, P. A., & Doveh, E. (2008). Firefighters, critical incidents, and drinking to cope: The adequacy of unit-level performance resources as a source of vulnerability and protection. *Journal of Applied Psychology, 93*, 155-169. Baranyi, B., Cassidy, M., Fazel, S., Priebe, S., & Mundt, A.P. (2018). Prevalence of Posttraumatic Stress Disorder in Prisoners. *Epidemiologic Reviews* (40) 134-146. Beck, A.T., Freeman, A. Davis, D.D. & Associates (2004). *Cognitive therapy of Personality Disorders.* New York: Guilford. Benight, C.C. & Bandura, A. (2004). Social cognitive theory of posttraumatic recovery: The role of perceived self-efficacy. *Behaviour Research and Therapy*, 42, 1129–1148. Bisson, J.I. (2009) *Systematic Review of Psychological First Aid*, Geneva, World Health Organisation. Bisson, J. I., Brayne, M., Ochberg, F. M., & Everly, G. S. (2007). Early psychosocial intervention following traumatic events. *American Journal of Psychiatry,* (164) 1016–1019. Blair, R.J.R., Mitchell, D. & Blair, K. (2005). *The Psychopath: Emotion and the brain*. Oxford: Blackwell.	(2018), Cooke et al. (2013), Corrigan & Hull (2015), Crespo & Fernandez- Lansac (2016), Cruwys et al. (2014), Currier et al. (2012), Day & Vess (2018), Dyregrov & Regel (2012), Dutra et al. (2009), Fazel & Danesh (2002), Forbes et al. (2010), Gehart (2012), Greenwald (2005), Greenwood (2012), Hine et al. (2018), Hobfoll et al. (2007), Hough (2010), Jones (2018), Jones et al. (2003), Joseph et al. (1997), Lee & James (2012), Mayhew (2004), Medical Research Council (2014), Meichenbaum (2014), Patterson et al. (2010), Pekevski (2013), Reyes & Elhai (2004), Rick et al. (2006), Rogers & Law (2010), Rogers & Silver (2002), Rosen & Lilienfeld (2008), Ruck et al. (2013), Ruzek et al. (2007), Smith et al. (2016), Tehrani et al. (2011), Tol et al. (2011), Yehuda & Golier (2009), Young (1990), and Young et al. (2003) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Bisson (2009) and Dieltjens et al. (2014) systematic reviews have been checked for any relevant references and no additional studies that meet the inclusion criteria were identified • Bisson (2007), Bradley et al. (2005) and Mørkved et al. (2014) are listed in excluded studies (Appendix K) of Evidence report D. These

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				Braddon, R. & Tait. A. (1993) *Selection, Management and Training of Victim Recovery and Identification Teams*, Home Office, Metropolitan Police. Bradley, R., Greene, J., Russ, E., Dutra, L. & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, 162, 214-227. Brewin, C., Andrews, B. & Valentine, J.D. (2000). Meta-analysis of risk factors for posttraumatic stress disorder in trauma-exposed adults. *Journal of Consulting and Clinical Psychology*, 68, 748–766. Brinn, A.J. & Auerbach, C.F. (2015). The warrior's journey: Sociocontextual meaning-making in military transitions. *Traumatology*, 21(2), 82–89. British Psychological Society (2002) *Psychological Debriefing – Professional Practice Working Party,* Leicester, British Psychological Society Budden, A. (2009). The role of shame in posttraumatic stress disorder: A proposal for a socio-emotional model for DSM-V. *Social Science & Medicine*, 69(7), 1032–1039. Byrne, D. (2013). Evaluating complex interventions in a complex world. *Evaluation*, 19, 217–228.	systematic reviews could not be included in their entirety as review questions and inclusion/exclusion criteria were not sufficiently similar. These systematic review were checked for any relevant references, however, no additional studies that met inclusion criteria were identified. • Brewin et al. (2000), Guay et al. (2006), Jobson (2009), Levy et al. (2011), Litz et al. (2018), Lyons-Ruth (2006), Maercker & Mueller (2004), Maniates et al. (2018), McNally et al. (2015), Mikulincer & Shaver (2007), Milliken et al. (2007), Mobbs & Bonanno (2018), Needs (2018), Neimeyer (2004), Saraiya & Lopez-Castro (2016), Schuder & Lyons-Ruth (2004), Seery et al. (2008), Sindicich et al. (2014), Stein & Tuval-Mashiach (2015), Stein et al. (2016), Straits-Troster et al. (2011), Twenge et al. (2003), Ungar (2013), and Widom (1989) do not meet inclusion criteria as risk and/or recovery factors for PTSD and the aetiology of PTSD are outside scope • Chmitorz et al. (2018), Mastem (2016), and Yilmaz (2017) are not included as they are not restricted to

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
				Charuvastra, A. & Cloitre, M. (2008). Social bonds and posttraumatic stress disorder. *Annual Review of Psychology*, 59, 301–328. Chmitorz, A., Kunzler, A., Helmreich, I., Tüscher, O., Kalisch, R., Kubiak, T., et al. (2018). Intervention studies to foster resilience—A systematic review and proposal for resilience framework in future intervention studies. *Clinical Psychology Review, 59,* 78–100. College of Policing (2018) Responding to Trauma in Policing: a practical guide. https://oscarkilo.org.uk/wp-content/uploads/2018/02/Responding_to_trauma_in_policing_eVersion150218.pdf Cooke, N.J., Gorman, J.C., Myers, C.W. & Duran, J. L. (2013). Interactive team cognition. *Cognitive Science*. 37, 255 – 285. Corrigan, F.M. & Hull, A.M. (2015). Neglect of the complex: Why psychotherapy for post-traumatic clinical presentations is often ineffective. *British Journal of Psychiatry Bulletin*, 39, 86–89. Crespo, M. & Fernandez- Lansac, V. (2016). Memory and narrative of traumatic events: A literature review.	people with PTSD and the outcome (resilience) is not prioritised in this review (see review protocols) • Hobbs et al. (1996) is included in the review in Evidence report C • Markowitz et al. (2015) is included in the review in Evidence report D • O'Cathain et al. (2014) and Spinazzola et al. (2005) are outside scope for the reviews as they are methodology papers • Ruf et al. (2010) is included in the review in Evidence report B • Tadmor et al. (2016) does not meet inclusion criteria as participants do not have PTSD and are not at risk of PTSD (as defined in the review protocols) • Zehnder et al. (2010) is included in the review in Evidence report A

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				Psychological Trauma: Theory, Practice and Policy. 8 (2), 149- 156. Cruwys, T., Haslam, S.A., Dingle, G.A., Haslam, C. & Jetten, J. (2014). Depression and social identity: An integrative review. *Personality and Social Psychology Review*, 18(3), 215–238. Currier, J.M., Holland, J.M. & Allen, D. (2012). Attachment and mental health symptoms among U.S. Afghanistan and Iraq veterans seeking health care services. *Journal of Traumatic Stress,* 25, 633–640. Day, A. & Vess, J. (2018). The importance of personal safety to therapeutic outcomes in the prison setting. In G. Akerman, A. Needs & C. Bainbridge (Eds.) *Transforming environments and rehabilitation: A guide for practitioners in forensic settings and criminal justice.* London: Routledge. Dieltjens, T. Moonens, I. VanPraet, K. DeBuck, E, Vanderkerckhove, P. (2014) A systematic literature search on psychological first aid: lack of evidence to provide guidelines. *Plos One* 9 (12) 1-13. Dyregrov, A. & Regel, S. (2012): Early Interventions following exposure to traumatic events: Implications for practice from recent research, *Journal of Loss and Trauma:*	

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				International Perspectives on Stress and Coping, 17:3, 271-291. Dutra, L., Bureau, J.F., Holmes, B., Lyubchik, A. & Lyons-Ruth, K. (2009). Quality of early care and childhood trauma: A prospective study of developmental pathways to dissociation. *The Journal of Nervous and Mental Disease*, 197, 383–390. Fazel, S., & Danesh, J. (2002). Serious mental disorder in 23000 prisoners: A systematic review of 62 surveys. *The Lancet,* 359, 545–550. Forbes, D., Creamer , M., Bisson, J.I., Cohen, J. A., Crow, B. E., Foa, E. B., et al. (2010). A guide to guidelines for the treatment of PTSD and related conditions. *Journal of Traumatic Stress*, 23(5), 537-552. Gehart, D. R. (2012). The mental health recovery movement and family therapy, Part I: Consumer-led reform of services to persons diagnosed with severe mental Illness. *Journal of Marital and Family Therapy*, 38(3), 429-442. Greenwald, R. (2005). *Child Trauma Handbook: A Guide for Helping Trauma-Exposed Children and Adolescents.* New York: Routledge.	

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				Guay, S., Billette, V., & Marchand, A. (2006). Exploring the links between post-traumatic stress disorder and social support: Processes and potential research avenues. *Journal of Traumatic Stress,* 19, 1-12. Greenwood, A. (2012) Assist: a model for supporting staff in a secure healthcare setting after traumatic events that is expanding into other European territories. R. Hughes, A. Kinder, C.L. Cooper (Eds.), Handbook of Workplace Trauma Support, Chichester: Wiley-Blackburn. Hine, R. H., Maybery, D., & Goodyear, M. J. (2018). Challenges of connectedness in personal recovery for rural mothers with mental illness. *International Journal of Mental Health Nursing*, 27(2), 672-682. Hobbs, M., Mayou, R., & Harrison, B. (1996). A randomised controlled trial of psychological debriefing for victims of road traffic accidents. *British Medical Journal,* 313, 1438–1439. Hobfoll, S.E., Watson, P., Bell, C.C., Bryant, R.A., Brymer, M. J., et al. (2007). Five essential elements of immediate and mid-term mass trauma intervention: empirical evidence. *Psychiatry,* 70: 283–315.	

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				Hough, M. (2010). Gold standard or fool's gold? The pursuit of certainty in experimental criminology. *Criminology and Criminal Justice*, 10(1), 11–22. Jobson, L. (2009). Drawing current posttraumatic stress disorder models into the cultural sphere: The development of the 'threat to the conceptual self' model. *Clinical Psychology Review*, 29, 368–381. Jones, L. (2018). Trauma- informed care and 'good lives' in confinement: Acknowledging and offsetting adverse impacts of chronic trauma and loss of liberty. In G. Akerman, A. Needs & C. Bainbridge (Eds.) *Transforming environments and rehabilitation: A guide for practitioners in forensic settings and criminal justice.* London: Routledge. Jones, N., Roberts, P. & Greenberg, N. (2003) Peer-group risk assessment: a post-traumatic management strategy for hierarchical organisations, *Occupational Medicine*, 53 469-475 Joseph, S., Williams, R., & Yule, W. (1997). *Understanding post- traumatic stress: A psychosocial perspective on PTSD and treatment.* Chichester: Wiley. Lee, D. & James, S. (2012). *The compassionate mind approach to recovering from trauma using compassion focused therapy.* London: Robinson.	

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				Levy, K. N., Ellison, W. D., Scott, L. N., & Bernecker, S. L. (2011). Attachment style. *Journal of Clinical Psychology, 67,* 193–203. Litz, B.T., Contractor, A.A., Rhodes, C., Dondanville, K.A., Jordan, A.H., Resick, P.A. et al. (2018). Distinct trauma types in military servicemembers seeking treatment for posttraumatic stress disorder. *Journal of Traumatic Stress,* 31, 286- 295. Lyons-Ruth, K. (2006). Interfacing attachment and intersubjectivity: Perspective from the longitudinal study of disorganised attachment. *Psychoanalytic Inquiry*, 26(4), 595–616. Maercker, A. & Mueller, J. (2004). Social acknowledgment as a victim or survivor: A scale to measure a recovery factor of PTSD. *Journal of Traumatic Stress*, 17, 345–351. Maniates, H., Stoop, T.B., Miller, M.W., Halberstadt, L. & Wolf, E.J. (2018). Stress-generative effects of posttraumatic stress disorder: Transactional associations between posttraumatic stress disorder and stressful life events in a longitudinal sample. *Journal of Traumatic Stress,* 31, 191 – 201.	

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				Markowitz, J.C., Petkova, E., Neria, Y., Van Meter, P.E., Zhao, Y., Hembree, E., … Marshall, R.D. (2015). Is exposure necessary? A randomized clinical trial of interpersonal psychotherapy for PTSD. *American Journal of Psychiatry*, 172(5), 430–440. Masten, A.S. (2016). Resilience in developing systems: the promise of integrated approaches. *European Journal of Developmental Psychology*, 13 (3), 297-312. Mayhew, E.R. (2004). *The reconstruction of warriors*. London: Greenhill Books. McNally, R.J., Robinaugh, D.J., Wu, G.W.Y., Wang, L., Deserno, M. & Borsboom D. (2015). Mental disorders as causal systems: A network approach to posttraumatic stress disorder. *Clinical Psychological Science*, 3, 836 - 849. Medical Research Council (2014). Process evaluation of complex interventions. https://mrc.ukri.org/documents/pdf/**complex-interventions**-guidance Meichenbaum, D. (2014). *Roadmap to resilience: A guide for military trauma victims and their families.* NC: Institute Press.	

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				Mikulincer, M. & Shaver, P.R. (2007). Boosting attachment security to promote mental health, prosocial values, and inter-group tolerance. *Psychological Inquiry*, 18(3), 139–156. Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War**.** *Journal of the American Medical Association, 298,* 2141-2148. Mobbs, C. & Bonanno, G.A. (2018). Beyond war and PTSD: The crucial role of transition stress in the lives of military veterans. *Clinical Psychology Review*, 59, 137-144. Mørkved, N., Hartmann, K., Aarsheim, L.M., Holen, D., Milde, A.M., Bornyea, J. & Thorp, S.R. (2014). A comparison of narrative exposure therapy and prolonged exposure therapy for PTSD. *Clincial Psychology Review,* 34, 453- 467. Needs, A. (2018). Only connect: implications of social processes and contexts for understanding trauma. In G. Akerman, A. Needs & C. Bainbridge (Eds.) *Transforming environments and rehabilitation: A guide for practitioners in forensic settings and criminal justice.* London: Routledge.	

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				Neimeyer, R.A. (2004). Fostering posttraumatic growth: A narrative elaboration. *Psychological Inquiry,* 15 (1), 53- 59. O'Cathain, A Thomas, K.J. Drabble, S.J., Rudolph, A. Good, J. Hewison, J. (2014) Maximising the value of combining qualitative research and randomised controlled trials in health research: the QUAlitative Research in Trials (QUART) study – a mixed methods study, *National Institute of Health Research*, 18 (38) 1366-5278. Patterson, G.R., Forgatch, M.S. & DeGarmo, D.S. (2010). Cascading effects following intervention. *Developmental Psychopathology,* 22, 941 – 970. Pekevski, J. (2013) First responders and psychological first aid. *Journal of Emergency Management,* 11: 39–48. Reyes, G., & Elhai, J.D. (2004) Psychosocial interventions in the early phases of disasters. *Psychotherapy: Theory, Research, Practice, Training, 41*(4), 399-411. Rick, J. Kinder, A. O'Regan (2006) *Early Intervention following trauma: a controlled longitudinal study at Royal Mail Group*. London, British Occupational Health Research Foundation. Rogers, A. & Law, H. (2010). Working with trauma in a prison setting. In J. Harvey & K. Smedley (Eds.),	

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				Psychological therapy in prisons and other secure settings. Abingdon, UK: Willan. Rogers, S. & Silver, S.M. (2002). Is EMDR an exposure therapy? A review of trauma protocols. *Journal of Clinical Psychology,* 58 (1), 43- 59. Rosen, G.M. & Lilienfeld, S.O. (2008). Posttraumatic stress disorder: An empirical evaluation of core assumptions. *Clinical Psychology Review*, 28, 837–868. Ruck, S. Bowes, N. Tehrani, N. (2013) Evaluating trauma debriefing within the UK prison service, *Journal of Forensic Practice*, 15 (4) 281-290 Ruf, M., Schauer, M., Neuner, F., Catani, C., Schauer, E. & Ebert, T. (2010). Narrative exposure therapy for 7- to 16 – year olds: A randomized control trial with traumatized refugee children. *Journal of Traumatic Stress,* 23 (4), 437-445. Ruzek, J.I., Brymer, M.J., Jacobs, A.K., Layne, C.M., Vernberg, E.M., et al. (2007) Psychological First Aid. *Journal of Mental Health Counselling* 29: 17–49. Saraiya, T. & Lopez-Castro, T. (2016). Ashamed and afraid: A scoping review of the role of shame in post-	

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				traumatic stress disorder (PTSD). *Journal of Clinical Medicine,* 5, 94 – 215. Schuder, M. & Lyons-Ruth, K. (2004). "Hidden trauma" in infancy: Attachment, fearful arousal, and early dysfunction of the stress response system. In J. Osofsky (Ed.) *Trauma in infancy and early childhood.* New York, NY: Guilford Press. Seery, M.D., Silver, R.C., Holman, E.A., Ence, W.A., & Chu, T.Q. (2008). Expressing thoughts and feelings following a collective trauma: Immediate responses to 9=11 predict negative outcomes in a national sample. *Journal of Consulting & Clinical Psychology,* 76, 657–667. Sindicich, N. et al. (2014) Offenders as victims: posttraumatic stress disorder and substance use disorder among male prisoners. *Journal of Forensic Psychiatry & Psychology,* 25:1, 44-60. Smith, J.C., Hyman, S.M., Andres- Hyman, R.C., Ruiz, J.L. & Davidson, L. (2016). Applying recovery principles to the treatment of trauma. *Professional Psychology: Research and Practice,* 47 (5), 347- 355. Spinazzola, J., Blaustein, M. & van der Kolk, B.A. (2005). Posttraumatic stress disorder treatment outcome research: The study of unrepresentative samples? *Journal of Traumatic Stress*, 18 (5), 425–436.	

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				Stein, J. & Tuval-Mashiach, R. (2015). The social construction of loneliness: An integrative conceptualization. *Journal of Constructivist Psychology*, 28(3), 210–227. Stein, J., Wilmot, D.V. & Solomon, Z. (2016). Does one size fit all? Nosological, clinical and scientific implications of variations in PTSD Criterion A. *Journal of Anxiety Disorders,* 43, 106 – 117. Straits-Troster, K., Gierisch, J.M., Calhoun, P.S., Strauss, J.L., Voils, C. & Kudler, H. (2011). Living in transition: Young veterans' health and the postdeployment shift to family life. In D.C. Kelly, S. Howe-Barksdale & D. Gitelson (Eds.), *Treating young veterans: Promoting resilience through practice and advocacy*. New York, NY: Springer. Tadmor, A., McNally, R.J. & Engelhard, I.M. (2016). Reducing the negative valence of stressful memories through emotionally valenced, modality- specific tasks. *Journal of Behavior Therapy and Experimental Psychiatry,* 53, 92- 98. Tehrani, N., Rainbird, C. Dunn, B. (2011). *Supporting the police following the 7/7 London terrorist bombs – an organisational approach*, In N. Tehrani (ed) Managing Trauma in the Workplace: supporting workers and organisations, London: Routledge.	

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				Tol, W.A., Patel, V., Tomlinson, M., Baingana, F., Galappatti, A. et al. (2011) Research priorities for mental health and psychosocial support in humanitarian settings. PLoS Med 8: 1-5. Twenge, J.M., Catanese, K.R. & Baumeister, R.F. (2003). Social exclusion and the deconstructed state: Time perception, meaninglessness, lethargy, lack of emotion, and self-awareness. *Journal of Personality and Social Psychology*, 85, 409–423. Ungar, M. (2013). Resilience, trauma, context and culture. *Trauma, Violence and Abuse*, 14(3), 255–266. Widom, C.S. (1989). Child abuse, neglect, and adult behavior: research and findings on criminality, violence, and child abuse. *American Journal of Orthopsychiatry* 59(3):355–367. Yehuda, R., & Golier, J. (2009). Is there a rationale for cortisol-based treatments for PTSD? *Expert Reviews of Neurotherapeutics*, 9, 1113–1115. Yilmaz, E.B. (2017). Resilience as a strategy for struggling against challenges related to the nursing profession. *Chinese Nursing Research,* 4, 9– 13.	

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				Young, J. E. (1990). *Cognitive therapy for personality disorders: A schema-focused approach*. Sarasota, FL England: Professional Resource Exchange, Inc. Young, J.E., Klosko, J.S., & Weishaar, M.E. (2003). *Schema therapy: A practitioner's Guide*. New York: Guilford Press. Zehnder, D., Meuli, M., & Landolt, M. A. (2010). Effectiveness of a single-session early psychological intervention for children after road traffic accidents: A randomised controlled trial. *Child and Adolescent Psychiatry and Mental Health*, 4, 1–31.	
The British Psychological Society	Guidance	4	1-2	***Principles of discussion/choice*** The principles of discussion and being allowed to make informed decisions are especially appropriate for people with a range of concerns that may not obviously be regarded as symptoms or as anxiety- related. The sometimes central importance of preoccupations such as betrayal and isolation, humiliation and shame, moral conflict or transgression has been recognised more extensively (Charuvastra & Cloitre, 2008; Litz et al, 2018; Saraiya & Lopez- Castro, 2016; Stein, Wilmot & Solomon, 2016) since the 2005 guidelines and practitioners should be aware of these possibilities. Accommodating these from	Thank you for your comment and for drawing our attention to the Charuvastra & Cloitre (2008), Gehart (2012), Litz et al. (2018), Saraiya & Lopez-Castro (2016), Smith et al. (2016), and Stein et al. (2016) citations. The committee did not consider it appropriate to recommend a 'recovery approach' as a specific service delivery model as the evidence for this model was not assessed. However, the committee agreed that it is important to be aware that people with PTSD may be apprehensive, anxious or ashamed and may avoid treatment, believe that PTSD is untreatable, or have difficulty developing

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				the position imposed by DSM- 5 and addressing other aspects of the internal and external context may be helped by the explicit adoption of a 'recovery' approach (Gehart, 2012; Smith et al, 2016).	trust and these considerations have now been captured in the amendments that have been made to the supporting engagement recommendation. The committee also agreed that it was important that a more hopeful and optimistic picture of the treatment of PTSD was presented and amended the promoting access recommendation to include *'emphasising that PTSD is a treatable condition*'.
The British Psychological Society	Guidance	5-6	26-30 1-3	***Recommendations for children after receiving emergency treatment following a traumatic event*** Given that around 30% of children who attend A&E after a Road Traffic Collision go on to develop PTSD, The Society welcomes the previous recommendation being strengthened. We would further welcome, in addition, the letter back to the GP from A&E included a reminder that the GP should review the child in 4-6 weeks.	Thank you for your comment. As specified in the scope, the recognition and assessment sections from the 2005 guideline were not included in this update. In line with NICE processes, the 2005 content has been carried across to this updated guideline. However, the evidence on recognition and assessment has not been reviewed and we are not able to make any changes to this section (except where they are necessary in order to clarify meaning).
The British Psychological Society	Guidance	6	5-8	***Screening for PTSD*** Screening on a validated measure at one month post-incident is to be encouraged although the existence of 'subsyndromal' symptoms, which may nonetheless cause	Thank you for your comment. As specified in the scope, the recognition and assessment sections from the 2005 guideline were not included in this update. In line with NICE processes, the 2005 content has been carried across to this updated guideline. However, the evidence on recognition and assessment has not been reviewed and we are

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				significant distress and impairment, should not be overlooked.	not able to make any changes to this section (except where they are necessary in order to clarify meaning).
The British Psychological Society	Guidance	6	9-12	***Screening of asylum seekers*** The Society believes that all refugee and asylum seekers have the right of access for treatment. Screening should be undertaken using material properly translated into a recipient's own language. A number of such instruments exist in both the Netherlands and UK/Norway.	Thank you for your comment. In response to your, and other stakeholder's comments, 'screening and assessment' have been added to a recommendation in the 'Language and culture' section that recommends that screening, assessment and interventions for PTSD are culturally and linguistically appropriate.
The British Psychological Society	Guidance	7	17- 19	***Transition to other services*** The Society believes that transfer to other services should not occur until the new service is engaged. As far as work with especially adolescent unaccompanied minors is concerned, we believe that it should be seen as unethical to refuse treatment on the grounds that they might be subject to removal.	Thank you for your comment. In response to your, and other stakeholder's comments, this recommendation has been amended to *'the referring team should not discharge the person before there is an agreed care plan in the new service*' in order to convey that the new service should be engaged.
The British Psychological Society	Guidance	7	22- 24	***Recovery principles*** Recovery principles (see Comment 3) are especially relevant to providing a care model that is seen as	Thank you for your comment and for drawing our attention to the Bacharach et al. (2008), Chmitorz et al. (2018), Masten (2016), Milliken et al. (2007),

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				accessible, relevant and engaging. This holistic approach might be especially relevant to clients, including veterans, who can be reluctant to seek or accept help. The latter were reported by Straits- Troster et al. (2011, p. 166) to favour" an approach that focused more on normal adjustment and less on 'fixing' the veteran, without using terms that might connote weakness such as 'disease' or 'disorder'." Acceptability and effectiveness may be enhanced if care models are not focused entirely on deficits. For people (such as emergency responders) subject to frequent exposure to potentially traumatic events care models might extend to supporting and promoting resilience and self-efficacy at unit level (e.g. Bacharach, Bamberger & Doveh, 2008; Yilmaz, 2017). Although, rather like PTSD, much research on resilience is not without problems (Chmitorz et al, 2018), the implications potentially are far- reaching and compatible with essential aspects of a recovery orientation at the level of both individuals and communities (Masten, 2016; Ungar, 2013). The alternative is that the loss of what formerly sustained resilience, upon for example transition from military to civilian life may be felt acutely (Mobbs & Bonanno, 2017) and be the point at which problems related to experiences in service emerge (Milliken, Auchterlonie & Hoge, 2007).	Mobbs & Bonanno (2017), Straits-Troster et al. (2011), Ungar (2013), and Yilmaz (2017) citations. The committee agreed that it was important that a more hopeful and optimistic picture of the treatment of PTSD was presented and amended the promoting access recommendation to include *'emphasising that PTSD is a treatable condition*'.

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The British Psychological Society	Guidance	8	16- 19	***Therapy recommendations for victims pre-trial*** Pre-trial therapies as recommended by NICE for PTSD (2005, reviewed 2015) can present a conflict with the Practice Guidance for the provision of therapy for vulnerable or intimidated adult witnesses prior to a criminal trial (Crown Prosecution Service, 1998, last updated September 2014; Practice Guidelines for the Provision of Therapy for Child Witnesses Prior to a Criminal Trial, 2002, last updated September 2014). From an objective review of the Practice Guidance it is easy to understand how the conclusion could be reached that undertaking evidence-based therapy for mental health issues pre-trial is incompatible with a decision for prosecution. The introduction to the Practice Guidance states that concern has been expressed that witnesses, including vulnerable or intimidated adult witnesses, have been denied therapy pending the outcome of a criminal trial for fear that their evidence could be tainted and the prosecution lost. This fear may conflict with the need to ensure that vulnerable or intimidated adult victims are able to receive, as soon as possible, immediate and effective treatment for any PTSD to assist their recovery.	Thank you for your comment. A cross-reference to the relevant CPS guidance has now been added to this recommendation.

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				The Society believes that clearer direction from NICE as to which therapies would be viewed as coaching in this context is required. Furthermore, there needs to be recognition that just as it would be unacceptable for an individual's physical injury to remain untreated until after a trial, such as often is the case for their mental health. Liaison between NICE, the British Psychological Society and the Crown Prosecution Service is recommended in order to develop new ways for evidence-based therapy for PTSD to be given without the risk of prejudicing a case. Lack of clarity of NICE Guidance is harmful to victims' mental health as it, along with the CPS Guidance, is contributing too many victims failing to access evidence-based therapy often for many months for fear of their case being jeopardised at trial.	
The British Psychological Society	Guidance	9	1-2	***Common reactions*** The Society believes that it may be helpful to outline 'common reactions' more comprehensively so that users of the guidelines do not focus solely on a narrow definition of 'symptoms of PTSD'. The symptoms of co- morbid disorders that may have a related origin in the appraisal of events according to certain themes such as loss, humiliation and lack of control may be considered (Cruwys et al, 2014). As indicated earlier (see Comment 1) a	Thank you for your comment and for drawing our attention to the Cruwys et al. (2014), Joseph et al. (1997), Maercker & Mueller (2004), and Stein & Tuval-Mashiach (2015) citations. The committee did not consider it necessary to outline 'common reactions' in this recommendation as the symptoms of PTSD are outlined in recommendation 1.1.1.

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				growing body of research has highlighted the often pivotal role of social and moral concerns that are not reducible to the presence or consequences of physical threat. A sense that others are either unable or unwilling to acknowledge let alone understand one's situation (Maercker & Mueller, 2004) can contribute to the isolation of what Stein and Tuval – Mashiach (2015) termed 'failed intersubjectivity' that may be a major impediment to adaptive sense- making (Joseph, Williams & Yule, 1997).	
The British Psychological Society	Guidance	9	13-17	***Maintaining safe environments*** The recognition of continued exposure to trauma- inducing environments is to be welcomed. This might extend to careful assessment of the propensity of some individuals to play an active role in encountering, even creating, new events of a potentially traumatic (or at least thematically consistent) nature (e.g. Maniates et al, 2018). Safety and stability are also essential within phased models of treatment e.g. the Fairytale model (Greenwald, 2005). In this model the phases of treatment include 1) evaluation; 2) motivational interviewing/goal setting; 3) trauma informed case formulation; 4) Treatment contracting; 5) Case management for safety and other needs - this may include parent training; 6) Self-management skills training; 7) trauma resolution; and 8)	Thank you for your comment and for drawing our attention to Baranyi et al. (2018), Battle et al. (2003), Blair et al. (2005), Bolton & Robinson (2009), Day & Vess (2018), Greenwald (2005), Jones (2018), Maniates et al. (2018), Sindicich et al. (2014), Widom (1989), Wolff & Shi (2012) citations. In response to your and other stakeholders' comments the maintaining safe environments recommendation has been amended to include the guidance that users of the guideline should 'avoid exposing people to triggers that could worsen their symptoms or stop them from engaging with treatment, for example, assessing or treating

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				consolidation of gains. There is a danger that psychological treatment for PTSD becomes overly focused on debates surrounding the preferred method of trauma resolution when this is only one aspect of it. Greater emphasis on phased model of treatments and the absolute necessity for case management for safety is required. We also highlight the challenges of PTSD for people in prison. Although this area has been a neglected area of research historically PTSD has been considered to be a major health problem in prisoners. This is owing to people in prison having experienced high rates of physical, sexual, and emotional violence (Widom 1989; Battle, Zlotnick, Najavits, et al, 2003. Wolff & Shi, 2012, cited in Baranyi, Cassidy, Fazel, Priebe, & Mundt, 2018). In an Australian prison study Sindicich, Mills, Barrett, Indig, Sunjic, Sannibale, et al. (2014) found that a history of substance dependence was almost universal (90%) and 56.7% met diagnostic criteria for PTSD with the remainder experiencing sub-threshold symptoms. A large systematic review of the prevalence of PTSD in prison populations based on 56 samples from 20 countries worldwide found high prevalence rates for PTSD (Baranyi et al, 2018). Pooled data identified point prevalence of PTSD as being 6% in male prison populations and 21% in female prison populations. Figures for one year prevalence were 10% in	people in noisy or restricted environments, placing them in a noisy inpatient ward, or restraining them'. The committee did not consider it appropriate to recommend the fairy tale model or another phased approach as a specific service delivery model as the evidence for these approaches was not assessed. However, the committee agreed that it is important to consider safety and stability needs and this is captured by the recommendation for adaptations that may be required for those with PTSD and additional needs. We agree that the treatment of PTSD in prison populations is important. However, mental health care in prisons is outside the scope of this guideline as there is an existing NICE guideline (NG66) on 'Mental health of adults in contact with the criminal justice system'. Please see https://www.nice.org.uk/guidance/ng66

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				male and 26% in female prison populations with lifetime prevalence estimates being 18% in male and 40% in female prison populations. Untreated PTSD not only impacts on functioning but results in an increased risk of self-harm and suicide (Bolton & Robinson, 2009). Levels of PTSD in women being three times higher than that for men. It is recognised that this is a challenge for groups such as people in prison where the prevalence of post-traumatic stress and complex trauma is very high. Blair, Mitchell and Blair (2005) recognise the potential role of abusive experiences in their neurocognitive theory of the development of reactive aggression whilst lack of safety in the current environment is antithetical to effective rehabilitation and other therapeutic outcomes (Day & Vess, 2018). It is suggested that local protocols for enhancing safety in prison environments are developed. These should include awareness of the possibility of parallels between present procedures, conditions and relationships and those associated with traumatogenic contexts (Jones, 2018). In addition, high prevalence rates should be reflected by commissioning adequate services for people in prison. It is noted that there are a large number of forensic psychologists in prisons but interventions for PTSD largely fall into mental health in reach services although both historically and geographically forensic psychologists in prison are well placed to be able to deliver between	

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				present procedures, conditions and relationships and those associated with traumatogenic contexts (Jones, 2018). In addition, high prevalence rates should be reflected by commissioning adequate services for people in prison. It is noted that there are a large number of forensic psychologists in prisons but interventions for PTSD largely fall into mental health in reach services although both historically and geographically forensic psychologists in prison are well placed to be able to deliver between present procedures, conditions and relationships and those associated with traumatogenic contexts (Jones, 2018). In addition, high prevalence rates should be reflected by commissioning adequate services for people in prison. It is noted that there are a large number of forensic psychologists in prisons but interventions for PTSD largely fall into mental health in reach services although both historically and geographically forensic psychologists in prison are well placed to be able to deliver role of abusive experiences in their neurocognitive theory of the development of reactive aggression whilst lack of safety in the current environment is antithetical to effective rehabilitation and other therapeutic outcomes (Day & Vess, 2018). It is suggested that local protocols for enhancing safety in prison environments are developed. These should include awareness of the possibility of parallels between present procedures, conditions and relationships and those associated with traumatogenic contexts (Jones, 2018). In addition, high prevalence rates should be reflected by	

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				commissioning adequate services for people in prison. It is noted that there are a large number of forensic psychologists in prisons but interventions for PTSD largely fall into mental health in reach services although both historically and geographically forensic psychologists in prison are well placed to be able to deliver interventions to address trauma.	
The British Psychological Society	Guidance	11	12-12	***Personal and social factors involved in development or maintenance*** This area might benefit from greater detail (examples might at least be on a par with the bullet points concerning 'Recognition' on pp 4 – 5.) These might include a number of developmental and contextual points. The former might encompass, for example, the effects of 'cumulative' trauma. This can make, for example, the selection of episodes for exposure- based therapies a little problematic (Stein et al, 2016), and perhaps especially if problems now relate to a pattern of experiences and an overall narrative rather than discrete or even single episodes. It is also known that early adversity including trauma (such as forms of abuse) and attachment difficulties can have major influences on later vulnerabilities (Brewin, Andrews & Valentine, 2000; Currier, Holland & Allen, 2012; Hartwell, James, Chen & Smelson, 2014).	Thank you for your comment and for drawing our attention to the Ashforth (2001), Benight & Bandura (2004), Brewin et al. (2000), Brinn & Auerbach (2015), Corrigan & Hull (2015), Currier et al. (2012), Dutra et al. (2009), Hartwell et al. (2014), Jobson (2009), Levy et al. (2010), Lyons- Ruth (2006), Mikulincer & Shaver (2007), Needs (2018), Patterson et al. (2010), Rogers & Law (2010), Schuder & Lyons- Ruth (2004), Spinazzola et al. (2005), Stein et al. (2016), and Vogel & Wei (2005) citations. In response to your, and other stakeholder's comments, this recommendation has now been amended to include the examples of *'childhood maltreatment and multiple traumatic experiences'*.

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				The present guidelines are rather unclear in this area. Partly this relates to the lack of detail on Complex PTSD and the following of DSM- 5 rather than ICD- 11 in its approach to this constellation of problem areas, despite the fact that practitioners in the UK are much more likely to use ICD – 11 and several authors have warned against treating complex cases using concepts and methods derived from and tested with more straightforward ones (Corrigan & Hull, 2015; Spinazzola, Blaustein & van der Kolk, 2005). In addition, however, it leads on to potentially very important areas where the consequences of the guidelines not being more explicit with regard to potential pitfalls could be serious. The following might be highlighted. Although maltreatment and attachment problems can co- occur and predispose to other disadvantages over the life course it is possible that in some cases attachment difficulties (notably the consequences of related patterns of interaction between child and care- giver) may be mistaken for the sequelae of more familiar forms of abuse (e.g. Schuder & Lyons- Ruth, 2004). This may even apply to specific tendencies sometimes associated with trauma such as dissociation (Dutra et al, 2009). The implications for interventions should be considered carefully. In the case of children and young people there may be scope for interventions that work at the level of the family system (e.g. Patterson, Forgatch & De Garmo, 2010) and of course the role of any adult in currently generating a	

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				'trauma- inducing environment' should not be ignored. However it is particularly important that direction is established through careful assessment and not assumption. We may remind ourselves of the 'false and recovered memories' controversy of the 1990s, whilst also being aware that the premature assumption of past trauma in settings such as prisons may be as damaging to individuals as neglect of trauma when it is present (Rogers & Law, 2010). Noting the role of attachment history in relation to help-seeking and within therapeutic engagement may be pertinent to constructing a therapeutic relationship (Levy, Ellison, Scott & Bernecker, 2010; Lyons- Ruth, 2006; Mikulincer & Shaver, 2007; Vogel & Wei, 2005). More attention might also be drawn in the guidelines to the need to be aware of possible influences of an individual's present social context (including relationships, employment, community involvement and so forth) on recovery- relevant aspects such as identity, meaning, self-efficacy and belonging (Benight & Bandura, 2004; Brinn & Auerbach, 2015; Jobson, 2009; Needs, 2018) that may have been affected by exposure to trauma and its aftermath. Achieving new reconciliations of such aspects in the wake of life changes appears necessary to successful transition in areas such as occupational functioning (Ashforth, 2001).	

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The British Psychological Society	Guidance	13	17- 18	***Prevention, how far do we go?*** If prevention is to be considered in relation to PTSD and complex trauma then this needs to extend to thinking more than in terms of what should be done in the first month after a critical incident. It will extend to the literature on early interventions for 'troubled families' and understanding children with emotional and behavioural difficulties, many of whom could have a trauma origin in the form of adverse childhood experiences (Anda, Felitti, Bremner, Walker, Whitfield, Perry et al, 2005). Negative influences from others and trauma are acknowledged to be associated with the formation of negative cognitive schemata in personality disorder (Beck & Freeman, 1990; Young 1990; Young, Klosko, & Weishaar, 2003). The association between child abuse and certain types of personality disorder was acknowledged in a large-scale prospective study by Spataro et al (2004) whilst, for example, McLean and Gallop (2003) found high rates of child sexual abuse in adults with borderline personality disorder. Stress and trauma have been indicated as significant to the development of psychiatric disorders, anxiety, and mood disorders (Yehuda, 2000) and childhood trauma features in	Thank you for your comment and for drawing our attention to the Anda et al. (2005), Beck & Freeman (1990), Donnelly et al. (1999), Ford et al. (1999), McLean & Gallop (2003), Miller (1995), Perry (1994), Read et al. (2001), Read et al. (2005), Spataro et al. (2004), Weber & Reynolds (2004), Weinstein et al. (2000), Yehuda (2000), Young (1990), Young et al. (2003), and Zanville & Bennett-Cattaneo (2009) citations. As highlighted in your response, the prevention of childhood neglect, abuse and other adverse childhood experiences, including attachment-related problems is outside the scope of this guideline.

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				the occurrence of psychopathology which can include depression, dissociation, anxiety, conduct disorder (Miller, 1995). It is also associated with the development of attention deficit hyperactivity disorder (Donnelly, Maya-Jackson & March, 1999; Perry, 1994; Weinstein Staffelbach & Biaggio, 2000) and oppositional defiance disorder (Ford, Racusin, Daviss, Ellis, Thomas, Rogers et al, 1999) whilst neglect, with which it often co- occurs, is associated with a range of developmental delays due to related abnormalities in brain development (Weber & Reynolds, 2004). There is a high prevalence of undetected trauma exposure in psychotic populations (Zanville & Bennett-Cattaneo, 2009) and a significant neglect of treatment of trauma in such populations (Read, van Os & Ross, 2005). Read, Perry, Moskowitz and Connolly (2001) highlighted the contribution of early traumatic events to schizophrenia in some patients in their Traumagenic Neurodevelopmental Model. The prevention of childhood neglect, abuse and other adverse childhood experiences, including attachment-related problems, which are associated with the occurrence of PTSD (especially complex presentations), a variety of mental illnesses and disadvantage in a range of areas is arguably beyond the scope of this current guidance. However it is recommended that additional guidance	

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				should be considered and the limitations in this area of the current guidance should be more explicit.	
The British Psychological Society	Guidance	14	20-23	***Offer of EMDR after 3 months for non-combat related trauma*** The Society has concerns regarding the time scale for offering EMDR and could be regarded as withholding treatment. It is not clear why this delay to treatment is being considered. Trauma focused CBT is not going to be the preferred choice of intervention in certain populations. For example, in the case of Post Intensive Care Unit PTSD the target for treatment is often the delirium memory. CBT is not considered anywhere near as effective as the experience allowed within EMDR processing. Individuals suffering from delirium invariably know that at least some aspects of their experience never happened, despite how real they feel. Employing cognitive up-dating or re-structuring or up-dating hot-spots duplicates the struggle they have already had in trying to manage the impact of delirium. EMDR provides a much more effective and efficient route. It is not considered to be acceptable for NICE Guideline to recommend against clinicians offering what in their experience is the most effective therapy at the most appropriate time. Hulme (2018) in an online article 'Using eye movement therapy to reduce trauma after intensive care' (Nursing Times [online]; 114: 3, 18-21)	Thank you for your comment. In the consultation version of the guideline, there was no evidence for EMDR within 1 month of trauma. Through stakeholder comments, one additional new study was identified and added to the analysis. The committee considered the new evidence for EMDR in the first month following trauma in adults (Gil-Jardiné 2018). However, the committee did not consider that it was appropriate to make a recommendation in this time period as evidence was limited to a small single study (N=71) that only reported on one clinical outcome of interest and the effect on the number of participants with PTSD at 3-month follow-up was not statistically significant. No eligible evidence was identified for EMDR following intensive care unit discharge and on this basis the committee did not consider that a recommendation for this specific group was warranted. The committee considered the evidence for EMDR in the 1-3 month period following trauma, and in

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				produced excellent outcomes in a pilot study of EMDR therapy for ex-ICU patients with significant PTSD, albeit in a small group of participants. It is believed that the efficacy of the intervention is related not only to its modality but also to the fact that people can be seen quickly and process the memory before it becomes too established.	response to stakeholder's comments, agreed that a new recommendation should be added to consider EMDR for adults with PTSD within 1-3 months of non-combat-related trauma. This recommendation is based on single-study evidence showing large benefits of EMDR relative to supportive counselling in the 1-3 month period and an extrapolation from stronger evidence for EMDR more than 3 months after trauma. This was a weaker recommendation (consider rather than offer) based on the limited direct evidence available. Hulme (2018) has not been included in the guideline as it does not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs).
The British Psychological Society	Guidance	15	16- 22	***Symptom specific CBT*** The advocacy of symptom- specific CBT interventions is welcome but might be extended to include deeper consideration of the possible interactions between symptoms and therefore sequencing (Mc Nally et al, 2015). In addition, consideration might be given at this stage to interventions targeting aspects of functioning, consistent with those identified by 'recovery' and 'transition' perspectives that might be influencing the response to	Thank you for your comment and for drawing our attention to the Budden (2009), Lee & James (2012), McNally et al. (2015), McPherson (2011), Meichenbaum (2014), Mørkved et al. (2014), and Ruf et al. (2010) citations. The bullet points of the symptom-specific CBT recommendation highlight when in terms of sequencing such an intervention should be considered, namely, when the person is unable or unwilling to engage in a trauma-focused

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				more standard trauma- focused interventions or other areas of adjustment in the person's life. So, for example, where the identity- related aspect of shame (e.g. Budden, 2009) appears a significant factor there may as a point of good practice be the utilising of an approach aimed at increasing self- compassion (Lee & James, 2012). Similarly, a disrupted sense of meaning may benefit from Narrative Exposure Therapy (McPherson, 2011); this and allied approaches appear to have a special resonance for refugees and asylum seekers (Mørkved, Hartmann, Aarsheim & Thorp, 2014) and veterans (Meichenbaum, 2014) and it should be noted that the approach has been adapted for use with children (Ruf et al, 2010). It is recommended that this approach is considered for explicit inclusion following paragraph 1.6.9.	intervention or has residual symptoms after a trauma-focused intervention. No eligible evidence was identified for Compassion Focused Therapy and on this basis the committee did not think that a recommendation was warranted. The guideline used a class approach for analysis and Narrative Exposure Technique (NET) is included within the trauma-focused CBT class. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. In response to stakeholder's comments, we have also made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and included the examples from the glossary in the recommendation. The committee did not think I that there was sufficient evidence to recommend NET specifically for the refugee and asylum seeking population or for veterans. The committee discussed the complication of determining relative efficacy for specific groups as there was not a specific review question to address this and the NMA and

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					economic analysis were not restricted by population.
The British Psychological Society	Guidance	15	24- 25	***Psychological Debriefing (Critical Incident Stress Debriefing)*** The Society has concerns regarding the recommendation against using psychological debriefing (PD) in the guidance. It is considered that this recommendation has had far reaching consequences contributing to the highly questionable assertion that such early interventions for trauma are harmful and retraumatising. The recommendation against the use of PD has been based largely on evidence from two studies from the 1990's with road traffic accident victims (Hobbs, Mayou, & Harrison, 1996) and burn victims (Bisson, Jenkins, & Alexander, 1997). These studies are criticised for having significant methodological flaws and having given insufficient training to those delivering the debriefing (British Psychological Society, 2002; Regel, Joseph & Dyregov, 2007). Dyregrov and Regel (2011) concluded that there is an increasing number of studies demonstrating the effectiveness of early interventions. To give an extended example, Holmes, James, Coode-Bate and Deeprose, (2009) described a 6-hour time frame during which memories are malleable. Subjects watched a 12-minute film containing themes of injury and death and were	Thank you for your comment and for drawing our attention to the Blanchet & Roberts (2013), British Psychological Society (2002), Cooke et al. (2013), Dyregrov & Regel (2011), Guay et al. (2006), Hine et al. (2018), Hobfoll et al. (2007), Pekeyski (2013), Regel et al. (2007), Reyes & Elhai (2004), Ruzek et al. 2007, Schuder & Lyons- Ruth (2004), Seery et al. (2008), Tol et al. (2011), and Twenge et al. (2003) citations. The recommendation to not offer psychologically-focused debriefing is not a recommendation against early intervention. The guideline recommends that an individual trauma-focused CBT intervention should be offered to adults who have acute stress disorder or clinically important symptoms of PTSD and have been exposed to 1 or more traumatic events within the last month. The committee did not agree that the effects of debriefing could be accounted for solely by potential methodological flaws in two of the included studies. Effects are fairly consistent across studies (whether the intervention is delivered individually or as the intervention was originally conceived as a group intervention for teams of emergency workers who

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				randomly assigned to a condition in which 30 minutes later they played the game 'Tetris' for ten minutes or were assigned to a no activity control group. The group that played Tetris had reduced frequency of flashbacks after 1 week. The researchers explained their findings by suggesting that the use of Tetris requires cognitive resources in specific brain areas for memory consolidation. Tetris was argued to be effective at reducing flashbacks as it provided competition and disruption for the visuospatial resources needed for memory consolidation of the trauma-related sensory information. In a later study Tetris use was noted to be serving more than as a distraction technique (Holmes, James, Kilford, & Deeprose, 2010). As summarised by Dyregrov and Regel (2011) an application of this finding to clinical practice is that key sensory impact on an individual should be investigated soon after an incident in order to be able to engage in a relevant cognitive-perceptual activity with the potential to impact on the actual creation of traumatic memories. Whilst there is evidence that pain management and reducing arousal pharmacologically after trauma exposure can be effective in limiting the development of symptoms of PTSD, even in environments such as ICUs where sedation has a central role there is a strong view from some practitioners in the field that EMDR should be available as part of an active strategy for alleviating distress and mitigating potential long- term problems. Dyregrov and Regel (2011)	are used to working together) and suggest non-significant effects of debriefing at best, and some suggestion of a trend in favour of no treatment. On this basis, the committee agreed that this recommendation should remain unchanged, as offering an ineffective intervention is potentially harmful as it means that people are being denied access to another intervention with greater evidence of benefits. Please see below for details on the inclusion/exclusion of each of the references you cite: • Holmes et al. (2009) and Holmes et al. (2010) could not be included as participants did not have PTSD and were not at risk of PTSD (as defined in the review protocols). • Adler et al. (2008) is listed in excluded studies (Appendix K) of Evidence Report D as the population is outside scope (trials of soldiers on active service). • Adler et al. (2009) is listed in excluded studies (Appendix K) of Evidence Report C as the

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				also noted that arousal could be reduced and calmness induced by association with caring helpers, social support and ready access to information, although this also raises questions concerning the possible additional benefits of social support (Guay, Billette & Marchand, 2006). Building upon the latter, there have been substantial advances in the field of cognition within teams (Cooke, Gorman, Myers & Duran, 2013) although this has rarely been integrated with the literature on psychological debriefing. As stated previously NICE's position that psychological debriefing should not be conducted has resulted in this being an area that has been under-researched. It is necessary to differentiate the various processes that might be involved in debriefing, also recognising likely heterogeneity in practice. For example, Seery, Silver, Holman, Ence and Chu (2008) examined the impact of the terrorist attacks of 11 September 2001 and found that those who did not provide an initial response to a survey request for discussion of their thoughts and feelings had better mental and physical health outcomes than those who did. The possibility of the immediate expression of emotion entrenching stress-reactions is certainly an area for further study. However a focus on social aspects might highlight, for example, the disabling of self- regulatory capacities by perceived social exclusion (e.g. Twenge, Catanese & Baumeister, 2003), that many forms of psychological disturbance are associated with a sense of	population is outside scope (trials of soldiers on active service). • Zehnder et al. (2010) is included in Evidence Report A. • Greenwood (2012), Rick et al. (2006), Ruck et al. (2013) and Tehrani et al. (2011) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Bisson (2009) and Dieltjens et al. (2014) systematic reviews have been checked for any relevant references and no additional studies that meet the inclusion criteria were identified.

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				lack of connectedness to others (e.g. Hine, Maybery & Goodyear, 2018) and parallels with the suggestion that in childhood the burden of distress without the help in self-regulation of others can itself constitute a "hidden trauma" (Schuder & Lyons- Ruth, 2004). As summarised by Dyregrov and Regel (2012), group debriefing has been found to help to reduce posttraumatic problems following military-related traumatic events especially in those with high combat exposure (Adler Litz, Castro, Suvak, Thomas, & Burrell et al., 2008; Adler, Bliese, McGurk, Hoge, & Castro, 2009). Such effects do not appear to be confined to groups: individual debriefing resulted in a reduction in post-traumatic symptoms in children exposed to road traffic collisions (Zehnder, Mauli, & Landolt, 2010). It is also noted from evidence review C that NICE has not considered other more recent psychological debriefings undertaken in the prison service, (Ruck et al., 2013) and in the British Transport Police (Tehrani et al. 2011). Further debriefing derivatives not mentioned in the evidence include Rick et al's (2006) study undertaken with the Royal Mail and that of Greenwood (2012) who introduced a debriefing model into a secure hospital. Whilst more research is needed into the contexts, processes and individual differences involved in effective, ineffective, or iatrogenic practice in this area, It is recommended that NICE consider updating the guidance in	

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				this area and remove the direction to not conduct psychological debriefing. ***Psychological First Aid*** Good crisis intervention is increasingly referred to as Psychological First Aid (PFA). PFA has been defined as ''a humane, supportive response to a fellow human being who is suffering and who may need support''. PFA is further operationalised as "an intervention approach aimed at helping people deal with the experience and the consequences of a disaster or adversity." PFA draws on the five principles of Hobfoll et al (2007) which comprise installing feelings of safety, calmness, self-and community efficacy, connectedness and hope. Systematic reviews of PFA have been conducted by Bisson and Lewis (2009) and Dieltjens, Moonens, Van Praet, De Buck, Vandekerckhove (2014). Dietltjens et al (2014) found that despite a higher sensitivity search, "*no studies could be identified concerning the effectiveness of PFA interventions*". Dietltjens et al. (2014) concluded that reliable scientific evidence to identify the benefits or highlight the risks of PFA practices is therefore lacking. Noting the difficulties of studies being undertaken during the aftermath of disasters and that the available research has employed flawed methods and that together this has led to low quality evidence. In addition, there is a lack of consensus of how PFA is defined which has led to different frameworks and	

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				interventions. To assist the development of empirical evidence for PFA Dietltjens et al. (2014) called for international consensus in relation to its definition. The authors point to the definition for PFA set by the European Red Cross/Red Crescent Network for Psychosocial Support. The field is increasingly demanding evidence-based approaches for psychosocial support following disasters and critical incidents (Reyes & Elhai, 2004; Blanchet & Roberts , 2013; Pekeyski, 2013; Ruzek Brymer, Jacobs, Layne, Vernberg, et al., 2007; Tol, Patel, Tomlinson, Baingana, Galappatti, et al. 2011). A needs assessment study performed by the Evidence Aid initiative identified that mental health and psychosocial support interventions within the top 30 priorities in disaster research. It is identified that NICE recommend or endorse a definition for PFA and for it to be an area of research.	
The British Psychological Society	Guidance	15	8- 9	***EMDR bilateral stimulation*** The evidence for the role any bilateral stimulation (not just eye movements) as a necessary active ingredient in EMDR is equivocal (see Tadmor, McNally & Engelhard, 2016) although there may be other benefits. However the emphasis on 'specific target memories' may preclude the advantages (e.g. personal relevance, enhanced	Thank you for your comment and for drawing our attention to the Tadmor et al. (2016) and Rogers & Silver (2002) citations. In response to your, and other stakeholder's comments, the section of the recommendation that applies to bilateral stimulation has been amended to '*use repeated in-session bilateral stimulation (normally with eye movements)*' with a footnote

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				engagement) of allowing a focus on other memories which emerge during the procedure (Rogers & Silver, 2002). This might be worded as a point of good practice.	added that '*Other methods of bilateral stimulation, including taps and tones, could be used if these are preferred or more appropriate (such as for people who are visually impaired)'*. The committee did not consider it was appropriate to amend the reference to 'specific target memories' as the protocol states that you always start with the specific target memory but within a bilateral stimulation episode you would 'allow' the memories to flow, and link with other memories.
The British Psychological Society	Guidance	17-18	22-25 1-5	***Disaster Planning*** The guidance advice leaves it to those responsible to for managing disaster plans to provide a fully co-ordinated psychosocial response and.has little to offer to their defined user groups in managing the preparation, response and aftermath of traumatic events. NICE should explain or address this limited coverage and provide a signpost to where organisational leaders and others should seek guidance and support. The Crisis, Disaster and Trauma Section of the BPS has provided some advice on its website. www1.bps.org.uk/networks-and-communities/member-microsite/crisis-disaster-and-trauma-psychology-section.	Thank you for your comment. As specified in the scope, the disaster planning section from the 2005 guideline was not included in this update. In line with NICE processes, the 2005 content has been carried across to this updated guideline. However, the evidence on disaster planning has not been reviewed and we are not able to make any changes to this section (except where they are necessary in order to clarify meaning).

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The British Psychological Society	Guidance	19	General	***Recommendations for research*** Recommendations for additional research that support the MRC approach and will help elaborate important areas for future development include the following. • How do clients experience intervention procedures and the processes of personal change? Qualitative research in this area should identify a range of aspects that might be operationalised in future large- scale quantitative research aimed at identifying the nature and sequencing of factors predictive of outcome (and hence a more comprehensive range of 'active ingredients') both within and across interventions. • What factors contribute to non- commencement (where there has been an arrangement to treat) and non- completion of interventions? Although these are likely to be rather elusive participants (and such research should if possible not be confined to quantitative data such as demographics), such research should help clarify an important issue in relation to RCTs and will have implications for removing obstacles and promoting engagement. • To what extent do clients' circumstances influence aspects of disorder (and vice versa)? There is	Thank you for your comment and for drawing our attention to the Crespo & Fernández-Lansac (2016), Markowitz et al. (2015), Mayhew (2004), Neimeyer (2004), and Scott & Lilienfeld (2008) citations. The committee considered these suggestions for additional research recommendations but the areas already prioritised were still assessed to be of greater importance.

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				some research on specific areas (e.g. intimate relationships) and symptom areas (e.g. avoidance) but understanding is rather fragmented. Such research should include the symptom areas newly incorporated into DSM – 5 and should be highly compatible with the 'transitions' and 'recovery' perspectives mentioned in earlier comments. It would have implications for the management of disorder, extend awareness of potential 'lifestyle' interventions and provide insight into mediating and moderating processes. • How should 'social support' in relation to interventions (and trauma itself) be conceptualised and implemented? Advances have been made in this area, but they also have in related fields such as the study of social, enactive and distributed cognition, not to mention the widespread application in other branches of science of concepts and methods from the field of complex adaptive systems. These developments have substantial implications for reframing social support that may extend, for example, to the reappraisal of challenged views in PTSD research (e.g. Crespo & Fernández-Lansac, 2016; Scott & Lilienfeld, 2008) centred on information- processing at the individual level. Theoretical issues aside, further research in this area would help inform practice in areas such as peer support, psychological debriefing and the	

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				continued development of interventions that may in some cases obviate the need for exposure- based therapies (Markowitz et al, 2015) or which foster post- traumatic growth (e.g. Neimeyer, 2004). Historical examples, such as the origins amongst former service personnel of the therapeutic community movement, or the levels of adjustment achieved by members of the Guinea Pig Club (see Mayhew, 2004)for severely burned airmen (where social support was paramount yet discussion of injury- causing episodes was taboo) provide strong encouragement for a renewed focus upon this area.	
The British Psychological Society	Guidance Scope and Evidence Review A, C, G, general	1	General	***Prevention*** The Society notes the realignment of the scope of the guidance. The original scope was to recognise, assess and treat PTSD but the guidance is now stated include prevention. The Society has concerns regarding the extent to which evidence relating to prevention was sought and reviewed.	Thank you for your comment. As outlined in the scope the groups that will be covered include adults, children and young people *at risk of* PTSD and the areas from the published guideline that will be updated section of the scope includes psychological, psychosocial and pharmacological interventions for the prevention of PTSD.
The British Psychological Society	Guideline	22	1-3	***Stepped care***	Thank you for your comment. The committee did not consider the evidence sufficient to recommend a stepped care model for the delivery of PTSD interventions.

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				The committee seems to have lost sight of the need for a stepped care approach, particularly when large numbers are involved. The committee recognise that Group CBT may be appropriate, but do not see that in schools it may have a stronger place.	
The British Psychological Society	Guideline	28	17- 19	***EMDR to be recommended for children should TFCBT fail*** In the previous guidelines, EMDR only just fell short of being recommended. In any stepped care approach, it is probably worth considering using it for 1 or 2 sessions before moving on to lengthier therapies. It is odd to see it being regarded as something to try after TF-CBT fails. The EMDR community should be able to clarify given the large number of studies undertaken in the intervening years.	Thank you for your comment. The committee considered the evidence for EMDR in treatment of children with PTSD and noted the limited evidence base, in terms of the number of studies/participants, the number of different comparisons, the breadth of outcomes reported, and the availability of long-term follow-up. The committee observed that the benefits of EMDR were not statistically significant relative to waitlist or treatment as usual, and the head-to-head comparisons against trauma-focused CBT (although suggestive of no significant difference) were not sufficiently powered to detect non-inferiority (single-study analyses). The committee also took into account the results of the NMA and economic base-case analysis which both suggested that EMDR was less clinically effective and cost-effective than all individual trauma-focused CBT interventions. On the basis of the clinical and cost-effectiveness and these additional considerations, the committee agreed that EMDR should only be considered for children and young people if they do not respond to or engage with trauma-focused CBT.

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The Havens Rape and Sexual Assault Centre	Guideline	General	General	It is important to address that clients require their basic needs to be met before meaningful psychological therapy can take place, such as a focus on stabilisation, provision of and safety within home environment, safeguarding etc. Furthermore, the guidelines do not state that there is a need to ensure the trauma is not ongoing before any meaningful therapeutic/recovery work can take place. Safety needs to be in place before starting therapy.	Thank you for your comment. The committee agreed that these are important considerations but considered that these needs were captured by existing recommendations. In the 'planning treatment and supporting engagement' section there is a recommendation that when discussing treatment options with people with PTSD, any social or personal factors that may have a role in the development or maintenance of the disorder should be taken into account. The recommendation on adaptations that may be needed for people with PTSD and additional needs, including those with complex PTSD also includes guidance that the safety and stability of the person's personal circumstances (for example their housing situation) and how this might impact on engagement with and success of treatment, should be taken into account.
The Havens Rape and Sexual Assault Centre	Guideline	General	General	We note that dissociation is not discussed in much detail throughout the guidelines when it is a symptom that frequently presents in PTSD. We feel the assessment and management of dissociation needs to be clearly addressed in the guidance.	Thank you for your comment. In response to your and other stakeholder's comments, and the recent publication of ICD-11 and the complex PTSD diagnosis, dissociation has now been added to recommendations 1.1.1 and 1.1.3 for the recognition and assessment of PTSD. The severity of PTSD symptoms, in particular dissociative symptoms, has also been added as a reason why you might not consider a computerised trauma-focused CBT intervention. Furthermore, in the recommendation on adaptations that may be

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					required to psychological interventions for those with PTSD and additional needs, including complex PTSD, guidance is given that the person should be helped to manage any issues (including dissociation) that might be a barrier to engaging with trauma-focused therapies.
The Havens Rape and Sexual Assault Centre	Guidelines	General	General	There is a sense that the guidelines are quite CBT-centric. This approach may not work for all, particularly those who struggle to verbalise their trauma/feelings/internal world/reflections and those for whom language may be an additional barrier to treatment. Once again, we believe it is best practice to use a formulation-based approach in deciding on what therapeutic modality may be best to use for individual clients with consideration of approaches such as Narrative Exposure Therapy, Compassion Focused Therapy as well as CBT and EMDR.	Thank you for your comment. The guideline used a class approach for analysis and Narrative Exposure Technique (NET) is included within the trauma-focused CBT class. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. We have also made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and examples of specific interventions (in the glossary) have been added to the recommendation. No eligible evidence was identified for Compassion Focused Therapy and on this basis the committee

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					did not agree that a recommendation was warranted. The recommendations about the structure and content of recommended interventions are written in such a way as to allow enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set. The guideline also includes recommendations that interventions are offered in a way that is culturally and linguistically appropriate for service users, and that interpreters and/or offering a choice of therapists are considered where language or culture differences present challenges to the use of psychological interventions.
The Havens Rape and Sexual Assault Centre	Guideline/Evidence	General	General	Leading on from the above, there is no mention or consideration in the guidelines of Narrative Exposure Therapy (NET) for children (see below emerging evidence). 1. Larsen, S. E., Fleming, C. J. E., & Resick, P. A. (2018). Residual symptoms following empirically supported treatment for PTSD. *Psychological Trauma: Theory, Research, Practice, and Policy,* doi:http://dx.doi.org/10.1037/tra0000384	Thank you for your comment. The guideline used a class approach for analysis and Narrative Exposure Technique (NET) is included within the trauma-focused CBT class. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The committee agreed that although some interventions within the Trauma-focused CBT class place an emphasis on exposure and others place an emphasis on cognitive techniques, there is considerable overlap in

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				2. Amone-P'Olak, K., Elklit, A., & Dokkedahl, S. B. (2018). PTSD, mental illness, and care among survivors of sexual violence in northern uganda: Findings from the WAYS study. *Psychological Trauma: Theory, Research, Practice, and Policy, 10*(3), 282-289. doi:http://dx.doi.org/10.1037/tra0000295 3. Neuner, F., Schauer, M., Klaschik, C., Karunakara, U., & Elbert, T. (2004). A comparison of narrative exposure therapy, supportive counseling, and psychoeducation for treating posttraumatic stress disorder in an african refugee settlement. *Journal of Consulting and Clinical Psychology, 72*(4), 579-587. doi:http://dx.doi.org/10.1037/0022-006X.72.4.579 4. Schauer, E., Neuner, F., Elbert, T., Ertl, V., Onyut, L. P., Odenwald, M. G., & Schauer, M. (2004). Narrative exposure therapy in children: A case study. *Intervention, 2*(1), 18-32. Retrieved from https://search.proquest.com/docview/42378479?accountid=48570	techniques and mechanisms. Definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. We have also made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and examples of specific interventions (in the glossary) have been added to the recommendation. Please see below for details on the inclusion/exclusion of each of the references you cite: • Larsen et al. (2018) is not included in the guideline as the comparison is outside protocol (within-class comparison, CPT versus PE) • Amone-P'Olak et al. (2018) and Schauer et al. (2004) have not been included in the guideline as they did not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Neuner et al. (2004) is included in Evidence report D
The Havens Rape and	Guideline	5	27	Purposively designing a leaflet for parents/carers that is disseminated nationwide to all emergency departments would help to ensure parity of information shared, whilst	Thank you for your comment. It was outside the committee's remit to purposively design a leaflet for parents and carers. However, the recommendation

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Sexual Assault Centre				providing parents/carers with a resource to refer to should they need it, and perhaps when they are not feeling so overwhelmed, at a later date.	outlines what information and support should include and the committee agreed that this was sufficiently detailed to enable implementation.
The Havens Rape and Sexual Assault Centre	Guideline	6	10	Guidelines talk about use of brief, validated screening instrument with refugees/asylum seekers. This could be more tentative, with an acknowledgement that some of these screening instruments are not culturally sensitive or meaningful.	Thank you for your comment. As specified in the scope, the recognition and assessment sections from the 2005 guideline were not included in this update. In line with NICE processes, the 2005 content has been carried across to this updated guideline. However, the evidence on recognition and assessment has not been reviewed and we are not able to make any changes to this section (except where they are necessary in order to clarify meaning).
The Havens Rape and Sexual Assault Centre	Guideline	6	25	The client/family/carers should be consulted and involved in this care planning decision, rather than informed.	Thank you for your comment. The committee agree and in response to your comment this recommendation has been amended to *involve* the person and, where appropriate, their family or carers.
The Havens Rape and Sexual Assault Centre	Guideline	7	18	This should not delay a referral being accepted and assessment/treatment beginning.	Thank you for your comment. In response to your and other stakeholder's comments, this recommendation has been amended to *'the referring team should not discharge the person before there is an agreed care plan in the new service*' in order to convey that the new service should be engaged.
The Havens Rape and	Guidelines	7	20	The guidelines do not address the assessment and treatment of complex trauma, how it may act as a barrier to therapy (Question 7 above related to Section 1.3.1) and	Thank you for your comment. In response to your and other stakeholder's comments, and the publication of ICD-11 we have amended the

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Sexual Assault Centre				affect choice of therapy and efficacy. Those who have experienced complex childhood trauma of a pervasive nature are highly vulnerable to abuse and exposure to further traumata. If PTSD is apparent – how is this thought about in terms of the relational/complex trauma and subsequent treatment?	recognition recommendation to include explicit reference to complex PTSD and the symptoms of complex PTSD have been added to this recognition recommendation as additional bullet points. Although the evidence was limited on interventions for people who have complex PTSD, the evidence suggested that trauma-focused therapies could also benefit this group. Based on their experience, the committee proposed ways of modifying interventions to address the barriers people with complex PTSD might have to engaging in treatment, like helping the person manage any issues that might be a barrier to engaging with trauma-focused therapies (such as dissociation, emotional dysregulation, interpersonal difficulties or negative self-perception), ensuring adequate time is included in treatment for the person to establish trust, offering more sessions and avoiding an abrupt end to treatment by planning ongoing support.
The Havens Rape and Sexual Assault Centre	Guidelines	7	20	There is little mention of cognitive capacity of clients (i.e. learning disability), how that may act as a barrier to therapy (Question 7 above related to Section 1.3.1) and affect choice of therapy and efficacy. People with disabilities are highly vulnerable to abuse and consequently trauma.	Thank you for your comment. As specified in the review protocols, this guideline does not cover people with learning disabilities as there is existing NICE guidance, 'Mental health problems in people with learning disabilities: prevention, assessment and management' which includes recommendations for this group. Please see NG54 https://www.nice.org.uk/guidance/ng54

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The Havens Rape and Sexual Assault Centre	Guideline	8	17	It is suggested that the Crown Prosecution Service (CPS) guidelines pertaining to pre-trial therapy are mentioned here as a point of reference. We note that the CPS guidelines are currently under review.	Thank you for your comment. A cross-reference to the relevant CPS guidance has now been added to this recommendation.
The Havens Rape and Sexual Assault Centre	Guideline	9	11	It would be beneficial to specify and elaborate on what is meant by *'delivered in a way that does not risk re-traumatisation'*, i.e. no discussion of trauma details.	Thank you for your comment. In response to your, and other stakeholder's, comments this recommendation has been amended and the phrase 'risk of re-traumatisation' has been replaced with *'the risk of exacerbating symptoms*' as the meaning is clearer and it is less open to unintended interpretations.
The Havens Rape and Sexual Assault Centre	Guideline	10	21	Support should be considered/ offered for interpreters who may be exposed to vicarious trauma.	Thank you for your comment. The needs of interpreters are outside the scope of the guideline unless they meet the criteria of having PTSD or being at risk of PTSD (as defined in the review protocols), and if so the recommendations in the guideline apply to those who have developed PTSD in response to work-related exposure to trauma (including remote exposure).
The Havens Rape and Sexual Assault Centre	Guideline/Evidence	11	15	Services should also have a more flexible DNA policy as trauma work can be difficult and has high drop-out rates (e.g. Schottenbauer, M. A., Glass, C. R., Arnkoff, D. B., Tendick, V., & Gray, S. H. (2008). Nonresponse and dropout rates in outcome studies on PTSD: Review and methodological considerations. *Psychiatry: Interpersonal and Biological Processes*, *71*(2), 134-168.)	Thank you for your comment and for drawing our attention to the Schottenbauer et al. (2008) citation. In response to your and other stakeholder's comments, this recommendation has now been amended to include *'allowing flexibility in service attendance policies'*.
The Havens Rape and	Guideline	11	19	Whilst the guidelines talk about 'active monitoring' in the initial months post exposure to a stressor, they do not	Thank you for your comment. Active monitoring is defined in further detail in the glossary. However,

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Sexual Assault Centre				explicitly state what is meant by this. Furthermore, they do not talk about the potential for increased risk of suicidal ideation or harm to self, nor do they talk about the need to actively manage this. It is also relevant to highlight that a change or increase in risk of harm to self could be an indicator of PTSD/exposure to a stressor.	the committee did not consider it appropriate to be more specific in terms of implementation as it was agreed that this was best left to clinical judgement. In response to your, and other stakeholder's concerns about the potential for increased risk of self-harm, the committee agreed to add self-harm to the following recommendation: *'For people with PTSD whose assessment identifies a significant risk of harm to themselves or others, establish a risk management and safety plan as part of initial treatment planning*'.
The Havens Rape and Sexual Assault Centre	Guideline	12	22	We are curious about what is meant by a validated manual for TF-CBT. Is it possible to have such a manual for such a broad range of potential traumata and trauma-survivors?	Thank you for your comment. This recommendation is for a class of interventions rather than a specific intervention and thus there will be a number of validated manuals that clinicians can choose to follow. In response to stakeholder's comments we have made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions.
The Havens Rape and Sexual Assault Centre	Guideline	12	23	This depends on the type and amount of trauma. Also the guidance shares some overlap with the NICE guidance for children who have been sexually abused, but the recommendations differ. See https://www.nice.org.uk/guidance/ng76/chapter/Recommendations#therapeutic-interventions-for-children-young-people-and-families-after-child-abuse-and-neglect, Section 1.7.17, (12 to 16 sessions, more if needed).	Thank you for your comment. In response to your and other stakeholder's comments, this recommendation has been amended to *'typically be provided over 6 to 12 sessions, but more if clinically indicated, for example if they have experienced multiple traumas'*. This amendment means that the recommendation about the number of sessions in the two guidelines no longer contradict each other.

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The Havens Rape and Sexual Assault Centre	Guideline	12	4-14	1.6.4 -1.6.6 We question why EMDR has not been considered here. There is some evidence that EMDR works well with children, including those who have experienced pre-verbal trauma. e.g. Went, M., & Struik, A. L. (2010, June). The use of EMDR with infants. Presentation at the 11th EMDR Europe Association Conference, Hamburg, Germany. It is also helpful to consider practice based evidence in terms of widespread use of EMDR with children under 7 years of age. Furthermore, this seems to contradict lines 2-4, paragraph 1, page 28, which states that *'…the committee could not recommend [Trauma-focused CBT] with the same certainty for under 7's but agreed it should be thought of as an option for them.*'	Thank you for your comment. No eligible evidence was identified for the use of EMDR with children and young people within 3 months of trauma, and on this basis the committee did not consider it appropriate to recommend EMDR as an early intervention for children and young people. The committee considered the evidence for EMDR in the delayed treatment of children with PTSD (more than 3 months after trauma) and noted the limited evidence base, in terms of the number of studies/participants, the number of different comparisons, the narrowness of outcomes reported, and the availability of long-term follow-up. The committee observed that the benefits of EMDR were not statistically significant relative to waitlist or treatment as usual, and the head-to-head comparisons against trauma-focused CBT (although suggestive of no significant difference) were not sufficiently powered to detect non-inferiority (single-study analyses). The committee also took into account the results of the NMA and economic base-case analysis which both suggested that EMDR was less clinically effective and cost-effective than all individual trauma-focused CBT interventions. On the basis of the clinical and cost-

					effectiveness and these additional considerations, the committee agreed that EMDR should only be considered for children and young people if they do not respond to or engage with trauma-focused CBT. For trauma-focused CBT there was some evidence that trauma-focused CBT was effective for children both over and under 7 years. The committee extrapolated from stronger evidence for children and young people aged 7-17 years to children aged under 7. However, there was limited evidence for EMDR for children and young people aged 7-17 years and even more limited for those under 7 years, e.g. only 1 of the 3 included EMDR delayed treatment studies included children under 7 in the age range (6-16 years) and that study found no significant effects. On this basis the committee did not consider it appropriate to recommend EMDR for children aged under 7. The committee do not consider routine datasets to be better or equivalent to RCT data as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading. Went & Struik (2010) could not be included as conference abstracts were not included (as outlined in the review protocols).

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The Havens Rape and Sexual Assault Centre	Guideline	12 13	4-25 1-13	1.6.4 - 1.6.19 The timescales for when therapy should start appear rigid and do not consider context and that a client-centered, formulation-driven approach to deciding what may be helpful and when would be more appropriate.	Thank you for your comment. Recommendations are based on what we know about when treatments might be effective, however, in an individual assessment and subsequent formulation decisions may be made as to whether to adjust when treatments are started.
The Havens Rape and Sexual Assault Centre	Guideline	13	1	A focus within psychoeducation on resilience and post-traumatic growth could be usefully included rather than an exclusively pathologising approach.	Thank you for your comment. The recommendations about the structure and content of psychological interventions is informed by the interventions in the RCTs, and modified by the expert advice of the committee. On this basis, the committee did not think that it was appropriate to make this change here. However, the committee agreed that it is important to promote a message of hope in terms of the likelihood of improvement and recovery and with this end in mind an amendment to the promoting access recommendation was made to include the guidance that people with PTSD should be reassured that it is a treatable condition.
The Havens Rape and Sexual Assault Centre	Guideline/Evidence	13	9-13	Clients should be given a choice about which therapy they prefer in combination with considering the formulation, we question the suggestion of EMDR as second choice. EMDR should not be offered as a last resort if something else does not work. Children can wish not to discuss (or not be able to due to age/development) the trauma, and so may prefer EMDR for this reason.	Thank you for your comment. Patient choice is a central element of the provision of effective healthcare. We have made recommendations in the 'planning treatment and supporting engagement' section which require those providing treatment and support for people with PTSD to set out the benefits and harms, and the requirements of individual

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				Some evidence for use of EMDR with children; 1. Grolnick, W. S., Schonfeld, D. J., Schreiber, M., Cohen, J., Cole, V., Jaycox, L., . . .Zatzick, D. (2018). Improving adjustment and resilience in children following a disaster: Addressing research challenges. *American Psychologist, 73*(3), 215-229. doi: http://dx.doi.org/10.1037/amp0000181 2. Adúriz, M. E., Bluthgen, C., & Knopfler, C. (2011). Helping child flood victims using group EMDR intervention in argentina: Treatment outcome and gender differences. *International Perspectives in Psychology: Research, Practice, Consultation, 1*, 58-67. doi:http://dx.doi.org/10.1037/2157-3883.1.S.58	interventions so as to enable people to make an informed choice. NICE guidelines make recommendations for interventions where there is evidence that they are clinically and cost effective. The purpose of recommending the interventions that we have for children and young people is not to remove patient choice, but rather to provide people with a choice from those interventions that have the greatest likelihood of being effective. The committee considered the evidence for EMDR in treatment of children with PTSD and noted the limited evidence base, in terms of the number of studies/participants, the number of different comparisons, the breadth of outcomes reported, and the availability of long-term follow-up. The committee observed that the benefits of EMDR were not statistically significant relative to waitlist or treatment as usual, and the head-to-head comparisons against trauma-focused CBT (although suggestive of no significant difference) were not sufficiently powered to detect non-inferiority (single-study analyses). The committee also took into account the results of the NMA and economic base-case analysis which both suggested that EMDR was less clinically effective and cost-

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					effective than all individual trauma-focused CBT interventions. On the basis of the clinical and cost-effectiveness and these additional considerations, the committee agreed that EMDR should only be considered for children and young people if they do not respond to or engage with trauma-focused CBT. Adúriz et al. (2011) and Grolnick et al. (2018) have not been included in the guideline as they do not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs)
The Havens Rape and Sexual Assault Centre	Guideline	13	14-16	Positive that the guidance that drug treatment should not be used for the prevention or treatment of PTSD in Children and Young People aged less than 18 years has been maintained.	Thank you for your comment.
The Havens Rape and Sexual Assault Centre	Guideline	14	24	Should specify that EMDR should be *delivered by a trained clinician*.	Thank you for your comment. In response to your, and other stakeholder's, comments this recommendation (and other recommendations about the structure and content of psychological interventions) has been amended to include the guidance that interventions should 'be *delivered by trained practitioners with ongoing supervision'*.
The Havens Rape and Sexual Assault Centre	Guideline	15	11	Whilst the guidelines talk about '*self-calming techniques'*, we feel that this is different from 'grounding techniques', which provide clients with concrete skills in managing symptoms of hyperarousal and/or dissociation. We feel the	Thank you for your comment. The committee did not consider it appropriate to make specific reference to grounding techniques in this recommendation as we do not have evidence that grounding techniques are better than other

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				use of grounding techniques is the very foundation of trauma work, in any form.	techniques such as mindful or controlled breathing. With this in mind, the committee amended the recommendation to include strategies for managing flashbacks.
The Havens Rape and Sexual Assault Centre	Guideline	15	17	We feel that it is also important to mention strong, debilitating feelings of guilt or shame. Practice-based evidence informs us that client-centred counselling can be helpful in working with such symptoms and offering a safe, containing and holding space to talk, work though and make sense of these painful feelings. Our service has had experiences of implementing a humanistic counselling therapeutic approach which clients have found beneficial, we would willing to submit our experiences to the NICE shared learning database.	Thank you for your comment. In response to your and other stakeholder's comments, this recommendation has been amended to include 'processing trauma-related emotions, including shame, guilt, loss and anger'. The committee considered the evidence for counselling for the treatment of PTSD in adults and noted that counselling was shown to be less cost-effective than no treatment in the guideline economic analysis. On this basis the committee did not consider it appropriate to recommend counselling. The committee do not consider routine datasets to be better or equivalent to RCT data as we cannot be sure that the populations treated with various interventions are the same and to assume so would be potentially misleading.
The Havens Rape and Sexual Assault Centre	Guideline	17	3	Level of substance misuse need to be assessed to determine ability to engage in therapy and process trauma effectively.	Thank you for your comment. In response to your and other stakeholder's comments changes have been made to recommendations to reflect that for some people substance misuse may need to be addressed to enable engagement with trauma-

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					focused intervention. The previous recommendation has been amended as follows: 'Do not exclude people with PTSD from treatment based *solely* on comorbid drug or alcohol misuse', and the recommendation for adaptations that may be needed to psychological interventions for people with PTSD and additional needs has been amended to recommend that people are helped to manage any issues, including substance misuse, that might be a barrier to engaging with trauma-focused therapies.
The Havens Rape and Sexual Assault Centre	Guidelines	31 32	26-29 1-3	Furthermore, why is EMDR framed on page 13, line 12 as a last resort, when at the bottom of page 31 and top of page 32 guidelines say there is a trend towards EMDR being more effective and more cost-effective?	Thank you for your comment. The EMDR recommendation that was on page 13 in the consultation version of the short guideline was for children and young people. While the EMDR rationale and impact section that was on page 31-32 was for the treatment of adults. The committee considered the evidence for EMDR in the treatment of children with PTSD and noted the limited evidence base, in terms of the number of studies/participants, the number of different comparisons, the breadth of outcomes reported, and the availability of long-term follow-up. The committee observed that the benefits of EMDR were not statistically significant relative to waitlist or treatment as usual, and the head-to-head comparisons against trauma-focused CBT

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					(although suggestive of no significant difference) were not sufficiently powered to detect non-inferiority (single-study analyses). The committee also took into account the results of the NMA and economic base-case analysis which both suggested that EMDR was less clinically effective and cost-effective than all individual trauma-focused CBT interventions. On the basis of the clinical and cost-effectiveness and these additional considerations, the committee agreed that EMDR should only be considered for children and young people if they do not respond to or engage with trauma-focused CBT. Trauma-focused CBT and EMDR are offered as equivalent options for adults with PTSD who have been exposed to non-combat-related trauma more than 3 months ago. In response to stakeholder's comments the EMDR recommendation has been amended and the words 'as an option' removed to make it clearer that EMDR is an equivalent option to trauma-focused CBT for adults exposed to non-combat related trauma.
The Havens Rape and Sexual Assault Centre	Research/Evidence	19	7	We suggest further research into more body based interventions for working with trauma, to be included in the recommendations for research. There is a growing evidence base regarding this, and it is in line with research outcomes regarding the neuroscience of trauma. See below emerging evidence;	Thank you for your comment. The committee did not make a research recommendation in this area

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				1. Price, M., Spinazzola, J., Musicaro, R., Turner, J., Suvak, M., Emerson, D., & van der Kolk, B. (2017). Effectiveness of an extended yoga treatment for women with chronic posttraumatic stress disorder. *The Journal of Alternative and Complementary Medicine*, *23*(4), 300-309. 2. Rhodes, A. M. (2015). Claiming peaceful embodiment through yoga in the aftermath of trauma. *Complementary therapies in clinical practice*, *21*(4), 247-256 3. Van der Kolk, B. A. (2006). Clinical implications of neuroscience research in PTSD. *Annals of the New York Academy of Sciences*, *1071*(1), 277-293. 4. Van der Kolk, B. A., Stone, L., West, J., Rhodes, A., Emerson, D., Suvak, M., & Spinazzola, J. (2014). Yoga as an adjunctive treatment for posttraumatic stress disorder: a randomized controlled trial. *J Clin Psychiatry*, *75*(6), e559-65.	as other areas were assessed to be of greater importance. Please see below for details on the inclusion/exclusion of each of the references you cite: Price et al. (2017) and Van der Kolk (2006) have not been included in the guideline as they did not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs). Rhodes (2015) would not meet inclusion criteria for the qualitative principles of care review (Evidence report H) because the outcomes are outside protocol (experiences of disorder or care with no explicit implications for management, planning and/or delivery of care). Van der Kolk et al. (2014) is included in Evidence report D.
The Royal College of Midwives	Guideline	General	General	We have no comments to make on the guideline – happy with what's written	Thank you for your comment.
Thought Field Therapy	Guideline	33	15 - 21	No mention of Thought field Therapy for mass trauma in resource poor settings, where the evidence base is strongest and is cost efficient.	Thank you for your comment. No eligible evidence was identified for TFT for the prevention of PTSD in people exposed to ongoing trauma (e.g. in a war

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Foundation UK Ltd					zone). There are two included studies of TFT for the treatment of PTSD in adults exposed to war as a civilian. The committee considered the results of the guideline economic analysis and noted the cost effectiveness of combined somatic and cognitive therapies (CSACTs; the class of interventions that includes TFT). However, they also noted the limited evidence for clinician-rated PTSD symptomatology (an outcome that can be blinded, there was no evidence for this outcome in comparisons with a non-active comparator), the limited evidence for outcomes other than self-rated PTSD symptoms, and the limited follow-up data (there was no follow-up data in comparisons with a non-active comparator) for CSACTs. The committee also expressed concerns about the generalisability of results given the more restricted trauma types and the broader inclusion criteria of the included studies on CSACTs in terms of clinically important PTSD symptoms rather than necessarily a diagnosis of PTSD. Therefore, after taking all evidence and additional considerations into account, they decided to make no recommendation for CSACTs.

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Thought Field Therapy Foundation UK Ltd	Evidence D	213	lines 14,15	No mention of a study in children: Sakai, Connolly & Oas (2010) J Emergency mental health, 12: 41-50. or Connolly, Roe-Sepowitz, Sakai & Edwards (2013) African journal of traumatic Stress 3: 82-90.	Thank you for your comment. Please see below for details on the inclusion/exclusion of each of the references you cite: • Sakai et al. (2010) did not meet the study design inclusion criteria for review questions about intervention efficacy (not an RCT or systematic review of RCTs) • Connolly et al. (2013) is listed in the excluded studies (Appendix K) of Evidence report D with the reason for exclusion that group assignment was not truly randomised (alternating group assignments)
Trauma Treatment international	Guideline	General	General	There is very little mention of the needs of specific groups that research has shown have high prevalence of PTSD (for example asylum seekers and refugees). Aside from the welcome recommendation of ensuring access to services, there is no guidance about the suitability of specific therapies for these groups, another unfortunate inevitable outcome of having grouped so many different therapies under the overall umbrella of trauma focused CBT.	Thank you for your comment. The guideline used a class approach for analysis. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. However, in response to stakeholder's comments, we have now made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and examples of

					specific interventions (in the glossary) have been added to the recommendation. Sub-analyses by specific intervention (within the trauma-focused CBT class) suggests some differential effects but within-subgroup heterogeneity remains high and benefits are observed across all interventions (although statistical significance varies). Similarly, sub-analyses by trauma type suggests some differences with larger effects associated with some trauma types but these are difficult to disentangle as the larger effects are associated with the single smaller study subgroups. In summary, benefits of trauma-focused CBT were seen across a wide range of specific types of trauma-focused CBT intervention of varying durations, and for different types of trauma. However, heterogeneity is high across outcomes and could not be accounted for by planned sub-analyses (by multiplicity of trauma, specific intervention, diagnostic status at baseline, or trauma type). The committee speculated on other potential causes of this heterogeneity, including sub-optimal patient to treatment matching. Based on these discussions, the committee drafted the recommendation about the content and structure of trauma-focused CBT in a way that allowed enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set.

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					The committee did not consider that there was sufficient evidence to recommend interventions specifically for the refugee and asylum seeking population as there was not a specific review question to examine the relative efficacy of different interventions within this population-only and the NMA and economic analysis were not restricted by population.
Trauma Treatment international	Guideline	14	3	By grouping together all trauma focused therapies with the exception of EMDR into one category of 'trauma focussed CBT', the evidence for trauma focussed CBT is inflated, and the guideline offers no advice regarding which of the large number of different approaches labelled as trauma focussed CBT are most effective nor which are most appropriate for the particular population / client in question. For example NET almost exclusively is used for the treatment of multiple trauma and particularly in contexts of organised violence while other approaches are more used for single incident trauma for accidents. NET is the most widely used therapy for PTSD in insecure, low resource and conflict and post conflict settings. By grouping all the studies in this way the clinician is not guided about which of the many treatments labelled trauma focussed CBT should be used. Rather it appears that there is equal evidence for any of the large number of studies labelled trauma focussed CBT across any context with any population with PTSD. At the same time, a 'heterogeneity across	Thank you for your comment. The guideline used a class approach for analysis. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The committee agreed that although some interventions within the trauma-focused CBT class place an emphasis on exposure and others place an emphasis on cognitive techniques, there is considerable overlap in techniques and mechanisms. Definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. The committee discussed categorisation at length and agreed that NET should remain in the trauma-

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				outcomes' is noted in the evidence review. Arguably, adding EMDR to this group and labelling it 'trauma focussed psychological therapies' rather then trauma focused CBT would be more accurate. As a result of this decision to combine the evidence in this way the recommendations are extremely broad, and potentially misleading, as the reader who does not analyse the evidence tables may not realise the number of different approaches included (and therefore recommended) here (including those which are often not considered CBT at all)	focused CBT class and that EMDR should remain in a distinct class. However, in response to your and other stakeholder's comments, we have now made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and the examples of the specific interventions (in the glossary) have been added to the recommendation. Sub-analyses by specific intervention (within the trauma-focused CBT class) suggests some differential effects but within-subgroup heterogeneity remains high and benefits are observed across all interventions (although statistical significance varies). Similarly, sub-analyses by trauma type suggests some differences with larger effects associated with some trauma types but these are difficult to disentangle as the larger effects are associated with the single smaller study subgroups. In summary, benefits of trauma-focused CBT were seen across a wide range of specific types of trauma-focused CBT intervention of varying durations, and for different types of trauma. However, heterogeneity is high across outcomes and could not be accounted for by planned sub-analyses (by multiplicity of trauma,

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					specific intervention, diagnostic status at baseline, or trauma type). The committee speculated on other potential causes of this heterogeneity, including sub-optimal patient to treatment matching. Based on these discussions, the committee drafted the recommendation about the content and structure of trauma-focused CBT in a way that allowed enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set. The committee did not think that there was sufficient evidence to recommend NET specifically for the refugee and asylum seeking population as there were only two studies (N=57) reporting different outcomes (self- versus clinician-rated PTSD symptomatology). The committee also discussed the added complication of determining relative efficacy for specific groups as there was not a specific review question to address this and the NMA and economic analysis were not restricted by population.
Trauma Treatment international	Guideline	14	6	The guidance suggests that approaches using validated manuals should be used. Ironically, it is only trauma focussed CBT that does not have a sole, validated manual, and yet the other manualised treatments have been grouped under this heading.	Thank you for your comment. The guideline used a class approach for analysis. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The definition of trauma-focused CBT in the glossary highlights that

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					a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. However, in response to your and other stakeholder's comments, we have now made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and examples of specific trauma-focused interventions (in the glossary) have been added to the recommendation.
Trauma Treatment international	Evidence review D	13	2-8	NET is inaccurately labelled as being a type of trauma focussed CBT. It does not share the same "broad approach" (line 3), is not similar to other therapies in having an emphasis on either "exposure or cognitive techniques" (line 5). This is a fundamental misunderstanding of NET. Our focus is limited to NET here as it is our area of expertise, (Maggie Schauer is our patron, Katy Robjant is in the research team) but it may also apply to other therapies that have been grouped together under the heading of trauma focussed CBT. NET includes exposure and cognitive techniques but also emphasises other techniques. There are similarities but also fundamental differences in the "proposed underlying mechanisms" (line 8). Narrative Exposure Therapy also shares similarities with psychodynamic therapy, and client-centred therapy as well as other exposure based approaches including PE, and EMDR. However, the	Thank you for your comment and for drawing our attention to the Schauer et al. (2003) citation. The guideline used a class approach for analysis and Narrative Exposure Technique (NET) is included within the Trauma-focused CBT class. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The committee discussed the categorisation of NET at great length and agreed that this intervention belonged in the trauma-focused CBT class, due to the considerable overlap in techniques and mechanisms. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, and Prolonged Exposure. In

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				underlying research on which NET was developed is different from that of trauma focussed CBT, and subsequent research into the societal and transgenerational effect of ongoing conflict and interpersonal trauma, together with epigenetic research, which supports and leads to developments in the applications of NET (including KIDNET, for children, and FORNET, for former combatants/perpetrators) takes NET much further from the areas of research typically investigated for CBT or other therapies. NET particularly recognises the 'building block effect' (eg Schauer et al, 2003) of loading trauma on trauma, and therefore uniquely attends to each trauma along the life line in chronological order. It emphasises a contextualisation of trauma, not solely in terms of altering traumatic memory, but also in terms of the actual political and social context in which the trauma occurred. NET therapists do not take a 'neutral' position and significant importance within the therapy is given to the testimonies which are an output of NET. For example, in NET the testimonies have been used for court cases and in group and community interventions to reduce stigmatisation and promote inclusion, in line with NET researcher's findings concerning the continuation of trauma within communities, families, and through biological transmission. Even the 'exposure' within Narrative Exposure Therapy is technically clinical different to that described in trauma focused CBT. In NET, the therapist is	response to stakeholder's comments we have made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and added the examples from the glossary to the recommendation.

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				'close and directive' in a constant 'pro-active exposure conversation style' with many interventions from the therapist to prevent dissociation and to retain a constant therapeutic contact between therapist and client, and to enable the repair of relational bonds. NET actively treats dissociation within the exposure rather than in a separate 'stabilisation' phase required by many other therapies.	
Trauma Treatment international	Evidence review D	Appendix B, C &K	General	A number of published NET trials have been evaluated despite not appearing in appendix K and despite meeting the eligibility criteria. It is unclear why these were not identified via the search strategies outlined in appendix B	Thank you for your comment. The list of excluded studies (Appendix K) lists only those studies excluded at the full-text review stage, so studies that were excluded on the basis of the title or abstract will not be listed here.
Trauma Treatment international	Evidence review D	Appendix D	general	In the table of included studies there are more studies included as trauma focussed CBT which in fact do not describe themselves as such (rather they are PE, CPT, DBT,NET, imaginal exposure, imagery rehearsal therapy, brief eclectic psychotherapy, exposure inhibition therapy, metacognitive therapy) than there are actual trauma focussed CBT studies (including individual trauma focussed CBT, group trauma focussed CBT, trauma focussed CBT plus medication, brief individual trauma focussed CBT and cognitive therapy). There are in fact nearly twice as many studies in the former category. This clearly invalidates the decision to name these therapies trauma focussed CBT, and to use this evidence in the former category as support for recommending trauma focussed CBT. Furthermore, there is clearly a difference in	Thank you for your comment. The guideline used a class approach for analysis. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The committee agreed that although some interventions within the trauma-focused CBT class place an emphasis on exposure and others place an emphasis on cognitive techniques, there is considerable overlap in techniques and mechanisms. Definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy

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				type of trauma and setting in which the different approaches have been used. By grouping them in this way, it suggests that any of the therapies under the umbrella term of trauma focussed CBT can be used as effectively as any other in vastly contrasting settings with very different populations.	for PTSD, Narrative Exposure Therapy, Prolonged Exposure. However, in response to your and other stakeholder's comments, we have now made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are referring to a class of interventions and included the examples of specific interventions in the recommendation. Sub-analyses by specific intervention (within the trauma-focused CBT class) suggests some differential effects but within-subgroup heterogeneity remains high and benefits are observed across all interventions (although statistical significance varies). Similarly, sub-analyses by trauma type suggests some differences with larger effects associated with some trauma types but these are difficult to disentangle as the larger effects are associated with the subgroups that include only a small single study. In summary, benefits of trauma-focused CBT were seen across a wide range of specific types of trauma-focused CBT intervention of varying durations, and for different types of trauma. However, heterogeneity is high across outcomes and could not be accounted for by planned sub-analyses (by multiplicity of

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					trauma, specific intervention, diagnostic status at baseline, or trauma type). The committee speculated on other potential causes of this heterogeneity, including sub-optimal patient to treatment matching. Based on these discussions, the committee drafted the recommendation about the content and structure of trauma-focused CBT in a way that allowed enough flexibility for the clinician to modify treatment to the individual, but enough specificity to ensure a minimum standard is set.
Trauma Treatment international	Evidence review D	Appendix D	General	There are almost as many NET trials as EMDR trials and yet EMDR is evaluated separately without justification. The only argument for failing to evaluate NET separately appears to be the assertion that NET is based on the same underlying theory or principles as trauma focussed CBT. This is factually incorrect, as has been made clear by the main researchers involved in NET and also by the creators of NET (see above, comment 3).	The guideline used a class approach for analysis and Narrative Exposure Technique (NET) is included within the trauma-focused CBT class. This approach was also taken by the previous guideline. Interventions were grouped into classes based on similar principles and mechanisms. The committee discussed the categorisation of NET at great length and agreed that this intervention belonged in the trauma-focused CBT class, due to the considerable overlap in techniques and mechanisms. The definition of trauma-focused CBT in the glossary highlights that a number of named therapies fall under this term: Cognitive Processing Therapy, Cognitive Therapy for PTSD, Narrative Exposure Therapy, Prolonged Exposure. In response to stakeholder's comments, we have made some changes to the wording of the trauma-focused CBT recommendations to make clear that we are

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					referring to a class of interventions and added the examples of specific interventions (from the glossary) to the recommendation.
Trauma Treatment international	Evidence review D	Appendix K	1275 onwards	There appears to be a problem with the whole table from page 1275 onwards. References are listed to 'Z' then inexplicably continue at 'L' and authors are attributed to the wrong studies. For eg Robjant 2010 is listed in the table of excluded papers in relation to a study that Robjant was not involved with (page 1306)	Thank you for your comment and for bringing this error to our attention. This table has now been replaced with a correctly formatted one.
Wish – A voice for women's mental health	Guideline	General	General	Question 7: We believe that the following groups face barriers accessing treatment for PTSD: - Prisoners. PTSD amongst offenders is poorly understood by prison healthcare services, though this is improving, and there are few targeted psychological interventions available to prisoners - People with a high risk of suicide, self harm, or dissociation. We have noticed that some specialist trauma therapy services are very risk-averse and have extremely narrow acceptance criteria, turning away service users for whom self harm and dissociation have been coping strategies (in the absence of any therapy to address the trauma at the root of their distress) – this seems counterintuitive given what we know about how people cope with PTSD symptoms. We believe that services should be asking how they can enable a person to	Thank you for your comment. Mental health care in prisons is outside the scope of this guideline as there is an existing NICE guideline on '*Mental health of adults in contact with the criminal justice system*'. Please see NG66 https://www.nice.org.uk/guidance/ng66 The committee agreed that it is very important that services prioritise inclusion rather than exclusion criteria in terms of engaging people with PTSD in treatment, however, the committee felt that this was covered by the following part of the promoting access recommendation: 'providing a care model that is clear about the range of interventions and services offered and the people that may benefit, *rather than prioritising reasons why services cannot be accessed*'.

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				participate in trauma therapy, rather than excluding them from services	
Wish – A voice for women's mental health	Guideline	General	General	Question 1: We are concerned that the assumption or expectation of competence in assessing for PTSD will be a significant challenge when implementing these guidelines. In our experience, working in services and delivering gender and mental health training to staff, and the experience of the women we work with, this is not a given. NHS staff tell us that they feel out of their depth and as though they lack the necessary knowledge when faced with a service user displaying the symptoms of PTSD. Many still think that PTSD is something only experienced by war veterans. We believe that many service users receive a diagnosis of Borderline / Emotionally Unstable Personality Disorder instead as a consequence.	Thank you for your comment. Knowledge of the full range of mental disorders, including PTSD, is part of the pre- and/or post- qualification training of all mental health staff working in the NHS. In addition those who are providing treatments for people with PTSD will have received specific additional training on the assessment of PTSD and this will include an understanding of the difficulty people have in disclosing their problems, talking about the experience of the traumatic event and the necessity to make appropriate adjustments to treatment to take into account people's experiences.
Wish – A voice for women's mental health	Guideline	5	17	Whilst it is important that clinicians bear in mind the possibility that PTSD might be at the root of multiple attendances with unexplained physical symptoms, there is a risk of diagnostic overshadowing if clinicians follow this path before other avenues of investigation have been exhausted. There is evidence to show the people with learning difficulties and people already diagnosed with mental health problems are particularly at risk of diagnostic	Thank you for your comment. The committee were aware that multiple attendance at GPs or unusual presentations can be related to undisclosed trauma. The committee considered that adding this question to any initial assessment does not incur significant costs in terms of time or resources but has the potential to provide a useful diagnostic clue as to the reasons for presentation. On this basis, the

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				overshadowing. Research also shows that women and Black and Minority Ethnic people also typically face delays in being diagnosed with some illnesses in comparison to white men.	committee did not consider it appropriate to make changes to this recommendation. The committee are aware that diagnostic overshadowing can be a potential problem for people with learning disabilities and have drawn attention to this in NICE 'Mental health problems in people with learning disabilities' guideline.
Wish – A voice for women's mental health	Guideline	9	14	We welcome the inclusion of a section in the guidelines around maintaining safe environments. It is also worth noting that prisons are also trauma-inducing environments for people with PTSD, so steps should be taken by prison healthcare units to make them as safe an environment as possible.	Thank you for your comment. We agree that steps should be taken to make prison environments as safe as possible. However, mental health care in prisons is outside the scope of this guideline as there is an existing NICE guideline on 'Mental health of adults in contact with the criminal justice system'. Please see NG66 https://www.nice.org.uk/guidance/qs163
Wish – A voice for women's mental health	Guideline	15	12	Computerised interventions have their place, however we are concerned that they cannot pick up on symptoms that the service user might not have much insight into, such as dissociation, which a therapist would be more likely to recognise when meeting face-to-face. It is important that this risk is thoroughly assessed before offering a computerised intervention as opposed to a face-to-face service.	Thank you for your comment. The committee agreed that this recommendation needed re-drafting as it was open to unintended interpretations. The re-drafted recommendation clarifies that supported trauma-focused computerised CBT should be considered for adults with established PTSD where the person has a preference relative to face-to-face trauma-focused CBT or EMDR and if the person does not have severe PTSD symptoms in particular dissociative symptoms and is not at risk of harm to themselves or others.

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Wish – A voice for women's mental health	Guideline	30	16	Whilst a recommendation for other interventions such as meditation and yoga was not included in the guidelines due to weak evidence, we believe that is important to note that there is anecdotal evidence from people with / survivors of PTSD that these interventions can be actively harmful, triggering flashbacks and dissociation, if not delivered by a skilled practitioner in a trauma-sensitive way.	Thank you for your comment. In the rationale and impact section of Evidence report D this point is made as follows *'The committee also discussed anecdotal evidence based on their experience that MBSR may be associated with potential harms, such as increasing the likelihood of intrusive thoughts*.'

None of the stakeholders who comments on this clinical guideline have declared any links to the tobacco industry.