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.

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Progress in PTSD

TO THE EDITOR: Drs. Stein and Rothbaum contributed an informative overview, published in the June 2018 issue of the *Journal*, of the history of posttraumatic stress disorder (PTSD), with lessons learned, forgotten, and rediscovered (1). The current era reflects substantial progress in phenomenology and therapeutics. Admittedly, many patients with PTSD continue to experience distress and disability despite treatment, but that is a common challenge in our field of psychiatry. However, what is missing in this scholarly review are traumatized children and adolescents, an oversight that parallels the absence of a reference to this substantial clinical population when PTSD was first named as a disorder in DSM-III in 1980 (2). The study of childhood PTSD has a notable record of accomplishment that complements our understanding of PTSD in adults, many of whom had first experienced traumatic adversity as children (3). Stein and Rothbaum begin their article with the statement, "Traumatic stressors have always been a part of the human experience" (1, p. 508). Let's not forget that human experience starts at birth.

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Foundations of Consultation-Liaison Psychiatry

TO THE EDITOR: Having spent a large part of my career working as a consultation-liaison psychiatrist, I was most interested to read Alison Heru's review, published in the May 2018 issue of the *Journal*, of Don Lipsitt's recent book, *Foundations of Consultation-Liaison Psychiatry: The Bumpy Road to Specialization*. I noticed some important errors in the review, none of which are present in the book. Although Dr. Heru correctly attributes the first use of the term liaison psychiatry to Edward Billings in 1939, she is incorrect in stating that it was Flanders Dunbar who first coined the term psychosomatics. According to Prof. Walter Jackson Bate, it was the English poet Samuel Taylor Coleridge "who coined the term psychosomatic a century before it was adopted by the medical world" (1, p. 103). This was pointed out by John Nemiah (2) three decades ago and more recently by Peter Shoenberg, who noted that the poet "spoke about his 'Psychosomatic *Ology*' in the course of a discussion of the origins and nature of the passions" (3, p. xi; 4, p. 1444). It is generally agreed, however, including by Lipsitt (5, pp. 98–99), that the term psychosomatic was introduced into the medical literature by Johann Christian August Heinroth, who was the first professor of psychiatry and psychotherapy in the Western world; he wrote about psychosomatic factors in insomnia in 1818, whereas Coleridge had used the term 7 years earlier (6).

Another error is the statement that Flanders Dunbar founded the journal *Psychosomatics* in 1939; she was actually one of the founding members and the first managing editor of the journal *Psychosomatic Medicine*, first published in 1939. As Lipsitt points out (5, p. 206), the journal *Psychosomatics* was founded in 1960 by Wilfrid Dorfman and has been the official journal of the Academy of Psychosomatic Medicine. A third error is the statement that Dunbar established the Society of Psychosomatics in 1942; it was the American Society for Research in Psychosomatic Problems that she helped establish (5, p. 102), and its name was changed in 1947 to the American Psychosomatic Society (7). Given that the Academy of Psychosomatic Medicine was recently renamed the Academy of Consultation-Liaison Psychiatry, it is important that the history of psychosomatic medicine and the role of pioneers in the field be recorded accurately.

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