

## **Eye Movement Desensitization and Reprocessing (EMDR) for Posttraumatic Stress Disorder (PTSD)**

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### Description of the Disorder

*Definition* : Those who develop PTSD do so after being exposed to a traumatic event. Their symptoms tend to fit into 3 main categories:

- (1) Re-experiencing the traumatic event. This may occur through nightmares, flashbacks, reliving the event, or having a great deal of distress when in a situation like the trauma
- (2) Avoidance. This may occur through avoiding having particular thoughts or feelings. The person with PTSD may avoid activities or having conversations related to the trauma. He or she may feel withdrawn, disinterested, or numb to emotions.
- (3) Arousal. This may come in the form of feeling “on edge”, having difficulty concentrating, or sleep problems.

*Prevalence*: Almost everyone who experiences a traumatic event will report symptoms of distress shortly after the event. Most persons, however, recover within 3 months after the trauma. For some individuals, high levels of fear, anxiety, and depression may persist even when full PTSD criteria are not met. A national survey found that about 10% of women and 5% of men will have PTSD during their lifetimes. Rates of PTSD range from about 65% in women who report rape, and about 4% in individuals experiencing natural disasters.

### Treatment Comparison

Many studies have shown that EMDR was better at reducing PTSD than control or other treatments. Only one study that was not scientifically designed showed that EMDR was worse than another treatment of PTSD.

*Comparison to No Treatment*. Several studies compared EMDR to waitlist (no treatment) controls. All of these studies reported that EMDR was more effective than no treatment. The studies also showed that EMDR significantly reduced symptoms of PTSD and depression. The effects of the EMDR were long-lasting. One study conducted on rape survivors reported a 90% elimination of the PTSD diagnosis after 3 EMDR sessions. Another study done on a wide range of trauma victims reported an 84% decrease in PTSD diagnosis 15 months after treatment. EMDR also has been proven effective among children who had been disaster victims. In addition to reducing PTSD, the children who received EMDR also had less medical visits after ending treatment.

*Comparison to Commonly Used Treatments*. Several clinical trials have found EMDR to be superior to other types of treatments for posttraumatic stress. These studies have shown that EMDR worked better than other treatments such as such as biofeedback relaxation, active listening, and other forms of individual therapies. One

study found an 100% elimination of PTSD in single trauma victims after participating in an average of 6 EMDR sessions. Another study found that two EMDR sessions brought posttraumatic stress scores within normal range. The one study to use a full course of EMDR treatment for combat veterans reported a 77% elimination of PTSD in 12 sessions.

Comparison to Exposure Therapy. Exposure therapy is frequently used as a PTSD treatment. In exposure therapy, the client relates his/her traumatic experience in detail for an hour in the treatment session. He or she then typically listens to an audiotape of the session as homework for an hour every day. Exposure therapy also requires homework in which the client engages in an avoided activity related to the trauma (e.g., going into Manhattan). Clients are recommended to spend an additional hour or so per day on such activities. The daily homework hours (e.g., 25-100 hours) are necessary, as PTSD improvements are related to homework completion. In comparison, EMDR does not require detailed descriptions of the trauma. EMDR also does not require fixed concentration on the event. It only requires in-session time for treatment. Homework in EMDR usually consists of the client writing down any problems he or she has between sessions and using a relaxation technique if needed.

There have been four studies comparing EMDR and exposure therapy alone. All have reported approximately equal results on most measures. Rates of getting better ranged from 50-80% in both treatment groups, despite the differences in assigned homework. One study that made homework the same for both EMDR and Exposure treatments showed better success in EMDR participants (70%) than Exposure participants (17%).

Comparison to Cognitive Therapy. There are several forms of cognitive therapy for PTSD. In one type, the client works on daily cognitive tasks to modify negative thoughts and beliefs related to the trauma. These therapies have been successful in making improvements after 10-12 sessions with daily homework.

There has been one randomized clinical trial comparing EMDR to cognitive plus exposure therapy. Both treatment groups showed significant decreases in all symptoms. The EMDR participants completed treatment in significantly fewer sessions than the participants in the cognitive plus exposure group. The EMDR participants had no homework while the other participants did have daily homework.

Comparison to Stress Inoculation Training. Stress Inoculation Training teaches a variety of skills to help the client reduce anxiety and related behaviors. These include controlled breathing and relaxation. Coping skills also are taught, such as how to think through problems and how to have positive self-talk.

One randomized clinical trial compared EMDR with a combination of Stress Inoculation Training plus Prolonged Exposure (SITPE). Both treatments achieved similar effects, with a significant decrease in symptoms. EMDR, however, was superior in reducing re-experiencing symptoms. EMDR group participants also showed better outcomes at 3-

month follow-up. The SITPE participants had 30 hours of homework compared to 3 hours for the EMDR group.

### Treatment Description

EMDR combines different elements of many effective therapies to maximize treatment effects. EMDR uses a procedure that reduces the intensity of the traumatic images. This process reduces the emotional response to the disturbing memories. A full description of the theory, sequence of treatment, and research on protocols and active mechanisms can be found in F. Shapiro (2001) *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures (2<sup>nd</sup> edition)* New York: Guilford Press.

EMDR involves attention to three time periods: the past, present, and future. Focus is given to past disturbing memories and related events. It is also given to current situations that cause distress. Attention also is given to developing the skills and attitudes needed for positive future actions. With EMDR, these items are addressed using an eight-phase treatment approach. The first phase is a history-taking session. 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 distressing memories and current situations that cause emotional distress. Other targets may include related incidents in the past. Emphasis is placed on the development of specific skills and behaviors that will be needed by the client in future situations. Initial EMDR processing may be directed to childhood events rather than to adult onset stressors or the identified critical incident if the client had a problematic childhood. Clients generally gain insight on their situations. They then may start to change their behaviors. The length of treatment depends upon the number of traumas and the age of PTSD onset. Generally, those with single event adult onset trauma can be successfully treated in under 5 hours. Multiple trauma victims may require a longer treatment time.

During the second phase of treatment, the therapist ensures that the client has several different ways of handling emotional distress. The therapist may teach the client a variety of imagery techniques the client can use during and between sessions.

In phases three through six, a target is identified and processed using EMDR procedures. These involve the client identifying three things:

1. The vivid visual image related to the memory
2. A negative belief about self
3. Related emotions and body sensations.

The client also identifies a positive belief. The therapist helps the client rate the positive belief as well as the intensity of the negative emotions. After this, the client is instructed to focus on the image, negative thought, and body sensations, while simultaneously engaging in an EMDR behavior. This behavior may include eye movements, taps, or tones. The type and length of these behaviors is different for each client. At this point, the EMDR client is instructed to just notice whatever spontaneously happens. After

each set of EMDR behaviors, 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 choose the next focus of attention. In most cases, the client is encouraged to direct where the focus goes next. This is repeated numerous times throughout the session. If the client becomes distressed or has difficulty in progressing, the therapist follows established procedures to help the client get back on track.

When the client reports no distress related to the targeted memory, s/he is asked to think of the preferred positive belief that was identified at the beginning of the session. The client then may adjust the positive belief if necessary, and then focus on it during the next set of distressing events. Clients generally report increased confidence in the positive belief over time. The therapist checks with the client regarding body sensations. If there are negative sensations, these are processed as above.

In phase seven, closure, the therapist asks the client to keep a journal during the week. The journal should document any related material that may arise. It also serves to remind the client of the self-calming activities that were mastered in phase two. The next session begins with phase eight. Phase eight consists of examining the progress made thus far. The EMDR treatment processes all related historical events, current incidents that elicit distress, and future events that will require different responses.

Francine Shapiro, Ph.D. is a senior research fellow at the Mental Research Institute. She also is the founder and President Emeritus of the EMDR Humanitarian Assistance Programs, a nonprofit organization that coordinates disaster response and pro bono trainings worldwide. Dr. Shapiro was designated as one of the "Cadre of Experts" of the American Psychological Association & Canadian Psychological Association Joint Initiative on Ethnopolitical Warfare, and has served as advisor to numerous trauma treatment and outreach organizations. She has written three books about EMDR: *Eye Movement Desensitization and Reprocessing* (Guilford Press), *EMDR* (BasicBooks), and *EMDR as an Integrative Psychotherapy Approach* (American Psychological Association Press). She is a recipient of the International Sigmund Freud Award of the City of Vienna, for distinguished contribution to psychotherapy, and the Distinguished Scientific Achievement in Psychology Award presented by the California Psychological Association.