

# Letters to the Editor

## EMDR for Treatment of PTSD

**Sir:** I am a psychiatrist interested in treating patients with a history of trauma. I am particularly interested in the use of eye movement desensitization and reprocessing (EMDR), since I have found it to be especially effective in resolving the residual of early and recent traumatic experiences of my patients. On the basis of my clinical observations and EMDR's extensive controlled research base, I wanted to support the expansion of training and use of EMDR, and I became a member of the board of the EMDR International Association. I am writing as a concerned clinician, not as a board member.

I am writing out of concern that the recent Supplement, "The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder"<sup>1</sup> has some problems in presentation that may distort the findings. In the supplement, the authors selected a substantial group of clinicians and researchers who were established in the area of posttraumatic stress disorder (PTSD). My concern is the way that the data were presented. The experts were asked to give their opinions regarding the efficacy of a variety of interventions, and for some of the interventions, such as psychoanalysis and EMDR, only a minority of the experts would have been trained in the method. If the results were presented as a function of the clinician's opinion of the methods in which he or she had been trained, then each clinician would have been speaking from his or her own knowledge base and personal experience. As it is, clinicians and researchers were being asked to report on the effectiveness of methods they may have little experience with or knowledge about. The results as reported wash out the opinions of those trained in EMDR because their opinions were averaged with those who had not been trained in EMDR. The ultimate result is that EMDR was assessed to be in the range of effectiveness as such interventions as psychoanalysis in the treatment of PTSD. We know from controlled studies that EMDR appears to be as effective or more effective than other treatments for PTSD.

To clarify and rectify this issue, would you ask the authors to reanalyze their data based on the above criteria? The results could be presented in a few paragraphs in an editorial.

### REFERENCE

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76

**Gary Peterson, M.D.**

The Southeast Institute for Group and Family Therapy  
Chapel Hill, North Carolina

**Sir:** The Expert Consensus Guideline Series is a commendable endeavor, and the design has obviously been carefully thought out. However, although the Guidelines may represent

the cutting edge in some respects, at least one element is definitely lagging behind. Design features led to a marked undervaluation of eye movement desensitization and reprocessing (EMDR) in the Guidelines issue on the treatment of posttraumatic stress disorder,<sup>1</sup> relative to published empirical support for the efficacy of EMDR as well as indications of preference for EMDR among both clinicians and patients with direct experience (e.g., van Etten and Taylor<sup>2</sup>).

This unfortunate and misleading outcome was due to the fact that the empirical support for EMDR is so recent that many of the designated experts have not yet obtained training in EMDR and therefore would be unlikely to have sufficient familiarity with the method to recommend it. This is in contrast to the other methods rated, which are likely to be familiar to all. Thus the design was biased against EMDR because other treatments had a chance of being rated positively by every expert, whereas EMDR could only be rated positively by a fraction of them.

It would be informative to do an additional analysis of the data including only the ratings of those with training in EMDR. Chances are very good that among this subgroup EMDR would be rated as a treatment of choice as well as a treatment that is efficient and effective.

### REFERENCES

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76
2. van Etten M, Taylor S. Comparative efficacy of treatments for posttraumatic stress disorder: a meta-analysis. *Clin Psychol Psychother* 1998;5:126-145

### The EMDR International Association Research Committee:

**Nancy J. Smyth, Ph.D. (Chair)**

University at Buffalo School of Social Work  
Buffalo, New York

**Ricky Greenwald, Psy.D.**

Mount Sinai Medical Center  
New York, New York

**Ad de Jongh, Ph.D.**

University of Amsterdam/Institute for Psychotrauma  
Amsterdam, the Netherlands

**Christopher Lee, Ph.D.**

Sir Charles Gairdner Hospital, QEII Medical Centre  
Perth, Australia

### Dr. Foa and Colleagues Reply

**Sir:** We are pleased to reply to the letters sent to you by Dr. Peterson and the EMDR International Association Research Committee concerning the issue of treatment selection for posttraumatic stress disorder (PTSD) as reported in the Expert Con-

sensus Guidelines.<sup>1</sup> The letters expressed concerns that the guidelines may be at odds with their clinical experience of the efficacy of eye movement desensitization and reprocessing (EMDR) because this treatment was not included as a first-line treatment for PTSD.

In selecting experts for this project, we have made conscientious efforts to select a large and diverse group of experts of psychotherapy for PTSD. As we noted in the Supplement (p. 4), participants in the Psychotherapy Expert Consensus Survey were identified from the following sources: recent publications, recipients of research grants, and membership of the International Society for Traumatic Stress Studies and the American Association of Behavioral Therapists. Although this method of expert selection reflected our attempt to include individuals with broad knowledge of the field, it has also introduced a bias in favor of clinicians who are active in research. As noted by Dr. Peterson and the EMDR International Association Research Committee, many experts have direct expertise in one area only. However, scholars are generally familiar with the literature of their area of expertise, in this case, treatment of PTSD. Thus, experts who were chosen responded according to personal experience, their own research, and their understanding of the literature. Therefore, the final recommendations reflect common consensus in the field rather than our opinion.

It is important to note that according to the experts, the evaluated EMDR did not receive a rating of a first-line therapy for PTSD on any of the questions about individual psychotherapies (i.e., 13 through 17).

We appreciate the authors' raising their concerns and giving us the chance to clarify the Expert Consensus Guideline process.

#### REFERENCE

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76

**Edna B. Foa, Ph.D.**

University of Pennsylvania  
Philadelphia, Pennsylvania

**Jonathan R. T. Davidson, M.D.**

**Allen Frances, M.D.**

Duke University Medical Center  
Durham, North Carolina

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#### Further Discussion of EMDR for Treatment of PTSD

**Sir:** We are writing in response to the publication of "The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder," for which each of us served as an expert. While we applaud the authors for their effort to collect and systematize expert opinion on the treatment of posttraumatic stress disorder (PTSD), we are concerned that these guidelines will cause serious misunderstanding and misinterpretations of the empirical status of eye movement desensitization and reprocessing (EMDR) in the treatment of PTSD.

We are particularly concerned that the selection process for the pool of experts markedly biased the reported results and the development of the suggested guidelines. After reviewing the published list of participating experts, we saw that nearly all of the 52 "psychotherapy experts" were selected from those who adhere to the treatments recommended, i.e., cognitive therapy

and exposure therapy. It is therefore not surprising that the collected views would strongly favor cognitive therapy and exposure. Because only a small number of EMDR experts were represented, their views would be statistically overcome. Our own views on EMDR's effectiveness and its relationship to cognitive therapy and exposure are not in any way reflected in the results of this survey. Given the large number of PTSD experts who have published on the application of EMDR to the treatment of PTSD, it is regrettable that the composition of this pool of experts was so nonrepresentative. Unfortunately, this selection bias was not made explicit in the Guidelines.

Balanced scientific reviews have found EMDR to be both effective and efficient. A task force of the American Psychological Association Division 12 (Clinical Psychology) evaluated approaches for the treatment of PTSD and rated exposure therapy, cognitive therapy, and EMDR all equally at a "probably efficacious level."<sup>2</sup> A recent independent meta-analysis described EMDR as at least as effective as both exposure and the cognitive behavior methods and probably both more efficient and better accepted by patients.<sup>3</sup>

Given that these Guidelines will be widely distributed and quoted by others, we believe additional statements on these limitations need to be included to lessen the risk that these results, as originally published, will harm patients by discouraging them from seeking the most efficacious and efficient available treatment methods. In addition, researchers applying for grants and graduate students seeking academic support for dissertation topics may find their paths blocked by misleading interpretations on existing psychotherapy methods for treating PTSD unless these Guidelines are supplemented with additional commentary. Specifically, it should be stated that "The panel of experts evaluating psychotherapy approaches was heavily weighted in favor of cognitive behaviorists, which may account for the high scores of the recommended methods." Such a clarification is appropriate both scientifically and ethically.

We urge that in the future, the process for selecting experts be designed to address diversity in the scientific literature in areas of emerging interventions. History and the philosophy of science tell us that new approaches often receive widespread opposition from those wedded to previous approaches. Such controversies can be the source of great growth in our knowledge when they are considered carefully. We regret that has not been done in this case.

#### REFERENCES

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76
2. Chambless D, Baker MJ, Baucom DH, et al. Update on empirically validated therapies, II. *Clin Psychol* 1998;51:3-16
3. van Etten ML, Taylor S. Comparative efficacy of treatments for posttraumatic stress disorder: a meta-analysis. *Clin Psychol Psychother* 1998;5:126-144

**Charles R. Figley, Ph.D.**

Traumatology Institute, Florida State University  
Tallahassee, Florida

**Andrew M. Leeds, Ph.D.**

Private Practice  
Santa Rosa, California

**Sandra A. Tinker-Wilson, Ph.D.**

Spencer-Curtis Foundation  
Colorado Springs, Colorado

**Bessel A. van der Kolk, M.D.**

Boston University School of Medicine  
Boston, Massachusetts

### Dr. Foa and Colleagues Reply

**Sir:** We are pleased to reply to the letter sent to you by Dr. Figley and colleagues concerning the issue of treatment selection for posttraumatic stress disorder (PTSD) as reported in the Expert Consensus Guidelines.<sup>1</sup> The authors of the letter expressed concerns that the Guidelines will cause misinterpretation of the empirical status of eye movement dissociation and reprocessing (EMDR) because this treatment was not included among the first-line treatments for PTSD.

In selecting experts for this project, we made conscientious efforts to identify a large and diverse group of experts on psychotherapy for PTSD. As we noted in the Supplement (p. 4), participants in the Psychotherapy Expert Consensus Survey were identified from the following sources: recent publications, recipients of research grants, and membership of the International Society for Traumatic Stress Studies and the American Association of Behavioral Therapists. Although this method of expert selection reflected our attempt to include individuals with broad knowledge of the field, it has also introduced a bias in favor of clinicians who are active in research. Notably, all 4 authors of the letter from Dr. Figley and colleagues were asked to participate in this project, 3 as experts on EMDR and 1 as an expert on medication. Importantly, experts responded according to personal experience, their own research, and their understanding of the literature. Therefore, the final recommendations do not reflect our personal opinions and, indeed, in some cases may be inconsistent with them.

It is important to note that according to expert opinion, EMDR did not receive a rating of a first-line therapy for PTSD on any of the questions about individual psychotherapies (i.e., 13 through 17).

We appreciate the authors' raising their concerns and for giving us the chance to clarify the Expert Consensus Guideline process.

#### REFERENCE

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76

**Edna B. Foa, Ph.D.**  
University of Pennsylvania  
Philadelphia, Pennsylvania  
**Jonathan R. T. Davidson, M.D.**  
**Allen Frances, M.D.**  
Duke University Medical Center  
Durham, North Carolina

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### Omission of Bupropion as a Recommended Treatment for PTSD

**Sir:** I read with interest Supplement 16 (1999), "The Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder."<sup>1</sup> Being a rather conscientious fellow, I began to think over the cases of posttraumatic stress disorder (PTSD) that I am treating and ask myself how my treatment stacks up against the recommendations of the experts.

As it happens, at least one of my PTSD patients is taking bupropion. I looked at the articles in this supplement and noted the recurrent refrain: SSRIs, nefazodone, venlafaxine. To my amazement, bupropion is not even mentioned!

I was actually frightened! I thought to myself, "I wonder if there is something that I don't know about bupropion that

makes it unsuitable to use for persons with PTSD." Then I thought that if that were so, surely the experts would have commented upon it and warned readers not to use it.

It was sometime later when I happened to notice the supplement's list of "unrestricted educational grants." I noticed that Glaxo Wellcome, the manufacturer of Wellbutrin brand of bupropion, is not listed among the donors of the grants supporting this study. I was stunned! Could this be the reason that bupropion was not mentioned?

I shudder to think that such could be the case. Yet I have found little else to explain the discrepancy. I imagine that you are aware of the great need and desire among us clinicians for clear, unbiased studies and of the high frequency of use of articles from your journal by various drug companies as they push their products and present studies which show that their medication is better than any other.

I do hope that you can help me to understand the omission of consideration of bupropion for some reason other than the failure of its makers to contribute financially to the study.

#### REFERENCE

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76

**Ralph M. Reeves, M.D.**  
The Reading Hospital and Medical Center  
West Reading, Pennsylvania

### Dr. Foa and Colleagues Reply

**Sir:** We are pleased to reply to Dr. Reeves' letter concerning the issue of treatment selection for posttraumatic stress disorder (PTSD) as reported in the Expert Consensus Guideline Series.<sup>1</sup> Experts who were chosen responded according to their personal experience and also their understanding of what is in the literature with respect to making treatment recommendations.

Bupropion was included as one possible approach (Guideline 35) and received a rating of 5 (i.e., equivocal, a second-line treatment that would sometimes be used) from the standpoint of representing the best combination of effectiveness, safety, and tolerability. At the time the guidelines were assembled, reported efficacy for bupropion in PTSD was extremely limited.

We do wish to point out that the experts were unaware of the sources of support for this project. Some forms of treatment received relatively high recommendations even when the treatment manufacturer had not contributed to these Guidelines. Among these is lamotrigine, an anticonvulsant that received solid second-line ratings as a mood stabilizer for the treatment of PTSD.

We appreciate Dr. Reeves' raising his concerns and for giving us the chance to clarify the Expert Consensus Guideline process.

#### REFERENCE

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76

**Edna B. Foa, Ph.D.**  
University of Pennsylvania  
Philadelphia, Pennsylvania  
**Jonathan R. T. Davidson, M.D.**  
**Allen Frances, M.D.**  
Duke University Medical Center  
Durham, North Carolina

## Psychodynamic Psychotherapy for PTSD

**Sir:** I was puzzled by the dismissal of psychodynamic psychotherapy in the recent "Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder."<sup>1</sup> It appeared in a sentence along with eye movement desensitization and reprocessing and hypnotherapy under the heading "Other Forms of Psychotherapy" and was dismissed as less effective than the other treatments described. I suspect that this statement reflects a selection bias of those surveyed and is unsupported by comparative, scientific data.

Many of the authorities who have been fundamental in the conceptualization of posttraumatic stress disorder (PTSD) have had their roots in psychodynamic theory and practice. Many clinicians experienced in the treatment of posttraumatic stress syndromes have described psychodynamically based approaches for adult-onset PTSD and for the complex sequelae of childhood abuse and neglect. For example, the psychoanalyst Mardi Horowitz in his classic book *Stress Response Syndromes*,<sup>2</sup> and in other books, describes a model and treatment approach based on principles from psychodynamic theory and information processing for which there are research data. Jacob Lindy<sup>3</sup> has written on the psychodynamic treatment of Vietnam veterans who have PTSD. Leonore Terr has published her seminal work on traumatized children in psychoanalytic journals such as the *Psychoanalytic Study of the Child*. Henry Krystal, Nannette Aurehan, Dori Laub, and other psychoanalysts have written extensively about their work with survivors of the Holocaust from a psychoanalytic perspective. Judith Herman is a leader in the field of trauma studies and in her book *Trauma and Recovery*<sup>4</sup> describes a treatment approach that is largely psychodynamic. Other clinicians with considerable experience in treating traumatized patients, such as Shengold,<sup>5</sup> Chu,<sup>6</sup> Messler Davies and Frawley,<sup>7</sup> and others, have described working within a psychoanalytic and psychodynamic model with this difficult population. This is a tiny list that could include many other reputable clinicians and researchers.

No comparative research data show one form of psychotherapy to be more effective than any other in the treatment of PTSD. Furthermore, the effects of trauma are so varied and complex that an eclectic and flexible approach is more advisable than adherence to rigid theoretical concepts. It is hard to imagine helping patients who have the complex sequelae of childhood abuse and neglect—including traumatic reenactments, rage, guilt, shame, difficulties with intimacy, aloneness, compartmentalization of images of self and others, deficits in self-reflection and symbolic thinking, and the complex defenses used to cope with intolerable affect and sustain a cohesive sense of self—without the guide of a psychodynamic frame of reference. Managing the complex transference and countertransference dynamics that complicate the treatment of such persons also benefits from a psychodynamic perspective.

I am not surprised that psychodynamic treatments are found to be less effective by those who practice predominantly cognitive-behavioral therapy, just as behavioral therapy would be less effective than psychodynamic therapy in my hands. There is nothing wrong with such preferences and biases. But if they are conveyed as "scientific fact" agreed upon by the experts, then personal, ideological, and political bias masquerades as science.

### REFERENCES

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76
2. Horowitz MG. *Stress Response Syndromes*. New York, NY: Jason

Aronson; 1976

3. Lindy JD. *Vietnam: A Casebook*. PsychoSocial Series No. 10. New York, NY: Brunner/Mazel; 1988
4. Herman JL. *Trauma and Recovery*. New York, NY: Basic Books; 1992
5. Shengold L. *Soul Murder*. New Haven, Conn: Yale University Press; 1989
6. Chu JA. *Rebuilding Shattered Lives: The Responsible Treatment of Complex Post-Traumatic Stress and Dissociative Disorders*. New York, NY: John Wiley & Sons; 1998
7. Messler Davies J, Frawley MG. *Treating the Adult Survivor of Sexual Abuse: A Psychoanalytic Perspective*. New York, NY: Basic Books; 1994

**José A. Saporta, M.D.**  
Massachusetts General Hospital  
Boston, Massachusetts

**Sir:** We read with interest tempered by some disappointment the recent Expert Consensus Guidelines for the treatment of posttraumatic stress disorder (PTSD)<sup>1</sup> published in the *Journal*. We applaud the authors' efforts to offer a comprehensive overview of treatment approaches for patients suffering from this disorder and their efforts to organize a panel of experts to identify the best treatment approaches and establish a sequence of alternatives for treatment-refractory cases. We were disappointed by the puzzling exclusion of a recommendation for consideration of psychodynamic psychotherapy for the treatment of any case of PTSD, regardless of how complex or treatment refractory. This seemed particularly puzzling because, throughout the century-long history of psychoanalysis and psychodynamic psychotherapy, cases involving trauma have been treated with significant benefit using this kind of treatment approach.

At our institution, we treat many patients who have had previously treatment-refractory PTSD, usually comorbid with mood disorders and personality disorders. In fact, we serve as a national referral center for these kinds of cases. Referrals come from a wide range of clinicians, managed care companies, and even Veterans Administration hospitals. With such patients, psychodynamic psychotherapy, as part of an interdisciplinary treatment plan organized and integrated by an overarching psychodynamic formulation, can offer real hope for patients who have failed to make adequate gains with a symptom-focused approach. The use of such a psychodynamic approach allows engagement of the frequent vulnerability to repeated instances of retraumatization in some of the most treatment-refractory cases. Engaging these repetitions through their reenactment in the transference-countertransference relationship, interpreting them, and bringing them into the patient's awareness and under his or her conscious control is, in our experience and that of others, often highly effective in interrupting the pernicious repetitive cycle of at least one presentation of treatment-refractory PTSD. The panel of experts would apparently disagree. We are most puzzled and troubled by this stance.

Of course, any set of guidelines determined by a panel of "experts" depends on the selection of the experts. Although neither of us knows everyone on the panel, we could identify only 2 members of the panel of psychotherapy experts who were on the roster of the American Psychoanalytic Association and none who were on the roster of the International Psychoanalytic Association. We are quite perplexed that the 2 analysts and others would omit mention of such a powerful, integrative treatment intervention for patients struggling with the effects of trauma, particularly in treatment-refractory cases.

One reason for this exclusion may be that psychiatry, particularly academic psychiatry, has tended to move away from a

psychodynamic interpretive stance and toward management of symptoms over the last 10 to 15 years. Few residents receive much training in psychodynamic concepts or treatment anymore, and many clinicians are unfamiliar with and unsophisticated in psychodynamic treatment approaches. It is an increasingly frequent experience for us to hear psychiatrists speak with a bias against a psychodynamic approach. It would be most unfortunate if the "experts," in their genuine efforts to help clinicians and patients select the best treatment approach for patients with PTSD, inadvertently enacted an unfortunate and unwarranted bias in the field.

It may be of interest that we are 7 years into a naturalistic, longitudinal study in collaboration with J. Christopher Perry, M.D., M.P.H., of changes in reliably measured descriptive and psychodynamic constructs in previously treatment-refractory patients, including those with treatment-refractory PTSD. Preliminary data demonstrating significant improvement in symptoms, defenses, and conflicts have already been presented at the American Psychiatric Association annual meeting and at meetings of the Society for Psychotherapy Research and the International Society for the Study of Personality Disorders. When our sample size is a bit larger, we will certainly offer our results for publication.

We are very interested in the authors' thoughts about these issues.

**REFERENCE**

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76

**Eric M. Plakun, M.D.**  
**Edward R. Shapiro, M.D.**  
Austen Riggs Center  
Stockbridge, Massachusetts

**Dr. Foa and Colleagues Reply**

**Sir:** We are pleased to reply to the letters sent to you by Dr. Saporta and Drs. Plakun and Shapiro concerning the issue of treatment selection for posttraumatic stress disorder (PTSD) as

reported in the Expert Consensus Guidelines.<sup>1</sup> Dr. Saporta as well as Drs. Plakun and Shapiro have expressed concerns about why psychodynamic psychotherapy was not rated among the first-line treatments for PTSD.

In selecting experts for this project, we have made conscientious efforts to identify a large and diverse group of experts on psychotherapy for PTSD. As we noted in the Supplement (p. 4), participants in the Psychotherapy Expert Consensus Survey were identified from the following sources: recent publications, recipients of research grants, and membership of the International Society for Traumatic Stress Studies and the American Association of Behavioral Therapists. Although this method of expert selection reflected our attempt to include individuals with broad knowledge of the field, it has also introduced a bias in favor of clinicians who are active in research. We agree with Drs. Saporta, Plakun, and Shapiro that psychodynamic psychotherapy has had a major historical role in the treatment of post-trauma psychopathology. However, experts who were chosen responded according to personal experience, their research, and their understanding of the literature. Therefore, the final recommendations do not reflect our personal opinions and, indeed, in some cases may be inconsistent with them.

It is important to note that psychodynamic psychotherapy did not receive a rating of first-line therapy on any of the questions that evaluated individual psychotherapies (i.e., 13 through 17).

We appreciate the authors' raising their concerns and for giving us the chance to clarify the Expert Consensus Guideline process.

**REFERENCE**

1. Expert Consensus Guideline Series: Treatment of Posttraumatic Stress Disorder. *J Clin Psychiatry* 1999;60(suppl 16):1-76

**Edna B. Foa, Ph.D.**  
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Philadelphia, Pennsylvania  
**Jonathan R. T. Davidson, M.D.**  
**Allen Frances, M.D.**  
Duke University Medical Center  
Durham, North Carolina