The Effectiveness of an EMDR Group Traumatic Episode Protocol in an Intensive Outpatient Dual Diagnosis Program

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According to the joint DoD-VA (2023) Clinical Practice Guidelines, Cognitive Processing Therapy (CPT), Eye Movement Desensitization and Reprocessing (EMDR), and Prolonged Exposure (PE) are the top recommended individual and manualized trauma-focused psychotherapies for the treatment of posttraumatic stress disorder (PTSD). EMDR is an eight-phase trauma treatment protocol focusing on a traumatic memory while simultaneously experiencing bilateral stimulation. Bilateral stimulation is associated with a reduction in the vividness of a traumatic memory, an ability to link fragments of a memory together, and put the memory away in an autobiographical format. This can consequently reduce a client's PTSD symptoms significantly and help people recover from trauma (Maxfield, 2019).

Group Traumatic Episode Protocol (G-TEP) was developed by psychologist Elan Shapiro after a need was identified to work with groups impacted by negative life-changing traumatic events. There is growing evidence that G-TEP is effective in reducing PTSD symptoms and other mental health disorders. There have been several studies using G-TEP with refugees, civilians, and health care workers. In addition, there have been two randomized control trials of G-TEP, one with EMDR treatment of COVID -related stress (Farrell et al, 2023) and another with internally displaced adults in Northern Iraq (Bizouerne et all, 2023). G-TEP has not been utilized as a treatment modality for any U.S. active-duty military population, nor has it been combined with individual EMDR treatment. At Madigan Army Medical Center at Joint Base Lewis-McChord, the first two authors integrated both a specific group EMDR protocol (G-TEP) and individual EMDR into an Intensive Outpatient Treatment Program (IOP) for six weeks with a dually diagnosed (PTSD and Alcohol Use Disorder) population of active-duty service members.

Method

The participants were referred by their primary behavioral health providers for treatment for ongoing PTSD symptoms and alcohol cravings. Participants were screened by the G-TEP-IOP providers for suitability to the group. All participants were required to have a minimum of 30 days of sobriety, no active suicidal ideation, and the ability to attend six consecutive weeks of treatment. All five service members (4 men; 1 woman) participated in the pre-, mid-, and post- evaluations. All participants (n = 5) processed multiple traumatic events during the duration of treatment. All service members met the diagnostic criteria according to the Diagnostic and Statistical Manual of Mental Disorder, Fifth Edition, text revision (American Psychiatric Association, 2022) for PTSD and Alcohol Use Disorder. Participants engaged in GTEP three times per week and individual EMDR therapy twice per week during the IOP. Active-duty service members included in this report were stationed at Joint Base Lewis McChord, Washington at the time of treatment.

In addition to the co-facilitators of this G-TEP-IOP, other staff included an addictions social worker, a psychologist, two yoga instructors, a recreation therapist, and a MSW practicum student. Group therapy was Monday through Friday from 0930-1230 and each service member had individual EMDR in the afternoons twice a week. The current pilot project was approved by the Department of Clinical Investigations at Madigan Army Medical Center as an Evidence-Based Project.

Group Sessions and Topics

G-TEP. G-TEP was held three times per week for 1.5 hours per session. These group sessions were focused on reprocessing a memory of an adverse life event or major trauma. During the first week of the IOP, GTEP groups were spent outlining IOP, information about EMDR compared to other evidence-based trauma treatments, and resource building using Group Resource Enhance Protocol.

Trauma and the Brain. These groups were held once per week for the first three weeks for 1 hour per session. These sessions were psychoeducation based and included information on PTSD, how traumatic memories are stored in the brain when unprocessed and when processed, ways to recognize triggers, and insight into the window of tolerance and participants' PTSD symptoms.

Addiction. These groups were held once per week for 1.5 hours per session for six weeks. These sessions were a blend of psychoeducation and processing groups to include topics such as substance use and the impact on your brain and body, triggers and cravings, the stages of change, values, and relapse prevention.

Interpersonal Skills. These groups were held once per week for 1.5 hours per session for six weeks. These sessions were psychoeducation based, and included insight into the benefits of vulnerability, communication styles and skills, attachment styles, and emotions.

Leisure and Recovery. These groups were 2.5 hours per session, for four sessions, during the six-week program. These groups were led by the recreation therapist,

and the program used was *12 Steps to Sober Leisure* by Abagail Bernard. The protocol uses a distinct emphasis on a person's leisure in recovery and incorporates elements of the Twelve Steps of Alcoholics Anonymous (Bernard, 2018).

Mindfulness. These groups were once per week for 1 hour per session for six weeks. These sessions were psychoeducation based and included information on mindfulness practices, and coping and grounding skills. All individuals participated in mindfulness exercises and were encouraged to use them outside of the group.

Expressive Therapy Group. This group met twice during the program for 2 hours per session. The activities included the "The Newspaper," and "The Mask." The newspaper activity had group participants write or draw three news articles about themselves. They highlighted their personal accomplishments in life and shared with the group. During the mask activity, participants wrote down their inner fears and then decorated a mask on how they presented to themselves to the world and shared with the group (Maltz et al., 2020).

Yoga. These sessions were once per week for 1 hour per session for five weeks. These sessions were led by certified yoga instructors to assist clients through different movements to facilitate awareness of the body and release built up emotions, stress, and tension.

Participants

Data was collected using the (PCL-5), Generalized Anxiety Disorder (GAD-7), (PHQ-9), (ISI), and the (PACS) at pre-, mid-, and post- treatment through a single study, quasi-experimental design.

Measures

Patients completed the following self-report measures during the course of clinical treatment:

PTSD Checklist (PCL-5). The PCL-5 is a 20-item self-report questionnaire, corresponding to DSM-5 symptom criteria for PTSD. It has shown to be valid and reliable in quantifying PTSD symptom severity (Blevins et al, 2015).

Generalized Anxiety Disorder (GAD-7). The GAD-7 is a 7-item self-report anxiety questionnaire that has been proven to be reliable and valid in primary care with the general population (Löwe et al., 2008). The GAD-7 was developed in 2006 to assess different aspects of anxiety related symptoms.

Patient Health Questionnaire (PHQ-9). The PHQ-9 is a 9-item self-report depressive symptom scale that was originally introduced in 2001 to screen adult patients in the general population. The PHQ-9 is a reliable and valid measure of depression severity (Kroenke et al., 2001).

Insomnia Severity Index (ISI). The ISI is a 7-item measure that assesses the subjective quality of sleep, the severity of symptoms, and the satisfaction with their sleep patterns. It is used as a brief screening tool for insomnia and was proven to be a reliable and valid instrument to detect insomnia in the general population (Morin et al. 2011).

Penn Alcohol Craving Scale (PACS). The PACS is a 5-item self-report scale to measure alcohol cravings and risk for relapse. The survey focuses on frequency, intensity and duration of thoughts about drinking. The PACS is a valid and reliable measure to assess for alcohol cravings (Flannery et al., 1999).

Results

Outcome measures at baseline and at follow-ups are presented in Table 1, Table 2, and Figure 1. There were significant and substantial reductions of both PTSD symptoms and alcohol cravings at the post-treatment evaluations compared to the baseline. The PCL 5 decreased from M = 48 (SD = 9.1) to M = 33 (SD = 13.2), t (4) = 4.8, p= .009. The PACS decreased from M = 13.6 (SD = 6.3) to M = 4 (SD = 4.2), t (4) = 4.9, p = .008. After six weeks of GTEP and individual treatment, PCL-5 and PACS scores reduced significantly in all five participants, with minimal to no changes among the GAD-7, PHQ-9 and ISI. Reductions of PTSD symptoms and alcohol cravings were associated with an overall improvement of a sense of wellbeing, ability to communicate more effectively with their partner, decreased alcohol cravings, decreased intrusive symptoms, and no longer feeling alone.

Table 1

Participant reported decreases in PTSD symptoms during GTEP

Case	Age	PCL-5 Baseline	PCL-5 Midpoint	PCL-5 Post	PCL-5 1-month Follow-up
1	39	49	40	38	28
2	26	62	48	48	17
3	22	39	18	12	0
4	43	49	53	35	38
5	31	41	47	32	39
Mean (SD)		48 (9.1)	41.2 (13.8)	33 (13.2)	24.4 (16.2)

Table 2

Participant reported decreases in alcohol cravings during GTEP

Case	Age	PACS Baseline	PACS Midpoint	PACS Post	PACS 1-month Follow-up
1	39	18	14	10	10
2	26	4	0	0	0
3	22	20	6	4	5
4	43	11	5	0	7
5	31	15	24	6	-
Mean (SD)		13.6 (6.3)	9.8 (9.4)	4.0 (4.2)	5.5 (4.2)

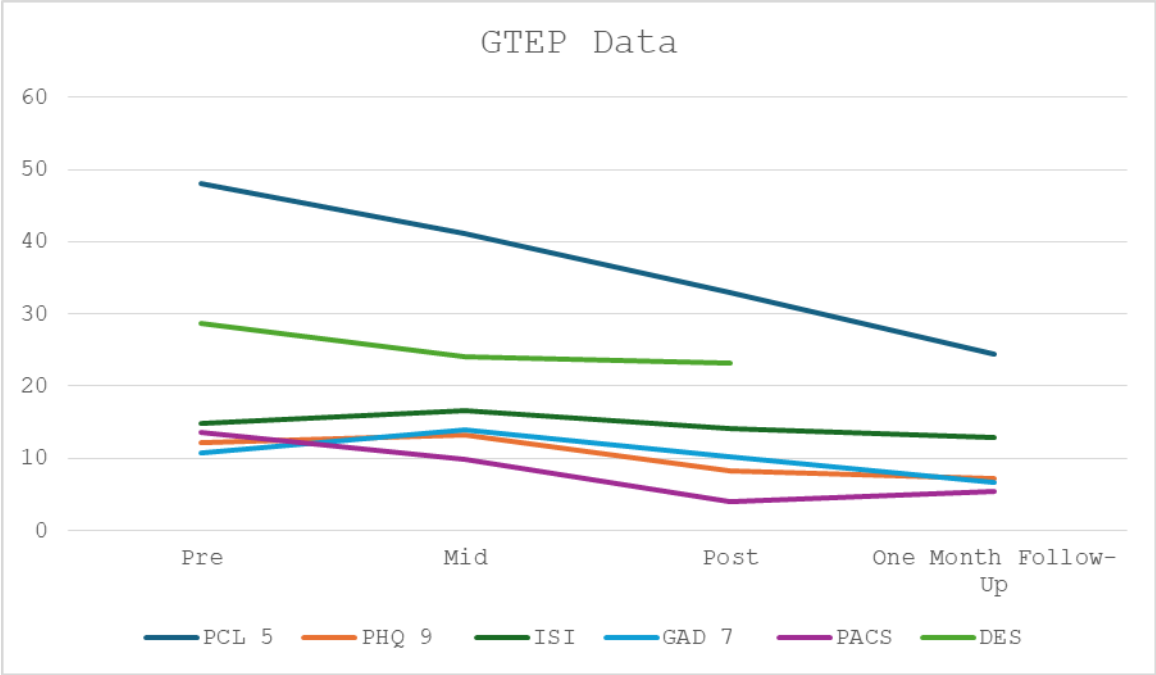

Figure 1. *Outcome measures over the course of the G-TEP treatment protocol*

Case Results of Two of the Participants

Case 1 - A 39-year-old combat engineer sought help for his intrusive memories and nightmares from his two deployments to Iraq and operational deployments to various locations. He was referred by his primary behavioral health therapist. After 19 years in the Army, he was struggling with the severity of his posttraumatic stress symptoms and suffering from the moral injury of war. One year prior to this program, he was suicidal with intent and was admitted to inpatient psychiatry. He had previously shown little progress in treatment. During G-TEP and individual EMDR, he reprocessed adverse life events from his teenage years, his father's death, and several memories of from deployment including explosions, the deaths of two battle buddies, witnessing others severely injured in vehicle accidents, and other traumatic aspect of war. As an example of one day of IOP in the six weeks of the program, he was able to reprocess a death from his first Iraq deployment during G-TEP, and in individual EMDR, he reprocessed a different deployment trauma. Over the duration of this 6-week IOP, his PTSD symptoms reduced on the PCL-5 from 49 to 38. At the one-month follow-up, the PTSD symptoms on the PCL-5 further reduced to 28.

Case 3 – A 22-year-old first generation Mexican male mechanic, sought help for nightmares of his best friend's suicide, the murder of a close friend, and the death of another friend from a drive by shooting - all occurring prior to his enlistment in the military. The memories of these deaths were causing him nightmares and other intrusive PTSD symptoms. This was interrupting his ability to work in his unit and causing dysfunction in his day-to-day life. He had only been enlisted in the Army for two years prior to this behavioral health IOP. During G-TEP and individual EMDR, he was able to reprocess memories of an adverse life event from childhood, a racial trauma, the suicide of his best friend, and the deaths of two other friends. Over the duration of this IOP, his PTSD symptoms reduced on the PCL-5 from 39 to 12 during the six weeks of

treatment. At the one-month follow-up, the PTSD symptoms on the PCL-5 further reduced to 0. At the end of treatment, he was able to return to his unit full time and discontinued behavioral health services since he felt he no longer needed services.

Discussion

This is the first report of both G-TEP and individual EMDR treatment utilized in an IOP setting for trauma and substance use with an active-duty military population. Based on the data and self-report by the participants, it enabled each participant to completely process multiple memories of traumatic events over the course of a few weeks. The ability to process multiple traumatic memories in both group and individual sessions resulted in a reduction of both PTSD related symptoms and alcohol cravings.

This evidence-based practice pilot project was limited by the small number of participants, difficulty obtaining participants, limited ability to probe answers when an increase in scores were reported, and potential risks of survey bias due to secondary gain. Despite these limitations, the positive results suggest that G-TEP can be used successfully to treat PTSD symptoms and alcohol cravings in an intensive outpatient program in military personnel. For future studies, we recommend a larger sample size, utilization of the moral injury scale, and a comparison study to examine the efficacy of EMDR therapy across protocols. Future trials should also assess how being in a group setting may influence the outcome of treatment and the benefits of using qualitative techniques to better understand the overall personal impact of G-TEP.

It is recommended that this group be replicated utilizing G-TEP and individual EMDR therapy in other intensive outpatient programs in combination with coping skills groups. Additionally, implementation may also be considered in an outpatient behavioral health clinic utilizing GTEP and individual EMDR once a week for service members who have sufficient coping skills. Finally, it is possible that if G-TEP and individual EMDR are utilized with service members with PTSD and no substance use disorder, it may be even more successful.

The opinions or assertions contained herein are the private views of the authors and are not to be construed as official or reflecting the views of the U.S. Government, the Department of Defense, the Department of the Army, or the Defense Health Agency. Correspondence concerning this article should be directed to Danielle Parker (danielle.n.parker16.mil@health.mil) or Camille Zeiter (camille.m.zeiter.civ@health.mil)

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