

# Intervening Early With EMDR on Military Operations

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## A Case Study

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The U.K. armed forces are currently involved in a number of military operations throughout the world. Offering structured psychological interventions such as eye movement desensitization and reprocessing (EMDR) in theater has a number of potential advantages. This single-case study describes how the EMDR recent event protocol (Shapiro, 1995) was used in theater with a 27-year-old active-duty U.K. soldier who was experiencing an acute stress reaction after treating a land mine casualty. The intervention took place 2 weeks posttrauma with four sessions conducted on consecutive days, resulting in a positive outcome, with the soldier able to return immediately to frontline duties. Treatment response was assessed with administration of four standardized measures at pretreatment, posttreatment, and 18-month follow-up. Treatment effects remained at 18-month follow-up. The challenges of conducting EMDR in operational theaters and clinical implications are explored.

**Keywords:** EMDR; military; early intervention; trauma

**M**ilitary personnel who are exposed to traumatic events are at risk of developing symptoms of traumatic stress. Personnel involved in traumatic incidents while serving at the front line will usually be monitored under the principle of “watchful waiting” (National Institute for Health and Clinical Excellence [NICE], 2005). If it is determined that they are developing symptoms of acute stress disorder (ASD) or posttraumatic stress disorder (PTSD), treatment is provided. This typically requires the individual to return home to their local Military Department of Community Mental Health (DCMH), possibly before completing their deployment, which can sometimes result in a delay to treatment. In addition, returning personnel home for treatment may be detrimental to their mental health such that it may stigmatize them and may disrupt the cohesion and functioning of the unit (Solomon, Laor, & McFarlane, 1996). Furthermore, there is

some evidence to suggest that psychiatric casualties evacuated from theater have a poor chance of later returning (Rundell, 2006).

While more timely interventions might be helpful, it should be noted that military operational theaters can be challenging places in which to offer psychological treatment and that most stress responses are transient (Bryant, 2007). There is also the risk of “professionalizing” and pathologizing normal distress and disrupting natural social networks of healing and support (Gist & Devilly, 2002). While McNally, Bryant, and Ehlers (2003) claimed that there is little research supporting any intervention within a month of the trigger event, Bryant (2007) argued that “there is a need to develop better early interventions that acutely traumatized people can tolerate and respond to” (p. 24). Clinicians at the front line in the military theater are able to detect and intervene early with problems. Early intervention has been suggested to

improve treatment outcomes (Lee, Gabriel, & Bale, 2005) and may help engage PTSD sufferers who are often reluctant to seek help (Weisaeth, 2001).

Previously, psychological debriefing (e.g., critical incident stress debriefing; Mitchell, 1983; Solomon, 2008) had been a mainstay of the interventions on offer in the military (and in the civilian world), but this intervention is no longer recommended by the U.K. military surgeon general or NICE (2005). Rather, in the 4 weeks posttrauma, NICE proposes practical and social support to all, watchful waiting for mild psychological reactions, and trauma-focused cognitive-behavioral therapy for severe PTS/PTSD. Research has shown that prolonged exposure therapy within 2 weeks of the trauma is an effective treatment for ASD (Bryant, Sackville, Dang, Moulds, & Guthrie, 1999) and that intervening early with exposure-based therapies may lead to better outcomes when compared to cognitive restructuring (Bryant et al., 2008).

Eye movement desensitization and reprocessing (EMDR) is frequently used by U.K. military mental health practitioners to treat serving military personnel suffering from traumatic stress and PTSD. EMDR is offered at DCMH in the United Kingdom, Germany, and Cyprus (Hacker Hughes, 2004; Hacker Hughes & Wesson, 2008). Offering EMDR as an early intervention in theater is a new development for U.K. military mental health services. The U.K. armed forces are well placed to offer EMDR treatment in theater as they deploy a range of mental health professionals with expertise and training in EMDR. Clinicians also have access to further in-house expertise in the United Kingdom for consultation and supervision as and when required.

There is also an emerging body of research supporting the use of EMDR to treat acute trauma. For example, Kutz, Resnik, and Dekel (2008) report that a single session of modified, abridged EMDR was effective at treating terrorist attack or accident victims suffering acute stress with 70% treated within 2 weeks of the index event. Similarly, research by Silver, Rogers, Knipe, and Colelli (2005) found that EMDR delivered within 4 weeks of the 9/11 World Trade Center terrorist attacks was effective for individuals suffering with acute stress. A case study of civilians post-9/11 further illustrates the usefulness of the recent event (RE) protocol (Colelli & Patterson, 2008).

Shapiro's (1995) EMDR RE protocol suggests that early after a traumatic event, the memory is fragmented, and therefore a different approach to the standard protocol is required to facilitate processing, integration, and consolidation. Rather than viewing

the event as a single memory, there may be discrete moments within the event that can be considered as unique targets. Shapiro (1995) describes the seven stages of the RE protocol:

1. Obtain a narrative history of the event.
2. Target the most disturbing aspect of the memory (if necessary).
3. Target the remainder of the narrative in chronological order.
4. Have the client visualize the entire sequence of the event with eyes closed and reprocess it as the disturbance arises. Repeat until the entire event can be visualized from start to finish without distress.
5. Have client visualize the event from start to finish with eyes open and install positive cognition.
6. Conclude with a body scan.
7. Process present stimuli if necessary.

There is some, albeit limited, evidence for the RE protocol with military personnel (Russell, 2006), but this study lacks of any follow-up data. More recently, Shapiro and Laub (2008) have devised a recent traumatic episode protocol that recommends targeting the recent event along with any significant subsequent experiences. The current case study describes how the first author intervened early with EMDR in the theater of operations using the original RE protocol.

## Introduction of the Case

"John" was a 27-year-old single male who had a stable childhood with no past psychiatric history or previous trauma. He enlisted in the army 7 years ago and completed one previous tour of duty. He had been in theater for 4 months. He reported good social support networks and a supportive chain of command. John presented to mental health services 5 days after the traumatic event. His colleague had stepped on a land mine, and John was one of the medics who delivered first aid at the scene and during the transit of the casualty to the helicopter over approximately a 30-minute period. The casualty was alive when transferred to the evacuation team, but John and the rest of the unit were informed later by the officer in charge that the colleague had died on route to hospital. John sought the help of the unit padre, who encouraged him to talk to a member of the Field Mental Health Team (FMHT). The FMHT comprised the first author and one other mental health nurse trained in EMDR to level 1.

## Presenting Problems

John's reexperiencing symptoms included intrusive thoughts (e.g., "I should have done more"), images

(e.g., injuries to the casualty's body), smells (e.g., of the casualty's stomach contents), and nightmares about the event. He described being horrified at the time of the incident, especially when first seeing the casualty. No avoidance symptoms were identified; however, he was temporarily stationed at a rearward location and was highly anxious about returning to frontline duties. He was placing pressure on himself to return so as not to let his team down. His physiological arousal symptoms included poor sleep and concentration as well as thinking about safety and checking that his colleagues were safe. He reported episodes of tearfulness, anger, and low mood and being frustrated that he could not control his thoughts and images.

## Assessment

Five days postincident, the first author conducted a full mental health assessment and delivered tailored psychoeducation (i.e., "psychological first aid"). The case was discussed with the principal medical officer on the camp, and, with John's consent, an occupational management plan was negotiated with his line manager. This involved him remaining in active employment at a rearward location to be reviewed at a later date for the potential to return to frontline duties. Over the next 10 days, the first author saw John on three occasions in accordance with the principles of "watchful waiting" (NICE, 2005). During this period, his low mood and anger improved, but he continued to be troubled by his physiological arousal and reexperiencing symptoms. John had also become increasingly anxious about returning to his primary role in the front line but feared that he would be failing his friends and colleagues if he did not return. Following clinical supervision, an EMDR assessment was carried out, and an initial "safe-place" exercise (Shapiro, 1995) was successful. John was motivated to try EMDR as a means of helping him deal with symptoms of reexperiencing and arousal.

## Measures

John completed four standardized brief self-report questionnaires at pretreatment, posttreatment, and 18-month follow-up. These included the PTSD Checklist—Civilian Version (PCL-C; Weathers, Litz, Herman, Huska, & Keane, 1993), the Impact of Event Scale—Revised (IES-R; Weiss & Marmar, 1997), the Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983), and the Beck Depression Inventory (BDI; Beck & Steer, 1987). The PCL-C comprises 17 items where a score of 44 or

above suggests a diagnosis of PTSD (Blanchard, Jones-Alexander, Buckley, & Forneris, 1996) and 17 is symptom free. The IES-R has 22 items with a score of 45 or higher suggestive of PTSD. The HADS suggests a cutoff value for clinical cases of >8. On the BDI, a score of less than 10 suggests normal or minimal depression, 10 to 18 mild to moderate depression, 19 to 29 moderate to severe depression, and 30 and higher severe depression.

## Case Conceptualization

In terms of Shapiro's adaptive information processing model (Shapiro, 1995), the impression was that John had been unable to fully "process" the incident because of experiencing overwhelming emotions (horror and possibly helplessness) during the event. His processing appeared to be looping particularly around images of the casualty's body, which was blocking access to positive memory networks and information and preventing adaptive information processing from taking place. His poor sleep and re-experiencing symptoms perhaps served to maintain a sense of current ongoing threat and further block processing. In addition, there was the impression that he was experiencing feelings of guilt and shame, namely, some responsibility for the death and that he had let himself and his colleagues down for not coping with his own reaction.

## Treatment Overview

**Session 1.** The RE protocol identified two separate targets indicating elements of a fragmented memory. The most disturbing aspect of the memory was of the casualty's body showing a catastrophic injury. John's negative cognition (NC) was "I am weak," and his positive cognition (PC) was "I am strong." Based on the 7-point Validity of Cognition Scale (VoC; Shapiro 1989), he rated his PC as 3, where 1 means "completely false" and 7 means "completely true." John was asked to rate his anxiety using the 11-point Subjective Units of Distress Scale (SUDS; Shapiro, 1989; Wolpe, 1958), where 0 represents neutral intensity and 10 the highest possible disturbance. His initial SUDS was 6. His emotions were sadness and anger with a stomach-churning sensation. Desensitization using eye movements elicited a range of images that seemed to be chronological and suggested reprocessing. During the session, John described a feeling of helplessness that he had experienced when he first approached the casualty and a return of the strong smell he endured while administering mouth-to-mouth resuscitation. As John progressed through the event, he felt the

difficulties he had faced trying to continue the first aid while transiting in a vehicle to the helicopter—one of frustration. Toward the end of the session, John was processing images of him receiving the news that the casualty had died, and, like at the time, a sense of sadness returned. Although John described a sense of relief at the end of the session, there was no reported SUDS reduction.

**Session 2.** The following day, John reported unchanged symptoms but a SUDS score of 4. However, shortly after further desensitization using eye movements, John noticed and reflected on the serious nature of the injuries and accordingly the poor prognosis. It seemed that the guilt he had held about not being able to save his colleague was beginning to dissipate.

**Session 3.** The next day, John reported a significant reduction in his intrusive symptoms. Desensitization continued bringing his SUDS score to zero, and John reported that “I can still remember it, but it doesn’t seem to have the power it did before.” The positive cognition was installed to a VoC of 7. The second disturbing aspect of the memory identified at assessment was then targeted. This was based on the difficulties he faced reaching the casualty on hearing the explosion. This was targeted with John choosing the same NC and PC as the previous target, with a VoC of 5. His emotion was anxiety, and SUDS was 2 with a bodily sensation of “butterflies” in the stomach. This target processed rapidly with his SUDS, soon reducing to 0 and VoC increasing to 7 after only a few sets of eye movements. The session closed with repeated visualizations of the event, both with eyes open and closed, until no disturbance was reported. The positive cognition remained at a VoC of 7. John spontaneously added, “It’s over now,” “I got through this,” and “I can learn from it.” The body scan revealed no further distress.

**Session 4.** The following day, during reevaluation, John’s SUDS remained at 0 and VoC at 7. Again, he

did not evidence any distress on the body scan exercise. Posttreatment measures were administered.

**Sessions 5 and 6.** Two reviews in theater over the following month revealed further reductions in his symptoms and improvements in his functioning and sleep. He had volunteered to return to frontline duties, which had been accepted by his line manager, and he was feeling very positive about this development.

**Follow-Up.** One year posttreatment, John reported that the treatment effects had been maintained. He was preparing to redeploy, and to help him prepare, two further sessions of EMDR using the future template were carried out. He was then discharged from the DCMH. While in theater, John emailed the first author to report that he was doing well and that EMDR had been very beneficial in helping him personally and in improving his confidence at work.

**18-month Follow-Up.** John was contacted again after his tour of duty, which was 18 months after the index trauma. He reported that he was doing very well and was effusive about EMDR and the importance of remaining in an environment surrounded by his friends and colleagues who understood and shared his experience.

## Results

Table 1 reports pretreatment, posttreatment, and follow-up scores on self-report measures. At baseline, John scored close to the threshold on both the PCL-C and the IES-R, suggesting significant distress. His HADS score suggested anxiety but no depression, consistent with his response on the BDI. Posttreatment, he showed significant reductions on the PCL-R and the IES-R. Both John and the first author felt that these scores reflected a normal response given that he was possibly returning to his frontline role. He showed a clinically significant reduction on the HADS and further decreases on the measures of

**TABLE 1. Pre- to Posttreatment and 18-Month Follow-Up Scores on Self-Report Measures**

	Pretreatment	Posttreatment	18-Month Follow-Up
PCL-C	35	21	17
IES-R	31	10	1
HADS-A	11	4	0
HADS-D	2	0	0
BDI	6	3	0

*Note.* Improvement indicated by reduction in score. PCL-C = PTSD Checklist; IES-R = Impact of Events Scale-Revised; HADS = Hospital Anxiety and Depression Scale (A = anxiety, D = depression); BDI = Beck Depression Inventory.

depression. At follow-up, John's scores on all measures were no longer clinically meaningful.

## Discussion of Treatment Implications

This case study is the first known clinical report of EMDR in theater with an active-duty U.K. soldier with long-term follow-up. Although recovery could have occurred naturally over time and there are a number of study shortcomings (e.g., the single-case study design, generalization), four sessions of EMDR helped the client return to his frontline duties and complete his tour of duty. The case provides some evidence that the EMDR RE protocol could benefit military personnel on operations and early after a traumatic event.

Factors that may have contributed to this positive outcome include John's stable background and supportive chain of command. In addition, his early presentation and commitment to starting therapy perhaps suggest a high level of motivation. Indeed, Russell's (2006) small-scale study found that armed forces personnel returning from an operational theater were motivated to seek EMDR treatment. It is possible that EMDR is more acceptable to service personnel who can be reluctant to engage in more traditional talking therapies. Overcoming the stigma of mental health and help seeking are significant issues for most armed services (Hoge et al., 2004; Langston, Gould, & Greenberg, 2007). Interestingly, during his deployments, the first author has observed an increased acceptance of the FMHT. John's willingness to seek help may be a reflection of the extensive and ongoing program of outreach work, psychoeducation, and briefings conducted across the U.K. armed services.

There appear a number of unique potential benefits of conducting EMDR within the military. Silver et al. (2005) suggest that EMDR is especially suited to mass-disaster situations where the number of clients may be high and contacts brief because of the movement of survivors. In addition, such situations would hamper many therapies that are delivered on a once-a-week between-session homework format. Many of these issues appear equally to apply to the military setting with the added complexity, as Russell (2008) notes, that there are often conflicting occupational demands on active-service personnel. EMDR and other psychological therapies that can potentially have rapid treatment effects and can be delivered over a short period are likely to be particularly valued by the military.

This case study suggests that the use of EMDR in the U.K. armed forces need not be confined to home-base DCMH. Indeed, removing individuals from theater for treatment has a number of implications. It discords with the approach espoused by combat psychiatry, namely, that treatment should be based on the PIE principle: *proximity* (the individual should be treated as close to the front of the battle as possible), *immediacy* (treatment should commence as soon as possible after the combat stress reaction), and *expectancy* (the individual will return to his unit and perform his duties) (Solomon & Benbenishty, 1986). On an individual level, removing from the theater of operations risks disrupting support networks and may generate feelings of failure and make postdeployment readjustments more difficult (Russell, 2006). In addition, avoidant behaviors can be challenged in theater with in vivo experiments, which can be difficult to recreate at the home base. On a unit level, occupational functioning may suffer through lowered morale and increased workload. On an organizational level, the military are keen to help individuals remain on deployments so that they can fulfill their occupational commitments, which is important given the current operational tempo for U.K. armed forces. Indeed, Rundell (2006) showed that less than 5% of personnel who were psychiatrically evacuated during approximately a 3-year period of Operation Iraqi Freedom and Operation Enduring Freedom (Afghanistan) returned to these campaigns.

However, offering EMDR in theater is challenging. The very nature of military operations, such that they are fast paced with little "occupational slack" in the system, means that they do not lend themselves to protracted periods of assessment and therapy. Decisions often need to be made early. Intervening early with mental health problems often raises, for some clinicians, the specter of psychological debriefing (for a recent review, see Adler et al., 2008). Certainly, in our opinion, in practice this limits the use of EMDR to experienced practitioners who are able to evaluate the costs and benefits of intervening early and whether the processing appears "stuck." In addition, where access to weapons and explosives is common, clinicians must be able to carry out comprehensive occupational assessments prior to deeming clients to be fit for their primary role. To support this work, the British military are actively reviewing and developing guidelines in this area (Ministry of Defence, 2008). Accordingly, we suggest that clinicians working in theater are properly trained in any clinical intervention and that EMDR clinicians should ideally have completed all levels/parts of EMDR training. This work can be stressful for the

client and therapist alike, and clinicians are often required and so must have the confidence to work relatively independently in theater. Therefore, access to regular supervision by an EMDR consultant (either through visits to theatre or remotely, via telephone, e-mail, or Webcam-based supervision) is integral and vital to this work and, in our opinion, to all clinical work, especially where the provider is learning a new skill. It is interesting to note that Maxfield and Hyer's (2002) meta-analysis of PTSD treatments highlights the importance of treatment fidelity in terms of positive outcomes. The U.K. Defence Clinical Psychology Service has been exploring ways of supporting front-line clinical work, including a supervision contract, tailored to treating in theater (e.g., to include remote access to supervision) to ensure proper support and regulation. Indeed, the first author was acutely aware of the valuable contributions his supervisor gave during this challenging work. Finally, logistical and practical constraints require the therapist and client to be flexible. John received four sessions on consecutive days, and this worked well. This raises interesting questions about the format and delivery of therapy.

## Recommendations

Intervening early with EMDR at the front line is an exciting and controversial development. On a professional level, some clinicians may be ethically uncomfortable with the concept of using psychological interventions to help individuals return to their front-line combat roles. Others may consider that intervening early risks pathologizing a normal reaction. However, the current case, along with the anecdotal evidence emerging from other armed forces engaged in this type of work, suggests that EMDR is potentially a promising early intervention technique to help service personnel deployed to the theater of operations. In our opinion, controlled trials and specific clinical guidelines to include supervision and minimum training standards are now required. Investigating the efficacy of Shapiro's RE protocol or Shapiro and Laub's recent traumatic episode protocol might be valuable first steps in determining whether a military specific protocol is needed.

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**Declaration of Interest.** Lt. Wesson and Dr. Gould are full-time employees of the U.K. Ministry of Defence. The views expressed in this article are those of the authors and do not reflect the official policy or position of any institution with which the authors are affiliated.

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