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## Inadequate Treatment and Research for PTSD at the VA

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The article by Karlin and Cross (January 2014) clearly laid out how to disseminate and implement evidence-based psychotherapy in the Veterans Health Administration. The only problem is that the list of evidence-based psychotherapies notably missed one of the most highly regarded and effective evidence-based psychotherapies for posttraumatic stress disorder (PTSD), eye movement desensitization and reprocessing (EMDR; see EMDR International Association, n.d.).

The VA/DoD *Clinical Practice Guideline for the Management of Post-Traumatic Stress* (Department of Veterans Affairs & Department of Defense, 2010) lists EMDR therapy as an “A” level treatment, described as “A strong recommendation that clinicians provide the intervention to eligible patients” (p. 202). According to

the recently published practice guidelines of the World Health Organization (2013), trauma-focused cognitive behavioral therapy (CBT) and EMDR are the only therapies recommended for children, adolescents, and adults with PTSD. However, major differences exist between the two treatments: “Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework” (World Health Organization, 2013, p. 1) These factors can make EMDR therapy easier for veteran treatment, as can be seen by the differences in retention rates and outcomes for CBT and EMDR.

Initial research using EMDR with military personnel found that EMDR led to remission of PTSD symptoms in 78% of soldiers, with positive effects maintained at follow-up (Carlson, Chemtob, Rusnack, Hedlund, & Muraoka, 1998). There was a 100% retention rate. By comparison, a 2012 report to Congress (Congressional Budget Office, 2012) found that only 40% of soldiers completed cognitive processing therapy (CPT) and prolonged exposure (PE) therapy, the therapies used by the Veterans Health Administration in the Department of Veterans Affairs (VA). A more recent study with 48 Iraq and Afghanistan combat veterans diagnosed with combat PTSD found that after treatment with EMDR, the symptoms of PTSD resolved after only four sessions for nonwounded personnel and eight sessions for wounded personnel (Russell, Silver, Rogers, & Darnell, 2007). The notoriously high dropout rate for CPT and PE and the positive results reported with the use of EMDR beg the question: *Why are there no funded studies of EMDR by the VA? And why is EMDR not included in the list of disseminated psychotherapies that are evidence-based at the VA?*

A growing body of evidence over the last 20 years has shown that EMDR provides effective trauma treatment for civilians, yet the VA has not conducted any EMDR research. Instead they have focused on pharmaceuticals, CPT and PE, and alternative therapies for PTSD including the use of pets, acupuncture, transcendental meditation, the “emotional freedom technique,” tai chi, art therapy, Reiki, yoga, and pharmaceutical agents (Government Accountability Office, 2011). Drugs studied include derivations of such drugs as marijuana and ecstasy. Treating PTSD with medication has not been found effective. In fact, psychoactive prescription drugs have been implicated as one of the causative

agents of the high rate of suicide of our troops. Antidepressants have been linked to suicidal thoughts and behaviors, and black box warnings alert consumers and prescribers to these risks. Of those veterans with PTSD, 80% were given psychoactive drugs, and 89% of these were prescribed antidepressants (Mohamed & Rosenheck, 2008). Meanwhile, the VA has ignored research supporting that EMDR is a more effective treatment for sustained symptom relief for PTSD than are antidepressants. In one study, both PTSD and depressive symptoms were lower at six-month follow-up for those treated with EMDR than for those treated with Prozac (van der Kolk et al., 2007). A more recent study found that five months after treatment, 60% of those on medication and 58% of those who received placebo still had PTSD, compared with only 20% of those who received psychotherapy (Shalev et al., 2012). *So why give medications at all when a sugar pill is just as effective without all the side effects?* It is time to stop simply prescribing and to start providing evidence-based treatment. The VA needs to develop a strong research and clinician training program for EMDR on a par with current research and training programs for CPT and PE.

How sad that our veterans do not have a choice of those psychotherapies that truly are evidence-based. Our soldiers deserve better. More soldiers have committed suicide than have died in the war in Afghanistan. The military/veteran mental health system is being overwhelmed and needs all the evidence-based psychotherapies as treatments to alleviate human suffering and counteract the enormous wave of tragic outcomes due to PTSD. In 2012, the Surgeon General of the Navy called for more research on EMDR. There is an ethical mandate and a moral responsibility to provide our troops with all the best psychotherapies available. EMDR is one of the most potent evidence-based therapies and should be available for the treatment of PTSD for all veterans and active duty service men and women.

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## Dissemination or Dialogue?

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I suppose my primary discomfort with the very ambitious effort by Karlin and Cross (January 2014) to disseminate evidence-based psychotherapies throughout the vast VA network is that I'm one of their targeted "providers," a psychotherapist (I prefer this name) who presumably lacks "knowledge . . . and/or skills" (p. 21) of their esteemed treatments and who, therefore, needs to be "disseminated" upon. Emotional reactions aside, I believe there are at least two related issues that the authors have yet to add to their list of lessons learned: (a) the considerable controversy about what constitutes evidence and the limitations and flaws of randomized controlled trial (RCT) methodology in social science research, and (b) the idea that dialogue between therapist and researcher (Greene, 2012, 2014) rather than unidirectional, top-down dissemination (a word used no less than 80 times in their article) may be a more fruitful way of dealing with the resistances, reluctances, and refusals that clinicians often demonstrate regarding the implementation of laboratory-based treatments.

With respect to the first of these issues, the authors seem to confer an exclusivity and supremacy to the RCT as the arbiter of therapeutic effectiveness. But this hegemony flies in the face of recent and mounting calls for a pluralistic and multimodal view of evidence (Dattilio, Edwards, & Fishman, 2010), including the importance and usefulness of practice-based evidence and clinician observations. By their taking such a narrow view, Karlin and Cross (2014) seem to implicitly subscribe to the logical fallacy that absence of (RCT) evidence is equivalent to evidence of absence. More than this, they ignore the many conceptual, clinical, and methodological critiques leveled at the psychotherapy RCT over the years (Greene, 2012; Wachtel, 2010). The most recent series of concerns focuses on the reproducibility of findings. It is important to remember that the significance of experimental findings only indicates the likelihood that the same results will obtain in subsequent studies if and only if the conditions in those studies are identical to those in the original study. Increasingly, critics in both the natural and social sciences are alarmed at the rates of

failure to replicate what initially appear as groundbreaking findings, suggesting, at least to one reporter (Johnson, 2014), the operation of unconscious biases that infiltrate even the most sanitized of laboratory environments. Take, for example, the early study by David Spiegel (cf. Spiegel et al., 2007) of supportive-expressive group therapy for breast cancer patients, a groundbreaking study that revealed not only the anticipated benefits of this intervention on mood symptoms but unexpected effects on survival rates. Alas, many subsequent studies and meta-analyses later, no corroborating data on these latter findings have been obtained. Thus the alarm over reproducibility joins the ranks of other problems such as the allegiance effect that suggest that the purity of the RCT is not immune to the influence of human needs and desires to stack the deck in a particular direction.

The second lesson not yet mastered by Karlin and Cross (2014) has to do with clinicians' concerns about manual-based therapies derived from RCTs. The authors give very short shrift to these concerns, labeling them, without elaboration or empathic consideration, as "negative attitudes" (p. 22). They seem not to have heard the frequent refrain that such research-generated, manual-driven therapies are not relevant to the complexities and nuances of the real-world clinical setting, where the primary clinical question is what techniques and common factors will optimize treatment responsiveness for this particular patient at this particular time. As McKinley (2011) pointed out,

Probabilistic generalizations are purchased at the price of leveling down the complexity of experience by only revealing that which is common across individuals. Admittedly, the aim of experimental studies is to yield nomothetic claims, but what about those individuals who do not trend with the statistical norm? This methodological limitation seems at odds with what is pertinent to practitioners who seek to understand the unique qualities, the idiosyncratic meanings, and the specific contexts of their patients' lives. (p. 28)

Implementation and application of evidenced-based treatment packages at the wrong time, in the wrong hands, or for the wrong patient can not only be unhelpful but can do damage. Let's consider the psychotherapeutic treatment of posttraumatic stress disorder (PTSD) within the VA, a major mental health priority. As a frontline senior psychologist, I have been asked on a number of occasions to pick up the pieces of cases gone awry by overly eager and ill-conceived applications of cognitive processing therapy for PTSD—one of those treatments bestowed the rarefied status of