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MILITARY VETERAN PTSD TREATMENT: HOW DOES EYE MOVEMENT
DESENSITIZATION AND REPROCESSING THERAPY COMPARE TO PROLONGED
EXPOSURE THERAPY?

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Introduction

The identification of post-traumatic stress disorder (PTSD) dates back to ancient times; and can be found in references in the Bible, Greek literature and Shakespeare.¹ The actual labeling of symptoms of insomnia, anxiety, somberness and being homesick in military veterans began during the civil war where they were labeled as having nostalgia.² During world war one these symptoms were recognized and labeled as, shell shock,² and in world war two would eventually adopt the first PTSD diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM) 1 of gross stress reaction.¹ During the Vietnam war the new term would be coined as PTSD and has endured to present day. Categorizing and recognizing this disorder has been difficult as these veterans have also been confused with malingering, hysteria, traumatic brain injury or having Munchausen syndrome currently known as factitious disorder.^{3,4}

Difficulty recognizing and classifying these individuals for the aforementioned reasons, along with the imposed stigmas of public perception, have created an environment where people do not want to seek treatment. The combination of being stigmatized combined with the lack of understanding of the disorder has led to variable approaches in treatment.³ The evolution of PTSD has been variant through each war's exposure to trauma, increased survivability rates, and trial and error with studies performed to better understand effective treatments.⁵

Mainstay treatment today primarily consists of cognitive behavioral therapy (CBT) combined with medication, and use of other forms of therapy; however, there is not a standard practice. Some of the identified effective forms of therapy include prolonged exposure therapy, and eye movement desensitization and reprocessing therapy (EMDR).⁶ Prolonged exposure therapy utilizes four areas that include: patient education regarding their condition, exposure to anxiety provoking environments, use of imagination and recall exposure of stressors, and emotional preparation. Over time the aforementioned areas diminish the emotional response of the individual to the exposure or recall of the stimuli (trauma) which is known as habituation.⁷ As a result long term improvements to one's cognitive and emotional responses are improved.⁸ EMDR differs from prolonged exposure therapy through an eight phase process that includes: history gathering, client preparation, assessment, desensitization, installation, body scan, closure and reevaluation.⁹ The desensitization phase is similar to prolonged exposure therapy in which the patient is to recall the traumatic stimuli; however, it differs because the patient does not have to verbalize this phase while they are being stimulated visually or through other methods such as alternating bilateral stimuli to the body.⁹

Therefore, the question to be answered is, in military veterans with PTSD, how does prolonged exposure therapy compare to eye movement desensitization and reprocessing therapy (EMDR) in regard to treatment success rates during treatment course? Our Veterans serve our country, protect us and some pay the ultimate sacrifice with their lives. We owe those who remain behind with invisible scars the effort and desire to find the best treatment.

Discussion

To answer the imposed question of which method of treatment is superior EMDR or prolonged exposure therapy, a literature search was performed. Of the studies researched, there

were significant variations from study to study; they included but were not limited to: the way data was collected (either from a database or through performing an experimental study), and sample sizes varied but were overall small. Most seemed to be uniform in using the Post Traumatic Stress Disorder – Military (PCL-M) questionnaire along with other questionnaires to measure level of PTSD at the beginning of treatment as well as after. Overall, in the research, most studies and discussions showed that it was difficult to obtain results either due to patient drop out, variation in how therapy was given, external influences, and the variation in patient severity.

Of the studies reviewed, each one contributed to answering how prolonged exposure therapy compared to EMDR in treatment success rates of military veterans with PTSD. The studies were helpful in showing the benefits of each of these therapies, and compared them against each other. The results regarding which therapy is superior were mixed. Some of the factors which could have contributed to the mixed reviews were: limited study sizes, lack of consistency in the method in which treatments were given, and outdated research since they were geared more towards PTSD of military members from Vietnam. Research on Veterans from current wars are still in progress or just emerging which creates one of the biggest limitations in deciding which treatments are the most efficacious.¹⁰

While the results varied, EMDR appeared to have a slight edge with better outcomes than prolonged exposure therapy. A study supporting this finding was performed by the Naval Center for Combat and Operational Stress Control, San Diego, CA; it took place March of 2009 and concluded in February of 2012 with a sample size of 331 military members that met the DSM criteria for post-traumatic stress (PTS).¹⁰ The comparison being made was those who received

EMDR (n =46) and those who did not (n=285); variables included use of other psychotherapies which included cognitive behavioral therapy, cognitive processing therapy, exposure therapy, non-trauma focused therapy, the use of more than one of the aforementioned therapies and in some cases use of pharmacotherapy.¹⁰ Results were measured by using the PCL-M questionnaire, all study participants at baseline had an average score measuring above a 50 which indicated a high prevalence of PTSD and were reassessed at the end of treatment.

The only significant difference between the two groups was the group that used EMDR scored higher on the combat experience scale.¹⁰ This could have skewed the results in favor of those not using EMDR; however the results exhibited: sixty-three percent had a ten point improvement on their PCL-M questionnaire which was forty percent higher than in those who did not receive EMDR, they had the need for fewer sessions, and some even fell below the loose criteria in the DSM to be diagnosed as having PTSD.¹⁰ Of the literature review performed this study had the most participants and was the most current; that being said, prolonged exposure therapy has been a mainstay therapy in the treatment of PTSD.

Prolonged therapy has been around longer, therefore more studies may show prolonged therapy as being more effective. EMDR hasn't been used as long as prolonged therapy, but in studies where both were used EMDR had slightly better success rates. The things that attributed to higher success rates were the lower dropout rates, higher percentages of remission, higher patient satisfaction with treatment approach, and lasting results on follow up after ten months to a year post treatment.^{9,11}

Prolonged therapy and EMDR fall into the same class of treatment, exposure therapy; but it appears the areas that make EMDR more successful are related to the autonomy the patient has

in guiding therapy and the desensitization process.^{9,12} Other areas in which EMDR excels is in are: the patient does not need to verbally recall the events, the patient has more control over therapy sessions with the therapist, and, the stimulus provided for desensitization involves a method without direct exposure to the stressor and retrains the autonomic nervous system for long term results.⁹ Verbal recall may contribute to why patients may drop out of therapy, verbally reliving the traumatic stimuli may be too painful and forces the patient to outwardly share what they have seen along with their emotions.⁵ The autonomy the patient has with the use of EMDR is identifying and prioritizing different traumatic experiences so they can address each one as they choose; in some cases this led to early termination of treatment due to the fact that the patient no longer had traumatic experiences to address and felt a resolution of symptoms.⁵ Lastly, the alternating bilateral body stimulus, usually visual, provides benefit to the patient, and works to provide habituation on a different level. The stimulus enables the patient's brain to increase awareness to potential suppressed memories and through increased awareness. This method allows for healing through desensitization of the visual stimulus and emotional response; as a result, it creates a relaxed response of the autonomic nervous system.⁹

Both prolonged therapy and EMDR are effective methods of treatment for PTSD, mainstay management seems to be CBT and pharmacotherapy.¹³ Many questions arise: How can we increase participation in PTSD studies? Is there a way to standardized training for these therapies? What current initiatives or new improved therapies are on the rise? What are the long-term effects of these therapies? How many people regress after therapy? How will future wars differ from past and present and how will that change the way we treat PTSD?

Conclusion

When it comes to PTSD treatment of military veterans, there are too many variations to create a standard.¹⁴ Therefore no one therapy is truly superior to another, it is whatever works for the patient. There are treatment options like prolonged therapy and eye motion desensitization and reprocessing therapy which have shown high success rates and should be considered as an option when selecting a type of treatment.¹⁴ When comparing prolonged therapy and eye motion desensitization and reprocessing therapy, they are closely as effective. Future investigation is warranted. As spotlighted in the study above, it appears not just one therapy is effective but rather the use of multiple psychotherapy methods plus or minus pharmacotherapy is the best approach. Therefore, based on these findings one treatment does not fit all. The tried and true treatments are medication and cognitive behavioral therapy but prolonged therapy and eye motion desensitization and reprocessing therapy have shown positive results and are worth implementing as solid mainstay treatment methods for PTSD.

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