

Andrew M. Leeds

A Guide to the
Standard EMDR Protocols
for Clinicians, Supervisors,
and Consultants

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and Consultants**

Andrew M. Leeds, Ph.D.

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About the Author

Andrew M. Leeds, PhD, is a California licensed Psychologist and Marriage and Family Therapist with 34 years of experience in the private practice of psychotherapy. He practices in Santa Rosa, California.

Dr. Leeds received his BA in Psychology with honors in 1972 from the University of California at Santa Cruz, an MA in Clinical Psychology in 1974 from Goddard College, and his PhD in Clinical Psychology in 1983 from International College.

After early training in Gestalt and Somatic psychotherapies, Dr. Leeds served a 2-year internship as program coordinator for an alcohol abuse treatment program in Santa Cruz and received his license as a Marriage and Family Therapist before going on to obtain his doctorate. During his doctoral program, he studied cognitive behavioral therapy, Ericksonian hypnosis, and self psychology.

Dr. Leeds received his initial EMDR training in 1991 and became an EMDR training supervisor that same year. In 1993, he became an EMDR trainer. He has conducted EMDR trainings for 15,000 clinicians at 140 training programs in the United States, Canada, France, England, and Japan.

He has presented papers on EMDR for regional, national, and international conferences. He is the author of a book, book chapters, and several journal articles on EMDR. He served for 2 years on the Standards and Training Committee of the EMDR International Association (EMDRIA) and for 3 years as an elected member of the EMDRIA Board of Directors. He presently serves as a member of the Editorial Advisory Board of the *Journal of EMDR Practice and Research*. He is an EMDRIA-Approved Consultant providing consultation to EMDR clinicians around the world.

Dr. Leeds contributed to the evolution of EMDR by articulating, publishing, and teaching the EMDR procedure he named *Resource Development and Installation* (RDI). In 1999, he received an EMDRIA award for creative innovation in the development of EMDR as well as the Ronald A. Martinez, PhD Memorial Award.

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MY PROFESSIONAL DEVELOPMENT WITH EMDR

Every book has a beginning. This one began when I completed Parts 1 and 2 of the basic EMDR training in 1991. A number of successful early experiences with applying EMDR in my private practice gave me a growing sense of confidence in EMDR. In late 1991, I began serving as a training supervisor for the practice portion of EMDR trainings. The opportunity to supervise the clinical practice of EMDR at trainings deepened my understanding of EMDR, conceptually and procedurally. I observed an incredible number of both common and rare deviations from the standard EMDR procedures. Having to find the words to clarify not only the standard EMDR procedures, but also to be able to offer a rationale from the theoretical model, strengthened my teaching skills and my conceptual understanding of EMDR.

In 1993, I began leading EMDR trainings throughout the United States and Canada and later in Europe and Japan. Through 2008, I led EMDR basic trainings for over 15,000 clinicians. This has been an incredibly rewarding experience. With the help of A. J. Popky, from 1996–2000, I served as the founding moderator of an EMDR e-mail discussion forum. I read over 15,000 e-mails from EMDR-trained clinicians from all over the world and sent over 2,500 e-mails in reply on topics including standard EMDR procedures, treatment planning, and the growing body of EMDR literature. From 2001–2003, I served on the EMDRIA Standards and Training Committee, and from 2003–2005, as elected member of EMDRIA's Board of Directors. Since 2003, I have compiled a summary of recently published EMDR research that appears in each quarterly issue of the *EMDRIA Newsletter*. These many years of service to the EMDR community and with EMDRIA have been essential in strengthening my understanding of EMDR.

Although I am profoundly indebted to all of my colleagues who have helped me evolve in my understanding of EMDR, the flaws, omissions, and other deficiencies in this work are my responsibility alone.

Acknowledgments

I am deeply indebted to all my colleagues who have contributed to my understanding of EMDR. Space does not permit me to name them all. First and foremost, I am grateful to Francine Shapiro for the gift of EMDR. EMDR has transformed my clinical work and opened doorways for professional development that I could never have imagined. I am also grateful for the community of EMDR trainers, training supervisors, and clinicians trained in EMDR. My dear friends and colleagues Carol York, Sandra Foster, and Curt Rouanzoin have been loyal comrades through many adventures. Carol York has been a steady source of support and intellectual stimulation in the evolution of my understanding of EMDR. Deborah Korn and I took turns sitting in each other's conference presentations for many years, finally teaching together in 1998 and coauthoring a paper in 2002. I have matured through their teaching and consultations over these many years. Other colleagues who have supported me directly or indirectly in ways that affect this book include Robbie Adler-Tapia, Nancy Errebo, Ulrich Lanius, Jennifer Lendl, Marilyn Luber, Philip Manfield, and Carolyn Settle.

Masaya Ichii and his colleagues, Masako Kitamura and Masamichi Honda in Japan gave me the opportunity to teach annually in Japan over a span of 10 years. The opportunity to teach with the exceptional translator/clinicians—Tomoko Osawa and Akiko Kikuchi—in Japan challenged me to find the essence of EMDR that would fit in half the speaking time and to develop illustrations for key EMDR concepts. Mark Russell has been an inspiration and a strong supporter to carry this project to completion. Louise Maxfield inspired me with her dedication and scholarship, invited me to serve on the Editorial Board for the *Journal of EMDR Practice and Research*, persistently encouraged me to write, and introduced me to key staff members at Springer Publishing Company. Rosalie Thomas, Wendy Freitag, Mark Dworkin, and many other colleagues with whom I served on the EMDRIA Board and the Standards and Training Committee helped enlarge my perspective about the needs of the larger EMDR community and the future of EMDR. My understanding of EMDR and the global evolution of EMDR have been profoundly affected by the support, teaching, and publications of my European colleagues, Ad de Jongh and Arne Hoffman.

I am deeply indebted to Ted Nardin, President of Springer Publishing Company, who first encouraged me to place this manuscript with Springer when we met in 2006, to Sheri Sussman—an extraordinary editor, raconteur and dancer—who supported me at crucial points and helped me to realize my vision for this book, and to Deborah Gissinger who shepherded me through the challenges of the publishing process of my first book.

I am grateful to my wife, Deborah Taylor-French, and daughter, Alexandra Leeds, who have patiently endured my closeting of myself in my office for so long during the preparation of this book. My wife also gave much helpful feedback at critical junctures in this process, and my daughter contributed the illustration for Figure 7.1.

This book is intended to provide an easy to use guide to the standard, research-supported EMDR protocols for graduate students, clinicians, consultants, supervisors, instructors, and researchers. It is intended to supplement the following requirements for all EMDR clinicians: a thorough reading of Francine Shapiro's (2001) text—*Eye Movement Desensitization and Reprocessing, Basic Principles, Protocols, and Procedures*; an EMDRIA-approved basic training in EMDR; and consultation in the use of EMDR from an EMDRIA-Approved Consultant.

Since the publication of the first edition of Francine Shapiro's standard text in 1995 and the founding of the EMDR International Association (EMDRIA), the role of consultation on the use of EMDR has expanded, becoming required in both basic training in EMDR and in EMDRIA's certification program, yet little has been published to offer guidance on the consultative process for EMDR-trained clinicians and consultants. EMDR finds a growing role in organized treatment programs in colleges and universities, nonprofit agencies, and community mental health centers where clinical supervisors need ways to document EMDR treatment planning, process, and outcomes. This book provides an orientation to these issues as well as forms that offer a starting point for documenting the clinical process with EMDR.

THE PLAN OF THIS BOOK

In planning this guide to standard EMDR protocols, decisions had to be made in selecting which areas of application to include and which to exclude. Several factors were considered, including the degree and nature of evidence of empirical validation, congruence with well-accepted principles of treatment in the behavioral literature, content required for EMDRIA-approved basic training in EMDR, and the need to keep the manual to a practical length. A significant number of proposed EMDR procedures and protocols for additional clinical applications that show promise, but did not meet some of these criteria, were omitted.

Section I of the book covers the conceptual framework for understanding EMDR, including the history and evolution of EMDR in chapter 1, the Adaptive Information Processing model in chapter 2; and an overview of the standard eight-phase model of EMDR and the three-pronged protocol in chapter 3. The three chapters in section II cover case formulation, treatment planning, and preparing patients for EMDR reprocessing.

Section III, six chapters in all, covers phases three through eight of the standard protocol for posttraumatic stress disorder (PTSD). The standard EMDR protocol for PTSD can be applied with equal effectiveness for patients who meet partial criteria for PTSD and whose symptoms develop after a range of adverse life events that do not meet criterion A (American Psychiatric Association [APA], 1994; Mol et al., 2005; Wilson, Becker, & Tinker, 1997). These procedural steps and the standard protocol for PTSD apply to patients with primary structural dissociation (van der Hart, 2007), which is always present to some degree in PTSD. Patients with secondary structural dissociation—including those with complex PTSD, borderline personality disorder,

or dissociative disorder not otherwise specified (DDNOS)—or with tertiary structural dissociation—dissociative identity disorder (DID)—will need additional interventions and a more complex treatment plan not covered in this text.

Section IV covers the application of EMDR to conditions other than PTSD with chapters devoted to specific phobias and panic disorder. Note that the standard EMDR PTSD protocol can be applied to patients with comorbid substance abuse when sufficient stabilization has been achieved—as described in chapter 6—and when the case conceptualization is that the substance abuse is secondary to the PTSD. When the substance abuse appears to be the primary condition—that is when it began first—and the PTSD appears to be secondary, alternate EMDR approaches may be more suitable as the initial focus of attention needs to be the treatment of the substance abuse itself. The Desensitization of Triggers and Urge Reprocessing (DeTUR) protocol (Popky, 2005; Vogelmann-Sine, Sine, Smyth, & Popky, 1998) continues to be the most promising EMDR approach for treatment of primary substance abuse, but research on DeTUR and other approaches to applying EMDR to substance abuse (Brown & Gilman, 2007; Brown, Gilman, & Kelso, 2008; Hase, Schallmayer, & Sack, 2008) is still at too early of a stage for inclusion in this guide.

Section V addresses issues of professional development in EMDR as clinicians go through the basic training in EMDR and obtain consultation or supervision on their clinical application of EMDR. The three appendices provide sections with fidelity checklists, forms, and resources referred to in the text.

THE PATH TO PROFICIENCY

Over many years of conducting training in EMDR I have at times been surprised at the number of clinicians who returned for the next phase of their training months or years later and who disclosed that they have used EMDR rarely or not at all. When I served on the EMDRIA Board of Directors I supported policies—subsequently implemented—to require inclusion of consultation on trainees' actual clinical use of EMDR as part of basic training in EMDR. As a trainer, I also sought ways to motivate and encourage training participants to get started early and persist in practicing EMDR. While teaching in Japan I developed the following metaphor for the process of learning EMDR. If you have ever seen a student and experienced potter each working with clay at a wheel and throwing a pot, perhaps you have seen what I try to convey in this guide: *EMDR, when done well, looks simple, but it is not easy.*

The student wedges the clay but introduces air bubbles. When fired, the pot made from this clay explodes. The student struggles to center the clay. Instead, it slides off the edge of the wheel. The student becomes frustrated and less able to concentrate. After gaining skills at centering, the student still cannot control the thickness of the pot, which collapses on one side and must be discarded or is too thick and lacks grace.

The experienced potter wedges the clay while avoiding trapping air bubbles. She firmly centers the clay on the turning wheel. Then, she raises the sides, thinning them evenly while retaining stability and grace in the form. In moments, making only simple motions, the pot is done.

It appears simple, but it is not easy. How does the student become proficient? Practice and more practice. Central to learning is the willingness to let others with more experience observe and give feedback on one's work. Only by being willing to reveal one's mistakes, accept feedback and by working together can we find the simplicity that yields graceful and lasting results. Scientific progress, our consultees, our students and most importantly our patients deserve no less.

The Conceptual Framework for Understanding EMDR

The most important fundamental laws and facts of physical science have all been discovered, and these are now so firmly established that the possibility of their ever being supplemented in consequence of new discoveries is exceedingly remote.

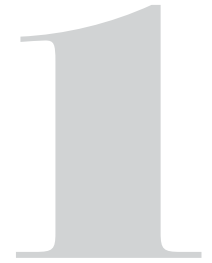
—Abraham Albert Michelson, 1903

The more original a discovery, the more obvious it seems afterwards.

—Arthur Koestler,

Whether you can observe a thing or not depends on the theory which you use. It is the theory which decides what can be observed.

—Albert Einstein, 1926



The History and Evolution of EMDR

CONTEMPORARY THEORY AND TREATMENT OF POSTTRAUMATIC STRESS SYNDROMES

Unlike other 20th century psychotherapies, Eye Movement Desensitization and Reprocessing (EMDR) began not from a particular theoretical perspective but from direct empirical observations (Shapiro, 1995, 2001). Nevertheless, other approaches and their theories clearly influenced the evolution of EMDR and its theoretical framework through four main periods from (a) a simple technique (eye movements), to (b) an initial procedure (EMD), to (c) a protocol (EMDR) for treatment of one condition (posttraumatic stress disorder [PTSD]), to (d) an overall approach to treatment. Even though EMDR began from more of an empirical than theoretical origin, an understanding of EMDR's theoretical framework, known as the Adaptive Information Processing model (AIP; Shapiro, 2001), is central to the successful clinical application of EMDR. The AIP model guides case conceptualization, informs treatment planning, supports resolving clinical impasses, and predicts clinical outcomes and potential new clinical applications.

Section I presents the conceptual framework for understanding EMDR. Chapter 1 begins with a review of selected aspects of four models that historically most directly support understanding the evolution of EMDR. These are hypnosis, psychodynamic, behavioral, and cognitive behavioral. An overview of these models and their research base as a treatment for PTSD can be found in *Effective Treatment for PTSD* (Foa, Keane, & Friedman, 2000; Foa, Keane, Friedman, & Cohen, 2009). After a review of these four models, the history of EMDR's evolution is summarized. Next, in chapter 2, the AIP model is presented followed by a summary of the leading proposals to explain EMDR treatment effects.

HYPNOSIS

The history of psychotherapy over the last 125 years begins with the use of hypnosis (Whalen & Nash, 1996) by Charcot, Janet, Breuer, Freud, and Prince (among others). From its early roots in psychotherapy, hypnosis was closely associated with the search to understand and treat the relationship between trauma and dissociation

(van der Kolk & van der Hart, 1989; Cardeña, Maldonado, van der Hart, & Spiegel, 2000). The early history and evolution of EMDR in turn has been deeply involved in the search to understand and treat the relationship between trauma and dissociation (Fine et al., 1995; Lazrove & Fine, 1996; Nicosia, 1994; Paulsen, 1995).

The 20th-century models of hypnosis were strongly influenced by Milton Erickson (Lankton, 1987; Rossi, 1980a, 1980b). Hypnosis has contributed key concepts relevant to the theory and practice of EMDR. *Rapport* refers to the qualities of trust, connection, and contingency (Siegel, 1999) needed in the relationship between the person being hypnotized and the hypnotist (Frederick & McNeal, 1999). *Frame of reference* and *narrowing of attention* both refer to phenomena central to hypnotic responses, leading to alternations in perception of the environment and the body. *Hypnotic suggestibility* varies widely in different individuals. Whether there is or is not a consistent, (measurable) altered state of consciousness produced by hypnosis remains a matter of some debate (Kirsch & Lynn, 1995). Preliminary evidence (Nicosia, 1995) suggested that use of standard EMDR procedures—described by Shapiro (1995, 2001) and in this text—do not induce an altered state in the brain similar to brain wave patterns that have been identified in hypnosis. Procedurally, hypnotic phenomena and suggestions are not central to EMDR's main treatment effects (Barrowcliff, Gray, & MacCulloch, 2002; MacCulloch & Feldman, 1996). Suggestibility has been found not to correlate with responses to EMDR treatment (Hekmat, Groth, & Rogers, 1994). While formal trance and suggestion are not central to EMDR treatment, Ericksonian principles, including *utilization*, *naturalistic methods*, and *metaphor*, play an important role in the “preparation phase” and in some strategies for working through *ineffective reprocessing*. In contrast to earlier models of hypnosis based on command suggestion, Milton Erickson was *interactive* and *responsive*, eliciting information and *utilizing* each patient's unique experience and symptoms as a source for solutions. These same principles inform the use of naturalistic strategies in *interweaves* (Shapiro, 1995, 2001) to assist patients in reprocessing intense emotional distress and to foster synthesis between maladaptive and adaptive memory networks.

PSYCHODYNAMIC APPROACHES

Psychodynamic approaches to the treatment of PTSD have a long history with a diverse range approaches and rich tapestry of constructs that have been developed. Of the many concepts and principles found in psychodynamic approaches, a number are relevant to understanding the similarities and differences between psychodynamic approaches and EMDR. Freud (1955) described traumatic events as breaching a *stimulus barrier* leading to a *repetition compulsion* in which periods of intrusive re-experiencing alternate with periods of avoidance. Freud initially explored the structured use of hypnosis pioneered by Charcot and Janet (van der Hart & Friedman, 1989) and advocated by his mentor Breuer (Breuer & Freud, 1955). Their approach focused on using hypnosis to help strengthen patients' abilities to function and then to develop a narrative understanding of traumatic events. For reasons beyond the scope of this overview, Freud literally turned away from his patients and shifted to the technique of *free association* in which he required patients to discuss their concerns without directive guidance while Freud assumed a stance of *neutrality*. This shift in technique was paralleled by a shift in focus from developing a narrative understanding of traumatic events to an exploration of the intrapsychic meaning (defensive purpose) of the patient's symptoms. Frequent sessions and minimal therapist responsiveness served to increase the intensity of the therapeutic relationship. (For the effects of the absence of contingent responsiveness on anxiety, see Siegel [1999].) This also encouraged the *projection of transference material*, which was considered to represent the unresolved *intrapsychic conflicts* of the patient. Interpretation of the defensive meaning of symptoms, verbal and memory lapses, and projected transference material became the primary active intervention.

During the evolution from EMD to EMDR (Shapiro, 1991a), Shapiro incorporated the principle of *free association* and moved further away from a *prolonged exposure model*. However, *interpretation* is normally explicitly avoided in the standard model of EMDR. Rather than pure neutrality, responsiveness to the patient's process is emphasized in EMDR. Transference and counter-transference are recognized, but when transference arises during reprocessing, it is normally addressed by making it the focus of further reprocessing without explicit interpretation or comment. Often, the personal memories that are the sources of projected transference material will emerge spontaneously as reprocessing continues in EMDR treatment sessions. If not, EMDR clinicians can actively encourage patients to explore associations to their personal memories during additional sets of *bilateral stimulation* through affective, somatic, and cognitive linkages.

BEHAVIOR THERAPY

Classical behavior therapy views PTSD through the lens of conditioning in which a powerful *conditioned association* is formed between *specific cues* (external and internal stimuli) that were present at the time of a traumatic event and the intense state of alarm (fear) evoked by the traumatic experience. Systematic desensitization and flooding (implosion) were the two dominant modes of treatment proposed by behaviorists (Wolpe, 1954, 1958; Keane, Fairbank, Caddell, & Zimering, 1989; Stampfl & Levis, 1967). In systematic desensitization, the patient identifies a hierarchy of cues ranging from mildly to highly disturbing. Then the patient is trained to achieve a state of deep relaxation through structured self-control techniques such as *progressive relaxation* or *biofeedback-assisted relaxation training*. Next, the patient is directed to focus on the least disturbing cue and to practice relaxing until a state of calm is achieved again. This is repeated as many times as necessary, working gradually up the hierarchy until the most disturbing cue can be focused on and the patient can remain calm. Only six studies have examined systematic desensitization as a treatment for PTSD. In part, this may be because it is time-consuming and other methods have been shown to be more effective and efficient for most patients (Foa et al., 2000; Solomon, Gerrity & Muff, 1992; van Etten & Taylor, 1998).

Flooding or *implosion therapy* (Stampfl & Levis, 1967) is a form of *imaginal exposure*. Flooding is based on the principle of *extinction*, which proposes that nerves can only continue to produce intense arousal for limited periods of time. Afterward, further exposure to frightening cues no longer produces a fear response. Flooding and related forms of *prolonged imaginal exposure* (PE) have been studied extensively as treatments for PTSD. See reviews in Foa et al. (2000) and Follette & Ruzek (2006). Early reports indicated that PE had a 50% dropout rate in treatment of combat veterans (Cooper & Clum, 1989) and little effect on emotional numbing and social avoidance (Keane et al., 1989). Later reports suggest similar dropout rates for exposure therapy, cognitive therapy, stress inoculation training, and EMDR (Hembree et al., 2003). However, recent reviewers suggest nonresponse and dropout rates vary widely—up to 50% in some behavioral studies—perhaps depending on the population being studied and call for better data in research reports to clarify these rates in treatments for PTSD (Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008).

Although PE has been found to be effective for reducing fear-related symptoms, questions remain regarding its effectiveness for resolving feelings of shame and guilt (Adshead, 2000; Pitman et al., 1991; Stapleton, Taylor, & Asmundson, 2006). This has led to approaches such as cognitive processing therapy (Resick & Schnicke, 1993) and stress inoculation training (Meichenbaum, 1985), which combine PE with cognitive therapy. It is possible that the effects of flooding may result in part from patients being unintentionally trained to dissociate (emotional numbing) so that they no longer feel the disturbing material rather than forming new associations to the disturbing cues (Rogers & Lanius, 2001).

COGNITIVE BEHAVIORAL THEORY

Cognitive behavioral theory accepts the paradigm of classical conditioning as a foundation for understanding posttraumatic syndromes (and other anxiety disorders), but turns toward *information processing models* and to the concept of *emotional processing* for models of how to reshape conditioning from these adverse events. Cognitive behavioral models that focus on the intervening variables of irrational beliefs or negative schemas may be more familiar to clinicians from Ellis's (1994) rational emotive behavior therapy (REBT) and Beck's (Beck, Emery, & Greenberg, 2005) cognitive therapy. However, the less widely known cognitive behavioral models of *emotional information processing* are central to understanding the principles that underlie the standard model of EMDR. The key concepts supporting the cognitive model of emotional information processing build on the work of Lang (1977, 1979), Rachman (1980), Bower (1981), Foa and Kozak (1985, 1986), and Foa and Riggs (1995).

COGNITIVE BEHAVIORAL MODELS OF EMOTIONAL INFORMATION PROCESSING

Lang (1968) operationalized the concept of anxiety as involving behavioral responses in the following three systems: physiological activity, overt behavior, and subjective report. Lang proposed a general model (1977, 1979) for treating anxiety

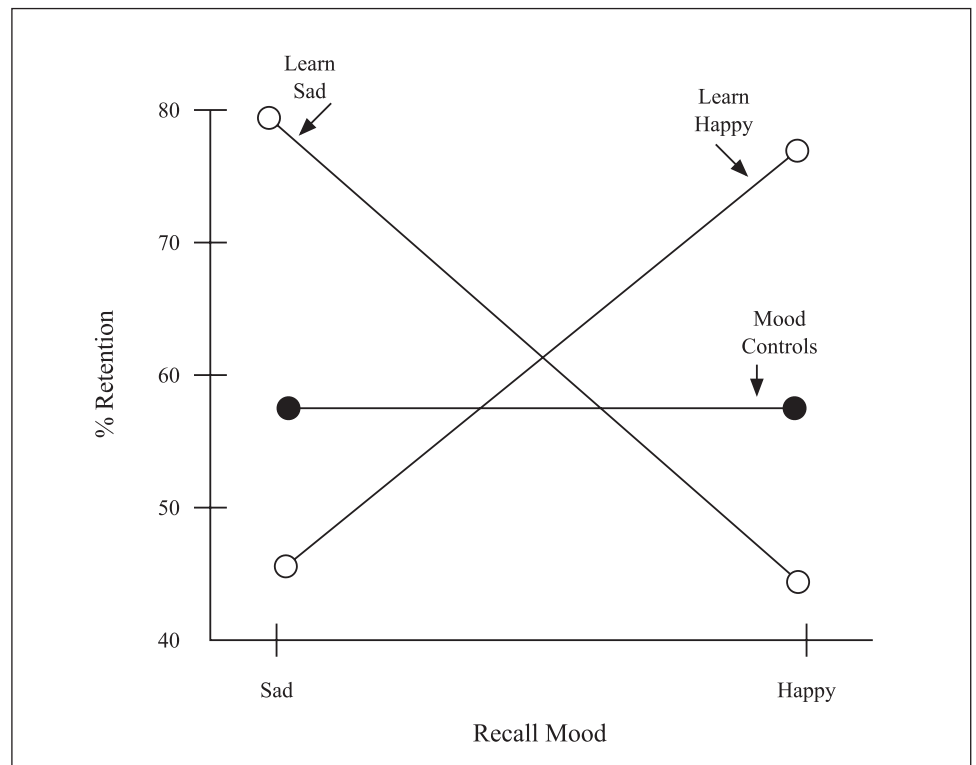


Figure 1.1 Bower State Dependent memory

Percentage retention scores for three groups of hypnotizable subjects tested on recall of lists of happy and sad words. Mood during learning and recall was induced by hypnosis-guided imagery. Mood during testing is shown on horizontal axis. Mood controls were in neutral mood on learning and recall test. Crossing lines with mood reversed on testing from learning show affect-state dependent learning effect. Similar effects were shown for autobiographical recall.

Note. From "Mood and Memory," by G. H. Bower, 1981, *American Psychologist*, 36(2), pp. 129–148. Copyright 2000. Reprinted with permission.

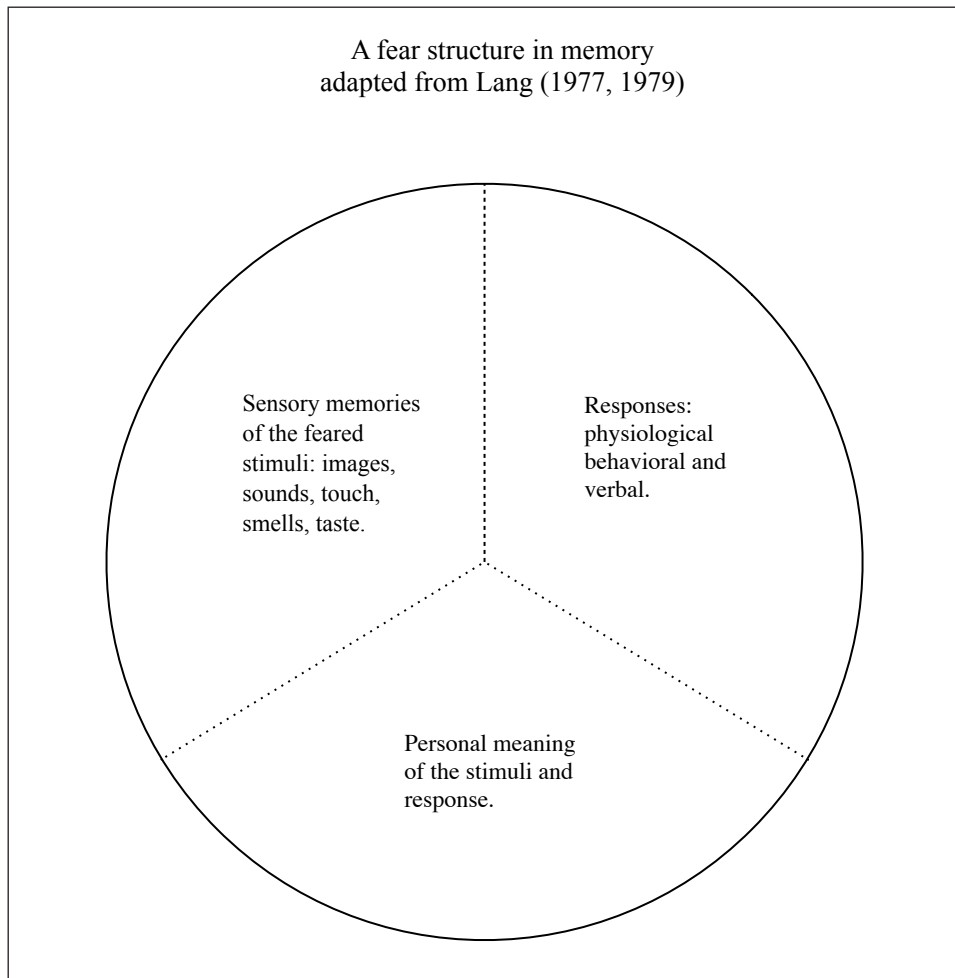


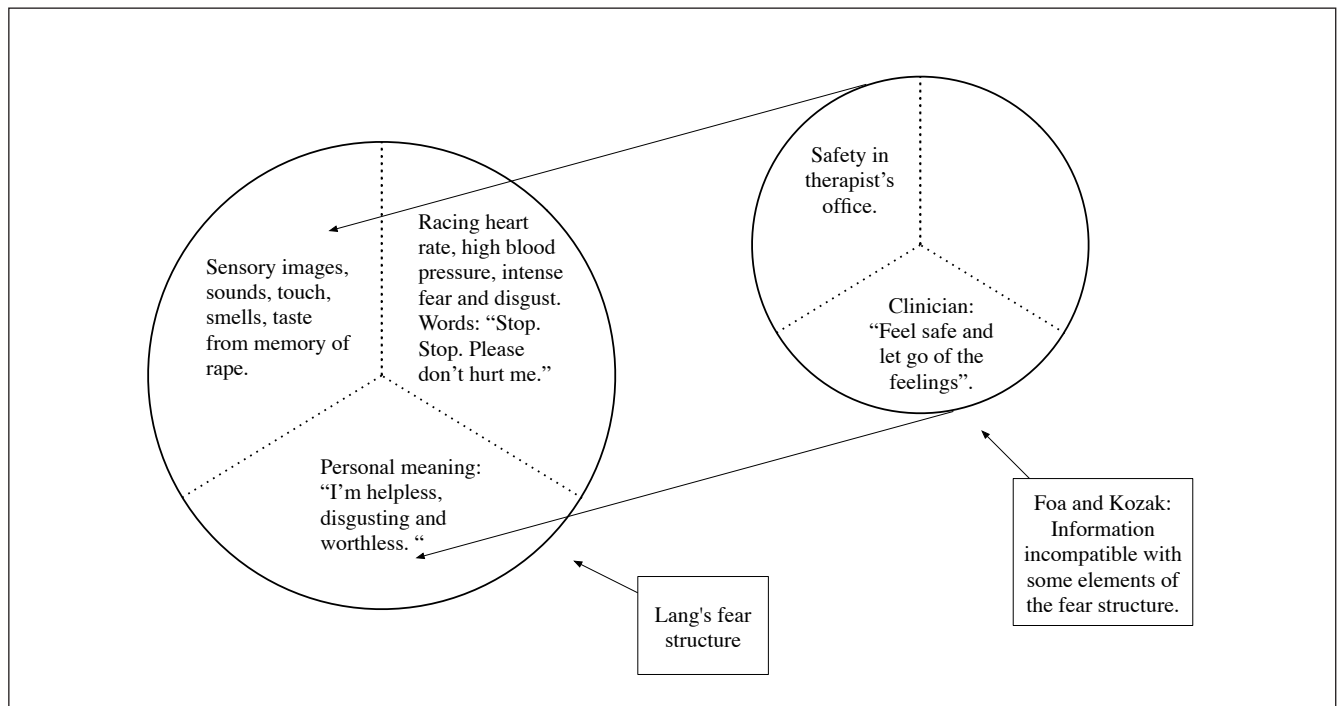
Figure 1.2 Lang fear structure

disorders when using *imagery* (in contrast to *in vivo* treatment). First, some of the response components, holding these emotional memories in *fear structures*, must be activated. The idea that imaginal treatment must first activate *emotionally valenced memory structures* is parallel to Bower's *state specific model* (1981). Bower proposed that access to *recalling* and *modifying emotional information* is dependent on the emotional state (mood) the individual is in at the time.

Lang described fear structures as containing information about the following: (a) the feared stimulus; (b) verbal, physiological, and behavioral responses; and (c) meaning of the stimulus and response. Starting from Mathews' hypothesis (1971, p. 88) that "one of the effects of relaxation may be to increase the vividness of imagery experienced during desensitization," Rachman (1980) proposed that the increased vividness of imagery resulting from relaxation leads to fear reductions by *first producing stronger physiological responses to phobic imagery*. He called this sequence of effects *emotional processing*. Rachman also proposed that repeated *test probes* of phobic imagery were needed to determine the degree to which emotional processing had occurred. These repeated test probes are direct antecedents to the EMDR procedure of returning to target to reaccess the *memory network* and reassess the degree to which reprocessing has occurred. Foa and Kozak (1985, 1986) later proposed that for emotional processing of fear to occur, information—cognitive and affective—incompatible with fear must be available and integrated to modify the fear structure and form a new memory. In EMDR, this concept is described as the need for relevant adaptive memory networks to be present and accessible so that

Figure 1.3

Emotional processing of fear with imaginal exposure based on Foa and Kozak (1985, 1986) and Foa and Rothbaum (1998).



synthesis can take place between the selected maladaptive memory network and adaptive memory networks.

The cognitive behavioral model of clinical anxiety has had a powerful effect on treatment and research. The cognitive behavioral approach to treatment of post-traumatic syndromes, which is still evolving, includes the following: (a) the principle of prolonged exposure derived from the early behavioral models of flooding—that started with the most traumatic memory, (b) some elements of systematic desensitization that started with the least disturbing elements and involve practicing dearousal (relaxation) in the here and now, and (c) some elements of cognitive restructuring. Indeed, there does not yet appear to be agreement on how to manualize treatment of PTSD within a cognitive behavioral model. Different research teams studying models of exposure-based treatment for PTSD have different treatment manuals that change from one study to the next.

Several theoretical questions arise in the cognitive behavioral model of emotional processing as described by Foa and Kozak (1986). First, what prevents or enhances the integration of the information incompatible with fear when fear structures are activated and information incompatible with fear is present? Rachman (1979) suggested that a key element in emotional processing may be relaxation. Is relaxation the only factor? What other factors enhance or inhibit emotional processing? To the degree that relaxation is a factor in facilitating emotional processing, how can relaxation best be evoked when asking a person to focus on a terrifying memory, involving a perception of eminent death or injury to self or other?

Systematic desensitization and stress inoculation training provide patients with training in structured anxiety regulation techniques that are alternated with prolonged exposure to anxiety-provoking imagery. These approaches stand in contrast to EMDR in which patients are challenged to initially simultaneously

attend to their anxiety-provoking imagery and to neutral, bilateral sensory stimulation that appears to have a “compelled relaxation response” (Barrowcliff, Gray, MacCulloch, Freeman, & MacCulloch, 2003; Wilson, Silver, Covi, & Foster, 1996, p. 227). However, during EMDR reprocessing, patients are not asked nor required to continue to maintain attention to their anxiety-provoking imagery. Indeed, most patients report that they are unable to maintain persistent attention on their original anxiety-provoking imagery during bilateral sensory stimulation. Instead, most patients begin to report various associations from aspects of their original anxiety-provoking imagery that can lead to other disturbing, neutral, or even positive imagery, sensations, emotions, and thoughts. Thus, psychophysiological arousal tends to move from a zone of hyperarousal to a zone of optimal arousal that facilitates the emotional information processing originally described by Rachman (1979). See Figure 1.5, Yerkes–Dodson later in this chapter.

In cognitive approaches to emotional processing, the two central strategies for integrating information incompatible with a fear response are the following: (a) to have the patient engage repeatedly in daily homework assignments of self-directed imaginal exposure until new, less frightening memories are formed and (b) to have the therapist make statements or ask questions while the patient is engaging in imaginal exposure. These strategies contrast with standard EMDR treatment that requires no patient homework and encourages the patient to reprocess with a minimum of therapist verbalizing during and between sets of bilateral sensory stimulation. Case formulation strategies—described in chapters 4, 5, and 6—call on clinicians to assess before starting EMDR reprocessing, the degree to which patients possess and can access adaptive responses and information *incompatible with a fear response*. When these are absent or difficult to access, EMDR clinicians must take steps both in the preparation phase of treatment and during active reprocessing to assure that this integration can place.

THE PHASE-ORIENTED CONSENSUS MODEL

Nearly all contemporary approaches to the treatment of trauma derive significant elements from the pioneering work of Pierre Janet (1889, 1977). Among Janet’s many contributions is the foundational principle of a phase-oriented approach: (a) stabilization and symptom reduction, (b) uncovering and modifying traumatic memories, and (c) personality reintegration. Judith Herman (1992) describes these three phases as (a) safety, (b) remembrance and mourning, and (c) reconnection. Parallel models have been described by Briere (1996), Brown and Fromm (1986), Chu (1998), Courtois (1988, 1999), Gil (1988), Horowitz (1979, 1986), Kluft (1993, 1999), McCann and Perlman (1980), Putnam (1989), Scurfield (1985), van der Hart and Friedman (1989), and van der Kolk, McFarlane, and Weisaeth (1996). Christine Courtois in *Recollections of Sexual Abuse: Treatment Principles and Guidelines* (1999, p 176) described many facets of this evolving *consensus model* of posttraumatic treatment and characterized it as “sequenced, titrated, focused on symptom relief and functioning.”

The principles of EMDR (Shapiro, 1995, 2001) situate it within this consensus model. In EMDR, various strategies can be employed to support the goals of stabilization and symptom reduction. Some stabilization strategies commonly used in EMDR were developed in other traditions such as *progressive relaxation* (Jacobson, 1938), self-hypnosis (Eisen & Fromm, 1983; Sanders, 1991), biofeedback (Brown, McGoldrick, & Buchanan, 1997), and meditation (Benson, 1975; Goldstein, 1994). Other stabilization strategies such as the calm or safe place exercise (Shapiro, 2001, pp. 125–127) and Resource Development and Installation (Leeds, 1998; Leeds & Shapiro, 2000) integrate a specific set of stabilization procedures from hypnosis and guided imagery in ways that are unique to EMDR. Regardless of which stabilization strategies are used in treating PTSD, the consensus model recognizes

that it is essential to provide adequate stabilization before and during uncovering and resolving traumatic memories to avoid what John Briere calls (1996, p. 11) “overshooting the therapeutic window.” This phrase refers to uncovering details about disturbing memories or exposing intense negative emotions at a pace that exceeds the patient’s cognitive, emotional, or behavioral coping skills. This problem of *overwhelming patients’ coping skills* can occur in both the *history-taking* phases of treatment as well as in the *working-through* phases of treatment. The goal in trauma-informed psychotherapy is to pace the work within “the therapeutic window.” Working within this therapeutic window provides sufficient *access* to the maladaptive memory networks that give rise to the patient’s symptoms and current functioning while not exceeding the patient’s cognitive, emotional, or behavioral coping skills.

A BRIEF HISTORY: FROM EMD TO EMDR

The history of the development of EMDR can be summarized in the following four stages:

1. Discovery and investigation of a simple technique (eye movements).
2. Defining and testing of the EMD procedure.
3. Evolution, clarification, and validation of the standard EMDR protocol as a treatment for PTSD and related syndromes.
4. Extending the theory and application of EMDR to additional clinical syndromes as a general model of psychotherapy. The current status of EMDR is in the process of movement from stage 3 to stage 4.

DISCOVERY AND INVESTIGATION

While walking in a park in 1987, Francine Shapiro (1995, pp. 2–14; 2001, pp. 7–16) noticed a specific effect of saccadic eye movements on certain disturbing thoughts. The emotional component of these thoughts rapidly and spontaneously decreased. She determined to investigate this effect in others. Her first discovery was that most others had difficulty generating sufficient saccadic eye movements to achieve this effect. So she asked others to engage in tracking eye movements by watching her move her hand back and forth about 12–14 inches in front of their faces.

Through her informal investigations with about 70 individuals, Shapiro discovered that several factors assisted different individuals to achieve similar decreases in the emotional component of disturbing thoughts. With some, the pace of the eye movements needed to be faster or slower, or diagonal eye movements were more effective. With others, a wider or narrower range of horizontal eye movements were more effective. Some needed to focus on an image, others on a body sensation, some on a thought, and some on an emotion. Some needed a combination of these elements. By combining several of these factors into a deliberate set of steps, she found that she was able to reliably achieve a decrease in emotional disturbance in a wide range of individuals not suffering from any identified disorder.

She then offered this procedure to a combat trauma survivor with persistent trauma-related symptoms related to a specific incident. A single brief session of this procedure led to a resolution of the emotional disturbances and an extinguishing of the intrusions that had been associated with this memory. The apparent efficacy of this procedure to deal not only with mildly disturbing thoughts in nonpatients, but also with a severely disturbing memory in a combat trauma survivor, encouraged Shapiro to conduct a controlled investigation with a defined population of those suffering from PTSD.

DEFINING AND TESTING EMD

In exploring the literature on the treatment of trauma and anxiety, Shapiro examined Wolpe's (1954) systematic desensitization and flooding (Stampfl & Levis, 1967; Fairbank & Keane, 1982). Wolpe considered *reciprocal inhibition* between relaxation and anxiety to be the primary basis of systematic desensitization—and all effective psychotherapeutic treatments for neuroses. Yet, Wolpe acknowledged that only low levels of anxiety were amenable to treatment with his approach. As in flooding, Shapiro focused her eye movement procedure on the most disturbing aspect of the index trauma. Unlike flooding, this new procedure did not require prolonged exposure or intense abreaction. Instead, Shapiro observed what appeared to be some type of reciprocal inhibition between the conditioned emotional disturbance in the memory of trauma and the specific effects of the eye movements. Years later, in the first physiological study of EMDR, David Wilson (1996, p. 227) would refer to this as a “compelled relaxation response.” Since reciprocal inhibition rather than extinction appeared to be the mechanism, in honor of Wolpe's model of systematic desensitization, she decided to name this procedure “Eye Movement Desensitization” or EMD (1989a, 1989b).

DESIGN AND PROCEDURES OF THE EMD PILOT STUDY

In 1980, posttraumatic stress disorder (PTSD) was first explicitly included in the *Diagnostic and Statistical Manual, Third Edition* (DSM III; American Psychiatric Association, 1980; Parrish, 1999). By 1988, there was a widespread and growing recognition of this disorder and of the severe limitations of existing methods for its treatment. Shapiro decided to focus her efforts on a field trial of this new EMD method with individuals who were already in treatment for PTSD. Rather than take on the larger question of whether EMD could resolve all PTSD-related symptoms, her more modest goal in this pilot study was to determine whether intrusive disturbance associated with a single, traumatic memory could be treated to resolution in a single session. She recruited 22 subjects, ages 11–53, from clinicians who were treating them for PTSD symptoms related to rape, sexual abuse, or Vietnam combat trauma.

Half the subjects were randomly assigned to the EMD condition and half to a control group—described by Shapiro (1989a, p. 202) as a “placebo condition”—that received an alternate exposure procedure with no eye movements. All subjects described and quantified their presenting complaints such as intrusive thoughts and sleep disturbances. Each selected a single memory and an image that represented the worst part of the incident or the entire incident. Each subject identified a negative belief such as, “I am helpless” or “I have no control” in response to being asked (Shapiro, 1989a, p. 204), “What words about yourself or the incident best go with the picture?” Subjects were then asked to focus on the traumatic image and their negative words and to assign a Subjective Units of Disturbance level from 0–10 (SUD scale; Wolpe, 1954). Subjects were then asked to say what words they would rather have with their selected picture and to rate these positive self-statements while focusing on their selected image using a Validity of Cognition scale (VoC) (Shapiro, 1989a) from 1–7. Subjects were then advised that they would be asked for their level of disturbance (SUD) periodically during the rest of the treatment session and were told to “. . . let whatever happens, happen” (p. 204).

Subjects in the EMD condition were then asked to imagine their traumatic scene and rehearse their negative statement while Shapiro induced an initial set 10–20 bilateral, rhythmic eye movements. After each set of eye movements, subjects were asked to “Blank it (the picture) out, and take a deep breath.” (p. 205) After each set of eye movements, they were then asked to focus on the picture and the negative words and to rate their disturbance from 0–10. Between sets of eye movements, subjects were sometimes asked to report what they were noticing with the question “What do you get now?” (p. 205) Further sets of eye movements were

offered until no other traumatic memory or disturbing thought was reported and their SUD level was stated to be 0 or 1. This took from 3–12 sets. Subjects were then asked to rate their preferred statement on the VoC scale from 1–7. Subjects whose VoC was then less than <6 were asked to focus on their selected memory and their positive self-statement and were led in 2–3 more sets of eye movement until a VoC of 6 or 7 was reached.

Subjects in the control group were asked to describe the participants, environment, and events of their traumatic memory in detail. To parallel the number of SUD ratings in the EMD condition, the descriptions in the control group were interrupted seven times at 1- to 1.5-minute intervals to obtain a SUD rating. Subjects were asked if the picture had changed or if anything else had emerged. Then they were instructed to continue their detailed description of their memory. After the seventh SUD rating, subjects' positive self-statements were checked with the VoC rating. After completing this placebo control condition, Shapiro provided all subjects in this group the EMD treatment and then termed this group the “delayed treatment condition” (p. 206).

RESULTS, LIMITATIONS, AND CONTRIBUTIONS OF THE EMD PILOT STUDY

Subjects in both groups were interviewed for 30 minutes at 1 month and 3 months following their single treatment session. SUD and VoC ratings were checked along with each subject's presenting complaints. In most cases (18 of 22 subjects), self-report of changes in presenting complaints were confirmed by referring therapist or a family member.

The design of this pilot study (1989a, 1989b) can be faulted on several grounds. These include the absence of standardized psychometrics or diagnosis, overreliance on self-report measures, incomplete physiological measures (pulse rate only was taken in some conditions), and a nonstandard, combined-treatment control condition. The pilot study did produce significant effects in the experimental (and delayed treatment) condition. In the absence of prolonged exposure or prolonged abreaction, self-reported disturbance (SUD) on the selected traumatic memory decreased significantly ($p < .001$). Belief in the preferred self-statement (VoC) increased significantly ($p < .001$). Nearly all initial presenting complaints were eliminated and the remainder were improved. Results were maintained or improved on follow up.

Given the paucity of treatment outcome studies in existence at that time and the rapidity and size of treatment effects reported, one might have expected a series of follow-up studies. In fact, it took 5 years before a well-designed follow-up study was reported (Wilson, Becker, & Tinker, 1995). Nevertheless, the pilot study did attract considerable attention. Shapiro continued to reevaluate her initial concepts and procedures between 1989 and 1991. This reevaluation led to a series of changes both in conceptual framework and in the standardized procedural steps. It also led to a change in the name of the procedure from EMD to EMDR.

EVOLUTION, CLARIFICATION, AND VALIDATION OF THE STANDARD EMDR PROTOCOL

Between 1989 and 1991, several factors led to evolution in the conceptual model of EMDR and in the standard procedural steps. One factor in the evolution of Shapiro's model was the persistent demand for an explanation of what underlying principles were producing these results. Neither exposure–extinction nor simple desensitization could adequately explain the reported results of EMD (Rogers & Silver, 2002). With prompting from her research assistant, Mark Russell (Russell, 1992; Shapiro, 1995, p iv),

Shapiro turned her attention to the literature on emotional processing and information processing models described by Lang (1977, 1979), Rachman (1980), Bower (1981), and Foa and Kozak (1985, 1986). This culminated in the publication of a paper describing the shift from the desensitization paradigm to an information processing model (Shapiro, 1991a) and the renaming of EMD as EMDR.

Another factor was the result of further reflection on the observed effects of the procedure. Shapiro noted consistent, simultaneous, and parallel changes in arousal, emotion, sensations, and cognitive structures. She was impressed by the remarkable shifts in association to material that was often peripheral to the immediate circumstances of the selected trauma memory. These associations pulled attention away from the selected trauma memory. Yet, Shapiro observed that when she permitted this rapid free association, it led to important, generalized treatment effects on both the selected trauma memory and on related memories and cues. This observation led her to the principle of the “self-healing” paradigm (Shapiro, 1995, p. 31). Her idea was that there is an innate information processing capacity that tends to move disturbing experiences to a state of adaptive resolution by forging new connections between the traumatic memory and existing adaptive memory networks. To accommodate the ways in which this procedure and its evolving theoretical model diverged significantly from both exposure–extinction and from systematic desensitization, she renamed the procedure Eye Movement Desensitization and Reprocessing. During this same period, she made a series of significant procedural changes and clarifications.

In setting up each treatment session, Shapiro extended what she decided to call the “assessment phase” by asking the patient to identify at least one specific emotion – just before obtaining the initial SUD rating – by pairing the memory and the negative self-statement—which was now referred to as the “negative cognition.” She also completed the assessment phase by asking the patient to identify a physical location for the perceived emotional or somatic disturbance. During the reprocessing, to permit associative chaining, she no longer returned patients’ attention to the picture that represented the worst part of the memory after each set of eye movements. Instead, she instructed patients—and the clinicians she trained—to return to the selected memory only when the associations were reported to be neutral or positive or when the reported contents of the reprocessing were unchanged or became confused.

She decided to make the step focused on the positive self-statement more consistent and named it the “installation phase.” After reaching an SUD of 0 or 1 on the target memory, every patient was directed to pair a preferred self-statement with the remaining representations of the target memory until the VoC was rated at 6 or 7 and was no longer changing. She then added a “body scan phase.” With eyes closed, every patient was asked to focus on the remaining representations of the target memory, think of the preferred self-statement, and scan sensations from head to toe and to report any “tension, tightness or unusual sensations.” (Shapiro, 2001, p. 162) The body scan phase grew out of her observations that the last element to resolve in some patients involved body sensations that represented emotional or somatic resonances with the target memory. Sometimes these sensations represented defensive somatic responses to the target memory. Sometimes, they were links to other, unresolved memories. Other times there were feelings of relief, joy, or other positive experiences that emerged with the resolution of the target memory.

OFFERING RESEARCHERS AND CLINICIANS TRAINING IN EMDR

During this period of evolution in the EMDR procedures, Shapiro began to offer training to qualified clinicians and researchers interested in learning her new procedure. Motivated by a desire to lessen suffering and advance scientific understanding, she provided a series of small training sessions to about 250 clinicians and researchers in 1990. In the interest of advancing research on EMDR, any qualified

researcher who stated that they did not have the means to pay for training was granted a complete scholarship. The pace of interest in EMDR training was burgeoning faster than anyone could have predicted.

By late 1990, troubling reports of patients being harmed by EMDR (Shapiro, 1991b) had begun reaching Shapiro. These reports indicated that some recently EMDR-trained clinicians had immediately begun to offer their own EMDR trainings. Patients being treated by the students of these inexperienced EMDR trainers reported significant adverse effects from their treatment. Investigation revealed dramatic deviations from the procedures and principles that Shapiro was teaching. Having originally assumed that professional ethics would protect patients from such practices, she concluded that to adequately protect patients from this danger (Principle 1.16, American Psychological Association, 1992) she would have to institute a written agreement to be required of all participants at her trainings that they would not provide training to others without written permission from her. While compelled by published ethical standards and intended for patient protection, this requirement led to allegations that Shapiro was trying to control the commercial market for EMDR training. This training restriction remained in place until 1995, when Shapiro published the first edition of her basic text (Shapiro, 1995). This text provided a comprehensive reference to which clinicians, patients, licensing boards, and professional associations could turn to evaluate training programs and treatment practices alleging to be EMDR. She then released all who had completed her EMDR training from this restriction and revised the training agreement to ask participants not to offer training to others until qualified to do so. She then encouraged clinicians who had trained with her to start a professional association to establish standards for research, training, and clinical application of EMDR. This led to the founding of the EMDR International Association (EMDRIA, 2008b).

ALTERNATE MODES OF BILATERAL STIMULATION

During this early period (1989–1991) of evolution, variations in technique were developed to address situations in which patients had a medical history of eye problems, blindness in one or both eyes, or adverse responses to the mechanics of engaging in eye movements (such as eye strain). Auditory tones and hand taps were proposed as alternative forms of stimulation. Initially, snapping fingers toward alternate sides of the patient's head or using a clicker would generate alternating left–right tones. Later, electronic tone generators were used with headsets and a control box where speed could be easily changed. Hand (or shoulder) taps were proposed as another variant on eye movements. These were initially offered by having the clinician briefly touch the back of the patient's hands with a finger or with a cork tipped mallet. Later, small paddles connected to a control box became commercially available, which could generate alternating vibrations while held in the patient's hands. A series of electronic devices for generating eye movements were also eventually produced to avoid mechanical injury and fatigue for clinicians. While anecdotal reports have indicated that tones and taps (or vibrations) are often as effective as eye movements (and may be the only practical alternatives for patients with vision problems), there is insufficient controlled research to make definitive statements (Servan–Schreiber, Schooler, Dew, Carter, & Bartone, 2006).

By 1991, nearly all the procedural and theoretical elements of EMDR had evolved to the form in which they appeared in Dr. Shapiro's 1995 text. Researchers trained after 1991 were encouraged to employ the procedural steps that had been presented in EMDR Institute trainings. The training itself had grown from a 1-day workshop in early 1990 to, by mid-1991, 2 weekends comprising 34 hours of training including 13 hours of supervised practice exercises. Part 2 of the training focused on clarifying the basic procedural steps, introducing the *cognitive interweave* and principles for applying EMDR to the treatment of various acute stress and posttraumatic syndromes including phobias with a traumatic origin.

GROWTH IN THE PEER-REVIEWED LITERATURE ON EMDR

The peer-reviewed professional literature on EMDR grew from 2 reports in 1989 to a cumulative total of 79 by 1995 and 257 through the end of 2001 (Baldwin, 2002). It is not possible or appropriate to attempt to review this entire burgeoning literature base here. As of 2002, approximately 16 controlled PTSD treatment outcome studies of EMDR had been completed. The quantity of PTSD treatment outcome data on EMDR has continued to grow rapidly and now represents the largest cohort of individuals studied in PTSD treatment outcome studies and the largest literature on a specific method for the treatment of PTSD. In spite of a robust literature and generally consistently large treatment effect sizes (Maxfield & Hyer, 2002), the status of EMDR remains mixed among some scientists and third-party payors notably in the United States. In European countries, and elsewhere in the world, government health care systems, hospitals, and scholars accept EMDR as an empirically supported and well-tolerated treatment for PTSD. For an excellent review of the controversies and misunderstandings surrounding these issues in the United States, see Perkins and Rouanzoin (2002). Several published meta-analyses (Maxfield & Hyer, 2002; Sack, Lempa, & Lamprecht, 2001; Spector & Read, 1999; van Etten & Taylor, 1998) have reported EMDR to be an efficient and effective treatment for PTSD.

The International Society for Traumatic Stress Studies in its first review of all treatments for PTSD (Foa et al., 2000, p 333) rated EMDR A/B meaning “EMDR was found to be more efficacious for PTSD than wait-list, routine-care and active treatment controls.” In its second edition review (Foa, Keane, Friedman, Cohen, & International Society for Traumatic Stress Studies, 2009, p. 575), they stated that “EMDR is rated as a Level A treatment for its use with adults. Quality clinical trials support its use for patients with PTSD.” For children and adolescents, they rated it a Level B treatment and noted a need for further studies (p. 576). In a meta-analysis of all published (59) psychological and drug treatment outcome trials for PTSD (van Etten & Taylor, 1998, p 140) concluded that “The results of the present study suggest that EMDR is effective for PTSD, and that it is more efficient than other treatments.”

In 2004, the American Psychiatric Association published *Practice Guidelines for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder*, which stated:

“EMDR appears to be effective in ameliorating symptoms of both acute and chronic PTSD” (p. 35).

EMDR belongs within a continuum of exposure-related and cognitive behavior treatments. EMDR employs techniques that may give the patient more control over the exposure experience (since EMDR is less reliant on a verbal account) and provides techniques to regulate anxiety in the apprehensive circumstance of exposure treatment. Consequently, it may prove advantageous for patients who cannot tolerate prolonged exposure as well as for patients who have difficulty verbalizing their traumatic experiences (p. 36).

Also in 2004, the U.S. Department of Veterans Affairs and the Department of Defense published *Clinical Practice Guideline for the Management of Post-Traumatic Stress* in which EMDR, along with three other methods, was given the highest rating for level of evidence of efficacy and recommended for treatment of PTSD. Similar conclusions have been reached by several other national and international organizations including the Australian Centre for Posttraumatic Mental Health (2007), the Cochrane Database of Systematic Reviews (Bisson & Andrew, 2007), the Dutch National Steering Committee Guidelines for Mental Health Care (2003), and the National Institute for Clinical Excellence (2005).

Grass roots clinical interest, scholarly recognition, and institutional acceptance of EMDR have grown steadily in European countries. In contrast, in the United States, grass roots clinical interest in EMDR continues to grow at steady pace, while

scholarly controversies and inconsistent institutional acceptance of EMDR persist. Misleading and inaccurate descriptions of the status of EMDR and meta-analyses continue to appear in the literature. The most recent of these by the Institute of Medicine (IOM, 2007) has been vigorously rebutted (Lee & Schubert, 2009). A full analysis of the disparity between controversies surrounding EMDR in the United States and the widespread acceptance of EMDR in Europe and other regions—such as Japan, South Korean, and South American—is beyond the scope of this chapter. In part, this disparity in acceptance may relate to issues commonly surrounding scientific revolutions (Kuhn, 1996). A recently published, thorough review of these issues by Mark Russell (2008c) explores both Kuhn's (1996) and Barber's (1961) analyses of resistance by scientists to scientific discoveries. Complicating the picture has been the developer's emphasis on the use of nonstandard and idiosyncratic nomenclature. This shift in nomenclature has served to emphasize the idea that the AIP model is a fundamental departure from earlier information processing models rather than an evolutionary step, building on the work of scholars in earlier emotional processing models.

In addition, early opportunities for U.S. federal recognition of EMDR by Substance Abuse and Mental Health Services Administration (SAMHSA) were not followed in a timely manner. Many state and federally funded clinical programs and research-granting bodies look to the SAMSHA listing of empirically support methods in deciding what methods to permit and to fund. This oversight was finally corrected in 2008 with an application by EMDRIA that remains pending as this book went to press. However, in the meantime, clinicians working in the United States find themselves confronting refusal by some clinical directors to permit the use of EMDR in some community mental health care (CMHC) programs and some Veterans Affairs (VA) treatment centers, while other CMHC and VA clinical directors strongly encourage the use of EMDR. Profound structural barriers have also limited the ability of both active duty and combat veterans to obtain treatment with EMDR (Russell, 2008a), while several regional programs are actively providing EMDR treatment to current and former military personnel. The FBI and some other federal and local law enforcement agencies (McNally & Solomon, 1999; Wilson, Tinker, Becker, & Logan, 2001) have embraced EMDR as part of their critical incident stress management programs, but this is by no means yet a universal or widespread practice.

EXTENDING EMDR TO A GENERAL MODEL OF PSYCHOTHERAPY

Since 2001, EMDR has moved into a transition period from stage 3 to stage 4 of its development. In this period of transition, research continues to extend the evidence of EMDR's efficacy for acute stress disorder for both civilian and combat-related trauma (Fernandez, 2008; Krause & Kirsch, 2006; Kutz, Resnik, & Dekel, 2008; Ladd, 2007; Russell, 2006; Todder & Kaplan, 2007; Zaghrouh-Hodali, Alissa, & Dodgson, 2008) and PTSD (Ahmad, Larsson, & Sundelin-Wahlsten, 2007; Brown & Gilman, 2007; Chemali & Meadows, 2004; Chemtob, Nakashima, & Carlson, 2002; Edmond & Rubin, 2004; Elofsson, von Scheele, Theorell, & Sondergaard, 2007; Heber, Kellner, & Yehuda, 2002; Hogberg et al., 2007; Hogberg et al., 2008; Ironson, Freund, Strauss, & Williams, 2002; Jaberghaderi, Greenwald, Rubin, & Zand, 2004; Kelley & Selim, 2007; Kim & Kim, 2004; Konuk et al., 2006; Lamprecht et al., 2004; Lansing, Amen, Hanks, & Rudy, 2005; Lee, Gavriel, Drummond, Richards, & Greenwald, 2002; Lee, Taylor, & Drummond, 2006; Oh & Choi, 2004; Oras, Ezpeleta, & Ahmad, 2004; Pagani et al., 2007; Power, McGoldrick, & Brown, 2002; Propper, Pierce, Geisler, Christman, & Bellorado, 2007; Ricci, Clayton, & Shapiro, 2006; Rothbaum, Astin, & Marsteller, 2005; Sack, Lempa, Steinmetz, Lamprecht, & Hofmann, 2008; Schneider, Nabavi, & Heuft, 2005; Sprang, 2001; Tufnell, 2005; van der Kolk et al., 2007).

Work is also underway on two additional fronts. The first is research to clarify the mechanisms underlying EMDR's effectiveness with empirical studies on the effects of the bilateral stimulation procedures used in EMDR. The second is research to extend the application of EMDR to additional clinical syndromes as a general model of psychotherapy. A full review of the research that has already been done in these areas is beyond the scope of this book. Here is a brief summary for those interested in these areas.

In the area of elucidating the mechanisms contributing to the effects of the bilateral stimulation used in EMDR, a growing number of papers in recent years have proposed psychological, psychophysiological, and neurological explanations for EMDR's well-established treatment effects on PTSD (Barrowcliff, Gray, Freeman, & MacCulloch, 2004; Barrowcliff et al., 2003; Bergmann, 2001; Christman, Garvey, Propper & Phaneuf, 2003; Gunter & Bodner, 2008; Kavanagh, Freese, Andrade, & May, 2001; Kuiken, Bears, Miall, & Smith, 2001–2002; Lansing et al., 2005; Lee, Taylor, & Drummond, 2006; Oh & Choi, 2004; Sack et al., 2008; Stickgold, 2002; van den Hout, Muris, Salemink, & Kindt, 2001). These papers build on earlier studies and theoretical papers from the 20th century (Andrade, Kavanagh, & Baddeley, 1997; Armstrong & Vaughan, 1996; Dyck, 1993; MacCulloch & Feldman, 1996; Merckelbach, Hogervorst, Kampman, & de Jongh, 1994; Nicosia, 1994). Together, this body of research makes it clear that the bilateral eye movements used in the standard EMDR procedures have demonstrated effects that include the following: (a) enhancing the retrieval and reducing the vividness of autobiographical memories, (b) increasing attentional flexibility thereby promoting new associations to old memories, and (c) decreasing psychophysiological arousal associated with negative autobiographical memories. The positive findings from standardized, self-report outcome measures have been confirmed with distinctive findings from SPECT imaging as well as psychophysiological measures in several case reports, case series, and one controlled study cited above.

A growing number of case reports and case series support the view that EMDR can be viewed as a general model for psychotherapy for any condition where environmental factors play a role—that is learning, conditioning, or stress. Notable among the conditions where EMDR is emerging as a potentially helpful treatment are substance abuse (Amundsen & Kårstad, 2006; Besson et al., 2006; Brown & Gilman, 2007; Brown, Gilman, & Kelso, 2008; Popky, 2005; Vogelmann–Sine, Sine, Smyth, & Popky, 1998) and a range of somatoform disorders including chronic pain (Grant, 1999; Grant & Threlfo, 2002), phantom limb pain, (Russell, 2008b; Schneider, Hofmann, Rost, & Shapiro, 2008; Tinker & Wilson, 2005; Wilson, Tinker, Becker, Hofmann, & Cole, 2000), epilepsy (Chemali, & Meadows, 2004; Schneider et al., 2005), chronic eczema (Gupta & Gupta, 2002), gastrointestinal problems (Kneff & Krebs, 2004), and body dysmorphic disorder (Brown et al., 1997; Dziegielewski & Wolfe, 2000). In addition, early case reports and strategies have appeared describing the application of EMDR to the treatment of personality disorders (Bergmann, 2008; Brown & Shapiro, 2006; Grand, 2003; Korn & Leeds, 2002; Knipe, 2003). Recent books on EMDR describe additional applications of EMDR to couples and family systems (Shapiro, Kaslow, & Maxfield, 2007), integration of EMDR with a range of well-accepted psychotherapy approaches (Shapiro, 2002b), and a role for EMDR in the treatment of ego-state and dissociative disorders (Forgash & Copeley, 2008; International Society for the Study of Dissociation, 2005).

SUMMARY

In less than 20 years, EMDR has moved rapidly from an observed effect of bilateral eye movements to a standardized procedure, to an internationally recognized method for the treatment of acute stress and PTSD. While some controversies and misleading myths about EMDR's empirical status persist, primarily in the United

States, EMDR has achieved a remarkable global acceptance as an empirically supported treatment offering a new paradigm to alleviate human suffering. More than 150,000 clinicians worldwide have been trained in EMDR. With the help of EMDR treatment, millions of people have recovered from the effects of natural and man-made disasters, motor vehicle, train and airplane crashes, civil war, combat trauma, terrorism, sexual assault, childhood abuse, the trauma of being diagnosed with a terminal illness, phantom limb pain, chronic substance abuse, and a range of somatoform disorders. EMDR professional associations exist on five continents. EMDR conferences are held in at least six countries annually.

These achievements reflect the vision and persistence of Francine Shapiro. She has personally taught EMDR around the world. She encouraged and cajoled graduate students, clinicians, and researchers to conduct and publish case reports, case series, and treatment outcome studies. She has published tirelessly. She fostered the development of Humanitarian Assistance Programs both in the United States and in Europe to bring EMDR training and treatment to people and places where there is no mental health infrastructure or no funding to pay for professional training. She trained a remarkable corps of clinicians in the United States and overseas to become EMDR trainers and consultants. How she has done all this in less than 20 years is a remarkable story that deserves to be told in its own right.

However, the story of EMDR's remarkable evolution and growth is more than the story of what Francine Shapiro has personally achieved. It is a story of the researchers, clinicians, and graduate students who have taken EMDR training and themselves been transformed by the human experience of a change in consciousness. This change in consciousness does not happen to everyone during the practice portion of EMDR training, but it does occur with a significant percentage of those who experience EMDR reprocessing during the training process. For those who experience this transformation, EMDR reprocessing reveals something to us about our human potential to evolve and grow as individuals and as a species. The experience of EMDR's treatment effects awakens something in us that says, "Where did the pain go? Where did the fear, the shame, and the anger go? I thought they were part of me. Without all of that, so much more is possible. I am free to act now." This experience is a compelling one for many. It creates a boundless energy and an excitement to find out what else might be possible.