National Institute for Health and Care Excellence (NICE) – Final Version/DF/22.7.18

NICE Guidance: Post-traumatic Stress disorder (up-date) - In development [GID-NG10013]

Response to Draft Guideline Consultation from EMDR UK & Ireland Association as a Registered Stakeholder

Additional Contributors: International Colleagues/ Experts in EMDR Therapy

Ref: EMDRUKI/DF/UW/NICE/GID-NG10013/072018

Date: 22nd July 2018

On behalf of the EMDR UK & Ireland Association , EMDR Europe Association and the wider international EMDR Therapy Community), we would like to thank the National Institute for Health and Care Excellence **[NICE]** for its guidance, advice and important information with regards to Post-Traumatic Stress Disorder [PTSD]. This up-date **[June 2018]** is both timely and necessary – particularly as the global burden of psychological trauma continues unabated.

Although EMDR UK & Ireland Association is a registered stakeholder to NICE, the feedback provided to GID-NG10013 [PTSD] also includes comments from the broader EMDR Therapy International Community – including EMDR Europe.

The intention of this feedback is to highlight areas of consensus, but importantly, from an EMDR Therapy perspective, areas where there is clear disagreement with the current guidance for PTSD GID-NG10013.

For the purpose of context - Eye Movement Desensitization & Reprocessing [EMDR] Therapy is a form of psychotherapy/ psychological treatment, that has been extensively researched and proven effective for the treatment of the effects due to exposure to adverse life events

– mainly PTSD and Complex PTSD[1] [2]. Its theoretical construct is that of Adaptive Information Processing (AIP), which holds that the primary source of psychopathology is the presence of memories of adverse life experiences that have been insufficiently processed [3] [4].

Since 2013, EMDR Therapy has been included in the recommendation issued by the World Health Organization [5], as one of two elective therapies for treating PTSD in children, adolescents and adults. To date, this WHO meta-analysis offered the most comprehensive review of treatment interventions for stress – including PTSD. The World Health Organization and the UN Refugee Agency [UNHCR] – Mental Health GAP Humanitarian Intervention Guide (mhGAP-HIG), further supported this: Clinical management of mental, neurological and substance use conditions in humanitarian emergencies[6]. Furthermore, the Department of Veterans Affairs and the Department of Defence guidelines describes the strength of research evidence underpinning EMDR Therapy – for PTSD, as '***Strong***'[7].

Consequently, there appears to be some divergence between the WHO (2013), UNHCR [8], VA/Department of Defence Clinical Practice Guideline for the Management of Post-traumatic Stress Disorder and Acute Stress disorder, NICE PTSD Guideline [CG26 – published March, 2005], and this proposed NICE PTSD Guideline [GID-NG10013].

As figure 1 highlights, by the end of 2017, there were some 38 controlled studies dealing with the treatment of severe trauma and Post-traumatic stress disorders. The body of EMDR Therapy Publications [9] [10] include the following

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[1] Bromet E, Karam E, Koenen K, Stein D, editors. Trauma and Posttraumatic Stress Disorder: Global Perspectives from the WHO World Mental Health Surveys. Cambridge University Press; 2018 Aug 31.

[2] Brewin CR, Cloitre M, Hyland P, Shevlin M, Maercker A, Bryant RA, Humayun A, Jones LM, Kagee A, Rousseau C, Somasundaram D. A review of current evidence regarding the ICD-11 proposals for diagnosing PTSD and complex PTSD. Clinical Psychology Review. 2017 Sep 6.

[3] Shapiro F, Wesselmann D, Mevissen L. Eye Movement Desensitization and Reprocessing Therapy (EMDR). In Evidence-Based Treatments for Trauma Related Disorders in Children and Adolescents 2017 (pp. 273-297). Springer, Cham.

[4] Shapiro F. Eye Movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols and procedures.

[5] World Health Organization. (2013). *Guidelines for the management of conditions that are specifically related to stress*. World Health Organization.

[6] World Health Organization and United Nations High Commissioner for Refugees. mhGAP Humanitarian Intervention Guide (mhGAP-HIG): Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: WHO, 2015.

[7] https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGClinicianSummaryFinal.pdf

[8] https://data2.unhcr.org/en/documents/download/39722

[9] https://emdr-europe.org/research/research-studies/

[10] https://emdria.site-ym.com/page/EMDRResearch?

• EMDR Treatments:	**452**
• EMDR and PTSD:	**337**
• EMDR and Trauma:	**212**
• EMDR Reviews:	**139**
• EMDR and Anxiety:	**136**
• EMDR and Depression:	**87**
• EMDR Mechanisms:	**75**
• EMDR in Children:	**72**
• EMDR and Pain:	**14**
• EMDR and Refugees:	**14**
• EMDR and Addiction:	**11**
• Meta-Analysis:	**34**

Figure 1: Empirical Evidence Base in Support of EMDR Therapy by end of 2017

This aptly demonstrates the increasing empiricism underpinning EMDR Therapy as a safe, effective and efficient psychological treatment intervention[11] [12] which has also been significantly enhanced by its neurobiological underpinnings [13] [14] [15] [16].

As with the NICE guideline CG26, EMDR UK & Ireland Association acknowledges that PTSD is a global public health issue, significant in its magnitude, and potentially devastating for individuals, families, communities and society as a whole. NICE Guidance on PTSD is vital in recognizing, assessing and treating PTSD in children, young people and adults. Any recommendations that aims to raise awareness of PTSD and improve co-ordination of care, is welcomed, not just by EMDR UK & Ireland & EMDR Europe, but by the global EMDR Therapy Community.

In response to the NICE PTSD Guideline DRAFT (June 2018) – EMDR UK & Ireland Association and EMDR Europe are in ***broad agreement*** with the following sections:

[11] Bongaerts H, Van Minnen A, de Jongh A. Intensive EMDR to treat patients with complex posttraumatic stress disorder: A case series. Journal of EMDR Practice and Research. 2017 May 1;11(2):84-95.
[12] Wagenmans A, Van Minnen A, Sleijpen M, De Jongh A. The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD. European journal of psychotraumatology. 2018 Jan 1;9(1):1430962.
[13] Calancie OG, Khalid-Khan S, Booij L, Munoz DP. Eye movement desensitization and reprocessing as a treatment for PTSD: current neurobiological theories and a new hypothesis. Annals of the New York Academy of Sciences. 2018 Jun 21.
[14] Pagani M, Amann BL, Landin-Romero R, Carletto S. Eye movement desensitization and reprocessing and slow wave sleep: a putative mechanism of action. Frontiers in psychology. 2017 Nov 7;8:1935.
[15] González A, del Río-Casanova L, Justo-Alonso A. Integrating neurobiology of emotion regulation and trauma therapy: reflections on EMDR therapy. Reviews in the Neurosciences. 2017 May 24;28(4):431-40.
[16] Hase M, Balmaceda UM, Ostacoli L, Liebermann P, Hofmann A. The AIP model of EMDR therapy and pathogenic memories. Frontiers in psychology. 2017 Sep 21;8:1578.

1.1 Recognition of post-traumatic stress disorder

- 1.1.1
- 1.1.2
- 1.1.3
- 1.1.4
- 1.1.5

Specific recognition issues for children

- 1.1.6
- 1.1.7

Screening of people involved in a major disaster, refugees and asylum seekers

- 1.1.8
- 1.1.9

1.2 Assessment and co-ordination of care

- 1.2.1
- 1.2.2

Supporting transitions between services

- 1.2.4
- 1.2.5
- 1.2.6

1.3 Access to Care

- 1.3.1
- 1.3.2

We particularly welcome this inclusion:

"Do not delay or withhold treatment for PTSD because of court proceedings or applications for compensation. Discuss with the person the implications of the timing of any treatment to help them make an informed decision about if and when to proceed. **[2018])"**

1.4 Principles of care – supporting people with PTSD

- 1.4.1
- 1.4.2

1.4.3 Peer support

1.4.4 Maintaining safe environments

1.4.5 Involving and supporting families and carers

1.4.6
1.4.7
1.4.8

1.5 Language and culture

1.5.1
1.5.2
1.5.3

We welcome these up-dates:

1.5.1 *"Pay particular attention to identifying people with PTSD in working or living environments where there may be cultural challenges to recognising the psychological consequences of trauma (see recommendations on avoiding stigma and promoting social inclusion in the NICE guideline on service user experience in adult mental health)".* **[2005, amended 2018]**

1.5.2 **"***When offering interventions, ensure they are culturally and linguistically appropriate for service users."* **[2005, amended 2018]**

1.6 Management of PTSD in children, young people and adults: Planning treatment and supporting engagement

- 1.6.1
- 1.6.2
- 1.6.3 – active monitoring
- 1.6.11 – drug treatment for children and young people

1.6.19 – Psychologically focused debriefing

1.6.20 – Drug treatment for adults

- 1.6.21
- 1.6.22

1.7 Care for people with PTSD and complex needs

- 1.7.1
- 1.7.2
- 1.7.3
- 1.7.4

1.8 Disaster planning

- 1.8.1

However, EMDR UK & Ireland Association and EMDR Europe **does not concur** with the guidance regarding Children & Adolescents, Adults, and Military Populations – with each area addressed separately. Regarding PTSD in Children and Adolescents, EMDR UK & Ireland Association and EMDR Europe does not support the following sections:

1.6 Management of PTSD in children, young people and adults: Planning treatment and supporting engagement

Prevention for children and young people

- 1.6.4
- 1.6.5

Treatment for children and young people

- 1.6.6
- 1.6.7
- 1.6.8
- 1.6.9
- 1.6.10

EMDR Therapy Response to Prevention and Treatment for Children and Young People

> "Consider Eye Movement Desensitization and Reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD 10 or clinically important symptoms of PTSD more than 3 months after a 11 traumatic event ***only if they do not respond to or engage with trauma-focused CBT.***"
>
> "*There was limited evidence for eye movement desensitisation and reprocessing (EMDR) suggesting possible benefits on PTSD symptoms in children aged over 16 years. Based on uncertainties in this evidence, the committee decided it* ***should be considered only if children do not respond to or engage with trauma-focused CBT,*** *an intervention that is supported by better evidence."* [Page 13 of 57]

EMDR UK & Ireland Association and EMDR Europe recommends to the committee to consider three randomised control trails [RCT's] that have been published demonstrating the effectiveness of EMDR Therapy with children. These include the following:

- Diehle et al., (2015)[17] – N = 48
- De Roos et al., (2011)[18] – N= 52
- De Roos et al, (2017) – N = 103

A summary of the Diehle et al (2015) study is as follows:

[17] Diehle J, Opmeer BC, Boer F, Mannarino AP, Lindauer RJ. Trauma-focused cognitive behavioral therapy or eye movement desensitization and reprocessing: What works in children with posttraumatic stress symptoms? A randomized controlled trial. European child & adolescent
psychiatry. 2015 Feb 1;24(2):227-36.

[18] de Roos C, Greenwald R, den Hollander-Gijsman M, Noorthoorn E, van Buuren S, De Jongh A. A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster-exposed children. European Journal of Psychotraumatology. 2011 Jan 1;2(1):5694.

> "To prevent adverse long-term effects, children who suffer from posttraumatic stress symptoms (PTSS) need treatment. Trauma-focused cognitive behavioral therapy (TF-CBT) is an established treatment for children with PTSS. However, alternatives are important for non-responders or if TF-CBT trained therapists are unavailable. Eye movement desensitization and reprocessing (EMDR) is a promising treatment for which sound comparative evidence is lacking. The current randomized controlled trial investigates the effectiveness and efficiency of both treatments. Forty-eight children (8–18 years) were randomly assigned to eight sessions of TF-CBT or EMDR. The primary outcome was PTSS as measured with the Clinician-Administered PTSD Scale for Children and Adolescents (CAPS-CA). Secondary outcomes included parental report of child PTSD diagnosis status and questionnaires on comorbid problems. The Children's Revised Impact of Event Scale was administered during the course of treatment. TF-CBT and EMDR showed large reductions from pre- to post-treatment on the CAPS-CA (−20.2; 95 % CI −12.2 to −28.1 and −20.9; 95 % CI −32.7 to −9.1). The difference in reduction was small and not statistically significant (mean difference of 0.69, 95 % CI −13.4 to 14.8). Treatment duration was not significantly shorter for EMDR (p = 0.09). Mixed model analysis of monitored PTSS during treatment showed a significant effect for time (p < 0.001) but not for treatment (p = 0.44) or the interaction of time by treatment (p = 0.74). Parents of children treated with TF-CBT reported a significant reduction of comorbid depressive and hyperactive symptoms. TF-CBT and EMDR are effective and efficient in reducing PTSS in children."

We highlight to the committee the following summary from the study:

> "***TF-CBT and EMDR are effective and efficient in reducing PTSS in children.***"

In addition, there is the de Roos (2011)[19] study, which highlighted the following:

> "Standardised CBT and EMDR interventions can significantly improve functioning of disaster-exposed children. Both treatment approaches produced significant reduction on all measures, which were maintained at follow-up. Treatment gains of EMDR were reached in fewer sessions."

EMDR UK & Ireland and EMDR Europe does not understand why the committee did not consider the RCT carried out by De Roos (2017)[20] entitled: Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioural writing therapy, and wait-list in paediatric posttraumatic stress disorder following single-incident trauma: a multi-centre randomized clinical trial. Yet this RCT clearly met the committee's specific inclusion criteria?

[19] de Roos C, Greenwald R, den Hollander-Gijsman M, Noorthoorn E, van Buuren S, De Jongh A. A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster-exposed children. European Journal of Psychotraumatology. 2011 Jan 1;2(1):5694.

[20] - de Roos C, van der Oord S, Zijlstra B, Lucassen S, Perrin S, Emmelkamp P, de Jongh A. Comparison of eye movement desensitization and reprocessing therapy, cognitive behavioral writing therapy, and wait-list in pediatric posttraumatic stress disorder following single-incident trauma: a multicenter randomized clinical trial. Journal of Child Psychology and Psychiatry. 2017 Nov;58(11):1219-28.

A summary of the study is as follows:

> **"BACKGROUND:**
> Practice guidelines for childhood posttraumatic stress disorder (PTSD) recommend trauma-focused psychotherapies, mainly cognitive behavioral therapy (CBT). Eye movement desensitization and reprocessing (EMDR) therapy is a brief trauma-focused, evidence-based treatment for PTSD in adults, but with few well-designed trials involving children and adolescents.
>
> **METHODS:**
> We conducted a single-blind, randomized trial with three arms (n = 103): EMDR (n = 43), Cognitive Behavior Writing Therapy (CBWT; n = 42), and wait-list (WL; n = 18). WL participants were randomly reallocated to CBWT or EMDR after 6 weeks; follow-ups were conducted at 3 and 12 months posttreatment. Participants were treatment-seeking youth (aged 8-18 years) with a DSM-IV diagnosis of PTSD (or subthreshold PTSD) tied to a single trauma, who received up to six sessions of EMDR or CBWT lasting maximally 45 min each.
>
> **RESULTS**:
> Both treatments were well-tolerated and relative to WL yielded large, intent-to-treat effect sizes for the primary outcomes at post-treatment: PTSD symptoms (EMDR: d = 1.27; CBWT: d = 1.24). At post-treatment 92.5% of EMDR, and 90.2% of CBWT no longer met the diagnostic criteria for PTSD. All gains were maintained at follow-up. Compared to WL, small to large (range d = 0.39-1.03) intent-to-treat effect sizes were obtained at post-treatment for negative trauma-related appraisals, anxiety, depression, and behaviour problems with these gains being maintained at follow-up. Gains were attained with significantly less therapist contact time for EMDR than CBWT (mean = 4.1 sessions/140 min vs. 5.4 sessions/227 min).
>
> **CONCLUSIONS:**
> EMDR and CBWT are brief, trauma-focused treatments that yielded equally large remission rates for PTSD and reductions in the severity of PTSD and comorbid difficulties in children and adolescents seeking treatment for PTSD tied to a single event. Further trials of both treatments with PTSD tied to multiple traumas are warranted."

In addition, we would like to bring to the attention of the committee the following research publications relating to EMDR Therapy and children – these are also summarised:

1. **Trentini, C., Lauriola M., Giuliani, A., Maslovaric, G., Tambelli, R., Fernandez, I., Pagani, M. (2018) Dealing with the aftermath of mass disasters: A field study on the application of EMDR Integrative Group Treatment Protocol with child victims of the 2016 Italy earthquakes. *Frontiers in Psychology, doi: 10.3389/fpsyg.2018.00862***

   This study explored the effects of the EMDR Integrative Group Treatment Protocol (EMDR-IGTP) on child survivors of the earthquakes that struck Italy in 2016. Three hundred and and thirty-two children from severely disrupted villages received 3 cycles of EMDR-IGTP. At T3, older children showed a reduction of distress and anger, whereas younger children reported an increase on these domains; moreover, older children reported a greater reduction of anxiety than younger ones. A greater reduction of distress, anxiety, and need for help was evidenced in females, whereas a greater improvement in depressive symptoms was

evidenced in males. The effects of the EMDR-IGTP treatment on post-traumatic symptoms were particularly evident in older children, compared to younger ones, and marginally greater in females than in males; moreover, a greater improvement was found in children who had received a timelier intervention, than in those who received delayed treatment. These results provide further evidence for the utility of EMDR-IGTP in dealing with the extensive need for mental health services in mass disaster contexts. Also, these data highlight the importance of providing EMDR-IGTP in the immediate aftermath of a natural disaster, to contribute significantly in restoring adaptive psychological functioning in children, especially in older ones.

2. **R. C. Brown, A. Witt, J. M. Fegert, F. Keller, M. Rassenhofer and P. L. Plener (2017). Psychosocial interventions for children and adolescents after man-made and natural disasters: a meta-analysis and systematic review.** ***Psychological Medicine*****,** ***doi:10.1017/S0033291717000496***

In the light of increasing numbers of refugees under the age of 18 years worldwide, there is a significant need for effective treatments. This meta-analytic review investigates specific psychosocial treatments for children and adolescents after man-made and natural disasters. Treatments investigated by at least two studies were cognitive–behavioural therapy (CBT), eye movement desensitization and reprocessing (EMDR), narrative exposure therapy for children (KIDNET) and class- room-based interventions, which showed similar effect sizes. CBT, EMDR, KIDNET and classroom-based interventions can be equally recommended.

3. **Verardo, A. R., & Cioccolanti, E. (2017). EMDR beyond PTSD. Traumatic experiences and EMDR in childhood and adolescence. A review of the scientific literature on efficacy studies.** ***Clinical Neuropsychiatry, 14(5), 313-320***

The aim of this review was to examine the efficacy of EMDR treatment on children and adolescents with post-traumatic stress disorder symptoms through comparisons with other established trauma treatment or no treatment control groups. Literature search was done concerning the effects of EMDR treatment on PTSD symptomatology in children and adolescents by analyzing digital databases like PsycINFO, MEDLINE, Google Scholar and Cochrane Library and with a traditional research method, targeting revisions and articles. Results show the efficacy of EMDR in respect of the number of sessions. Fewer EMDR sessions are associated with better outcomes. These findings support the use of EMDR for treating symptoms of PTSD in children, although further replications and comparisons are required.

4. **Mevissen, L., Didden, R., Korzilius, H., & de Jongh, A. (2017). Eye movement desensitisation and reprocessing therapy for posttraumatic stress disorder in a child and an adolescent with mild to borderline intellectual disability: A multiple baseline across subjects study.** ***Journal of Applied Research in Intellectual Disabilities*****,** ***30*****, 34-41.**

This study explored the effectiveness of eye movement desensitization and reprocessing (EMDR) therapy for post-traumatic stress disorder (PTSD) in persons with mild to borderline intellectual disability (MBID). For both participants, number of PTSD symptoms decreased in response to treatment and both no longer met PTSD criteria at post-treatment. This result

was maintained at 6-week follow-up. The results of this study add further support to the notion that EMDR can be an effective treatment for PTSD in children and adolescents with MBID.

5. **Moreno-Alcázar A, Treen D, Valiente-Gómez A, Sio-Eroles A, Pérez V, Amann BL. (2017) Efficacy of Eye Movement Desensitization and Reprocessing in Children and Adolescent with Post-traumatic Stress Disorder: A Meta-Analysis of Randomized Controlled Trials. *Frontiers in Psychology 10;8:1750. doi: 10.3389/fpsyg.2017.01750.***

Post-traumatic stress disorder (PTSD) can occur in both adults and children/adolescents. Untreated PTSD can lead to negative long-term mental health conditions such as depression, anxiety, low self-concept, disruptive behaviors, and/or substance use disorders. To prevent these adverse effects, treatment of PTSD is essential, especially in young population due to their greater vulnerability. The principal aim of this meta-analysis was to examine the efficacy of eye movement desensitization and reprocessing (EMDR) therapy for PTSD symptoms in children and adolescents. Secondary objectives were to assess whether EMDR therapy was effective to improve depressive or anxious comorbid symptoms. EMDR therapy was superior to waitlist/placebo conditions and showed comparable efficacy to cognitive behavior therapy (CBT) in reducing post-traumatic and anxiety symptoms. A similar but non-statistically significant trend was observed for depressive symptoms. The obtained results suggest that EMDR therapy could be a promising psychotherapeutic approach for the treatment of PTSD and comorbid symptoms in young individuals.

1.6.10 Consider eye movement desensitisation and reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event only if they do not respond to or engage with trauma- focused CBT. **[2018]**

1.6.11 Consider eye movement desensitisation and reprocessing (EMDR) for children and young people aged 7 to 17 years with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event only if they do not respond to or engage with trauma- focused CBT. **[2018]**

EMDR UK & Ireland and EMDR Europe Summary: We do not support recommendation 1.6.10 and 1.6.11 as it currently stands. The research highlighted above demonstrates the efficacy of EMDR Therapy with children and adolescents, and its equivalence with trauma focussed CBT. Consequently, we do not support using EMDR only if a child or young person does not respond to or engage with trauma focussed CBT – instead we would like to assert that children and young people be offered a 'choice' between TF-CBT and EMDR.

EMDR Therapy Response to Prevention and Treatment of Adults

Regarding PTSD in Adults, EMDR UK & Ireland Association and EMDR Europe does not support the following sections:

Psychological and psychosocial interventions for the prevention and treatment of PTSD in adults
1.6.12

Treatment in adults
1.6.13
1.6.14
1.6.15
1.6.16
1.6.17
1.6.18

EMDR UK & Ireland Association and EMDR Europe response to 1.6.12

Concerning EMDR Therapy as a treatment effect with Acute Stress Disorder, EMDR UK & Ireland Association and EMDR Europe concurs that there is a paucity of research regarding this specific disorder. However, there is increasing evidence of the effectiveness of using EMDR Therapy as an early intervention. As a result, we would like to bring the committee's attention the following references:

1. **Gil-Jardiné C, Evrard G, Al Joboory S, Saint Jammes JT, Masson F, Ribéreau-Gayon R, Galinski M, Salmi LR, Revel P, Régis CA, Valdenaire G. Emergency room intervention to prevent post-concussion-like symptoms and post-traumatic stress disorder. A pilot randomized controlled study of a brief eye movement desensitization and reprocessing intervention versus reassurance or usual care. *Journal of psychiatric research.* 2018 May 26.**

Summary: This is the first randomized controlled trial that shows that a short EMDR intervention is feasible and potentially effective in the context of the Emergency Room (ER).

2. **Pfefferbaum B, Nitiéma P, Tucker P, Newman E. Early child disaster mental health interventions: a review of the empirical evidence. In Child & Youth Care Forum 2017 Oct 1 (Vol. 46, No. 5, pp. 621-642). Springer US.**

Summary: This study highlights successful implementation of a range of interventions including CBT, narrative exposure, meditation relaxation, debriefing, and EMDR

3. **Saltini A, Rebecchi D, Callerame C, Fernandez I, Bergonzini E, Starace F. Early Eye Movement Desensitisation and Reprocessing (EMDR) intervention in a disaster mental health care context. Psychology, health & medicine. 2018 Mar 16;23(3):285-94.**

Summary: The results of this study suggest that EMDR is a viable treatment option in response to a disaster crisis and in reducing psychological distress of acutely traumatized individuals within the context of a natural disaster.

4. **Trentini C, Lauriola M, Giuliani A, Maslovaric G, Tambelli R, Fernandez I, Pagani M. Dealing with the aftermath of mass disasters: A field study on the application of EMDR Integrative Group Treatment Protocol with child victims of the 2016 Italy earthquakes. Frontiers in psychology. 2018;9:862.**

Summary: The effects of the EMDR-IGTP treatment on post-traumatic symptoms were particularly evident in older children, compared to younger ones, and marginally greater in females than in males; moreover, a greater improvement was found in children who had received a timelier intervention, than in those who received delayed treatment. These results provide further evidence for the utility of EMDR-IGTP in dealing with the extensive need for mental health services in mass disaster contexts. Also, these data highlight the importance of providing EMDR-IGTP in the immediate aftermath of a natural disaster, to contribute significantly in restoring adaptive psychological functioning in children, especially in older ones.

5. **Yurtsever A, Konuk E, Akyüz T, Zat Z, Tükel F, Çetinkaya M, Savran C, Shapiro E. An Eye Movement Desensitization and Reprocessing (EMDR) Group Intervention for Syrian Refugees With Post-traumatic Stress Symptoms: Results of a Randomized Controlled Trial. Frontiers in psychology. 2018;9.**

Summary: This study indicated that EMDR G-TEP effectively reduced PTSD symptoms among refugees living in a camp, after two treatment sessions conducted over a period of 3 days.

EMDR UK & Ireland Association and EMDR Europe response to 1.6.13 – 1.6.18

In Section 1.6.16 the committee recommends the following

> "Typically be provided over 8 to 12 sessions but more if clinically indicated, for example, where people have experienced multiple traumas."

However, we would like to bring to the committee's attention the following study by Nijdam et al (2012)[21]

As summary is as follows:

> **Background**
> Trauma-focused cognitive–behavioral therapy (CBT) and eye movement desensitization and reprocessing therapy (EMDR) are efficacious treatments for post-traumatic stress disorder (PTSD), but few studies have directly compared those using well-powered designs and few have investigated response patterns.
>
> **Aims**
> To compare the efficacy and response pattern of a trauma-focused CBT modality, brief eclectic psychotherapy for PTSD, with EMDR (trial registration: ISRCTN64872147).
>
> **Method**
> Out-patients with PTSD were randomly assigned to brief eclectic psychotherapy (n = 70) or EMDR (n = 70) and assessed at all sessions on self-reported PTSD (Impact of Event Scale – Revised). Other outcomes were clinician-rated PTSD, anxiety and depression.
>
> **Results**
> Both treatments were equally effective in reducing PTSD symptom severity, but the response pattern indicated that EMDR led to a significantly sharper decline in PTSD symptoms than brief eclectic psychotherapy, with similar drop-out rates (EMDR: n = 20 (29%), brief eclectic psychotherapy: n = 25 (36%)). Other outcome measures confirmed this pattern of results.
>
> **Conclusions**
> Although both treatments are effective, EMDR results in a faster recovery compared with the more gradual improvement with brief eclectic psychotherapy.

What this study clearly highlights is that 92% of the research participants lost their (single event) PTSD diagnosis after just 5 sessions of EMDR therapy, despite current guidance of between 8-12 treatment sessions. An important aspect of this particular research is that it is

[21] Nijdam MJ, Gersons BP, Reitsma JB, de Jongh A, Olff M. Brief eclectic psychotherapy v. eye movement desensitisation and reprocessing therapy for post-traumatic stress disorder: randomised controlled trial. The British Journal of Psychiatry. 2012 Mar;200(3):224-31.

one of the few studies that measured the time needed to treat the condition [PTSD] rather than adhering to a fixed number of treatment sessions.[22]

We would also like to bring to the attention of the committee the following reference in support of intensive treatment for adults with PTSD:

> ***Zepeda Méndez M, Nijdam MJ, ter Heide FJ, van der Aa N, Olff M. A five-day inpatient EMDR treatment programme for PTSD: pilot study. European journal of psychotraumatology. 2018 Jan 1;9(1):1425575.***
>
> ***Summary:***
> Background: Trauma-focused psychotherapies for posttraumatic stress disorder (PTSD) have been demonstrated to be efficacious, but also have considerable non-response and dropout rates. Intensive treatment may lead to faster symptom reduction, which may contribute to treatment motivation and thereby to reduction of dropout.
>
> ***Objective***: The aim of the current study was to investigate the feasibility and preliminary effectiveness of an intensive five-day inpatient treatment with Eye Movement Desensitization and Reprocessing (EMDR) and trauma-informed yoga for patients with PTSD.
>
> ***Method:*** A non-controlled pilot study with 12 adult patients with PTSD was conducted. At baseline the PTSD diagnosis was assessed with the Clinician-Administered PTSD Scale (CAPS-5) and comorbid disorders with the Mini International Neuropsychiatric Interview (MINI). Primary outcome was self-reported PTSD symptom severity (PTSD Check List for DSM-5; PCL-5) measured at the beginning of day 1 (T1), at the end of day 5 (T2) and at follow-up on day 21 (T3). Reliable change indexes (RCI) and clinically significant changes were calculated.
>
> ***Results:*** From T1 to T3, PTSD symptoms significantly improved with a large effect size (Cohen's d = 0.91). Nine of the 11 patients who completed treatment showed reliable changes in terms of self-reported PTSD. At T3, two of the patients no longer met criteria for PTSD as measured with the PCL-5. One patient dropped out after the first day. No serious adverse events occurred.
>
> ***Conclusions:*** The majority of patients in our pilot study experienced symptom reduction consistent with reliable changes in this five-day inpatient treatment with EMDR and yoga. Randomized controlled trials – with longer follow up periods – are needed to properly determine efficacy and efficiency of intensive clinical treatments for PTSD compared to regular treatment. This is one of the first studies to show that

[22] Bisson JI, Ehlers A, Pilling S, Dix P, Murphy A, Johnston J, Richards D, Turner S, Yule W, Jones C, King R. Post-traumatic stress disorder (PTSD): The management of PTSD in adults and children in primary and secondary care.

intensive EMDR treatment is feasible and is indicative of reliable improvement in PTSD symptoms in a very short time frame.

Section 1.6.16 continued:

> "be delivered in a phased manner and include psychoeducation about reactions to trauma; managing distressing memories and situations; identifying and treating target memories (often visual images); and 6 promoting alternative positive beliefs about the self "

We found this aspect difficult to understand, and was unsure upon which research studies this assertion was based upon. Consequently, we would seek further clarification on this aspect. However, we would like to bring to the attention of the committee the following study by Steinert (2016)[23], which indicates the following:

> "We conclude that a treatment focusing on stabilization rather than confrontation, by establishing a secure patient/therapist relationship, applying stabilization techniques, and putting an emphasis on a patient's own resources, significantly reduced symptoms of PTSD in comparison to a waiting list."

EMDR UK and Ireland Association and EMDR Europe would also like to bring attention to the emerging research in support of Adult PTSD, which focusses upon intensive treatment - utilising EMDR either as a 'stand-alone treatment' or in conjunction with other trauma-focussed treatment interventions. We are of the opinion that combined trauma treatments are insufficiently addressed, acknowledged or considered by this current guideline.

The following studies are therefore recommended to the committee:

1. ***Bongaerts H, Van Minnen A, de Jongh A. Intensive EMDR to treat patients with complex posttraumatic stress disorder: A case series. Journal of EMDR Practice and Research. 2017 May 1;11(2):84-95.***

Summary: CAPS scores decreased significantly from pre- to posttreatment, and four of the seven patients lost their PTSD diagnosis as established with the CAPS. The

[23] Steinert C, Bumke PJ, Hollekamp RL, Larisch A, Leichsenring F, Mattheß H, Sisokhom S, Sodemann U, Stingl M, Thearom R, Vojtová H. Treating post-traumatic stress disorder by resource activation in Cambodia. World Psychiatry. 2016 Jun;15(2):183-5.

results were maintained at 3-month follow-up. Effect sizes (Cohen's d) on the CAPS and PSS-SR were large: 3.2, 1.7 (pre/post) and 2.3, 2.1 (pre/follow-up), respectively. The results of this case series suggest that an intensive program using EMDR therapy is a potentially safe and effective treatment alternative for complex PTSD.

2. ***Wagenmans A, Van Minnen A, Sleijpen M, De Jongh A. The impact of childhood sexual abuse on the outcome of intensive trauma-focused treatment for PTSD. European journal of psychotraumatology. 2018 Jan 1;9(1):1430962.***

Summary: Large effect sizes were achieved for PTSD symptom reduction for all trauma groups [PE and EMDR therapy] (Cohen's d = 1.52–2.09). For the Clinical Administered PTSD Scale (CAPS) and the Impact of Event Scale (IES), no differences in treatment outcome were found between the trauma (age) groups. For the PTSD Symptom Scale Self Report (PSS-SR), there were no differences except for one small effect between CSA and NSA.

3. **Zoet HA, Wagenmans A, van Minnen A, de Jongh A. Presence of the dissociative subtype of PTSD does not moderate the outcome of intensive trauma-focused treatment for PTSD. European journal of psychotraumatology. 2018 Jan 1;9(1):1468707.**

Summary: Background: There is a widely-held belief in the trauma field that the presence of dissociative symptoms is associated with poor treatment response. However, previous research on the effect of dissociation in treatment outcomes pertained to specific patients and trauma populations.

Objective: To test the hypothesis that the presence of the dissociative subtype of PTSD (DS) would have a detrimental effect on the outcome of an intensive trauma-focused treatment programme.

Methods: PTSD symptom scores (Clinician Administered PTSD Scale [CAPS] and PTSD Symptom Scale Self-Report [PSS-SR]) were analysed using the data of 168 consecutive patients (70.6% female) who had been exposed to a wide variety of multiple traumas, including childhood sexual abuse, and of whom 98.2% were diagnosed with severe PTSD (CAPS > 65). Most of them suffered from multiple comorbidities and 38 (22.6%) met the criteria for DS. They took part in an intensive trauma-focused treatment programme for PTSD. Pre- and post-treatment differences were compared between patients with and without DS.

Results: Large effect sizes were achieved for PTSD symptom reduction on CAPS and the PSS-SR, both for patients with DS and those without. Although patients with DS

showed a significantly greater PTSD symptom severity at the beginning, and throughout, treatment, both groups showed equal reductions in PTSD symptoms. Of those who met the criteria for DS, 26 (68.4%) no longer fulfilled the criteria for this classification after treatment.

Conclusion: The results provide no support for the notion that the presence of DS negatively impacts trauma-focused treatment outcomes. Accordingly, PTSD patients with DS should not be denied effective trauma-focused treatments.

4. **Van Woudenberg, C., Voorendonk, E.M., Bongaerts, H., Zoet, H.A., Verhagen, M., Van Minnen, A., Lee, C.W., & De Jongh, A. (2018). The effectiveness of an intensive treatment programme combining prolonged exposure and EMDR for severe posttraumatic stress disorder (PTSD). European Journal of Psycho-traumatology, 9:1, https://doi.org/10.1080/20008198.2018.1487225**

Background: There is room for improvement regarding the treatment of severe posttraumatic stress disorder (PTSD). Intensifying treatment to increase patient retention is a promising development.

Objective: The aim of this study was to determine the effectiveness of an intensive trauma-focused treatment programme over 8 days for individuals suffering from severe PTSD.

Method: Treatment was provided for 347 PTSD patients (70% women; mean age = 38.32 years, SD = 11.69) and consisted of daily sessions of prolonged exposure and eye movement desensitization and reprocessing (EMDR) therapy (16 sessions in total), physical activity, and psycho-education. All participants had experienced multiple traumas, including sexual abuse (74.4%), and suffered from multiple comorbidities (e.g. 87.5% had a mood disorder). Suicidal ideation was frequent (73.9%). PTSD symptom severity was assessed by both clinician-rated [Clinician Administered PTSD Scale (CAPS)] and self-report [PTSD Symptom Scale Self Report (PSS-SR) and Impact of Event Scale (IES)] inventories. For a subsample (n = 109), follow-up data at 6 months were available.

Results: A significant decline in symptom severity was found (e.g. CAPS intention-to-treat sample Cohen's d = 1.64). At post-treatment, 82.9% showed a clinically meaningful response and 54.9% a loss of diagnosis. Dropout was very low (2.3%).

Conclusions: Intensive trauma-focused treatment programmes including prolonged exposure, EMDR therapy, and physical activity can be effective for patients suffering from severe PTSD and are associated with low dropout rates.

5. **Morgenthaler TI, Auerbach S, Casey KR, Kristo D, Maganti R, Ramar K, Zak R, Kartje R. Position paper for the treatment of nightmare disorder in adults:**

an American Academy of Sleep Medicine position paper. J Clin Sleep Med. 2018;14(6):1041–1055.

Position Statement:
The following therapies may be used for the treatment of PTSD-associated nightmares: cognitive behavioral therapy; cognitive behavioral therapy for insomnia; ***eye movement desensitization and reprocessing***; exposure, relaxation, and rescripting therapy; the atypical antipsychotics olanzapine, risperidone and aripiprazole; clonidine; cyproheptadine; fluvoxamine; gabapentin; nabilone; phenelzine; prazosin; topiramate; trazodone; and tricyclic antidepressants.

EMDR UK & Ireland and EMDR Europe Summary: We do not support recommendation 1.6.12 and 1.6.18 as it currently stands:

1.6.12 Offer individual trauma-focussed CBT to adults who have acute stress disorder or clinically important symptoms of PTSD and have been exposed to 1 or more traumatic events within the last month

1.6.18 Consider symptom specific CBT interventions (for symptoms such as sleep disturbance or anger) for adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event who:

- Are unable or unwilling to engage in a trauma-focussed intervention that specifically targets PTSD or
- Have residual symptoms after a trauma-focussed intervention. [2018]

The research highlighted above demonstrates the efficacy of EMDR therapy with adults between 1 and 3 months, including sleep disturbance/nightmares. The committee makes an assertion that there is 'limited evidence' (both TF-CBT and EMDR) – however, the research in support of EMDR Therapy as an intervention should be considered by means of 'choice', and balance between TF-CBT ***and*** EMDR therapy.

EMDR Therapy Response to Non-Combat -Related Trauma

We refer to page 31 of 57 of the proposed guidance - Eye movement desensitisation and reprocessing (recommendations 1.6.15 and 1.6.16)

> "Less evidence was found on EMDR than on trauma-focused CBT, but the committee agreed that what was available justified recommending EMDR as an option. Although studies that compared EMDR directly with trauma-focused CBT did not show significant differences, there was a trend towards EMDR. This trend in favour of EMDR was also present in the cost-effectiveness results. The evidence suggested EMDR may be less effective in people with military combat-related trauma, so the committee restricted their recommendation to non-combat-related trauma."

Regarding PTSD with Non-Combat-Related Trauma, EMDR UK & Ireland Association does not support the following sections:

> 1.6.15 - Offer eye movement desensitisation and reprocessing (EMDR) as an option for non-combat-related trauma to adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event. [2018]

This current guidance makes a clear distinction between combat and non-combat related PTSD – EMDR UK and Ireland Association and EMDR Europe would question the rationale for this assertion. As mentioned earlier, the US Military Guideline (2016) were EMDR & TF-CBT were given equal credibility.

Here is the hyperlink to the clinician summary version:

https://www.healthquality.va.gov/guidelines/MH/ptsd/VADoDPTSDCPGClinicianSummaryFinal.pdf

Please refer to page 6, section B, point 11

> "For patients with PTSD, we recommend individual, manualized trauma-focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioural therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure."

Please also find a hyperlink to the recent article published in Frontiers in Psychology entitled: The Use of Eye-Movement Desensitization Reprocessing (EMDR) Therapy in Treating Post-traumatic Stress Disorder—A Systematic Narrative Review

https://www.frontiersin.org/articles/10.3389/fpsyg.2018.00923/full

A summary is as follows:

> ***Results:*** Data from meta-analyses and Randomized-Controlled Trials included in this review evidence the efficacy of EMDR therapy as a treatment for PTSD. Specifically, EMDR therapy improved PTSD diagnosis, reduced PTSD symptoms, and reduced other trauma-related

> symptoms. EMDR therapy was evidenced as being more effective than other trauma treatments, and was shown to be an effective therapy when delivered with different cultures. However, limitations to the current evidence exist, and much current evidence relies on small sample sizes and provides limited follow-up data.

The majority of trauma treatment with military populations ostensibly focusses upon Prolonged Exposure and/or Cognitive Processing Therapy. We concur with the VA/DOD recommendation that the research evidence underpinning both these trauma interventions are 'strong'. Nonetheless, we would also like to bring to the committee's attention Steenkamp et al (2015)[24] study which concluded:

> "In military and veteran populations, trials of the first-line trauma-focused interventions CPT and prolonged exposure have shown clinically meaningful improvements for many patients with PTSD. However, nonresponse rates have been high, many patients continue to have symptoms, and trauma-focused interventions show marginally superior results compared with active control conditions. There is a need for improvement in existing PTSD treatments and for development and testing of novel evidence-based treatments, both trauma-focused and non–trauma-focused.

The International EMDR Therapy community accepts that more research is needed exploring the utilization of EMDR Therapy with military PTSD clinical populations.

> **1.6.15.** Offer eye movement desensitisation and reprocessing (EMDR) as an option for non-combat-related trauma to adults with a diagnosis of PTSD or clinically important symptoms of PTSD more than 3 months after a traumatic event. **[2018]**

Response: We do not recommend this guidance as it currently stands. The recommendation offered diverges from the VA/DOD guidelines, which states the following:

> "For patients with PTSD, we recommend individual, manualized trauma- focused psychotherapies that have a primary component of exposure and/or cognitive restructuring to include Prolonged Exposure (PE), Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), specific cognitive behavioural therapies for PTSD, Brief Eclectic Psychotherapy (BEP), Narrative Exposure Therapy (NET), and written narrative exposure. - ***Strength: Strong*** (ref. Section 4, recommendations; Part 11, page 34/200; page 46/200."

The VA document also states the following:

[24] Steenkamp MM, Litz BT, Hoge CW, Marmar CR. Psychotherapy for military-related PTSD: a review of randomized clinical trials. Jama. 2015 Aug 4;314(5):489-500.

> The trauma-focused psychotherapies with the strongest evidence from clinical trials are PE, CPT, and EMDR. These treatments have been tested in numerous clinical trials, in patients with complex presentations and comorbidities, compared to active control conditions, have long-term follow- up, and have been validated by research teams other than the developers. Other manualized protocols that have sufficient evidence to recommend use are: specific cognitive behavioural therapies for PTSD, BEP, NET, and written narrative exposure.

It also describes EMDR as the following:

> "EMDR incorporates imaginal exposure through narration and visualization to process the worst image, emotion, and negative cognition associated with the traumatic event, along with a more healthy cognitive reappraisal, with bilateral eye movements or other form of bilateral stimulation intended to create a dual awareness environment to facilitate processing and relaxation."

EMDR is also described as part of 'Trauma-focused psychotherapies—therapies that include consciously recalling or activating the traumatic memory either as part (or all) of the presumed therapeutic mechanism or to provide material for other therapeutic techniques (e.g., cognitive restructuring, relaxation, imagery substitution) [Page 49, 158]. This is alongside PET, CPT, TF-CBT, NET, etc.

Indeed, there is currently only limited evidence for the utilization of EMDR therapy involving combat-related PTSD. However, to consider this distinction – should there not be reservations also regarding other specific populations, for example intellectual learning disabilities, refugees, asylum seekers with PTSD? This paucity of evidence, with these populations, applies also to TF-CBT as much as it does to EMDR therapy.

One important study to bring to the committee's attention is a systematic review/ meta-analysis by Thompson et al (2018)[25] which explored psychological interventions for PTSD in refugees and asylum seekers. It states the following:

> ***Abstract summary:*** There is a high prevalence of post-traumatic stress disorder (PTSD) in refugee and asylum seeker populations, which can pose distinct challenges for mental health professionals. This review included 16 randomised controlled trials (RCTs) with 1111 participants investigating the effect of psychological interventions on PTSD in these populations. 525 trials were reviewed, 16 were

[25] Thompson CT, Vidgen A, Roberts NP. Psychological interventions for post-traumatic stress disorder in refugees and asylum seekers: A systematic review and meta-analysis. Clinical Psychology Review. 2018 Jun 15.

included with 15 contributed to meta-analyses. Despite the challenges of conducting research in this field, we found evidence for trauma-focused psychological interventions for PTSD in this population. Following sub-group analyses, we found evidence to support the use of EMDR and Narrative Exposure Therapy for PTSD symptoms. We considered these findings in relation to the broader PTSD treatment literature and related literature from survivors of large-scale conflict. These findings suggest that trauma focused psychological therapies can be effective in improving symptoms for refugees and asylum seekers with PTSD.

Furthermore, we would like to bring to the attention of the committee a critical research study missing from the guidance:

- van den Berg D.P.G., de Bont P.A.J.M., van der Vleugel B.M., De Roos C., De Jongh A., van Minnen, A. van der Gaag M. (2015). Prolonged Exposure versus Eye Movement Desensitization and Reprocessing versus Waiting List for Posttraumatic Stress Disorder in Patients With a Psychotic Disorder: A randomized Clinical Trial. JAMA Psychiatry, 72(3):259-267. https://doi.org/10.1001/jamapsychiatry.2014.2637

The conclusion from this important study indicated 'Standard PE and EMDR protocols are effective, safe, and feasible in patients with PTSD and severe psychotic disorders, including current symptoms.'

In addition, we would like to bring to the committee's attention the following references in support:

Lee DJ, Schnitzlein CW, Wolf JP, Vythilingam M, Rasmusson AM, Hoge CW. Psychotherapy versus pharmacotherapy for posttraumatic stress disorder: Systemic review and meta-analyses to determine first-line treatments. *Depress Anxiety.* Sep 2016;33(9):792-806.

Rothbaum BO, Astin MC, Marsteller F. Prolonged exposure versus eye movement desensitization and reprocessing (EMDR) for PTSD rape victims. *J Trauma Stress.* Dec 2005;18(6):607-616.

Watts BV, Schnurr PP, Mayo L, Young-Xu Y, Weeks WB, Friedman MJ. Meta-analysis of the efficacy of treatments for posttraumatic stress disorder. *J Clin Psychiatry.* Jun 2013;74(6):e541-550.

Recent publications evaluating outcomes with the US VA movement which utilises PE, PCT, and CPT (TF-CBT) models as PTSD treatment interventions, have raised questions regarding the extent of their efficacy among veterans[26] [27]. Steenkamp (2016)[28] noted the following:

> "While beneficial to many patients, between one-third and half of veterans receiving CPT or PE do not demonstrate clinically meaningful symptom improvement" (2016, page 431).

During this period EMDR therapy has held its own with more and more VA therapists being trained in EMDR.

Additional Comments from EMDR UK & Ireland Association

- Dropout rates from Trauma Treatment
- Practice-Based Evidence
- Integrative Approach to Trauma

Dropout Rates

Hoge & Chard (2018)[29] in an editorial paper highlighted the following:

> "The wars in Iraq and Afghanistan sparked tremendous investment to improve the care of service members and veterans with posttraumatic stress disorder (PTSD), including enhancing screening and treatment services, updating clinical practice guidelines, and initiating multicenter randomized clinical trials (RCTs) to refine treatment approaches.1 The most recent US Department of Veterans Affairs (VA) and Department of Defense (DoD) clinical practice guideline for management of PTSD recommends trauma-focused psychotherapies as first-line treatment ahead of medications, with prolonged exposure therapy and cognitive processing therapy the most widely used therapies. Despite these efforts, however, many challenges remain, including stigma, barriers to care, and high rates of patient dropout from treatment." (page 343)

[26] Foa EB, McLean CP, Zang Y, Rosenfield D, Yadin E, Yarvis JS, Mintz J, Young-McCaughan S, Borah EV, Dondanville KA, Fina BA. Effect of prolonged exposure therapy delivered over 2 weeks vs 8 weeks vs present-centered therapy on PTSD symptom severity in military personnel: A randomized clinical trial. JAMA. 2018 Jan 23;319(4):354-64.

[27] Hoge CW, Chard KM. A Window Into the Evolution of Trauma-Focused Psychotherapies for Posttraumatic Stress Disorder. Jama. 2018 Jan 23;319(4):343-5.

[28] Steenkamp MM, Larson JL, Litz BT. Posttraumatic Stress Symptoms Across the Deployment Cycle: A Latent Transition Analysis Alyssa M. Boasso VA Boston Healthcare System, Massachusetts Veterans Epidemiology Research and Information Center.

[29] Hoge CW, Chard KM. A Window Into the Evolution of Trauma-Focused Psychotherapies for Posttraumatic Stress Disorder. Jama. 2018 Jan 23;319(4):343-5.

Often, despite well-designed studies, including rigorous methodologies, including blinded assessment are also subject to 'loss to follow-up', which often approaches 50% at 6 months follow-up. The average dropout rate across treatments in PTSD clinical trials is approximately 20%[30].

Disorder	Treatment Approach	k	Dropout rate	95% CI	Between Groups Q-value	df (Q)	p-value
PTSD	Average	92	21.0%	18.8%, 23.5%	20.20	7	< .01
	Behavior Therapy (AR)	4	12.1%	5.5%,24.6%			
	Behaviour Therapy (exposure)	25	23.2%	19.4%, 27.6%			
	Cognitive Therapy	8	15.2%	9.6%, 23.3%			
	CPT	5	23.7%	16.3%, 33.1%			
	EMDR	**10**	**16.9%**	**10.0%, 27.2%**			
	Full CBT	27	28.5%	22.4%, 35.6%			
	Integrative	4	8.8%	2.9%, 23.7%			
	Supportive	9	15.3%	11.1%, 20.5%			

Table 1: Dropout Rates for PTSD – adapted version[31]

Results suggest that there is no significant difference between EMDR Therapy and other empirically supported treatment interventions for PTSD. Interestingly the dropout rates regarding integrative treatments are approximately (8.8%), whereas the drop-out rate for the Van Woudenberg et al (2018)[32] study was 2.3%. It is important to bring this study to the committee's attention. Consequently, this study is summarized as follows:

> "Treatment was provided for 347 PTSD patients (70% women; mean age = 38.32 years, SD = 11.69) and consisted of daily sessions of prolonged exposure and eye movement desensitization and reprocessing (EMDR) therapy (16 sessions in total), physical activity, and psycho-education. All participants had experienced multiple traumas, including sexual abuse (74.4%), and suffered from multiple comorbidities (e.g. 87.5% had a mood disorder). Suicidal ideation was frequent (73.9%). PTSD symptom severity was assessed by both clinician-rated [Clinician Administered PTSD Scale (CAPS)] and self-report [PTSD Symptom Scale Self Report (PSS-SR) and Impact of Event Scale (IES)] inventories. For a subsample (n = 109), follow-up data at 6 months were available.

[30] Imel ZE, Laska K, Jakupcak M, Simpson TL. Meta-analysis of dropout in treatments for posttraumatic stress disorder. Journal of consulting and clinical psychology. 2013 Jun;81(3):394.
[31] Swift JK, Greenberg RP. A treatment by disorder meta-analysis of dropout from psychotherapy. Journal of Psychotherapy Integration. 2014 Sep;24(3):193.
[32] Van Woudenberg, C., Voorendonk E., Bongaerts, H., Zoet, H.A., Verhagen, M.,Lee, C.W., Minnena, A.V., De Jongh, A. Effectiveness of an intensive treatment programme combining prolonged exposure and eye movement desensitization and reprocessing for severe post-traumatic stress disorder. EUROPEAN JOURNAL OF PSYCHOTRAUMATOLOGY 2018, VOL. 9, 1487225 https://doi.org/10.1080/20008198.2018.1487225

> ***Results:*** A significant decline in symptom severity was found (e.g. CAPS intention-to-treat sample Cohen's d = 1.64). At post-treatment, 82.9% showed a clinically meaningful response and 54.9% a loss of diagnosis. Dropout was very low (2.3%)."

Another important article in regard to 'dropout rates is:

Najavits, L. M. (2015). The problem of dropout from "gold standard" PTSD therapies. *F1000prime Reports*, *7*, 43. doi:10.12703/P7-43

Quoting from the abstract of Najavits

> The two PTSD therapies most studied in relation to retention and dropout are ***Prolonged Exposure and Cognitive Processing Therapy***, which have been the subject of massive, formal, multi-year dissemination roll-outs. Both of these evidence-based treatments are defined as gold-standard therapies for PTSD and showed positive outcomes and reasonable retention of patients in randomized controlled trials (RCTs). ***But an emerging picture based on real-world practice indicates substantial dropout***. Such ***real-world studies are distinct from RCTs***, which have consistently evidenced far lower dropout rates, but under much more restricted conditions (e.g. a more selective range of patients and clinicians). In this paper, the phenomena of retention and dropout are described based on real-world studies of Prolonged Exposure and Cognitive Processing Therapy, including rates, characteristics of patients, clinicians, and programs in relation to retention and dropout, and identification of clinical issues and future research on these topics. ***It is suggested that the term "gold-standard" evidence-based treatments should be reserved for treatments that evidence both positive results in RCTs but also feasibility and strong retention in real-world settings.***

on page 6 she states:

> "We are at a pivotal historical moment with regard to PTSD therapies. There has now been substantial investment in development of therapies, testing of them in rigorous RCTs, and dissemination of them in large-scale treatment systems. Such efforts indicate that the actual performance of the "gold standard" therapies PE and CPT consistently perform less well in real-world implementation with regard to retention and dropout than in the RCT literature.
>
> As Hoge et al.[33] recently stated in relation to the problem of PTSD patients dropping out of therapy: "Dropping out of care is clearly the most important predictor of treatment failure; therefore the most promising strategies to improve efficacy of evidence-based treatments will be those that address engagement, therapeutic rapport, and retention."

[33] Hoge CW, Chard KM. A Window Into the Evolution of Trauma-Focused Psychotherapies for Posttraumatic Stress Disorder. Jama. 2018 Jan 23;319(4):343-5.

Integrative Approaches to PTSD/ Complex PTSD Treatment

The intensive trauma treatment study mentioned earlier highlights both the benefits of intensive treatment, but also integrative approaches. The Van Woudenberg et al (2018) study indicates that intensive trauma-focused treatment programmes - including prolonged exposure, EMDR therapy, and physical activity can be effective for patients suffering from severe PTSD and are associated with low dropout rates.

EMDR UK & Ireland Association and EMDR Europe considers that the committee be mindful, and cognizant with 'Modular/ Integrative Treatment', which often consider trans-diagnostic approaches (including co-morbidity factors) concerning PTSD. The Van Woudenberg et al study (2018) is a seminal work in this area.

Returning to the issue of 'dropout rates' EMDR UK & Ireland Association and EMDR Europe would like to bring to the attention of the committee the following quotation from Swift & Greenburg study (2014):

> "After the integrative approaches, applied relaxation, cognitive therapy, supportive approaches, and EMDR were also found to have relatively lower rates of premature discontinuation (ranging from 12.1% to 16.9%) for PTSD clients. In contrast, the highest rates of premature discontinuation in PTSD were found in full cognitive–behavioral therapy (28.5%), followed by exposure (23.2%) and cognitive processing therapy (23.2%)." [Page 202]

Practice-Based Evidence and EMDR therapy

Whilst we concur that NICE primarily focusses on Evidence-Based Practice [EBP] in knowledge that since its inception during the 1980's EBP has become a primary driver of health policy within the United Kingdom. The application of EBP has had a major impact upon psychological therapies in the endeavor towards delivering rigorous, empirically supported treatment interventions that are safe, effective and efficient. Nonetheless, this also raises concerns regarding clinical relevance in 'real' clinical environments and settings.

Enhancing treatment quality is driven instead by 'Practice-Based Evidence' [PBE]. Inevitably, there is a tension between the two[34].

EMDR Europe consists of a membership of over 22,000 people – all of which trained through an EMDR Europe Accredited Training Provider. It would be reasonable to state that many members of EMDR UK & Ireland Association, in particular, do not support some of the new guidance implications for the NICE [2018] PTSD.

The following are several examples of important narratives – from experienced EMDR Therapists (including many who are also BABCP Accredited), in specific regard to this proposed PTSD guideline:

> "The NICE [2018] guideline for PTSD will lose credibility with the clinical sector if they argue for a preference over CBT for Trauma as opposed to EMDR when both are indicated to be effective." **[Therapist A]**
>
> "I am really frustrated to see how the NICE PTSD guidelines are 'downgrading' EMDR. I think a big issue that reflects EMDR v TFCBT results is that many services have very few EMDR trained clinicians. In my current service, we have a large trauma waiting list but as there are only three EMDR trained clinicians in a team of over 20 clinicians TF-CBT is always offered as a first treatment." **[Therapist B]**
>
> "As an EMDR Therapist in an IAPT service, it is very important that we offer clear choice, for our PTSD clients, between TF-CBT and EMDR. Although there are more CBT therapists in the team, recovery rates for EMDR therapy are consistently better than TF-CBT. In addition, dropout rates from EMDR therapy is much, much lower. But, getting access to the data to support this is – challenging." **[Therapist C]**
>
> "As ex-military myself, my experience, as an EMDR Europe Accredited Therapist, of working with soldiers with PTSD, is that they prefer EMDR to TF-CBT as they don't want to talk through trauma in detail." **[Therapist D]**
>
> "I am trained in all 3 trauma based interventions - EMDR, TF-CBT and NET (for refugee populations) – with a lot of experience of working with complex trauma/severe and enduring MH difficulties. EMDR is now my main model, and the outcomes are far superior to those I ever achieved with TF-CBT. With TF-CBT attrition was a problem, emotional shifts happened less quickly, high 'fear states' were more prolonged, and clients drop out of treatment more." **[Therapist E]**

[34] Barkham M, Mellor-Clark J. Bridging evidence-based practice and practice-based evidence: Developing a rigorous and relevant knowledge for the psychological therapies. Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice. 2003 Nov;10(6):319-27.

> "My background is I qualified as a registered mental health nurse in the NHS then joined the Royal Air Force as a mental Health Nurse for 10 years treating trauma. I completed my EMDR training in 2006 and left the services in 2015 and currently work with the military veterans service in the north-west NHS. As I am not BABCP qualified in CBT I have always treated my patients with EMDR with good success. Within both the MOD and the NHS military veterans service. At assessment, patients have always been offered a choice of trauma focused CBT or EMDR." **[Therapist F]**
>
> "My view of working with military veterans and serving soldiers with EMDR is that it is more affective when working with different nationalities due to language and cultural differences as they relate very well to feelings in the body and not always content of thought." **[Therapist G]**
>
> "I also feel there is a benefit of EMDR when you take into account the average reading age of an infantry soldier is seven years old so many find reading and writing difficult. Soldiers are also "task orientated" so engage with EMDR well as they feel that something practical is happening and they can engage with it. If this change comes into effect patients will suffer with lack of choice in treatment and may suffer due to their learning needs." **[Therapist H]**

These are just some examples from within the EMDR UK & Ireland Association Community – narratives that we hear repeated time, and time again. What they highlight are the following themes:

- Maximizing choice of treatment interventions
- Paucity of access to EMDR Therapy
- Insufficient numbers of EMDR Therapist available within current services
- Client preference for EMDR therapy over TF-CBT
- Distinct advantages in working with EMDR as opposed to TF-CBT
    - Language
    - Translators
    - Shame-based trauma
    - Unspoken trauma
    - Cultural appropriateness
- Dealing with somatic trauma memories using EMDR therapy

A further cogent international narrative are comments by Professor Brigadier (Retired) Mowadat H Rana, MB, FCPS, FRC Psych (UK), Former Advisor in Psychiatry to Pakistan Armed Forces (2003-2013), Patron EMDR Pakistan (2009 to date), Chair, Department of Behavioural Sciences, University of Health Sciences, Lahore, Pakistan, Chief editor, Journal of Pakistan Psychiatric Society. He states the following:

> "NICE guidelines are a constant resource in developing practice guidelines in psychiatry in Pakistan Armed Forces as well as for clinical practice recommendations

made by Pakistan Psychiatric Society. Most mental health professionals in Pakistan draw strength and preferences for both pharmacological as well as non-pharmacological / psychotherapeutic interventions from the evidence and recommendations of NICE.

Since its introduction in Pakistan through EMDR UK & Ireland, in 2007, EMDR has become the mainstay of treatment for PTSD in this part of the world. In a country challenged by natural, as much as man-made disasters, and people and its armed forces at the forefront of war on terror, Pakistan has probably experienced more psycho-trauma than any other nation in the world. With less than three hundred psychologists and almost no therapists trained in trauma focused CBT, the only two interventions available for PTSD patients in Pakistan have been medication, and EMDR. The choices of these interventions have been made based on WHO guidelines, NICE guidelines and VA recommendations. In the absence of trauma focused CBT practitioners, the current burden is being carried ***exclusively*** by a hundred odd EMDR practitioners working in military and civil health settings.

The services of EMDR practitioners have consistently shown beneficial outcomes and positive responses from patients of PTSD both in military and civil. An ongoing double blind randomized controlled trial by Pakistan Armed Forces psychiatrists suffering from military trauma in war against terror, has shown response rates of as high as 90% with EMDR . Unfortunately, the permission to publish the study, or share findings of this study in scientific journals or circles has not been allowed by the concerned quarters for operational reasons. However, we continue to find reports, commentaries, and presentations made in national and international psychiatric, psychological, and EMDR conferences of the excellent outcomes in patients of PTSD treated with EMDR.

While none of this is of scientific value as evidence to support the case of EMDR as a successful treatment of PTSD, it is of great significance at a qualitative and inspirational level for mental health professionals in resource constrained countries like Pakistan where there are no CBT specialists.

In case EMDR is removed as a first choice intervention for PTSD in adults, children, and military trauma, from the NICE guidelines, it will do an irreparable damage to mental health services in countries like Pakistan which lack CBT facilities and practitioners.

Pakistan and many countries currently in war zones in Asia especially Middle East, EMDR is currently the only psychotherapeutic resource. Once it loses credibility at the hands of NICE, the PTSD patients in military and civil settings will be well in their right to opt out of EMDR, and yet have no other credible psychotherapeutic intervention available to them.

It is with these concerns in mind that NICE may reconsider the recommendations referred to earlier in the document."

EMDR UK & Ireland Association and EMDR Europe therefore strongly recommends that the committee be mindful of Practice-Based Evidence concerning the guidance provided by NICE, in regard to PTSD, and its subsequent application into clinical practice and service delivery

Summary of EMDR UK & Ireland Association and EMDR Europe's position on NICE Guidance: Post-traumatic Stress disorder (up-date) - In development [GID-NG10013]

The recommendations from EMDR UK & Ireland Association and EMDR Europe are as follows:

1. EMDR UK & Ireland Association and EMDR Europe ***support*** the following sections in their current iteration:

    1.1
        1.1.1 – 1.1.9
    1.2
        1.2.1 – 1.2.6
    1.3
        1.3.1 – 1.3.2
    1.4
        1.4.1 – 1.4.8
    1.5
        1.5.1 – 1.5.3
    1.6
        1.6.1, 1.6.2, 1.6.3, 1.6.11, 1.6.21, 1.6.22
    1.7
        1.7.1 – 1.7.4
    1.8
        1.8.1

2. EMDR UK & Ireland Association and EMDR Europe ***does not support*** the following sections in their current iteration:

    1.6
        1.6.4 – 1.6.18

3. EMDR UK & Ireland Association and EMDR Europe considers patient choice, concerning the treatment of PTSD, to be an important imperative. As the research evidence base in support of effective treatment for PTSD demonstrates strong levels

of consistency with both TF-CBT and EMDR therapy, we therefore recommend to the committee a continuation of the NICE PTSD CG26 [2005] guideline advise:

- **CG26 PTSD NICE [2005]**

"All PTSD sufferers should be offered a course of trauma-focused psychological treatment (trauma-focused cognitive behavioural therapy or eye movement desensitisation and reprocessing). These treatments should normally be provided on an individual outpatient basis." [Section 1.9.2.1]

- **CG26 PTSD Review Recommendation Final December 2011**

"Section 17: "Through the process no areas were identified which would indicate a significant change in clinical practice. There are no factors described above which would invalidate or change the direction of current guideline recommendations." [Page 5 of 49]

4. EMDR UK & Ireland Association and EMDR Europe would like to direct the committee to the recommendations asserted by the WHO (2013)[35] Guidelines for the Management of Conditions Specifically Related to Stress – ***PTSD recommendations for children, adolescents and adults***

- "Recommendation 14: Individual or group cognitive-behavioural therapy (CBT) with a trauma focus, eye movement desensitization and reprocessing (EMDR) or stress management should be considered for adults with posttraumatic stress disorder (PTSD)." [Page 8]

- "Recommendation 15: Individual or group cognitive-behavioural therapy (CBT) with a trauma focus or eye movement desensitization and reprocessing (EMDR) should be considered for children and adolescents with posttraumatic stress disorder (PTSD)." [Page 9]

We therefore consider that the up-dated NICE Guidance for PTSD should be more closely aligned with the WHO (2013) recommendation for treating children, adolescents and adults diagnosed with PTSD

[35] World Health Organization. Guidelines for the management of conditions specifically related to stress. Geneva: WHO, 2013.

5. EMDR UK & Ireland Association and EMDR Europe does not support the distinction between combat and non-combat related trauma – in specific regard to the current empirical evidence. Consequently, we would strongly recommend alignment with the VA/DOD (2017) recommendation:

    - "The trauma-focused psychotherapies with the strongest evidence from clinical trials are PE, CPT, and EMDR. These treatments have been tested in numerous clinical trials, in patients with complex presentations and comorbidities, compared to active control conditions, have long-term follow- up, and have been validated by research teams other than the developers."

6. EMDR UK & Ireland Association and EMDR Europe acknowledges that offering 'patient choice' in treatment interventions for PTSD does have financial and resource implications for service provision with regards to validated/ accredited training in TF-CBT and EMDR therapy and appropriate, robust clinical supervision. Nonetheless, as the is '***strong evidence***' in support of both TF-CBT and EMDR therapy service provision should maximize choice between the main treatment modalities for children, adolescents and adults diagnosed with PTSD.

In conclusion – EMDR UK & Ireland Association and EMDR Europe is committed to evidence-based practice and the continued need for high quality research and development for those traumatized by adverse life experiences.

As a critical stakeholder of NICE concerning PTSD, we trust you find our feedback useful. We therefore look forward to a detailed reply to our recommendations.

If you require any clarification regarding any of the matters raised, the point of contact is:

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