

Eye Movement Desensitization and Reprocessing (EMDR)

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What is EMDR?

Eye movement desensitization and reprocessing was developed by Francine Shapiro, PhD as a treatment for trauma-related disorders. Although EMDR has been used primarily as therapy for post-traumatic stress disorder (PTSD), it has also been used for other such other disorders as phobias and depression.^{1,2} EMDR is recognized by the VA/DOD Guidelines as an evidence-based, trauma-focused psychotherapeutic treatment for PTSD.³ However, a good deal of debate surrounds its mechanism of action and whether EMDR is superior to other forms of treatment for PTSD.

What are the Core Elements of EMDR?

EMDR draws from elements of more than one type of therapy and includes imaginal exposure, desensitization, cognitive processing, assessment, psychoeducation and coping strategies. During the EMDR procedure, the patient is instructed to recall a traumatic event, an associated negative thought, an associated positive thought, and a rating of the validity of the associated positive thought. The patient then identifies and rates emotions and physical sensations associated with the traumatic event.

During the desensitization and reprocessing phase, the patient is encouraged to focus on the mental image of the event, the negative thought, and the accompanying physical sensations while tracking the therapist's fingers being waved back and forth approximately 12 inches from the patient's face. Alternatives to using eye movements include alternating auditory tones, flashing lights or finger tapping. After about 20 eye movements the patient is asked to provide another rating of the associated physical sensations and emotions. The process is repeated until the rating approaches zero.

The patient then begins a new set of eye movements while focusing on the positive thought. This process is repeated until the rating of the validity of the positive thought is raised as high as possible. In the next phase of treatment the patient identifies any continuing tension or discomfort and these are attended to with eye movements and ratings as above. Finally, the patient is provided with coping strategies, such as relaxation skills, and journaling between sessions is encouraged. At the end of each session, the therapist evaluates the patient's progress and schedules additional sessions as needed.⁴ The treatment manual suggests 12 treatment sessions.⁵

How Does EMDR Work?

Although there is no definitive evidence to explain how EMDR works, a number of theories have been posited by Shapiro and others. Shapiro suggests that EMDR changes the way that information regarding a traumatic memory is processed and the bilateral eye movements somehow accelerate healing.⁶ Others argue that it is likely that the mechanisms of action for EMDR are related or similar to other exposure or cognitive-based therapies and that the eye movement or EM component is unnecessary.^{3,7-10} It has also been proposed that the therapeutic mechanisms of EMDR can be explained by the application of sound psychotherapy principles.¹¹ Some of these principles include that it promotes positive growth, uses nondirective patient-centered therapy, makes use of treatment expectations, and has a cognitive component.

How Does EMDR Compare to Other Treatments for PTSD?

A number of comparative reviews and meta-analyses have been conducted to evaluate the effectiveness of EMDR at reducing symptoms of PTSD. One such comparative review of randomized trials of psychological treatments for PTSD showed that EMDR did significantly better than waitlist/usual care and “other therapies,” including supportive therapy, non-directive counseling, psychodynamic therapy and hypnotherapy.¹² There were no significant differences between EMDR and trauma-focused cognitive behavioral therapy/exposure therapy or stress management.

Davidson and Parker conducted a meta-analysis of 34 studies that tested the effectiveness of EMDR with a variety of populations and outcome measures.¹ All but two studies made use of random assignment to an EMDR group and a control group. The authors concluded that EMDR is effective when post-test scores are compared with pre-test scores within EMDR treatment groups and when EMDR is compared with a control group. It was not concluded that EMDR was more effective than exposure therapies or EMDR without the eye movement component.

Further sub-analyses of studies that intended to study parts of EMDR as compared with the manualized version revealed no significant advantage of the eye movement component and no significant advantage of alternatives to the eye movement component, such as alternate finger tapping. Davidson and Parker further surmised that there is no benefit in using therapists trained by the EMDR institute and that EMDR is no more or less effective with any particular population. A meta-analysis of seven studies comparing EMDR with cognitive-behavioral therapy (CBT) was conducted by Seidler and Wagner.¹³ All seven studies used manualized protocols for EMDR and CBT, random assignment to treatment, PTSD diagnosis according to DSM III-R or IV criteria, and reliable and valid measures of PTSD as the treatment outcome. The study concluded that EMDR is an effective treatment for PTSD but did not suggest that one form of therapy is better than another. Prior reviews and meta-analyses have not focused on studies of EMDR used for treatment of the combat veteran with a PTSD diagnosis. Albright and Thyer completed a review of the literature on studies of the effectiveness of EMDR used for the treatment of PTSD among combat veterans.¹⁴ An

exhaustive search of the literature found six randomized controlled trials and three quasi-experimental studies. Participants from all studies had been recruited from Veteran Administration-related facilities.

Of the nine studies reviewed, only one showed significant treatment effects relative to the comparison condition, three showed improvement in both EMDR and comparison conditions, and five showed no improvement or worsening of symptoms. All studies suffered from methodological limitations, such as low statistical power (nine studies), few or unreported number of treatment sessions (eight studies), non-standardized EMDR protocol (four studies), poor or unreported adherence to the treatment protocol (eight studies), and no or unreported clinician training (four studies).

The authors conclude that there is “limited evidence supporting the effectiveness of EMDR in reducing PTSD in combat veterans” and that EMDR resembles a “placebo treatment overlaid on behavioral practices.” This last assertion, that EMDR resembles a placebo treatment, echoes the opinions of McNally⁸ and Lohr et al.¹⁰ The authors further say that EMDR is no more than an exposure therapy and the eye movement procedure is unnecessary. It should be noted that none of the studies reviewed included OEF or OIF combat veteran populations.

Is EMDR a Good Treatment Option for Service Members with PTSD?

The answer is unclear. EMDR is a widely accepted form of treatment for PTSD and has shown promise with some populations. The exact mechanisms that contribute to its success or differentiate it from other exposure and cognitive therapies remain unclear. Empirical outcome studies of the efficacy of EMDR show contradicting results.

There is still a good deal of research that needs to be done before we can determine whether EMDR is a more effective therapy than exposure or cognitive therapies for service members or veterans presenting with PTSD. There remains a clear need for well-designed and properly controlled studies of EMDR as a treatment for PTSD with military populations. Nonetheless, EMDR is recognized by the VA/DOD Guidelines as an evidence-based, trauma-focused psychotherapeutic treatment for PTSD. Further research could identify patient characteristics or situations that may make EMDR a good choice for some but not for others.

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