Below is a paper submitted to the Journal of Traumatic Stress. It was invited by the journal editor after I objected to the methodology of a paper by Harik et al. (2020) which claimed that when given unbiased descriptions of various evidence-based PTSD psychotherapy treatments subjects rated EMDR least favorable. While the article purported that the descriptions of all the methods studied were neutral and vetted by experts in each, the descriptions of EMDR were the only ones that included negative information. Before the commentary could be published the editor accepted a retraction of the Harik paper. A copy of the retraction follows the submitted paper.

Howard Lipke 4.23.22

Response to Harik

Running head: Response to Harik et al. 2020

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Abstract

As part of the methodology in their study testing the effect of description

format on subject treatment preferences Harik (et al. 2020) offered descriptions of four highly rated psychotherapy treatments for PTSD. The descriptions were not included in the published paper. When obtained and examined, only one of the methods (EMDR) could be seen to have been described as being inferior; inferior in ways not justified in the paper itself and not consistent with existent research. In addition, there appeared to be an unjustified underestimation of the risks of at least two of the methods. Whether or not these problems have materially affected conclusions on comparison of the formats, they do lead to concern about the accuracy of claims circulated about these PTSD treatments.

Key words: Evidence based intervention, Treatment outcome, EMDR, Cognitive-behavior therapy

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In their study about the effect of the format of treatment description on subject choice of PTSD treatment Harik (et al., 2020) subjects rated five different treatments. While the stated purpose of their research was to examine effects of format, one important take away from the study would be a purportedly methodologically sound evaluation of the relative attractiveness of the five methods considered: prolonged exposure (PE), cognitive processing therapy (CPT), eye movement desensitization and reprocessing (EMDR), stress inoculation training (SIT) and selective serotonin uptake inhibitors/serotonin norepinephrine reuptake inhibitor (SSRI/SNRI). However, the methodology of the study produced findings, while not necessarily germane to the stated purpose, that could lead to propagating a particularly negative impression of one of the psychotherapy methods studied, EMDR. The methodology also, incidentally, revealed another problem in the way risks of psychotherapy are considered.

In the comparison among the four psychotherapy methods EMDR fared poorly. As EMDR has some relatively attractive features, such as not requiring clients reveal details of the traumatic event(s), a relatively short course of treatment, as well as positive ratings by a variety of scientific organizations it seemed worth exploring the methodology in more detail. Part of the motivation to pursue this was the fact that, despite the positive research results and ratings, EMDR is not well received in US academic departments of psychology, as indicated by the lack of departments of psychology which teach it in clinical training. So, it is concerning that a report that it does not appear desirable to potential clients could lead to further unwarranted marginalization.

A co- author of the Harik paper quickly responded to a request for the descriptions of the treatment methods offered to the subjects, as this was not present in the paper as published. Examination of the content of these provided led to the three areas of concern to be addressed here. Two of these were specifically related to EMDR but a third, perhaps more important concern, applies to what is acceptable in the way the risks of psychotherapy treatment are portrayed in general.

To start with the objection not specific to EMDR, PE is described as having the “risk” of leading to “mild to moderate” discomfort. This appears to be an important underestimation of the distress some clients feel during PE (Pitman et al., 1991; Kehle-Forbes et al., 2016 ), as well as sometimes, but less so, with EMDR (Lipke 1995). While the research on the specifics of the negative effects of PTSD treatments is sparse (outside the reporting of dropout rates), it would be fair to say that if “risk” is to be described in this manner by the authors, some research support for that stance should be offered. The lack of specificity regarding possible negative effects in the existing research strongly suggests that, despite it being uncomfortable to the proponents of the methods (who usually initiate their study), more attention must be paid to understanding these effects.

To turn to the ways in which EMDR was comparatively described, first EMDR was noted as having a “large” effect while the other psychotherapy methods were described as having “very large” effects. The differential rating of efficacy was not supported in the paper, nor does it appear to be supportable by VA/DoD guidelines (2010, 2017). Furthermore, in the introduction section, the authors’ statement endorsed the idea that “these interventions are similarly effective in reducing PTSD symptoms” (p. 455), which might lead a reader to mistakenly think that the authors described the several methods to the subjects as equally effective.

The second objection relates to the “how it works” section. There, only EMDR had any doubt cast upon it in the descriptions of the methods. For this section the authors wrote: “Other experts believe that the eye movements are not important, and that EMDR works by using ideas from other treatments (like cognitive-behavioral therapies). “ The impartiality of the descriptions in the article is supported by Harik (et al., 2020) through claimed reliance on the expertise of the National Center for PTSD experts understanding of the methods evaluated. It is difficult to imagine that a true expert on EMDR in their committee could let this description stand, given that by 2013 even Richard J. McNally, one of EMDR’s most visible and academically prestigious critics, acknowledged that research on the subject supports a role for eye-movement. The other methods were described in their own terms; only the description EMDR included a critique.

Whether or not the stated purpose of the Harik (et al., 2020) paper, comparing the effects of two ways of presenting information to potential PTSD treatment clients, is affected by the errors noted above, the levels of attractiveness reported may well have an effect on scientists being willing to study it and therapists being willing learn and then offer it to clients in the way research on its efficacy indicate it should be. This outcome would be a violation of the responsibility to take an unbiased approach to science and clinical practice.

Finally, the way in which “risk” were addressed suggests two problems that are more general to our field, the underestimation of risk to clients and the lack of detailed exploration of what the risks actually are. If this is the case, better understanding and description of risk are necessary if psychotherapy is going to be as science based an enterprise as we like to portray it.

References

Department of Veterans Affairs & The Department of Defense (2017)

VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder version 3.0. https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGClinicianSummaryFinal.pdf

Harik, J. M., Grubbs, K. M. & Hamblen J. L. (2020). The impact of treatment description format on patient preferences for posttraumatic stress disorder treatment. *Journal of Traumatic Stress*, 33, 455 – 464.

Kehle-Forbes,S.M., Meis, L.A., Spoont, M.R. & Polusny, M.A. (2016) Treatment initiation and dropout from prolonged exposure and cognitive processing therapy in a VA outpatient clinic. *Psychological Trauma: Theory, Research, Practice and Policy*, 8(1), 107 – 114

Lipke, H.J. (1995) Eye Movement Desensitization and Reprocessing(EMDR): A quantitative study of clinician impressions of effects and training requirements. EMDR clinicians survey. In: Shapiro, F. *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures.* New York: Guilford.

McNally, R. J. (Fall, 2013) The evolving conceptualization and treatment of PTSD: A very brief history. *Trauma Psychology, pp.* 7-11.

Pitman, R. K., Orr, S. P., Altman, B.,Greenwald, E., Longpre, R., Poire’, R.E., & Steketee, G.S. (1991) Psychiatric complications during flooding therapy for posttraumatic stress disorder. *Journal of Clinical Psychiatry, 52*, 17 – 20.

Spates, C.R. & Cusack, K. (1999) The cognitive dismantling of eye movement desensitization and reprocessing (EMDR) treatment of posttraumatic stress disorder (PTSD). *Journal of Anxiety Disorders* (13) 87 – 99.

Department of Veterans Affairs & The Department of Defense (2017)VA/DoD Clinical Practice Guideline for the Management of Posttraumatic Stress Disorder and Acute Stress Disorder version 3.0. <https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGClinicianSummaryFinal.pdf>

The Management of Post-Traumatic Stress Working Group (2010) VA/DoD Clinical Practice Guidelines for Management of Post-Truamatic Stress 2.0 https://www.healthquality.va.gov/guidelines/MH/ptsd/cpg\_PTSD-FULL-201011612.pdf

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