

Clinician's Corner: EMDR Therapy

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Eye Movement Desensitization and Reprocessing (EMDR) therapy is an eight-phase psychotherapeutic approach that emphasizes the physiological information processing system in the origin and treatment of mental health issues (Shapiro, 2001, 2014a). Its theoretical basis is the Adaptive Information Processing (AIP) model, which holds that the primary source of psychopathology is the presence of memories of adverse life

experiences that have been inadequately processed. These inappropriately stored episodic memories, which include the perceptions, sensations, beliefs and emotions that occurred at the time of the adverse life event, can be triggered by current internal and external stimuli, contributing to ongoing dysfunction. This model was developed in the early 1990s and since then has been supported by research demonstrating the role played by disturbing life events in the genesis of many forms of psychological and somatic symptomology (e.g., Affifi et al., 2012; Felitti et al., 1998).

Based on extensive research (> 25 randomized controlled trials - RCTs) demonstrating its effectiveness, EMDR therapy has been officially designated an empirically validated trauma treatment in established practice guidelines worldwide. (For an annotated list of research and guidelines see <http://www.emdrhap.org/content/what-is-emdr/research-findings/>). Most recently, the World Health Organization (2013) Guidelines indicated that trauma-focused Cognitive-Behavioral Therapy (CBT) and EMDR are the only psychotherapies recommended for children, adolescents and adults with PTSD. However, clear distinctions were described: “Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event. 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” (p.1). These procedural differences underscore the theoretical tenets of the respective therapies. For instance, according to the AIP model, the dysfunctional behaviors and self-beliefs, such as “I am worthless,” are not viewed as the cause of psychopathology, but rather as manifestations of the stored unprocessed memory, together with its associated affect and physical sensations.

EMDR therapy addresses the clinical picture by means of a series of standardized procedures (see Shapiro 2001). These include history-taking, stabilization and phases to identify and process (a) the client’s memories of the adverse experiences underlying the presenting symptoms, (b) current circumstances that trigger psychological disturbance, and (c) skills required for appropriate future behavior. During processing, the client is assisted in accessing the memory in a certain way and holding it in mind briefly while exposed to bilateral dual

attention stimulation. This stimulation is usually provided by means of lateral eye movements, but sometimes takes the form of tactile or auditory stimuli. Although the use of eye movements was a source of controversy in the past, a recent meta-analysis (Lee & Cuijpers, 2012) of 26 RCTs has confirmed their positive effects, including rapid decreases in emotional disturbance and imagery vividness. An additional ten RCTs demonstrated increased attentional flexibility, recognition of true information and episodic memory retrieval as a result of the eye movements. Two hypotheses that have been supported by research are that the eye movements (a) tax working memory and (b) initiate memory processing in ways akin to REM sleep. As indicated in the client transcript below, during EMDR processing, corrective information is spontaneously generated during the sets of eye movements. At this time, the client experiences insights, positive emotions, beliefs and physical responses, as the presenting symptoms resolve. In short, the disturbing event becomes both a learning experience and the foundation for future resilience.

To illustrate an EMDR therapy reprocessing session, a partial transcript involving the treatment of moral injury appears below. “Jim” is an OIF medic with two tours in Iraq who presented with PTSD due to ten disturbing combat events. He was treated with EMDR therapy during five successive days (twice a day). The final incident targeted for reprocessing involved responding to a mass casualty situation where a U.S. Army convoy hit an improvised explosive device. Jim was working with another medic to triage the victims and believed he had fallen down on his duty to those soldiers by “letting them die.” During the Assessment Phase, in which the event is evaluated, he reported feelings of guilt, anger and anxiety and rated them on the “0-10” SUD scale as a “12” (because it was “so intense”). Current Negative Cognition: “I am inadequate” (causing people to die). His preferred Positive Cognition, “I am effective,” was rated “2” on the Validity of Cognition scale (1= completely false to 7= completely true). When asked to scan his body and identify the location of any disturbing physical sensations, he reported feelings in his chest and stomach. To target the memory during reprocessing, he was asked to hold in mind an image that best represented the event for him, the negative cognition and where he felt it in his body. Having been instructed to “Let whatever happens, happen,” he then responds at the end of each set of eye movements to the question, “What do you get now?” Depending upon what the client reports, the clinician directs the next focus of attention according to standardized protocols and applies another set of eye movements (Shapiro, 2001). In this case, processing was unimpeded and at the end of each response the therapist asked Jim to, “Notice that” (what he had just verbalized). In the transcript, >>> indicates that the therapist said, “Notice that,” followed by a set of eye movements and the question, “What do you get now? We pick up after the third set:

- “Medics have a unique responsibility, if we do our jobs, we save lives and if we don’t people die.”
- “If Pete hadn’t pulled me off him, I would still be trying to revive him.”
- “I kept him alive until we got to the CSH [combat support hospital] and the docs said, ‘He’s gone!’ I was mad and had blood all over me. I said, ‘I did it all for this?!’”
- “Pete pulled me away and said, ‘Come over brother, let’s go.’”
- “I don’t feel as angry as I did before.”
- “Even surgeons lose people.”
- “I did what I was trained to do; I actually saved peoples’ lives.”

- “It’s time I stopped beating myself up over this. As of right now I determine to stop beating myself up.”

By the end of the session, Jim’s SUD dropped from a “12” to a “0”. He reported a VOC of “7” (completely true) for the positive cognition, “I am effective” and a clear Body Scan (no physical disturbance). After the one-week EMDR treatment he enrolled in vocational rehab to become an EMT.

As we can see above, the corrective information Jim needed to resolve the memory during processing spontaneously arose from forgotten aspects of the trauma or other life events already stored in his brain. When processing stalls, the clinician uses additional standardized procedures to elicit the information. These reprocessing effects are consistent with research indicating substantial PTSD remission rates with military personnel of the Vietnam era and active-duty military of the current wars (see Russell & Figley, 2012; Silver & Rogers, 2002).

Colleagues report that veterans and active military personnel respond particularly well to the EMDR therapy approach. In their assessment (which also appears relevant to civilian multiple-trauma victims) this occurs due to a variety of factors, including the ability to process memories without descriptions of the event. Those veterans who feel guilty or ashamed are not forced to verbalize or focus on the details. In addition, clients are given a sense of control by being instructed to use a “stop signal” in case they want a break during processing. They can then employ a relaxation technique and return to processing when ready. The rapid decline in emotional disturbance during the processing of a targeted memory illustrated in this transcript is typical of EMDR. The relatively brief, dosed attention directed at the event employed in the associative approach of EMDR therapy allows the memory to be addressed with manageable segments, resulting in reduced distress during the session and thereby ending with the veteran maintaining a sense of security and stability.

Effective results within a brief period of time, including the generalization of positive treatment effects to similar memories, enhance the veteran’s hope and treatment motivation. Further, there is no need to engage in homework to achieve positive therapeutic results. Consequently, all memory exposure takes place in the affect-regulating presence of the therapist. This assists the client to feel secure during the process, even when the veteran views the world as an unsafe place. Comprehensive treatment of military personnel attends to all aspects of the clinical picture.

However, when needed, rapid relief of individual symptoms can be efficiently attained. Sleep disturbances can be addressed through EMDR processing by directly targeting nightmares, and phantom limb pain (PLP) can be substantially reduced or eliminated by targeting the physical sensations. The high success rate reported by colleagues in four published articles (see Shapiro, 2014a) indicates that PLP is generally not an indication of neuropathology, but rather a component of the trauma memory that can be eliminated through processing. Future RCTs with military personnel can further address this issue, as well as the effects of PTSD treatment with and without moral injury. Since no homework is needed, EMDR therapy sessions can be conducted daily, which allows treatment to be completed in one or two weeks, rather than months. Therefore, RCTs with military personnel can be conducted efficiently.

Given the high levels of traumatization worldwide and the dire consequences for individuals, families and society (see Carriere, 2014; Shapiro, 2014b), it is vital that timely empirically supported therapies be widely disseminated. The ability to complete treatment rapidly using

daily or extended sessions without the need of homework or detailed descriptions has allowed EMDR therapists to provide culturally sensitive and effective treatment after natural and manmade disasters worldwide (e.g., Mehrotra, 2014; see Shapiro, 2014b). Pro bono humanitarian assistance programs using both individual and group protocols have been conducted by EMDR associations throughout the U.S., Asia, the Middle East, Europe, Latin America and parts of Africa.

Colleagues report that since detailed descriptions of the trauma are not needed, EMDR therapy is amenable to members of reticent cultures, as well as those who may be suffering shame or guilt due to war or sexual trauma. In a few cultures (e.g., Polynesian), bilateral tones or taps are recommended, as the eye movements can be interpreted as impolite or “magic.” In some cultures, verbal expressions of a positive self-statement are considered inappropriate. In that case, the therapist might elicit the information by asking, “What would the tribal elder think?” In other cultures, trauma victims often struggle to connect their emotional and cognitive states. What has emerged clearly is that most of these clients are more comfortable expressing their emotional pain through reference to their bodies rather than verbally. In these cases the cognitive component is dropped and clients’ attention is directed to their physical experience. Drawings, pictures and songs are also used for effective reprocessing with lower levels of literacy.

Colleagues working with refugee populations caution that it is important to explain that EMDR will help with their symptoms and take the pain away but *not their memories*. This population often fears losing the recollections of their relatives, whether living or dead, since memories are all they have left. It is useful to consider that refugees have often experienced torture, rape and great loss, and most of them have come by sea after a horrifyingly dangerous journey. Colleagues underscore the utility of providing EMDR treatment to this population on consecutive days, since individual and group protocols minimize descriptions and demonstrate immediate reductions in disturbance. Rapid results have also been reported for sexual assault victims worldwide. For instance, rape victims have been successfully treated within three sessions in the Democratic Republic of the Congo using both individual and group protocols. It is significant to note that the rape victims in the Congo consistently reported the simultaneous remission of back and abdominal pain post treatment. These physical sensations appear to be located in parts of the body where they were forcefully held down. These processing results are consistent with the previously mentioned remission of PLP with EMDR therapy.

Efficacy is high and dropout rates low when EMDR therapy is conducted with appropriate clinical parameters. A meta-analysis (Maxfield & Hyer, 2002) of EMDR RCTs reported a positive correlation between therapeutic efficacy and treatment fidelity. A meta-analysis (Bradley et al., 2005) indicated a median completion rate of 92% for EMDR RCTs. Studies cited as flawed based on “questionably adequate treatment dosage duration, and/or fidelity” in the 2000 ISTSS Practice Guideline indicate the need for appropriately administering a sufficient number of sessions for multiply traumatized clients. Examples include a rigorous 12-session DVA study that reported zero dropouts and 78% PTSD remission as compared to the poor results reported in military studies that used only two sessions, and a DoD/DVA training evaluation citing differential treatment times for wounded and non-wounded soldiers (Russell et al., 2007). While emotional disturbance may be reduced for a targeted individual memory within one or two EMDR sessions, more treatment time is needed for full PTSD remission with multiple traumas.

RCTs have reported high PTSD remission rates (84-90%) in single-trauma victims after three 90-minute sessions. Fifty-minute sessions can also be used, as indicated in a Kaiser Permanente

study reporting a 100% remission rate with single-trauma and 77% for multiple-trauma survivors after a mean of six sessions. Research findings underscore the need to provide sufficient treatment time and attention to address complex issues. For instance, an RCT using eight sessions of EMDR therapy reported high PTSD remission rates for both adult-onset (91.7%) and child-onset (88.9%) groups. However, there was a pronounced difference in asymptomatic end-state functioning, which highlights the importance of comprehensive treatment to address the full clinical picture through processing the myriad adverse experiences contributing to psychopathology (see Shapiro, 2001, 2014a). The standard EMDR therapy protocols guide the clinician to identify and process the earlier adverse events that are contributing to both individual and relational dysfunction. The goal is to help produce a healthy adult with the ability to self-soothe, feel a full range of emotion, have a positive outlook, interact and bond properly, and become an integral and productive member of society.

Those interested in EMDR therapy training can obtain a list of standardized programs through the regional EMDR association in their area. Pro bono trainings are often available after disasters through affiliated humanitarian projects. For an international list of associations see <http://www.emdria.org/emdrtherapytrainings>.

About the Author

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