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Eye-Movement Desensitization and Reprocessing: Implementation and Utilization of EMDR as a Treatment for Trauma

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Kelly is a senior majoring in social work. With funding from the Adrian Tinsley Program, Kelly was able to conduct this research study and present it at the International Social Work Conference in Chennai, India in January of 2009. Dr. Lucinda King-Frode provided guidance and encouragement throughout the research process by acting as Kelly's mentor. Kelly will attend Columbia University to pursue her Master's degree in social work. She hopes that this study will encourage clinicians to investigate new methods of treating trauma.

Trauma is a pervasive global issue that affects both children and adults. It is officially defined in the most recent Diagnostic Manual as an event that threatens death or serious injury, and that elicits a response of fear, helplessness, or horror (American Psychiatric Association, 2002). Other respected definitions include a "sudden, unexpected, overwhelmingly intense emotional blow....[that] quickly becomes incorporated into the mind" (Terr, 1992, p. 8), and something that makes "both internal and external resources... inadequate to cope with external threat" (Van der Kolk, 1989, p. 393). Literature suggests that people who have experienced trauma may present with symptoms including depression, anxiety, insomnia, phobias, delayed development, difficulty maintaining social relationships, and personality disorders.

In the United States alone, at least one quarter of all children experience trauma; it is believed that the numbers are much higher for children from low-income families and those of racial and ethnic minorities (Cooper, Masi, Dababnah, Aratani, & Knitzer, 2007). Each year, five million more children will experience trauma (Child Trauma Academy, 2002). Many will need mental health services, specialized educational plans at school, and possibly long-term therapeutic care. According to the National Center for Children in Poverty, "trauma exposure among children and youth is associated with lifelong health, mental health, and related problems and with increased related costs" (Cooper et al., 2007, p. 5). It is, therefore, necessary to seek out and assess new treatments for those who have experienced childhood trauma. Such treatments, when their efficacy has been established, will help us to better aid in our clients' recovery; we can then make a long-term investment in their healthy futures, free of unnecessary medical costs.

This study focused on a fairly new alternative treatment for trauma: Eye-Movement Desensitization and Reprocessing (EMDR). The study explores the decisions made by therapists regarding the implementation and possible modification of the EMDR protocol in their practice, as well as the criteria used by these therapists to determine which clients are promising candidates for EMDR therapy. I have focused specifically on the treatment of childhood trauma, both in children and adults. I was also interested in learning exactly how clinicians make decisions about incorporating new therapeutic techniques into their practice. I wanted to find out how they are introduced to new methods, how they assess these methods, and how they decide which clients are best suited for any one particular intervention.

Background Research

Eye-Movement Desensitization and Reprocessing is a psychotherapy that was accidentally discovered in 1989 by Dr. Francine Shapiro. It is cognitively based, and involves a client calling a specific traumatic memory to mind. The client is led through a strictly-outlined protocol by the therapist; this protocol includes the replacement of negative cognitions with positive ones. Specific scales are used to measure the intensity of traumatic symptoms and distress throughout treatment. A major part of the process is something known as bilateral stimulation. While the client is discussing their trauma and moving through the protocol, the therapist uses a variety of bilateral stimulation techniques. There are a number of approved methods: the therapist can have the client follow his or her fingers back and forth with their eyes (called eye-movements); he or she can use auditory stimulation, with headphones and alternating sounds in one ear and then in the other; the therapist can tap the client on alternate knees, wrists, hands, temples, or shoulders; the client can hold small paddles that vibrate alternately in their hands; a light bar can be used, which has lights that speed from one side of the bar to the other that the client follows with their eyes; or any of these approved methods can be used together.

The theory behind bilateral stimulation is based on our knowledge of REM sleep. During REM sleep, our eyes dart back and forth; it is believed that this movement stimulates both sides of our brains, allowing us to resolve problems through our dreams. The bilateral stimulation used in the EMDR protocol has this aim. While people usually experience trauma only through the emotionally-charged left hemisphere of their brains, bilateral stimulation seems to force the more rational right hemisphere to become active at the same time. This enables clients to feel the traumatic emotions while thinking rationally about their experience, and this process may help to resolve their trauma (Bradley, Greene, Russ, Dutra, & Western, 2005; American Psychiatric Association, 2004; Department of Veterans Affairs & Department of Defense, 2007; Morris-Smith, 2007).

There has been, however, a substantial amount of controversy surrounding EMDR since its conception some twenty years ago. The critics focused primarily on the fact that while it is known that EMDR works, it is unclear exactly how it works. Psychiatrists have been unable to determine exactly what the scientific mechanism underlying this therapy is. In addition, there have been a few small experiments that contested the efficacy of EMDR (Edmond, Sloan, & McCarty, 2004). Some of these studies have been criticized for not following the EMDR protocol closely enough, thereby affecting the findings. Other researchers have argued that the eye movements themselves add nothing substantial to the treatment (Edmond, et al., 1994).

Despite all of this, there have been many small-scale studies and meta-analyses that demonstrate the efficacy of EMDR. As described by Edmond, et al., there have been three recent studies, among others, that compared EMDR to other forms of therapy - "prolonged exposure (Ironson, Freund, Strauss, & Williams, 2002); stress inoculation training with prolonged exposure (Lee, Gavriel, Drummond, Richards, & Greenwald, 2002); and exposure with cognitive restructuring (Power et al., 2002)" (p. 260-261). In all three of these studies, EMDR was as effective in reducing PTSD symptoms, and it was more effective in terms of achieving success more quickly (p. 261). More research is certainly needed to further the scientific understanding of EMDR, which might enhance its acceptance by the larger professional community.

Methodology

This was an exploratory study. Interviews were used to explore the experiences practitioners have had with EMDR - what they have found to work or fail, through trial and error, in their actual day-to-day experiences with EMDR and traumatized clients.

Sample

Interviewees were identified through both convenience and snowball sampling methods. A published list of EMDR-certified practitioners in my area from the official EMDR website was originally used to locate potential subjects; when much of that data turned out to be outdated, snowball sampling was used. I asked the few therapists I had made contact with to refer me to other EMDR practitioners. With the help of these referrals, ten therapists were located who became my interviewees.

These therapists were all educated and licensed as either psychologists, social workers, or mental health counselors. All were certified in EMDR. The subjects worked in a variety of settings, including private practices, schools, prisons, and non-profit agencies. They ranged in age from their late twenties to sixties. There were three men and seven women.

The subjects encountered a variety of issues in their practice. Given that many of their clients have experienced trauma, many also suffer from depression and anxiety. These symptoms sometimes manifest as insomnia, panic attacks, low self-esteem, and phobias, and may also lead to behavioral problems such as substance abuse. Many of these clients have co-occurring issues such as diagnosable personality disorders, concerns around sexual orientation, and neurological issues such as Asberger's disease.

Interview Process

Each interview was scheduled at the time and place of the subject's choice. They lasted about one hour, and consisted of sixteen questions:

1. Can you describe your clinical practice for me - what kinds of clients you see and what their presenting problems are?
2. In general, what therapeutic methods do you tend to use in your practice?
3. How did you get interested in EMDR? What was the source of the suggestion?
4. Were you aware of the controversy surrounding EMDR when you were first introduced to it?
5. If you were in practice with other therapists, was there any controversy among your colleagues about introducing EMDR into your practice?
6. How do you decide which clients are good candidates to use EMDR with?
7. At what point during treatment do you decide to introduce EMDR - is it the primary treatment method, or do you use it in conjunction with other therapies?
8. Since EMDR is an alternative type of treatment, how do you explain the process to your clients?
9. Have you experienced any skepticism?
10. Have you modified the EMDR protocol in any way to better suit your clients?
11. Have you found that certain "approved" variations work better than others?
12. What measures do you use to assess the effectiveness of treatment? How effective have you determined it to be?
13. In general, how many sessions does it typically take you to resolve the traumatic symptoms with your clients through EMDR? Have you found it to be more efficient than other forms of therapy?
14. Do you have any information on whether there are lasting effects - good or bad?
15. Do you feel comfortable using this treatment? Will you continue to use it and/or recommend it to other practitioners?
16. Finally, what has been your most interesting case or use of EMDR? Can you offer any anecdotes? Have you ever used EMDR to treat a problem not usually treated with this therapy?

After the interviews were completed, each was transcribed. I originally transcribed the interviews verbatim, but had to modify my transcription method due to time constraints. Using the list of questions as a guide, I listened to each interview and only transcribed the specific answers each subject gave. This significantly cut down on the amount of time required to transcribe each interview and helped to distinguish the significant information. After all the interviews were transcribed, coding categories for the responses to each question were developed. These categories were used to identify the overarching themes and patterns within the answers. Finally, the responses were all analyzed based on these established codes.

Findings and Discussion

The subjects used a variety of methods in their everyday practice. These included cognitive behavioral therapy, EMDR, counseling and psychotherapy methods, self-soothing techniques (meditation, breathing, che-gong, mindfulness, etc.), solution-focused interventions, and systems and gestalt therapies. Others utilized methods such as play therapy and hypnotherapy.

Most of the subjects had been introduced to EMDR through their colleagues and agencies. Others had read about this therapy in the professional literature or learned of it through mailings and trainings offered by their insurance companies, through academic and professional conferences, and/or as consumers of the method while in therapy themselves. There was only a single subject who had learned of EMDR through her school. This may suggest that EMDR - and possibly other alternative therapies - are not widely integrated into traditional professional curricula; further research would be necessary to investigate this suggestion.

As mentioned, there has been much controversy surrounding EMDR. Negative views were widely held in the early stages of its implementation. Many of my subjects, for example, required the approval of reliable professional sources before they would try EMDR. As one subject stated, she thought EMDR was "hokey" until she heard a group of classically-trained Yale Medical School students present on it at a trauma conference. When they were first introduced to EMDR, seven of the ten subjects were aware of this controversy. Despite widespread knowledge of the criticisms of EMDR, only two subjects felt that they had experienced 'skepticism' from their colleagues when they decided to integrate EMDR into their therapeutic practice. Many stated that their agencies were "open-minded" about the methods that employees used and were accepting and encouraging of new techniques. One subject mentioned during the interview that she had had a "heated discussion" with a colleague very recently; her colleague felt that EMDR

could “re-victimize” clients. Conversely, nine out of the ten subjects said that they had experienced skepticism on the part of their clients or had a client refuse to participate in the EMDR therapy at some point.

Many of the subjects mentioned that they were directed during the EMDR trainings to “dive right in” to EMDR and begin using it right away. After trying to do this, however, several practitioners found that it was inappropriate to use EMDR as a blanket treatment method for all clients. When asked how they determined which clients would be good candidates for the EMDR therapy, the subjects described a variety of criteria they had developed that clients must meet before being considered for EMDR. Therapists have indicated that there are a number of practical concerns that must be weighed before using EMDR with a client. These include practicalities like making sure that the client’s insurance will cover enough sessions to work through the entire protocol, making sure the client has stable housing and income, making sure that they have consistent transportation to get to therapy, and resolving addiction issues prior to beginning the treatment. The nature of the client’s trauma is also important: single-incident traumas were reported to be far easier to treat with EMDR than complex trauma. For example, a client who was traumatized by a bad car accident might enjoy greater success with EMDR than someone who was sexually abused for years as a child.

When the subjects were asked whether they used EMDR as the primary treatment method with their clients or if it was used as an adjunctive therapy, only two stated that they used it as the primary intervention. The majority of the subjects use EMDR in conjunction with other forms of therapy. When the therapists begin to introduce their clients to EMDR, all ten said they use some form of verbal explanation to describe the process. These verbal explanations can include a description of the protocol steps, a story about the therapist’s personal experience undergoing the treatment, and metaphors about how EMDR works. One popular metaphor was the “Train Metaphor”, by which the client is told that the process of EMDR is much like the experience of riding on a train. Their trauma is like the scenery: it is speeding by outside the window, and while they can see the scenery and describe it, they are not actually outside participating in it. During EMDR, they should be able to think about and describe their traumatic experience without actually reliving it. A number of other metaphors may be used to help clients better understand the therapy. Many of the subjects also give their clients articles about EMDR and refer them to EMDRIA.org, the official EMDR International Association website, to do research on their own.

Making modifications to the protocol has been generally frowned upon in the official EMDR trainings. However, half of my subjects have made modifications and felt that they were successful. These modifications included cutting out steps (such as a body scan or measurement scales that are standard parts of the protocol), rearranging the steps, doing the process without requiring the client to have any particular or identifiable memories of trauma, using physical symptoms of trauma rather than visual memories, using parts of EMDR like the bilateral stimulation in conjunction with entirely different therapies, and not completing the process at all. Of the other half who have not made any modifications, some said it was because they didn’t feel that they had the skills or experience necessary to make changes, and others felt that it was wrong to modify the protocol. There were two subjects who were unhappy when they heard that others were making modifications; one stated that “you shouldn’t make any modifications because that bastardizes the process”, while another said that “the person who’s rearranging [the steps of the protocol] is not really doing EMDR”.

Although modifications are not generally accepted at the trainings, therapists are presented with a number of approved variations to choose from when working with a client. These variations allow flexibility to find what works best for each client. Variations are mainly found in the type of bilateral stimulation used and the number of “passes” the therapist does of any one stimulus (i.e., waving their fingers back and forth for the client ten times instead of twenty-five). Nine out of the ten subjects felt that certain approved variations worked better than others. Of those, over half felt that eye movements were best; some said that eye movements elicit a stronger response from the clients, and others simply liked them better because they felt that the touching required by tapping a client was inappropriate or would cause further distress.

There was only a single subject who did not usually use the “VOC” and “SUD” scales that are included in the standard EMDR protocol. These are Likert scales that measure the level of a client’s distress from one to seven. They are meant to be used throughout the EMDR process to determine whether the feelings of distress and anxiety associated with their trauma are being reduced. Over half of the subjects also used client feedback to measure the level of traumatic symptoms. Client feedback includes both the immediate response of a client following a therapeutic session, as well as the notes they keep in between sessions regarding their emotions and traumatic symptoms. Two of the therapists used their own observations of the clients to measure their success, and one subject used the Beck Depression Index as a pre- and post-test for his clients.

Nine out of ten of the subjects felt that EMDR was a more efficient treatment for childhood trauma than more traditional therapies such as cognitive behavioral therapy. The efficiency of any given treatment is always an important aspect of its success and usage by therapists. It is almost always more desirable to resolve a client's traumatic symptoms in a matter of sessions, weeks, or months than it is to resolve them over the course of years of therapy sessions. However, although almost all of the subjects felt that EMDR was more efficient than other forms of therapy, the same number of therapists felt that the typical number of sessions required to resolve traumatic symptoms varied far too widely to give any numerical estimate. Many said that it depended on the type of trauma (single-incident versus a long and complex history of abuse, for example), and others felt that they couldn't give a numerical value because they used EMDR in conjunction with other interventions.

When asked if they had any information on whether the clients had any long-term positive or negative effects after undergoing EMDR, six of the subjects said that their clients had experienced long-term positive effects. One of these subjects had also had a client who had experienced long-term negative effects. There were four other therapists who were unable to answer

the question, as they did not have access to any follow-up information from their clients. Every therapist stated that they felt comfortable using EMDR in their therapeutic practice, and have recommended (or would recommend) the therapy to other practitioners and colleagues.

A variety of unanticipated uses for EMDR emerged during my conversations with therapists, such as using EMDR to treat dementia, issues surrounding sexual orientation, addiction, and low self-esteem. One subject even cured a cab driver of his insomnia by having him follow his windshield wipers back and forth while he was parked as a form of bilateral stimulation. These issues stray from the traditional traumatic focus that EMDR research has been based on. Just as therapists seek out new and more efficient treatments for trauma, they also seek out more effective interventions for other presenting problems. The more we understand how the neurology of our minds work in conjunction with our affect, the easier it will be to apply similarly neurologically-based methods to a variety of problems and issues. For this reason, further research into these unexpected applications of EMDR and exactly how it resolves each issue could lead to an overall better understanding of therapeutic treatments.