What is EMDR | History of EMDR | EMDR Theory

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What is EMDR?

EMDR therapy is recognized as an effective form of trauma treatment in numerous practice guidelines worldwide. In the US, this includes organizations such as the American Psychiatric Association and Department of Defense. More than twenty randomized studies support the effectiveness of the therapy in the treatment of PTSD. Further, more than twenty randomized studies have demonstrated positive effects of the eye movements. Go to http://www.emdr.com/general-information/trauma-research.html to see an annotated list of guidelines and studies.

Eye Movement Desensitization and Reprocessing (EMDR)[1] is a comprehensive, integrative psychotherapy approach. It contains elements of many effective psychotherapies in structured protocols that are designed to maximize treatment effects. These include psychodynamic, cognitive behavioral, interpersonal, experiential, and body-centered therapies[2].

EMDR psychotherapy is an information processing therapy and uses an eight phase approach to address the experiential contributors of a wide range of pathologies. It attends to the past experiences that have set the groundwork for pathology, the current situations that trigger dysfunctional emotions, beliefs and sensations, and the positive experience needed to enhance future adaptive behaviors and mental health.

During treatment various procedures and protocols are used to address the entire clinical picture. One of the procedural elements is "dual stimulation" using either bilateral eye movements, tones or taps. During the reprocessing phases the client attends momentarily to past memories, present triggers, or anticipated future experiences while simultaneously focusing on a set of external stimulus. During that time, clients generally experience the emergence of insight, changes in memories, or new associations. The clinician assists the client to focus on appropriate material before initiation of each subsequent set.

Eight Phases of Treatment

The first phase is a history taking session during which the therapist assesses the client's readiness for EMDR and develops a treatment plan. Client and therapist identify possible targets for EMDR processing. These include recent distressing events, current situations that elicit emotional disturbance, related historical incidents, and the development of specific skills and behaviors that will be needed by the client in future situations.

During the second phase of treatment, the therapist ensures that the client has adequate methods of handling emotional distress and good coping skills, and that the client is in a relatively stable state. If further stabilization is required, or if additional skills are needed, therapy focuses on providing these. The client is then able to use stress reducing techniques whenever necessary, during or between sessions. However, one goal is not to need these techniques once therapy is complete.

In phase three through six, a target is identified and processed using EMDR procedures. These involve the client identifying the most vivid visual image related to the memory (if available), a negative belief about self, related emotions and body sensations. The client also identifies a preferred positive belief. The validity of the positive belief is rated, as is the intensity of the negative emotions.

After this, the client is instructed to focus on the image, negative thought, and body sensations while simultaneously moving his/her eyes back and forth following the therapist's fingers as they move across his/her field of vision for 20-30 seconds or more, depending upon the need of the client. Although eye movements are the most commonly used external stimulus, therapists often use auditory tones, tapping, or other types of tactile stimulation. The kind of dual attention and the length of each set is customized to the need of the client. The client is instructed to just notice whatever happens. After this, the clinician instructs the client to let his/her mind go blank and to notice whatever thought, feeling, image, memory, or sensation comes to mind. Depending upon the client's report the clinician will facilitate the next focus of attention. In most cases a client-directed association process is encouraged. This is repeated numerous times throughout the session. If the client becomes distressed or has difficulty with the process, the therapist follows established procedures to help the client resume processing. When the client reports no distress related to the targeted memory, the clinician asks him/her to think of the preferred positive belief that was identified at the beginning of the session, or a better one if it has emerged, and to focus on the incident, while simultaneously engaging in the eye movements. After several sets, clients generally report increased confidence in this positive belief. The therapist checks with the client regarding body sensations. If there are negative sensations, these are processed as above. If there are positive sensations, they are further enhanced.

In phase seven, closure, the therapist asks the client to keep a journal during the week to document any related material that may arise and reminds the client of the self-calming activities that were mastered in phase two.

The next session begins with phase eight, re-evaluation of the previous work, and of progress since the previous session. EMDR treatment ensures processing of all related historical events, current incidents that elicit distress, and future scenarios that will require different responses. The overall goal is produce the most comprehensive and profound treatment effects in the shortest period of time, while simultaneously maintaining a stable client within a balanced system.

After EMDR processing, clients generally report that the emotional distress related to the memory has been eliminated, or greatly decreased, and that they have gained important cognitive insights. Importantly, these emotional and cognitive changes usually result in spontaneous behavioral and personal change, which are further enhanced with standard EMDR procedures.

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[1] **Shapiro, F. (2001)**. Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures (2nd ed.). New York: Guilford Press.

[2] **Shapiro, F. (2002)**. EMDR as an Integrative Psychotherapy Approach: Experts of Diverse Orientations Explore the Paradigm Prism. Washington, DC: American Psychological Association Books.

History of EMDR

In 1987, **Francine Shapiro** was walking in the park when she realized that eye movements appeared to decrease the negative emotion associated with her own distressing memories[1,2]. She assumed that eye movements had a desensitizing effect, and when she experimented with this she found that others also had the same response to eye movements. It became apparent however that eye movements by themselves did not create comprehensive therapeutic effects and so Shapiro added other treatment elements, including a cognitive component, and developed a standard procedure that she called Eye Movement Desensitization (EMD)[1].

Shapiro then conducted a case study[4] and a controlled study[1] to test the effectiveness of EMD. In the controlled study, she randomly assigned 22 individuals with traumatic memories to two conditions: half received EMD, and half received the same therapeutic procedure with imagery and detailed description replacing the eye movements. She reported that EMD resulted in significant decreases in ratings of subjective distress and significant increases in ratings of confidence in a positive belief. Participants in the EMD condition reported significantly larger changes than those in the imagery condition.

Shapiro wrote "a single session of the procedure was sufficient to desensitize subjects' traumatic memories, as well as dramatically alter their cognitive assessments[6]." Unfortunately, Shapiro has often been erroneously cited as claiming that "EMDR can cure [posttraumatic stress disorder] PTSD in one session (F. Shapiro, 1989)."[7] Shapiro never made this statement; what she actually wrote was that the EMD procedure "serves to desensitize the anxiety … not to eliminate all PTSD-related symptomatology and complications, nor to provide coping strategies for the victims[8]" and reported "an average treatment time of five sessions"[8] to comprehensively treat PTSD.

1989 was the first year that controlled studies investigating the treatment of PTSD were published. Besides Shapiro's article, three other studies[9,10,11] were published. The Brom et al.[9] study compared the results of psychodynamic therapy, hypnotherapy, and desensitization and provided an average of 16 sessions. It found clinically significant treatment effects for 60% of the civilian participants, with no differences between the conditions. The Cooper and Clum[10] study compared flooding to standard care in a Veterans Administration Hospital. They reported moderate clinical effects after 6-14 sessions, with a 30% patient drop-out rate. The Keane et al.[11] (1989) study compared flooding to a wait-list control for veteran participants and reported moderate clinical effects after 14-16 sessions. [See **Comparison of EMDR and Cognitive Behavioral Therapies** for more information: http://www.emdr.com/index.php?option=com_content&view=article&id=15&Itemid=62]

Shapiro continued to develop this treatment approach, incorporating feedback from clients and other clinicians who were using EMD. In 1991 she changed the name to Eye Movement Desensitization and Reprocessing[12] (EMDR) to reflect the insights and cognitive changes that occurred during treatment, and to identify the **information processing theory** that she developed to explain the treatment effects. [http://www.emdr.com/general-information/what-is-emdr/theory.html]

Because EMDR therapy was an effective treatment, achieving results very quickly for many clients, Shapiro felt an ethical obligation to teach other clinicians so that individuals suffering from PTSD could find relief. However, EMDR was still experimental since it had not received independent confirmation through other controlled studies. She attempted to resolve this ethical dilemma by teaching EMDR only to licensed clinicians, and by ensuring that everyone who learned the approach was trained by the EMDR Institute in the same model. That way safeguards would be in place, clinicians would be taught to inform clients of its status, and a feedback system would allow everyone that was trained to get the most up to date information. In 1995, after other controlled studies had been published, the label "experimental" and the training restrictions were removed and a textbook of

procedures was published[13]. Shapiro has been severely criticized by some for her method of dissemination, because she initially restricted training and because she taught an experimental procedure. However, these critics ignore the APA ethics code mandated responsibilities of an innovator to determine training practices and the fact that even as late as 1998, there were no treatments for PTSD that were designated as well-established and empirically validated[15]. At that time, independent reviewers for the Clinical Psychology Division of the American Psychological Association identified three treatments with "probable efficacy." These were EMDR, exposure therapy, and stress inoculation therapy.

Since the initial studies were published in 1989, hundreds of case studies have been published, and there have been numerous controlled outcome studies[16]. These studies have demonstrated EMDR's effectiveness in PTSD treatment and EMDR is now recognized as efficacious in the treatment of PTSD [See **Efficacy of EMDR** at: http://www.emdr.com/training-information/qualificationrequirements-for-attending/21.html and **Summary of PTSD Studies** at: http://www.emdr.com/training-information/qualificationrequirements-for-attending/153.html].

A professional association, independent from Shapiro and the EMDR Institute was founded in 1995 to establish standards for training and practice. The EMDR International Association (EMDRIA) declares that its primary objective is "to establish, maintain and promote the highest standards of excellence and integrity in Eye Movement Desensitization and Reprocessing (EMDR) practice, research and education." Information about EMDRIA is available at www.emdria.org.

Despite its demonstrated effectiveness, similar to most new approaches in psychotherapy, EMDR has been surrounded by controversy. While some critics have labeled EMDR a "**pseudoscience**" others have commented that these conclusions are based on misinterpretations of the literature [see **"Confusion, Misinformation, and Charges of "Pseudoscience"** at http://www.emdr.com/training-information/qualificationrequirements-for-attending/52.html].

Another area of debate is the role of eye movements in EMDR [See **Eye Movements and Alternate Dual Attention Stimuli** at [http://www.emdr.com/training-information/qualificationrequirements-for-attending/14.html] and **What has research determined about EMDR's eye movement component?** at: http://www.emdr.com/training-information/qualificationrequirements-for-attending/39.html

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[1]**Shapiro, F. (1989).** Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. Journal of Traumatic Stress, 2, 199-223.

[2]**Shapiro, F. & Forrest, M. (1997).** EMDR The Breakthrough Therapy for Overcoming Anxiety, Stress and Trauma. New York: Basic Books.

[5]**Shapiro, F. (1989).** Eye movement desensitization: A new treatment for post-traumatic stress disorder.Journal of Behavior Therapy and Experimental Psychiatry, 20, 211-217.

[6]**Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories.** Journal of Traumatic Stress, 2, 199-223.

[7] **Lohr, J. M., Tolin, D. F., & Lilienfeld, S. O. (1998).** Efficacy of eye movement desensitization and reprocessing: Implications for behavior therapy. Behavior Therapy, 29, 123-156.

[6]**Shapiro, F. (1989).** Efficacy of the eye movement desensitizatioin procedure in the treatment of traumatic memories. Journal of Traumatic Stress, 2, 199-223.

[9]**Brom, D., Kleber, R. J., & Defares, P. B. (1989).** Brief psychotherapy for posttraumatic stress disorders. Journal of Consulting and Clinical Psychology, 57, 607-612.

[10]**Cooper, N.A., & Clum, G.A. (1989).** Imaginal flooding as a supplementary treatment for PTSD in combat veterans: A controlled study. Behavior Therapy, 20, 381-391.

[11]**Keane, T.M., Fairbank, J.A., Caddell, J.M., & Zimmering, R.T., (1989).** Implosive (flooding) therapy reduces symptoms of PTSD in Vietnam combat veterans. Behavior Therapy, 20, 245-260.

[12]**Shapiro, F., (1991).** Eye movement desensitization & reprocessing procedure: From EMD to EMD/R-a new treatment model for anxiety and related traumata. Behavior Therapist, 14, 133-135.

[13]**Shapiro, F. (1995).** Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures (1st edition). New York: Guilford Press.

[15]**Chambless, D.L., Baker, M.J., Baucom, D.H., Beutler, L.E., Calhoun, K.S., Crits-Christoph, P., Daiuto, A., DeRubeis, R., Detweiler, J., Haaga, D.A.F., Bennett Johnson, S., McCurry, S., Mueser, K.T., Pope, K.S., Sanderson, W.C., Shoham, V., Stickle, T., Williams, D.A., & Woody, S.R. (1998)** . Update on empirically validated therapies, II., The Clinical Psychologist, 51, 3-16.

[16] For complete listing see **See Shapiro, F., (2001).** Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures (2nd edition). New York: Guilford Press.

EMDR Theory

Shapiro developed an information processing theory[1,2,3] to explain and predict the treatment effects seen with EMDR therapy. This theoretical model also describes the development of personality, psychological problems and mental disorders. The following is a simplified description of Shapiro's theory.

All humans are understood to have a physiologically-based information processing system. This can be compared to other body systems, such as digestion in which the body extracts nutrients for health and survival. The information processing system processes the multiple elements of our experiences and stores memories in an accessible and useful form. Memories are linked in networks that contain related thoughts, images, emotions, and sensations. Learning occurs when new associations are forged with material already stored in memory.

When a traumatic or very negative event occurs, information processing may be incomplete, perhaps because strong negative feelings or dissociation interfere with information processing. This prevents the forging of connections with more adaptive information that is held in other memory networks. For example, a rape survivor may "know" that rapists are responsible for their crimes, but this information does not connect with her feeling that she is to blame for the attack. The memory is then dysfunctionally stored without appropriate associative connections and with many elements still unprocessed. When the individual thinks about the trauma, or when the memory is triggered by similar situations, the person may feel like she is reliving it, or may experience strong emotions and physical sensations. A prime example is the intrusive thoughts, emotional disturbance, and negative self-referencing beliefs of posttraumatic stress disorder (PTSD).

It is not only major traumatic events, or "large-T Traumas" that can cause psychological disturbance. Sometimes a relatively minor event from childhood, such as being teased by one's peers or disparaged by one's parent, may not be adequately processed. Such "small-t traumas" can result in personality problems and become the basis of current dysfunctional reactions.

Shapiro proposes that EMDR can assist to successfully alleviate clinical complaints by processing the components of the contributing distressing memories. These can be memories of either small-t or large-T traumas. Information processing is thought to occur when the targeted memory is linked with other more adaptive information. Learning then takes place, and the experience is stored with appropriate emotions, able to appropriately guide the person in the future. A variety of neurobiological contributors have been proposed[4,5,6,7,8]

See the **Commonly Asked Questions** section at http://www.emdr.com/faqs.html for more information about the following questions:

- ✓ **Do eye movements contribute to outcome in EMDR?**
- ✓ **What are some hypothesized mechanisms of action for eye movements in EMDR?**

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[1] **Shapiro, F., (1995).** Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures (1st edition). New York: Guilford Press.

[2] **Shapiro, F., (2001).** Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures (2nd edition). New York: Guilford Press.

[3] **Shapiro, F., (2002).** Paradigms, Processing, and Personality Development. In F. Shapiro [Ed.]. EMDR as an Integrative Psychotherapy Approach; Experts of Diverse Orientations Explore the Paradigm Prism. Washington, D.C.: American Psychological Association Books.

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[7] **Siegel, D. (2002).** The Developing Mind and the Resolution of Trauma: Some Ideas About Information Processing and an Interpersonal Neurobiology of Psychotherapy. In F. Shapiro (Ed.), EMDR as an integrative treatment approach: Experts of diverse orientations explore the paradigm prism, Washington, D.C.: American Psychological Association Books.

[8] **MacCulloch, M.J., & Feldman, P. (1996).** Eye movement desensitization treatment utilizes the positive visceral element of the investigatory reflex to inhibit the memories of post-traumatic stress disorder: A theoretical analysis. British Journal of Psychiatry, 169, 571-579.