EMDR in the Treatment of Military Veterans

Workshop Handout

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EMDR International Association
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Slide 1

EMDR in the treatment of military veterans

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Slide 2

AS REQUESTED, I PUT MY PRESENTATION ON ONE Power Point SLIDE.

I HAD TO OBEY ALL OF THE WHITE SPACE, BUT I THINK IT WAS WORTH IT TO FIT EVERYTHING ON ONE PAGE.

IT'S ACTUALLY ONLY ONE BULLET POINT, BUT IT WOULD HAVE TAKEN ONE.

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Official: PowerPoint bad for brains

- “Researchers at the University of New South Wales in Australia found the brain is limited in the amount of information it can absorb - and presenting the same information in visual and verbal form - like reading from a typical PowerPoint slide - overloads this part of memory and makes absorbing information more difficult.”
Professor Sweller said: "The use of the PowerPoint presentation has been a disaster. It should be ditched."

Nonetheless...

Make a mistake long enough and it ceases to be an error and becomes a hallowed tradition.

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Who is Silver?

- Director, inpatient PTSD Program, VA Medical Center, Coatesville, PA, 1982-2008
- EMDR since 1990. Senior Trainer, EMDR Institute. First Programs Chairperson of EMDR-HAP. EMDBIA certified Clinician, Consultant, Trainer.
- Publications, research, academic stuff, etc. Coauthor, *Light in the heart of darkness: EMDR and the treatment of war and terrorism survivors.*

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Who is Rogers?

- Staff Psychologist/ Research Coordinator, inpatient PTSD Program, VA Medical Center, Coatesville, PA, 1991-2013
- Senior Trainer, EMDR Institute, former EMDBIA research committee, editorial board Journal of EMDR Practice and Research
Welcome to the Global War On Terror.

Slide 8

What are we facing?

By 2013

- Number of deployments: Approximately 4,000,000
- Number of service members deployed: 2,600,000
- Includes both Active Duty, Reserves, and National Guard.

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Preparation in DoD and VA

There was no mandatory training of DoD MH personnel for treating trauma reactions.

There is no mandatory training of VA MH personnel for treating trauma reactions.
Slide 10

The crisis for VA and DoD

Loss of the "baby boomers" and its impact on the VA.

Burn-out of MH professionals within DoD (>40%/70%)

Increasing demand for services

The "Perfect Storm" scenario

Slide 11

What does this mean?

The military cannot possibly treat all veterans with PTSD and its capability to do so will probably degrade in the near future.

The VA cannot possibly treat all veterans with PTSD and its capability to do so will probably degrade in the near future.

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Which leaves you...

Welcome to the Global War on Terror.
Slide 13

Additional good news...

It is not just Iraq...

We have veterans of WWII, Korea, Vietnam, Grenada, Panama, Beirut, Mogadishu, Somalia, Afghanistan, and places not talked about on CNN.

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The GWOT experience is a massive trigger for combat veterans of all wars and eras.

Triggers include:

News
Books
Daughters and sons
Etc.

Slide 15

Or as one Vietnam War veteran said...

"The only f**king difference I see between Iraq and Vietnam is that everything is brown instead of green."
Slide 16

So...

While OIF/OEF has the public attention...

Everything we say here is applicable to survivors of ALL wars, ALL conflicts, ALL acts of terrorism.

Key is adaptation, of course.

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War-Related Post-traumatic Stress Disorder:

History Of Its Conceptual Development and Diagnostic Symptoms

Slide 18

A quick review of labels

WWI Labels: Shell Shock, Hysteresis, Neurasthenia, Cowardice

WWII Labels: War Neurosis, Combat Exhaustion, Battle Fatigue

Vietnam War Labels: "Vietnam Syndrome" "PTSD" (1980)
Slide 19
PTSD as a “normal” reaction
1. Trying to complete the pattern.
2. Just like everyone else, except…
   "The persistence of memory…"
3. Time is irrelevant to the brain.
4. "Treatment" that avoids the trauma is worse than irrelevant.

Slide 20
Biological Markers of Post-Traumatic Stress Disorder
- Caveat – Ongoing research in this area.
- Some of these markers have been used in research on psychotherapy for PTSD.
- "Not a real doctor."
- Overview of these areas:
  1. Psychophysiology – How things work
  2. Hormones – Better living thru chemistry
  3. Brain activity – Awake/Asleep at the switch
  4. Brain Structure – Nuts and bolts

Slide 21
Biological Markers: PSYCHOPHYSIOLOGY
- Physiological reactivity to trauma-related stimuli.
- Nonhabituating startle response.
- Chronic hyperarousal.
Slide 22

**Biological Markers:**

**HORMONES**

- Long-term changes in cortisol.
- ‘Hair trigger’ release of endorphins in response to stress.

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**Biological Markers:**

**BRAIN FUNCTION**

- Decreased activity in higher brain centers like prefrontal cortex.
- Decreased activity in Broca’s area (expressive language) when the trauma memory is stimulated.
- Decreased activity in the anterior cingulate cortex.

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**Biological Markers:**

**BRAIN STRUCTURE**

- Decreased hippocampal volume.
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Military Culture and Values

- Know your population.
- The U.S. Military: The same and different
- A bureaucracy that is not just a bureaucracy
- A different orientation: Warrior Ethos

Slide 26

Current Issues In Reintegration
Slide 28
Current Major Issues
- Deployment and Redeployment
- Preparation (SRP and education)
- Family support
- Post-Deployment Health Reassessment
- PTSD and Combat Stress Reactions
- Suicide

Slide 29
Stigma
- Still an issue but we’ve come a long way...

Slide 30
Medical Boards
- “Soldier-friendly” – emphasis upon retention and soldier’s wishes
- Multi-layered
- Records from all care providers used
- Testimony of soldier used.
- Input from command used.
**Evaluation Issues**

- Care providers do NOT evaluate for deployability.
- Some care providers doing “record dumping” to avoid saying anything.
- Some care providers not responsive to requested evaluation.
- Soldiers not clear on what they are seeking.

**Treatment**

- All treatment is done within the community
- Treatment clearly varies in quality
- Ineffective treatment is a career stopper

**Rising Issues**

- Families and children
- Continued and repeated deployments
- Stress effects, including suicide
Families and Children

- The U.S. military provides school and preschool services for 1.6 million children, have under the age of 6
- Vietnam Era: Average age 22; 1 in 10 married
- GWOT Era: Average age 27; 1/3 married

The Therapist and War Trauma
Some things to consider...
- Or...
- A guide to personal survival

Issue Number One
- Trauma work isn’t for everyone and that’s all right...
Slide 37

Impact of the work

"For the therapist war is hell for three reasons: (1) confrontation with one’s own personal vulnerability to catastrophe;...

"(2) the challenge to one’s own moral attitudes about aggression and killing;...

"(3) the almost unbearable intensity of the transference and countertransference."


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If you haven’t been there...

• You didn’t miss much...

• What being a survivor means that is useful:
  Language
  History
  Initial acceptance

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If you haven’t been there...

NCO  GWOT  VBED  IED  NVG
ROE  FOB  ACU  QRF
CST  BDU  COE
MOS/AOS  MRE  PFC

Not so much a language as a code sometimes…
Slide 40

If you haven’t been there... (con’t)

- What being a survivor means that is NOT useful:
  - Filling in the blanks
  - Elicitation of unresolved material
  - Countertransference
  - Transference

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If you haven’t been there... (con’t)

- What NOT being a survivor means:
  - Slower initial acceptance often.
  - Role of student to elicit experiences.
  - Bridge to "the world."

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It really comes down to...

- Attributes rather than identification
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Successful Therapist Attributes

- Figley’s “Winning.”

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Successful Therapist Attributes

- Figley’s “Winning.”
- Empathy (especially for EMDR therapists)

Slide 45

Successful Therapist Attributes

- Figley’s “Winning.”
- Empathy (especially for EMDR therapists)
- Self-awareness
Successful Therapist Attributes

- Figley’s “Winning.”
- Empathy (especially for EMDR therapists)
- Self-awareness
- Flexibility
- A moral sense
- A willingness to learn
Slide 49

The Four Cs

- Commitment – much will be forgiven
- Competency – doing it right
- Courage – your clients as models
- Compassion – the human link

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Injured Therapists

- Burn-out defined
- Vicious traumatization (aka secondary traumatization) defined

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Injured Therapists (con’t)

Prevention “How-to”

- Issue Number One (is not always the issue)
- Self-awareness (and the other Attributes)
- Professional resources in place and used
- Taking care on one’s self is a requirement
  “...Yeah, but I’m Superman...”
No, you’re not...
Burnout responses –
- Time off
- Checking workload and triage
- Pacing and self-care
- The body is the focus

You’re still not Superperson...
Vicarious traumatization responses –
- Identification of the issue(s).
- Using professional resources already in place.
- Reconnecting to the world.
- The head is the focus.

Other issues
The role of educator - teaching others is vital
Advocacy – perils and opportunities
Slide 55

Tools for the Immediate Aftermath

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Bilateral Stimulation for Stabilization

- Developed by Gary Quinn, MD for use in emergency rooms
- Goal: Get the patient stabilized to assist in their own treatment
- Stabilization only
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**EMD: Very early intervention**

- Developed by Mark Russell, Ph.D., CDR, USN;
  Developed on hospital ship as initial intervention for combat wounded.
- Goal: Reduction in psychological reactions.
- Traumatic event focused.
- Term: “EMD”

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**“EMD”**

- No Body Scan Phase on recently wounded.
- Complex linking avoided.
- Pretrauma links avoided.
- Anecdotal evidence only at this point.

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**R-TEP**

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Presenting EMDR

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Combat versus Noncombat PTSD

- More severe symptoms
- Less remission in past year
- Less likely to have sought treatment since leaving the military

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Veterans less responsive to treatment

- Chronicity
- Compensation
- Multiple severe stressors
- Dissociation
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EMDR PTSD Effect Sizes

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<th>Effect Size</th>
<th>Population</th>
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<tbody>
<tr>
<td>Taylor</td>
<td>10</td>
<td>2.41 Civilians</td>
</tr>
<tr>
<td>Power</td>
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<tr>
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<tr>
<td>Devily</td>
<td>2</td>
<td>0.50 Veterans</td>
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EMDR in the VA

- Early training projects
- VA/DOD Clinical Practice Guidelines
- IOM report
- VA training rollout
- NCPTSD

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IOM report

- Synthesis: The committee found the overall body of evidence for EMDR to be low quality to inform a conclusion regarding treatment efficacy. Four studies, three of medium and one of small sample size, had no major limitations, but only two showed a positive effect for EMDR. The committee is uncertain about the generality of an effect, and believes that future well-designed studies will have an important impact on confidence in the effect and the size of the effect.

- Conclusion: The committee concludes that the evidence is inadequate to determine the efficacy of EMDR in the treatment of PTSD.
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Current situation in the Veterans Administration

EMDR is recommended in the Joint DoD/VA Clinical Practice Guidelines for PTSD (JCPG-PTSD) but has not been part of the VA's training rollout.

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Current Situation

- Early critiques of EMDR have not been revised.
- Banned in the past in some medical centers.
- Administrators are naturally conservative.
- EMDR sounds weird.
- National Center ambivalent.

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NCPTSD

"Research comparing EMDR to the more generally accepted cognitive-behavioral techniques shows significantly better results with CBT than with EMDR, particularly at three-month follow-up. CBT results also show greater sustainability. Research looking at different components of EMDR shows that eye movement adds no additional benefit to the imagery exposure and the process of dealing with negative beliefs"
Slide 70

Resistance to EMDR
(Cole, J., Benson, T. & Cone, J. (2009))

- Didn't know anyone who was using EMDR
- Didn't understand the mechanism
- Didn't find the theory compelling or familiar
- Uncomfortable moving their hands
- Training was expensive and had to be obtained outside their hospital
- Found Shapiro's initial offer of training overly aggressive

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EMDR in DoD

- Early trainings
- AMEDD training rollout
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**EMDR Empirical Status**

Recognized by:
- American Psychological Association
- American Psychiatric Association
- International Society for Traumatic Stress Studies
- VA/DOD Clinical Practice Guidelines
- TriCare
- Cochrane Database
- NICE Guidelines
- SANEUSA
- World Health Organization

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**Educational approaches**

- Reviewing the research can be appropriate and very useful.
- But you need to be able to explain it.
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Devilly et al.,

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Slide 77

Carlson et al., 1998

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**EMDR Advantages**

- Faster and more comfortable
- No homework
- No equipment or forms
- Nonverbal - advantage for TBI
- Immediate feedback
- Pain applications
- Applicable to other problems
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**Agencies for Involvement with Veterans**

- Military One Source
- Military Family Life Consulting Program
- TRICARE
- Contract Fee Providers - Vet Centers

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**Treating Military Trauma with EMDR**

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**Symptoms for veterans entering PTSD treatment**

(Ruvo, J.D., & Toc, 2023)

- PTSD 80%
- Anger 37%
- Sleep 27%
- Nightmares 19%
- Isolation 21%
Slide 85

- Pain 72%
- Sleep 62%
- Cognitive issues 61%
- Vocational 53%
- Education 49%
- Finances 42%
- Relationships 37%
- Anger 30%
- Substance Abuse 23%
- Social Support 20%

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PTSD Stressor Criterion

- Exposure to death, injury, sexual violence (actual or threatened)
  - Directly
  - Witnessed in person
  - Indirectly (relative or friend directly exposed - violent or accidental)
  - Repeated/extreme exposure as a professional (collecting body parts, exposed to details of child abuse)

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PTSD criterion B

- Recurrent, involuntary, intrusive memories*
- Nightmares
- Flashbacks
- Reactivity to reminders: emotional distress and/or physiological arousal
PTSD criterion C

- Avoidance of trauma-related reminders, thoughts or feelings

PTSD criterion D

- Inability to recall key features of the trauma (not due to head injury or intoxication)
- Persistent distorted negative beliefs about self/world
- Persistent negative emotions
- Decreased interest in activities
- Social estrangement
- Constricted affect (inability to experience positive)

PTSD criterion E

- Irritability
- Self-destructive or reckless behavior*
- Hypervigilance
- Startle
- Poor concentration
- Sleep disturbance
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PHASE 1 - History

- Psychosocial vs. experiential history
- Phase 2 before Phase 1 for some
- Obtaining a narrative of the deployment(s)
- Include non-combat traumas
- Identify precipitating event
- Think beyond PTSD diagnosis

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Phase 1-History

- Identify resources, may be military experiences
- Discuss previous treatment
- Identify treatment priorities
- Obtain list of trauma memories and triggers
- “Any events you’re not ready to discuss?”
- Other things to review

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EMDR selection criteria

- Life-threatening substance abuse
- Serious suicide attempts
- Self-mutilation
- Serious assultive behavior
- Dissociation
Phase 2- Preparation

- Don’t call it the “Safe Place”
- BLS for “state change” in anxiety or pain
- Determining readiness for processing
- Covert processing
- Never sugarcoat the intensity of processing
- Leave time for questions

Front-loading resources

- Atonement principles
- “Missing” information
- “Monsters” never call themselves that.
- Resolution is more the rule than the exception

Phase 3- Assessment

- Explanation of EMDR—“letting” something happen instead of “making” something happen
- Low initial SUD may be numbing
- Disclosure of details welcome but not necessary
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### Treatment Plan

- Behavioral Goals
- Issues
- Targets for Processing

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Slide 98

### Phase 4 - Desensitization

**Obstacles to Processing:**
- Numbing and dissociation
- Aversion
- Resistance
- Expectancies

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### Dissociation

- Assess throughout treatment
- Educate
- Develop a vocabulary
- Have simple grounding techniques available
Slide 100

Abreaction

- Key is proper Client Preparation
- Don’t continuously check SUDS (never)
- Use your voice

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Expectancies

- Key is proper Client Preparation.
- High demand characteristics are not uncommon.

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Blocked processing

- Use the whole toolbox
- Monitor how they process for ideas about which tools to use.
- Be comfortable with Cognitive Interweaves
Slide 103

Cognitive Interweaves

- General cautions:
  - Avoid discussion!
  - “Just go with that.”
  - Short and succinct
  - Target blocks to the CI that emerge

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Interweave Types

- Direct question or statement
- I’m confused
- Socratic questioning
- What if your child/buddy did it?
- Let’s pretend
- Metaphor/analogy
- Linking client’s perspectives

Slide 105

I’m Confused…

- ...You just said that you should have known what was going to happen but earlier you said there was no way to know because it happened so fast…
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Socratic Questioning

- What factors did you have control over?
- What information did you have at the time?
- What condition were you in?
- How much time did you have to make a decision?

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What if your buddy did it?

It sounds like it was total chaos. Listen, what if Jack had been leading the squad and he had made the same decision as you, what would you have thought of him?

He wouldn’t have… (Common response).

…I don’t know what he would have done, but if he made the same decision as you, what would you have thought of him?

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Let’s pretend

…Let’s pretend you’d gone the other way. How do you know it would have been better?
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Metaphor/Analogy

It sounds like it was like being at the bottom of a mountain when an avalanche comes down; control of the situation is no longer yours.

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Linking client perspectives

(Blending of client's points of view)

...Ok, I want you to hold those two thoughts together, “I'm a failure” and “It takes experience.”

Slide 111

Phase 5 – Installation

• Look for resistance
**Slide 112**

Phases 6 & 7 - Body Scan & Closure

- Hypervigilance
- Headaches
- Interim PCs, containers
- “Please complain”

**Slide 113**

Phase 8 - Re-evaluation

- 24-hour feedback
- Logs
- Repeated review of processed targets

**Slide 114**

Special Issues

- Anger
- Guilt
- Pain
- Grief
- Meaning
Slide 115

Anger

- Advantages of anger in combat
- Assessment of anger
- Therapist comfort
- Anger during processing
- Resources

Slide 116

Guilt

- Guilt prevalence
- Association with depression and suicide
- Assessing combat-related guilt
- Survivor vs ‘perpetrator’ guilt

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Kubany’s guilt typology

- Survivor
- I should have known better
- Impossible choices
- Error
- I should have done more
Slide 118

**Kubany’s guilt typology**

- The pleasure of violence
- Participation in atrocity
- I should have felt worse

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**What if they did do something wrong?**

- Atonement as information to be introduced in Client Preparation for later access.
  - Has past behavior worked?
- Who is the target?
  - Maybe the scales have to be balanced.
  - No one has a time machine, so...

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**Guilt**

- Resolutions often involve a response in the present and future. (I can help others not make my mistakes...)
- Resolutions often involve a greater understanding of self. (I know what matters to me)
Slide 121

Chronic Pain

- 50-70% of combat-exposed PTSD clients report chronic pain
- Associated emotions include hopelessness, anger, fear of pain worsening in the future
- Opiate addiction is an increasing problem among VA patients

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Pain, continued

- Treatment of chronic pain

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Protocol for immediate relief

- Where does it hurt?
- On a 0-10 scale, how bad is the pain?
- Focus on it and follow my hand
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Pain, continued

- Long sets
- May increase before it decreases
- Testing results (cautiously)
- May or may not link spontaneously to trauma

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Grief

- Remember, EMDR cannot take away anything a person needs to keep.
EMDR v Guided Mourning (Sprung, 2002)

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Grief

- Fear of being disloyal
- Fear of losing control of emotion
- Fear of vulnerability to loss in the future

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Loss of Meaning

- An existential crisis is traumatic
- Can greatly increase probability of suicidal behavior

"...Trauma arising between the ages of 18 and 30 years is associated with a diminished sense of meaning in life..."
-Krause, 2005
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The role of meaning

It is not what happens... But what it means... to each of us individually: The story of Red

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Specific impact of a loss of meaning

Clues in Client History:

- Previous values may become questioned
- Traumatic experiences generate helplessness
- Loss of values
- Loss of purpose (a role in the world) and goals
- Loss of self worth

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Other clues to a need for meaning

- Unusual volunteering
- Fighting with God
- Judgments and the passing of sentences
Slide 132

**History of survivors who made it**

- What did they have in common?
- Permission for the search for a task
- Examples can be used in Client Preparation

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**Identification of the task**

- Meaning found through *doing*
- "It did not really matter what we expected from life, but rather what life expected from us...Life ultimately means taking the responsibility to find the right answer to its problems and to fulfill the tasks which it constantly sets for each individual."
  
  - Frankl

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**Task components**

- Giving
- Sacrifice
- Value to others
- Achievement involves the role of client judgment
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Meaning and EMDR

- A trauma is a trauma is a trauma...
- The therapist does not supply the answers (don’t rush in) but CAN do education by examples.
- Protocol remains the same but meaning often comes up later rather than sooner; sometimes it is a block: “I don’t deserve to get better.”
- Resolution often involves action in the present and future.
- Future prone on obstacles to performing task.

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Some wisdom...

- “We honor our warriors because they are brave and because, by seeing death on the battlefield, they come to appreciate the greatness of life.”
  -Winnebago elder, 1985

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Complex PTSD Issues

Military Sexual Trauma, Childhood Trauma, and Dissociation
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What is generally not needed

- RDJ – Apparently higher than average availability of resources.
  Severely limited resources (e.g., developmental lacks) are not typical and may be an indicator of severe pathology.
- Panic over dissociation – remember numbing may be a pro-survival tool.

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MST

- In general, EMDR processing is normal but...
- Targets may be multiple: sexual trauma and additional stressors (e.g., investigation, testimony, ostracization)
- Complexity: Ongoing investigations; multiple occurrences
- Key: Future Prong – template should include anticipated situations

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Typical Issues (con’t)

- Childhood Trauma

  Complexity: Triggered either by combat trauma or by treatment for that trauma. Multiple abusive episodes may surface.
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**Childhood Trauma**

- Contract and Time become issues.
- Complexity: Triggered either by combat trauma or by treatment for that trauma. Multiple abusive episodes may surface.
- Maintenance of focus may become an issue.
- If time is pressing, be prepared:
  - To be more directive;
  - To use the Cognitive Interweave

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**About Dissociation (review)**

- See remarks from Phases discussion.
- True Dissociative Disorder is rare in the military.
- Dissociation (“numbing”) common feature of trauma in terrorism/combat experiences.
- Associated conditioning may take place.

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**Encountering Dissociation**

- Still with you?
- Numb – regard as another emotional state and target.
- Be alert for what the numbness was hiding, protect.
- Flashbacks – Reorientation key
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Present Triggers

- Source 1: Client History
  - What have they already reported?
  - What does in vivo exploration bring in?
- Source 2: Therapist knowledge
  - “CSI” sources – what you suspect from the survivor’s experience
  - What have other survivors reported?

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Present Triggers (con't)

- What is seen
- What is smelled
- What is heard
- And everything else...
  - In vivo searching uncovers targets;
  - May reveal new issues;
  - Gives client a sense of control.

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Targeting triggers

- Same as it ever was but...
- Links to unresolved experiences common.
- Almost always benefit from being checked for Future Prons work.
- Start simple: trigger and reaction is the starting place.
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Future Prong

- What about the deal with lightning never striking twice?
- Maybe not but repeated tours are very common and war is war

**KEY:** What's the issue?

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Future Prong Targeting

- Encountering a similar event

  “Think about being mortared again. What do you get now?”

  Or

  “Think about going back to the combat zone. What do you get now?”

Remember, soldiers may redeploy and terrorism survivors may encounter terrorism again.

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Future Prong Targeting

Encountering a similar issue.

- Clinical judgment: What has been the theme of your client's work? (Or themes)
- How will that theme be encountered in the future?
- E.g., “Where do you expect to encounter being responsible in the future and how are you going to handle that?”
Slide 150

Future Prong and Encountering New Material

- Not uncommon
- Present it as good news, “Your brain is deciding it’s time to pay attention to this other stuff. Great. Let’s clean it all out.”
- Remember they’ve been successful with the past stuff already.

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Future Prong and New Material (cont)

- Clinical judgment: New Assessment Phase or jump on it.
- What’s the momentum?
- Remember, encountering “new material” means...
  Possible new Present Triggers and a new Future Prong (even if just reinforcing).

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RELATED POPULATIONS
- Aging veterans
- Families
- Buddies
Slide 153

AGING VETERANS

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Slide 154

FAMILIES
- Preparation for homeostatic responses
- Helping others damaged by the ripples of PTSD

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Slide 155

BUDDIES
- Responses to deaths after the war
The End

- Questions?
EMDR Discussion

EMDR has been identified as an effective treatment for PTSD by the following independent reviewing bodies:

American Psychological Association (1998)
- International Society for Traumatic Stress Studies (2000, 2008)
- Cochrane Database (2007)
- RAND Corporation (2008)
- SAMHSA (2011)
- World Health Organization (2013)

The Institute of Medicine Report appears to be the most conservative of these reviews, identifying only prolonged exposure as having sufficient empirical support. In that review EMDR was rated as having insufficient research to permit evaluation. It appears that CPT did not meet this research standard either, but has been promoted on the grounds that it is also “exposure based”, even though it has less of an exposure component than EMDR (this is even truer of the CPT-C variant currently being promoted in the VA rollout).

It should be noted that there have been no randomized clinical trials of prolonged exposure with male combat veterans. While the Schnurr study of prolonged exposure was a rigorous, well-conducted study with a large sample of female veterans, only 6% of the subjects in that study identified a combat stressor as the primary source of their PTSD.

<table>
<thead>
<tr>
<th>CPT (Monson et al., 2006)</th>
<th>PE (Schnurr et al., 2007)</th>
<th>EMDR (Carlson et al., 1998)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subjects with Combat Trauma</td>
<td>75%</td>
<td>6%</td>
</tr>
<tr>
<td>Remission (% losing PTSD dx after treatment)</td>
<td>30%</td>
<td>41%</td>
</tr>
<tr>
<td>Dropout</td>
<td>20%</td>
<td>38%</td>
</tr>
</tbody>
</table>

While PE and CPT both showed a 40% remission rate post-treatment, the remission rate for CPT fell to 30% at a one month follow-up. Dropout rates for both PE and CPT were substantial. A recent open trial of group exposure for veterans (Ready et al., 2009) showed a low dropout rate, but also showed that 40% of the veterans approached about participating in the treatment declined. These treatments, while effective, may be difficult to apply for a substantial
proportion of the veteran population. This suggests that the VA should broaden the number of treatments being promoted in rollouts.

VA clinicians who are using PE and CPT with veterans are reporting that the homework requirement for those treatments can pose difficulties for many veterans. One of the advantages of EMDR is that it requires no homework, nor does it require the veteran to verbalize the details of the trauma for the therapist. VA clinicians treating veterans with PTSD plus TBI have reported that EMDR’s largely non-verbal approach is an advantage with population.

Though questions about the durability of EMDR effects have been raised, all twelve of the randomized outcome studies of EMDR show treatment effects maintained at follow-up. One recent study showed maintenance of treatment effects 35 months after the termination of EMDR treatment (Hogberg et al, 2008). A study of the use of EMDR with German military personnel showed maintenance of treatment effect at 29 months (Zimmerman et al, 2007). A NIMH-funded comparison of EMDR and Fluoxetine showed the percentage of subjects meeting good end-state criterion continued to increase during the 8 months after EMDR treatment (van der Kolk et al., 2007). In the Carlson et al. (1998) study of Vietnam veterans with chronic combat-related PTSD, the post-treatment remission rate of 78% for EMDR was maintained at a 15 month follow-up.

While some reviewers have suggested that the eye movements do not contribute to EMDR outcome, a widely-disseminated meta analysis (Davidson and Parker, 2001) showed, while the eye movements do not have a significant effect on outcome with nonclinical population (anxious undergraduates), they have shown an effect in studies conducted with clinical populations and a “spectacular” (Davidson & Parker) effect on within-session anxiety with clinical populations. More recent studies have shown that the eye movements generate an immediate decrease in arousal during treatment sessions with PTSD patients (Elofsson et al., 2007; Sack et al., 2008), which poses a distinct advantage for clients who become hyperaroused when focused on their trauma memories.

Research is currently being conducted to determine the mechanism of action in EMDR. Recent studies have shown the following pre-post physiological changes in PTSD subjects:

- Decreased physiological reactivity to trauma script (Sack et al., 2004)
- Increased activity, medial prefrontal cortex and anterior cingulate during trauma script (Levin et al., 1999)
- Reduced P3a (evoked potentials) (Lamprecht et al., 22004)
- 10% increase in hippocampal volume (Bossini et al., 2007)

References:


EMDR References Relevant to Military Treatment Issues

Ahmadizadeh, M.J., Eskandari, H., Falsafinejad, M.R. & Borjali, A. (2010) Comparison the effectiveness of “cognitive-behavioral” and “eye movement desensitization reprocessing” treatment models on patients with war post-traumatic stress disorder. Iranian Journal of Military Medicine 12(3), 173-178. Randomized group study comparing EMDR, CBT and untreated controls on the M-PCL and Symptom Checklist. Both treatments were effective at reducing general distress compared to no treatment. EMDR was more effective at reducing symptoms of PTSD. EMDR was done in 4 individually-administered sessions, CBT was done in 11 individually- and group-administered sessions.


Boudewyns, P.A., Stwertka, S.A., Hyer, L.A., Albrecht, J.W. & Sperr, E.V. (1993) Eye movement desensitization for PTSD of combat: a treatment outcome pilot study. the Behavior Therapist, 16(2), 29-33. Randomized group comparison of two sessions of EMD with and without eye movements for Vietnam veterans with chronic PTSD. Neither group showed reliable change in subjective or physiological response to taped trauma scripts. However, the eye movement group showed a significant reduction of distress during the treatment sessions.


posttraumatic stress disorder. Journal of Traumatic Stress, 11, 3-24. A randomized group study comparing 12 sessions of EMDR to biofeedback-assisted relaxation training and routine care. Compared with the other treatments, greater effects were obtained with EMDR and were maintained at a nine month follow-up. This is the strongest study of EMDR with a military population and meets all of the ‘gold standard’ criteria.

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Cooks, J.M., Biyanova, T. & Coyne, J.C. (2009) Comparative case study of diffusion of eye movement desensitization and reprocessing in 2 clinical settings: Empirically supported treatment status is not enough. Professional Psychology: Research and Practice 40(5) 518-524. Summary of interviews of staff members in 2 VA PTSD treatment programs, one in which EMDR was used, one in which it was not. Reasons for the difference discussed.

Devilly, G.J., Spence, S.H. & Rapee, R.M. (1998) Statistical and reliable change with eye movement desensitization and reprocessing: treating trauma within a veteran population. Behavior Therapy, 29, 435-455. Randomized group comparing EMDR with and without eye movement and supportive treatment. 67% of the EMDR group showed reliable symptom improvement, compared with 41% of the non eye movement group and 10% of the supportive counseling group. However, the description of treatments in the procedure section raise questions about the fidelity to the EMDR protocol.


Errebo, N. (2005) EMDR-HAP trains clinicians. Vet Center Voice, 26(2), 30-33. This article describes Dr. Errebo’s experiences as a volunteer with the EMDR Humanitarian Assistance Programs, including the training conducted for VA and DOD clinicians.

Errebo, N. (2007) Like a ghost: using EMDR to revive a traumatized veteran’s marriage. Psychotherapy Networker, Jan-Feb. This critiqued case report gives a detailed description of the course of treatment of a veteran with combat-related PTSD and the improvement in marital relations.


Howard, M.D. & Cox, R.P. (2006) Use of EMDR in the treatment of water phobia at Navy boot camp: a case study. Traumatology e-journal, http://tmt.sagepub.com/cgi/content/abstract/12/4/302 A detailed case report describing the treatment of a Navy recruit with water phobia based in childhood trauma (brother’s drowning death). The trauma was resolved in four treatment sessions and the recruit was able to pass his swim test.


Jensen, J. (1994) An investigation of eye movement desensitization and reprocessing (EMDR) as a treatment for posttraumatic stress disorder (PTSD) symptoms of Vietnam combat veterans. Behavior Therapy, 25, 311-35. Randomized group study comparing 2 sessions of EMD with VA standard care. The fact that fidelity checks were failed renders this study uninterpretable.


Nettz, S. L. (1996, July). Effects of a single session of EMDR, flooding, and a credible placebo treatment on traumatic memories in male veterans. Dissertation Abstracts International: Section B: The Sciences and Engineering, 57(1-B), 0687. Comparison of the effects of a single session of EMDR, exposure or active control on 45 veterans. There were no change in heart rate or blood pressure for any group, both active treatments resulted in significant change in self-reported anxiety. Exposure resulted in a significantly greater increase in skin temp than the control.


Occhietti, K. E. (2012). The effectiveness of PTSD treatment on symptoms of PTSD and depression in military veterans. (Master’s thesis, St. Catherine University). Retrieved from http://sophia.stkate.edu/cgi/viewcontent.cgi?article=1068&context=msw_papers. Comparison of veterans treated with EMDR, prolonged exposure or Cognitive Processing Therapy in a VA program. All three treatments were comparably effective initially but significant symptom rebound was observed at 6, and 1 month follow-ups.

Vietnam veterans with chronic stress disorder. Comprehensive Psychiatry, 37, 419-429. This randomized group study was designed to evaluate the contribution of eye movements to treatment outcome. EMDR was compared to an identical analog condition in which eye movements were replaced with a complex control procedure (staring at a point and tapping thumbs while the therapist moved their hand in front of the clients face). Relative to untreated controls, both conditions were effective. There were no significant differences in outcome. The study was limited by small sample size and the fact that the long treatment trials were focused on a single memory.

Rogers, S., Silver, S., Goss, J., Obenchain, J., Willis, A. & Whitney, R. (1999) A single session group study of exposure and eye movement desensitization and reprocessing in treating posttraumatic stress disorder among vietnam veterans: preliminary data. Journal of Anxiety Disorders, 13(1-2), 119-130. A randomized group comparison of one session of EMDR and prolonged exposure with hospitalized Vietnam veterans. Both groups showed improvement. The EMDR group showed significantly greater reductions in within-session distress and self-monitored intrusive re-experiencing with a trend toward greater reductions in heart rate during trauma script. The study was limited by the use of different therapists for the EMDR and exposure conditions.

Russell, M. (2006) Treating combat-related stress disorders: a multiple case study utilizing eye movement desensitization and reprocessing (EMDR) with battlefield casualties from the Iraqi War. Military Psychology, 18(1), 1-18. A case report with standardized measures showing the successful resolution of trauma memories in four combat-wounded evacuees in 1-2 sessions. Though limited by a lack of follow up, the study demonstrates the utility of EMDR as an early intervention close to the front.


Russell, M.C. & Friedberg, F. (2009) Training, treatment access, and research on trauma in the armed services. Journal of EMDR Practice and Research, 3(1), 24-31. Examines the ability of the Department of Defense to meet mental health needs and argues for increasing the availability of evidence-based treatments, including EMDR.

Russell, M & Silver, S.M. (2007) Training needs for the treatment of combat-related posttraumatic stress disorder: a survey of Department of Defense Clinicians. Traumatology 13:4-10. doi:10.1177/15347656305440. 137 clinicians from all military branches were surveyed about their training in evidence-based PTSD treatments. 90% reported not using any of these treatments and those who did were trained prior to their affiliation with the military.

Russell, M., Silver S., Rogers, S. and Darnell, J. (2007) Responding to an identified need: a joint DOD-VA training program in EMDR for clinicians treating trauma survivors. International Journal of Stress Management, 14(1), 61-71. This article is focused on the development and evaluation of an EMDR training program for VA and DOD clinicians. Clinician ratings of the training program were very positive. Treatment outcome data on 73 patients shows that trainees were able to successfully implement EMDR in their practices.


Silver, S.M., Brooks, A. & Obenchain, J. (1995) Treatment of vietnam war veterans with PTSD: a comparison of eye movement desensitization and reprocessing, biofeedback and relaxation training. Journal of Traumatic Stress, 8, 337-342. A nonrandomized study of the incremental effects of EMDR, biofeedback and relaxation training when added to a VA inpatient PTSD treatment program. The EMDR group showed a significantly greater improvement than the groups receiving the other treatments.

Thomas, R. & Gafner, G. (1993) PTSD in an elderly male: treatment with eye movement desensitization and reprocessing (EMDR). Clinical Gerontologist, 14, 57-59. This case report describes the use of EMDR with a veteran of WWII and Korea. Trauma symptoms were resolved in two sessions. Two month follow-up showed good maintenance of improvement. The report shows that EMDR can be used for the resurgence of PTSD symptoms often seen in elderly veterans.


Wesson, M. & Gould, M. (2009) Intervening early with Eye Movement Desensitization and Reprocessing on military operations: a case study. Journal of EMDR Practice and Research 3(2), 91-97 Describes the treatment of an active duty soldier’s acute stress reaction with 4 sessions of EMDR on consecutive days with successful resolution of symptoms and ability to return to frontline duty. Treatment effects were maintained at 18 month follow up.


Zimmerman, P., Biesold, K.H., Barre, K. & Lanczik, M. (2007) Long-term course of post-traumatic stress disorder (PTSD) in German soldiers: effects of inpatient eye movement desensitization and reprocessing therapy and specific trauma characteristics in patients with non-combat-related PTSD. Military Medicine, 172(5), 456-460. Retrospective study of 89 German soldiers receiving inpatient treatment for posttraumatic stress disorder. A follow-up 29 months after treatment showed that soldiers receiving EMDR were significantly less symptomatic than those receiving supportive treatment and relaxation training. Limitations of the study include nonrandom assignment and nonstandardization of treatment times. However, the study does demonstrate the durability of EMDR’s effects.

Related issue - Use of EMDR with chronic pain


Schneider, J., Hofmann, A., Rost, C. & Shapiro, F. (2007) EMDR and phantom limb pain: theoretical implications, case study and treatment guidelines. Journal of EMDR Practice and Research, 1(1), 31-45. This case study describes the successful resolution of treatment-resistant phantom pain with 9 sessions of EMDR. Treatment gains were measured with subjective and standardized measures and were maintained at 18-month follow up. This study illustrates the potential of a non-medication approach that can be applied to combat veterans. Article also reviews the literature on EMDR treatment of somatic problems.