Letters to the Editor

The Range of Psychotherapies for PTSD

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TO THE EDITOR: In the June 2018 issue of the *Journal*, Murray Stein and Barbara Rothbaum note in their generally clear-sighted and useful overview of the history of posttraumatic stress disorder (PTSD) and its treatment that "trauma-focused treatments had more evidence for their efficacy in the treatment of PTSD than any other intervention" (1, p. 512). This is undeniably the case, but there are psychotherapeutic alternatives to trauma-focused treatment. Inasmuch as Stein and Rothbaum also accurately indicate that current treatments have limited efficacy, a more balanced perspective might have indicated that trauma-focused exposure treatment is not for everyone (patients or therapists)—there is no panacea—and that alternative treatments with growing evidence bases exist. Having the most evidence does not discount other evidence. Focusing on affect and interpersonal issues may provide an alternative to a cognitive-behavioral trauma focus, and there is room for both. The *Journal* has published studies of non-exposure interpersonal psychotherapy (2), which in one trial showed comparable overall outcome to prolonged exposure therapy and advantages for patients with sexual trauma–related PTSD or major depression, as well as studies of skills training in affect and interpersonal regulation therapy (3). These empirically supported treatments are beginning to appear in treatment guidelines (4).

I join Stein and Rothbaum's call for further research on psychotherapies and pharmacotherapies for PTSD, and I add that research should cover all, not just some, of the promising bases. Our field has too often suffered from ideological schism (5, 6), yet there is room and need for more than one treatment approach for most psychiatric disorders.

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Dire Need for New and Improved Therapies for PTSD: Response to Markowitz

TO THE EDITOR: We thank Dr. Markowitz for his comments on our historical overview of the treatment of posttraumatic stress disorder (PTSD). In our overview, we emphasized that trauma-focused psychotherapies with prominent exposure and/or cognitive restructuring elements have the strongest evidence base for their utility. This statement is entirely consistent with the recommendation in the 2017 practice guidelines from the U.S. Department of Veterans Affairs and Department of Defense (1) that Dr. Markowitz refers to in his letter. Although it is indeed the case, as Dr. Markowitz mentions, that treatments such as interpersonal psychotherapy (IPT) "are beginning to appear in treatment guidelines," those same practice guidelines indicate that the evidence in favor of IPT is weak (1).

We wholeheartedly agree that there are some promising new (and repositioned not so new) therapies for PTSD on the horizon (e.g., psychotherapeutic, psychopharmacological, device-based), and we anxiously await their further testing. If proven effective, beyond single studies, they will no doubt begin to be used and will offer much-needed alternatives to existing therapies, none of which currently meet the needs of all patients with PTSD.

REFERENCE

1. VA/DoD Clinical Practice Guidelines: Management of Posttraumatic Stress Disorder and Acute Stress Reaction, 2017. https://www.healthquality.va.gov/guidelines/MH/ptsd/

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