ples of change are guidelines that specify how elements of the relationship and intervention techniques can be tailored based on the individual characteristics of the patient. This kind of treatment matching has been shown to lead to positive clinical outcomes.

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One-Size-Fits-All Approach to PTSD in the VA Not Supported by the Evidence

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Karlin and Cross (January 2014) described innovations in disseminating evidence-based psychotherapies in the Veterans Health Administration (VHA), including therapies for posttraumatic stress disorder (PTSD), a complex and chronic disorder among veterans. The multidimensional model they presented aims to promote the delivery of evidence-based psychotherapies nationally in order to redress the research-to-practice gap reflected in the infrequent use of evidence-based psychotherapies for PTSD in the VHA (Shiner et al., 2013). In our view, however, the validity of this otherwise worthy strategic goal is built upon the questionable assumption that there is strong and sufficient evidence to support the use of the therapies being disseminated.

Two PTSD treatments—prolonged exposure (PE) and cognitive processing therapy (CPT)—were selected for system-wide dissemination, and VHA guidelines mandate that all veterans with PTSD have access to PE or CPT. Although several large-scale trials are currently ongoing, few treatment outcome studies of PE and CPT for military-related PTSD have been published, and most have been small-sample open trials (see Steenkamp & Litz, 2013). Two randomized controlled trials (RCTs)—the traditional gold standard of treatment outcome studies—of individual PE and three RCTs of individual CPT in veterans have been published. Of these, only one examined VHA patients receiving PE or CPT for combat-related PTSD (Monson et al., 2006). The remaining four were either international studies with marked contextual differences from VHA care or studies involving sexual trauma. Although important, RCTs of sexual trauma among primarily women veterans (two of which have been published, Schnurr et al., 2007, and Surís, Link-Malcolm, Chard, Ahn, & North, 2013) do not speak to the modal trauma treated by the VHA, namely, combat trauma among male veterans.

The general finding across all RCTs is that individual PE and CPT *work* in that they reduce military-related PTSD symptoms. However, it is less clear whether PE and CPT *work well,* that is, decrease symptoms to the point of low impairment and distress. Across studies, at least half of, but typically most, veterans still meet diagnostic criteria for PTSD following treatment. For example, at one-month follow-up in the Monson et al. (2006) trial, over two thirds (70%) of participants in the CPT intent-to-treat condition (drop-out from CPT was 20%) retained their PTSD diagnosis. It is also unclear whether treatments *work reliably*. Metrics of meaningful change show considerable variability in outcomes: Some patients improve substantially and some very little. PE and CPT thus do not have uniform effects and are not effective for all patients.

Perhaps more important for the dissemination of PE and CPT, which rests on the assumption of the superiority of these treatments over other psychotherapies, is the question of how PE and CPT have fared when compared with other active therapies, such as present-centered therapy (PCT). Of the three RCTs that have compared individual PE and CPT with PCT in veterans, findings have yet to demonstrate clear superiority of PE and CPT. In the Surís et al. (2013) trial, CPT was not superior to PCT on primary outcomes (clinician-assessed PTSD scores), and in the case of Schnurr et al. (2007), initial differences between PE and PCT on primary outcomes were not maintained at a six-month follow-up. The one exception, a trial of CPT versus treatment as usual in Australian veterans (Forbes et al., 2012), demonstrated more robust between-group differences but did not assess differences beyond a three-month follow-up. Thus, the assumption that "evidence-based" PTSD care in veterans is markedly superior to PCT has yet to be borne out by the evidence.

In sum, rather than being highly effective for most veterans who receive them, in clinical trials, PE and CPT do not sufficiently or reliably meet the treatment needs of many veterans, and their incremental value over non-trauma-focused therapies remains unclear. Although PE and CPT are useful and important for clinicians to learn, even if the dissemination is highly successful, a significant portion of veterans with PTSD will require alternative or additional treatment. As such, dissemination should include contingencies that recognize the limitations of available evidence-based treatments, particularly if the evidence base also demonstrates clear shortcomings to these treatments' effectiveness, acceptability, and tolerability. For example, flexible application of a range of therapeutic strategies (including approaches that are supportive and focused on daily stressors, which RCTs show can be helpful) may better meet the needs of a broader range of veterans. Overall, dissemination models must move beyond simple one-size-fits-all conceptualizations of treatment if they are to adequately reflect the evidence base and the complexity of PTSD in veteran populations.

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Inadequate Treatment and Research for PTSD at the VA

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

The *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress* (Department of Veterans Affairs & Department of Defense, 2010) lists EMDR therapy as an "A" level treatment, described as "A strong recommendation that clinicians provide the intervention to eligible patients" (p. 202). According to the recently published practice guidelines of the World Health Organization (2013), trauma-focused cognitive behavioral therapy (CBT) and EMDR are the only therapies recommended for children, adolescents, and adults with PTSD. However, major differences exist between the two treatments: "Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework" (World Health Organization, 2013, p. 1) These factors can make EMDR therapy easier for veteran treatment, as can be seen by the differences in retention rates and outcomes for CBT and EMDR.

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

A growing body of evidence over the last 20 years has shown that EMDR provides effective trauma treatment for civilians, yet the VA has not conducted any EMDR research. Instead they have focused on pharmaceuticals, CPT and PE, and alternative therapies for PTSD including the use of pets, acupuncture, transcendental meditation, the "emotional freedom technique," tai chi, art therapy, Reiki, yoga, and pharmaceutical agents (Government Accountability Office, 2011). Drugs studied include derivations of such drugs as marijuana and ecstasy. Treating PTSD with medication has not been found effective. In fact, psychoactive prescription drugs have been implicated as one of the causative agents of the high rate of suicide of our troops. Antidepressants have been linked to suicidal thoughts and behaviors, and black box warnings alert consumers and prescribers to these risks. Of those veterans with PTSD, 80% were given psychoactive drugs, and 89% of these were prescribed antidepressants (Mohamed & Rosenheck, 2008). Meanwhile, the VA has ignored research supporting that EMDR is a more effective treatment for sustained symptom relief for PTSD than are antidepressants. In one study, both PTSD and depressive symptoms were lower at six-month follow-up for those treated with EMDR than for those treated with Prozac (van der Kolk et al., 2007). A more recent study found that five months after treatment, 60% of those on medication and 58% of those who received placebo still had PTSD, compared with only 20% of those who received psychotherapy (Shalev et al., 2012). *So why give medications at all when a sugar pill is just as effective without all the side effects?* It is time to stop simply prescribing and to start providing evidence-based treatment. The VA needs to develop a strong research and clinician training program for EMDR on a par with current research and training programs for CPT and PE.

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

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