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

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Contents

Preface to the Second Edition .............................................................. vii
Preface to the First Edition ................................................................. ix
Acknowledgments ................................................................................ xi
Introduction .......................................................................................... xiii

SECTION I
The Conceptual Framework for EMDR Therapy

Chapter 1 The History and Evolution of EMDR Therapy ......................... 3
Chapter 2 The Adaptive Information Processing Model ............................. 21
Chapter 3 An Overview of the Standard Eight-Phase Model
of EMDR Therapy and the Three-Pronged Protocol ............................... 49

SECTION II
Case Formulation, Treatment Planning, and Preparing Patients for EMDR Reprocessing

Chapter 4 Case Formulation and Treatment Planning ............................ 63
Chapter 5 Assessing Readiness for Reprocessing .................................. 93
Chapter 6 The Preparation Phase .......................................................... 109

SECTION III
Phases 3 to 8 of the Standard Protocol for PTSD
With the Standard Procedural Steps for EMDR Reprocessing

Chapter 7 The Assessment Phase ......................................................... 141
Chapter 8 The Desensitization Phase: Basic Procedures ......................... 155
Chapter 9 Maintaining and Restoring Effective Reprocessing
in the Desensitization Phase ............................................................ 163
Contents

Chapter 10  The Installation, Body Scan, and Closure Phases  ............................................. 187
Chapter 11  The Reevaluation Phase and Completing the Treatment Plan  ......................... 195
Chapter 12  Cases Illustrating EMDR Treatment of PTSD ...................................................... 211

SECTION IV
Research-Supported Standard EMDR Therapy Protocols for Other Disorders and Situations

Chapter 13  Treating Specific Phobia ................................................................. 233
Chapter 14  Treating Panic Disorder ................................................................. 253
Chapter 15  Cases Illustrating EMDR Therapy for Panic Disorder ............................. 283

SECTION V
Professional Development

Chapter 16  Professional Development in Clinical Application ................................. 309
Chapter 17  Supervising and Consulting on EMDR Therapy ............................................ 319

SECTION VI
Fidelity Checklists, Forms, Resources, and Glossary

Appendix A: Fidelity Checklists .............................................................................. 355
Appendix B: Procedural Scripts and Forms for Planning and Documenting EMDR Treatment ........................................................................................................... 365
Appendix C: Resources ......................................................................................... 391
Appendix D: Glossary ............................................................................................ 397
References .............................................................................................................. 403
Index .................................................................................................................... 433
Preface to the Second Edition

The Pace of Change

The pace of publication about EMDR therapy in peer-reviewed journal articles and professional books has been brisk over the last 6 years. Since the first edition of *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants* appeared in 2009, 22 scholarly books have appeared in English about EMDR therapy—not counting books on more general topics containing chapters about EMDR therapy. During this same period, more than 600 peer-reviewed journal articles related to EMDR therapy have appeared in English.

Despite the vigorous pace of publication, the fundamentals of EMDR therapy theory, principles, and procedures remain unaltered. As a result, the basic framework of *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants* remains unchanged, with the same chapter structure as the first edition. Nevertheless, much has changed, and these changes made a second edition both necessary and timely.

The scope of application of EMDR therapy has continued to broaden, with important studies showing that EMDR therapy now appears equally effective as prolonged exposure for treating individuals with psychoses, as well as for those with panic—with and without agoraphobia—as well as for cancer patients—both after and during medical treatment. Although it has been known for many years that EMDR therapy has significant effects on reducing or eliminating symptoms of depression in those with posttraumatic stress disorder (PTSD) or partial PTSD, two controlled studies published in the last 2 years indicate that EMDR therapy may be an effective treatment for major depressive disorder. In both of these controlled studies, patients received EMDR therapy for unipolar depression in addition to treatment as usual (psychodynamic therapy in one study and cognitive behavioral therapy in the other). Those receiving EMDR therapy showed significantly greater reductions in their depressive symptoms both at the end of treatment and on follow up (Hase et al., 2015; Hofmann et al., 2014). With multisite randomized controlled studies of EMDR therapy for depression now underway in Europe, such findings foreshadow a potential sea change in the treatment of depression and the scope of recognition of EMDR therapy. These and other advances in the application of EMDR therapy are covered in Chapter 1—The History and Evolution of EMDR Therapy. Research on the neurophysiology and neuropsychology of EMDR therapy has dramatically expanded along with a series of articles exploring theories on the mechanisms behind EMDR therapy. This led to a major rewriting of the portions of Chapter 2—The Adaptive Information Processing Model—focused on hypothesized mechanisms of action. In fact, every chapter of *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants* has been significantly rewritten to update references and the state of the field.

All references to diagnoses and their descriptions were updated to align the text with the *DSM-5*, which was published in 2013. The Glossary was expanded from 28 entries to 60. The references list has been updated with more than 250 new or revised entries. All four of the appendices have been updated with additional procedural scripts, forms, resources, and current references to websites. However, in spite of best efforts, due to the rapid changes of website structure, some web references may not remain accurate. A number of technical
errors in nomenclature, descriptions of alternative procedures, and copyediting issues from the first edition were rectified. Thanks to those members of the EMDRIA Training and Standards committee who in 2009 identified several of these errors and provided helpful feedback.


My deep appreciation goes to Louise Maxfield whose masterful skills as editor of the Journal of EMDR Practice and Research helped me mature as author, editor, and student of research design during my service in 2012 and 2013 as guest editor for volume 7 issue 3. My continuing evolution as an EMDR therapist and scholar has also been influenced during these intervening years by a series of collaborations with Anabel Gonzalez and my friend Dolores Mosquera as well as by the insightful periodic comments of Onno van der Hart and discussions with Jim Knipe.

While I have worked diligently this year to assure that this second edition fulfills the highest standards of scholarship and the evolving nature of EMDR therapy, the remaining flaws, omissions, and other shortcomings in this work are my responsibility alone.
My Professional Development With EMDR Therapy

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

In 1993, I began leading EMDR therapy trainings throughout the United States and Canada and later in Europe and Japan. Through 2008, I led EMDR therapy basic trainings for more than 15,000 clinicians. This has been an incredibly rewarding experience. With the help of A. J. Popky, from 1996 to 2000, I served as the founding moderator of an EMDR therapy e-mail discussion forum. I read more than 15,000 e-mails from EMDR therapy-trained clinicians from all over the world and sent more than 2,500 e-mails in reply on topics including standard EMDR therapy procedures, treatment planning, and the growing body of EMDR literature. From 2001 to 2003, I served on the EMDRIA Standards and Training Committee and from 2003 to 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 therapy.

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.
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 translators/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 has been profoundly affected by the support, teaching, and publications of my European colleagues, Ad de Jongh and Arne Hofmann.

I am deeply indebted to Ted Nardin, former CEO 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.
Introduction

This book is intended to provide an easy-to-use guide to the standard, research-supported EMDR therapy protocols for graduate students, clinicians, consultants, supervisors, instructors, and researchers. It is intended to supplement the following requirements for all EMDR therapy 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 therapy; and consultation in the use of EMDR therapy from an EMDRIA-approved consultant.

Since the publication of the first edition of Francine Shapiro’s standard text in 1995 and the founding of EMDRIA, the role of consultation on the use of EMDR therapy has expanded, becoming required in both basic training in EMDR therapy and in EMDRIA’s certification program, yet little has been published to offer guidance on the consultative process for EMDR therapy-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 therapy.

The Plan of This Book

In planning this guide to standard EMDR therapy 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 therapy, and the need to keep the manual to a practical length. A significant number of proposed EMDR therapy procedures and protocols for additional clinical applications that show promise, but did not meet some of these criteria, were omitted.


Section III, six chapters in all, covers Phases 3 to 8 of the Standard Protocol for PTSD. The standard EMDR therapy 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], 2013; 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 other specified dissociative disorder (OSDD)—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 Therapy to Conditions Other than PTSD with chapters devoted to specific phobias and panic disorder. Note that the standard EMDR therapy 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 PTSD, if present, appears to be secondary, alternate EMDR therapy 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 widely used EMDR therapy approach for treatment of primary substance abuse, but research on DeTUR and other approaches to applying EMDR therapy to substance abuse (Brown & Gilman, 2007; Brown, Gilman, & Kelso, 2008; Hase, 2010; Hase, Schallmayer, & Sack, 2008) is still at too early of a stage for inclusion in this guide. Only Cravex (Hase, 2010) has support from preliminary controlled research (Hase et al., 2008).

Section V addresses issues of Professional Development in EMDR therapy as clinicians go through the basic training in EMDR therapy and obtain consultation or supervision on their clinical application of EMDR therapy. The 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 therapy, 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 therapy 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 therapy as part of basic training in EMDR therapy. As a trainer, I also sought ways to motivate and encourage training participants to get started early and persist in practicing EMDR therapy. While teaching in Japan I developed the following metaphor for the process of learning EMDR therapy. 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 therapy, 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 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 Therapy

Contemporary Theory and Treatment of Posttraumatic Stress Syndromes

Unlike other 20th-century psychotherapies, Eye Movement Desensitization and Reprocessing (EMDR) therapy 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 therapy 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]), and to (d) an overall approach to therapy. Even though EMDR therapy first began from an empirical rather than theoretical origin, an understanding of its theoretical framework, known as the Adaptive Information Processing model (AIP; Shapiro, 2001), is central to the successful clinical application of EMDR therapy (Greenwald & Shapiro, 2010, 2011; Shapiro, 2009). 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 therapy. Chapter 1 begins with a review of selected aspects of four models of psychotherapy that historically most directly support understanding the evolution of EMDR therapy. 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 the possible mechanisms for EMDR therapy’s 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 (Cardeña, Maldonado, van der Hart, & Spiegel, 2000; van der Kolk & van der Hart, 1989). The early history and evolution of EMDR therapy in turn have been strongly associated with the search to understand and treat the relationship between trauma and dissociation (Fine et al., 1995; Lazrove & Fine, 1996; Nicosia, 1994; Paulsen, 1995).
Twenty-first-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 therapy. Rapport refers to the qualities of trust, connection, and contingency (Siegel, 2012) 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 alterations 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 the use of standard EMDR therapy procedures—described by Shapiro (1995, 2001) and in this text—does not induce an altered state in the brain similar to brain wave patterns that have been identified in hypnosis. Additionally, hypnotic phenomena and suggestions are not central to EMDR therapy’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). Although 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. In the Preparation Phase of EMDR therapy, these principles guide the creative application of the Resource Development and Installation (RDI) protocol (Korn & Leeds, 2002; Leeds, 1997, 2001; Leeds & Shapiro, 2000), which elicits, enhances, and strengthens access to adaptive memory networks. 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 of approaches and a 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 therapy. Freud (1955) described traumatic events as breaching a stimulus barrier leading to a repetition compulsion in which periods of intrusive reexperiencing 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 [2012].) 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 therapy.
Rather than pure neutrality, responsiveness to the patient’s process is emphasized in EMDR therapy. Transference and countertransference are recognized, but when transference arises during reprocessing, it is normally addressed by allowing it to be the focus of further reprocessing without explicit interpretation or comment. Often, the transference material will resolve or the personal memories that are the sources of projected transference material will emerge spontaneously as reprocessing continues. If not, clinicians trained in EMDR therapy can actively encourage patients to explore associations to their personal memories during additional sets of bilateral eye movements through affective, somatic, and cognitive linkages or by shifting the focus of attention to reprocessing defenses (Knipe, 2014; Mosquera, Gonzalez, & Leeds, 2012).

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 adverse or traumatic experiences and the intense state of alarm (fear and/or shame) evoked by the experience. Systematic desensitization and flooding (implosion) were the two dominant modes of treatment proposed by behaviorists (Keane, Fairbank, Caddell, & Zimering, 1989; Stampfl & Levis, 1967; Wolpe, 1954, 1958). In systematic desensitization, the patient identifies a hierarchy of cues ranging from mildly disturbing 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); Follette and Ruzek (2006); and Rauch, Eftekhar, and Ruzek (2012). 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 therapy (Hembree et al., 2003). However, other reviewers suggest that nonresponse and dropout rates in PE 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 (Kar, 2011; Schottenbauer, Glass, Arnkoff, Tendick, & Gray, 2008). A more recent review by Najavits (2015) examined dropout and retention rates in “gold standard” randomized controlled trials (RCTs) and “real world” PTSD treatment settings and cited remarkably low completion rates for PE and cognitive processing therapy (CPT) such as the 2% “adequate dose” reported by Watts et al. (2014) and the less than 10% completion rate reported by Mott et al. (2014).

Although PE has been found to be effective in 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 CPT (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 (Lanius, 2014; Merluzzi, Taylor, Boltwood, & Götestam, 1991; Rogers &
Lanius, 2001).

Cognitive Behavioral Theory

Cognitive behavioral theory accepts the paradigm of classical conditioning as a founda-
tion for understanding posttraumatic syndromes (and other anxiety disorders), but turns
toward information processing models and to the concept of emotional processing for mod-
els 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 therapy. The key
concepts supporting the cognitive model of emotional information processing build on the

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 (1977, 1979) proposed a general model for treating anxiety 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
(1981) state-specific model, illustrated in Figure 1.1. 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. See Figure 1.2. In the AIP model of memory networks, Lang’s
“sensory memories” are represented by the “image” and “thoughts and sounds”; Lang’s
“personal meaning” is represented by the negative cognition; Lang’s “responses”—which
omit explicit mention of emotion—are represented in the AIP model by “emotions” and
“physical sensations.” The overt “behavioral” responses highlighted by Lang are not explic-
titly identified in the AIP model (Shapiro, 1995, 2001). This omission is further explored in
the section on Memory Networks in Chapter 2.

Starting from Mathews’s (1971, p. 88) hypothesis 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
therapy procedure of returning to target to reaccess the memory network and reevaluate 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—incompat-
ible with fear must be available and integrated to modify the fear structure and form a
new memory as illustrated in Figure 1.3. In EMDR therapy, this concept is described as the
need for relevant adaptive memory networks to be present and accessible so that synthesis
can take place between the selected maladaptive memory network and adaptive memory
networks.
FIGURE 1.1  Bower state-dependent memory. Percentage retention scores for three groups of hypnotizable subjects tested on their 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 the 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.


FIGURE 1.2  Lang’s fear structure.
Section One: The Conceptual Framework for EMDR Therapy

The cognitive behavioral model of clinical anxiety has had a powerful effect on treatment and research. The cognitive behavioral approach to treatment of posttraumatic 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 (1980) 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 others?

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 therapy 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 or 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 eye movements (or alternate 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 (1980). See Figure 2.2, Yerkes-Dodson Law in Chapter 2.

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 eye movements (or alternate 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, clinicians offering EMDR therapy must take steps both in the Preparation Phase of treatment and during active reprocessing to ensure that this integration can take 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 (1992a, 1992b) 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 Pearlman (1990); Putnam (1989); Scurfield (1985); van der Hart and Friedman (1989); and van der Kolk, McFarlane, and Weisaeth (1996). Christine Courtois (1999, p 176), in Recollections of Sexual Abuse: Treatment Principles and Guidelines, 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 therapy (Shapiro, 1995, 2001) situate it within this consensus model. In EMDR therapy, various strategies can be employed to support the goals of stabilization and symptom reduction. Some stabilization strategies commonly used in EMDR therapy 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 RDI (Leeds, 1998a, 1998b; Leeds & Shapiro, 2000), integrate a specific set of stabilization procedures from hypnosis and guided imagery in ways that are unique to EMDR therapy. 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 (1996, p. 11) calls “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 therapy can be summarized in the following four stages:

1. Discovery and investigation of a simple technique (eye movements)
2. Defining and testing of the EMDR procedure
3. Evolution, clarification, and validation of the standard EMDR therapy protocol as a treatment for PTSD and related syndromes
4. Extending the theory and application of EMDR therapy to additional clinical syndromes as a general model of psychotherapy. The current status of EMDR therapy 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 to 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 was 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 (Fairbank & Keane, 1982; Stampfl & Levis, 1967). 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 therapy, David Wilson (Wilson et al., 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 (Shapiro, 1989a, 1989b).

**Design and Procedures of the EMD Pilot Study**

In 1980, PTSD was first explicitly included in the *Diagnostic and Statistical Manual of Mental Disorders* (3rd ed.; *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, 11 to 53 years old, 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 to 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 to 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 of 10 to 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 to 10. Between sets of bilateral 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 bilateral 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 to 12 sets. Subjects were then asked to rate their preferred statement on the VoC scale from 1 to 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 two to three 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 was confirmed by the referring therapist or a family member.

The design of this pilot study (Shapiro, 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 remaining ones 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 therapy 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 with 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” in several ways. After identifying an image and a negative
self-statement—now called the “negative cognition”—she asked the patient to identify a preferred belief—referred to as the “positive cognition.” Then she asked the patient to identify at least one specific emotion—just before obtaining the initial SUD rating—by pairing the memory and the negative “cognition.” She 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 bilateral eye movements. Instead, she instructed patients—and the clinicians she trained—to return to the selected target only when the associations were reported to be neutral or positive or when the material reported after sets of bilateral eye movements was unchanged or became confused.

She decided to make the phase of treatment 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 positive cognition with the remaining representations of the target 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 current 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. She asked the patient to focus on the identified body sensations and offered further sets of bilateral eye movements until the sensations were neutral or were no longer becoming more positive.

Offering Researchers and Clinicians Training in EMDR

During this period of evolution in EMDR therapy 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 therapy, 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 therapy training was burgeoning faster than anyone could have predicted.

By late 1990, troubling reports of patients being harmed by EMDR therapy (Shapiro, 1991b) had begun reaching Shapiro. These reports indicated that some recently EMDR therapy-trained clinicians had immediately begun to offer their own EMDR therapy trainings. Patients being treated by the students of these inexperienced EMDR therapy 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. Although 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 therapy 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 therapy. She then released all who had completed her EMDR therapy 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 therapy. This led to the founding of the EMDR International Association (EMDRIA, 2008b).

**Alternate Modes of Bilateral Stimulation**

During this early period (1989 to 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 repetitive bilateral eye movements (such as eye strain). Auditory tones and hand taps were proposed as alternative forms of bilateral 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. Although anecdotal reports have suggested that tones and taps (or vibrations) may be 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). Proponents of the working memory theory of action for EMDR therapy have published studies that found alternating eye movements superior to alternating tones at reducing the vividness and emotionality of recollections (van den Hout et al., 2010a, 2010b, 2012) in spite of observations that a majority of patients with PTSD preferred the less effective tones (de Jongh, Ernst, Marques, & Hornsveld, 2013).

By 1991, nearly all the procedural and theoretical elements of EMDR therapy 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, two 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 therapy to the treatment of various acute stress and posttraumatic syndromes including phobias with a traumatic origin. In 1999, EMDRIA established curriculum standards for basic training in EMDR modeled after the basic training programs developed by Dr. Shapiro. Other providers of basic training were soon accredited and began to offer different formats and models of training to meet the EMDRIA standards. In 2007, EMDRIA raised the curriculum standards in several ways, most notably by requiring 10 hours of consultation in developmental increments over the course of the training (EMDRIA, 2008b).

**Growth in the Peer-Reviewed Literature on EMDR Therapy**

The peer-reviewed professional literature on EMDR therapy grew from two reports in 1989 to a cumulative total of 79 by 1995 and 257 through the end of 2001 (Baldwin, 2002). A search of the Francine Shapiro Library (2015) in early 2015 returned 699 peer-reviewed journal articles on the key word “EMDR.” It is not possible or appropriate to attempt to review this entire burgeoning literature base here. By 2015, approximately 26 randomized controlled PTSD treatment outcome studies of EMDR therapy had been completed (EMDRIA, 2015c). The quantity of PTSD treatment outcome data on EMDR therapy 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 therapy remains mixed among some scientists and third-party payers, notably in the United States. In European countries, and elsewhere in the world, government health care systems, hospitals, and scholars accept EMDR therapy 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 (Lee & Cuijpers, 2013; Maxfield & Hyer, 2002; Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009; Sack, Lempa, & Lamprecht, 2001; Spector & Read, 1999; van Etten & Taylor, 1998) have reported EMDR therapy to be an efficient and effective treatment for PTSD and demonstrated a significant effect for the role of eye movement EMDR therapy in both laboratory and clinical studies (Lee & Cuijpers, 2014).

The International Society for Traumatic Stress Studies (ISTSS), in its first review of all treatments for PTSD (Foa et al., 2000, p. 333), rated EMDR therapy 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 et al., 2009, p. 575), it 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). Since the 2009 ISTSS report, three additional high-quality randomized controlled studies of EMDR therapy for children have been published (de Roos et al., 2011; Kemp, Drummond, & McDermott, 2010; Wanders, Serra, & de Jongh, 2008). 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 therapy, 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, et al., 2013), the Dutch National Steering Committee Guidelines for Mental Health Care (2003), and the National Institute for Clinical Excellence (2005).

In 2013, the WHO published Guidelines for the management of conditions specifically related to stress, in which trauma-focused Cognitive Behavioral Therapy (CBT) and EMDR are the only psychotherapies recommended for children, adolescents, and adults with PTSD.

Like CBT with a trauma focus, EMDR therapy aims to reduce subjective distress and strengthen adaptive cognitions related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework. (World Health Organization, 2013, p. 1)

Grass roots clinical interest, scholarly recognition, and institutional acceptance of EMDR therapy have grown steadily in European countries. In contrast, in the United States, grass roots clinical interest in EMDR therapy continues to grow at a steady pace, while scholarly controversies and inconsistent institutional acceptance of EMDR therapy persist.
Misleading and inaccurate descriptions of the status and meta-analyses of EMDR therapy continue to appear in the literature. One of these from the Institute of Medicine (IOM, 2007) has been vigorously rebutted (Lee & Schubert, 2009). A full analysis of the disparity between controversies surrounding EMDR therapy in the United States and the widespread acceptance of EMDR therapy in Europe and other regions—such as Japan, South Korea, and South America—is beyond the scope of this chapter. In part, this disparity in acceptance may relate to issues commonly surrounding scientific revolutions (Kuhn, 1996). A 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 therapy by the National Registry of Evidence-Based Programs and Practice (NREPP) of the 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 SAMHSA listing of empirically supported methods in deciding what methods to permit and to fund. This oversight was finally corrected in 2008 with an application by EMDRIA that was reviewed and published in October of 2010 (National Registry of Evidence-Based Programs and Practice, 2010). This delay led to clinicians working in the United States finding themselves confronting refusal by some clinical directors to permit the use of EMDR therapy 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 therapy. Profound structural barriers have also limited the ability of both active duty and combat veterans to obtain treatment with EMDR therapy (Russell, 2008a), while several regional programs are actively providing EMDR therapy treatment to current and former military personnel. The FBI and other federal and local law enforcement agencies (McNally & Solomon, 1999; Wilson, Tinker, Becker, & Logan, 2001) have embraced EMDR therapy as part of their critical incident stress management programs, but this is not yet a universal or widespread practice.

Extending EMDR to a General Model of Psychotherapy

Since 2001, EMDR therapy 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 therapy’s efficacy for acute stress disorder for both civilian (including health-related) and combat-related trauma (Fernandez, 2008; Jarero, Artigas, & Luber, 2011; Krause & Kirsch, 2006; Kutz, Resnik, & Dekel, 2008; Ladd, 2007; Russell, 2006; Todd & Kaplan, 2007; Zaghrout-Hodali, Alissa, & Dodgson, 2008) and PTSD (Abbasnejad, Mahani, & Zamyad, 2007; Ahmad, Larsson, & Sundelin-Wahlsten, 2007; Arabia, Manca, & Solomon, 2011; Brown & Gilman, 2007; Capezzani et al., 2013; Carlson et al., 1996; Chemali & Meadows, 2004; Chemtob, Nakashima, & Carlson, 2002; de Roos et al., 2011; Edmond & Rubin, 2004; Elofsson, von Scheele, Theorell, & Sondergaard, 2008; Heber, Kellner, & Yehuda, 2002; Högberg et al., 2007, 2008; Ironson, Freund, Strauss, & Williams, 2002; Jabergahderi, Greenwald, Rubin, & Zand, 2004; Kelley & Selim, 2007; Kemp et al., 2010; Kim & Kim, 2004; Konuk et al., 2005; Lamprecht et al., 2004; Lamping, Amen, Hanks, & Rudy, 2005; Lee, Gavriel, Drummond, Richards, & Greenwald, 2002; Lee, Taylor, & Drummond, 2006; Nijdam, Gersons, Reitsma, de Jongh, & Olff, 2012; Oh & Choi, 2004; Ores, Ezpeleta, & Ahmad, 2004; Pagani et al., 2007; Power, McGoldrick, & Brown, 2002; Propper, Pierce, Geisler, Christian, & 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 therapy’s effectiveness with empirical studies on the effects
of the bilateral eye movements or alternate bilateral stimulation procedures used in EMDR therapy (see reviews in Bergmann, 2010, 2012; Gunter & Bodner, 2009; Maxfield, 2008). The second is research to extend the application of EMDR therapy to additional clinical syndromes as a general model of psychotherapy. A full review of the research that has been done in these areas is beyond the scope of this book. Here is a brief summary for those interested in these areas.

Theories about possible mechanisms for the well-established treatment effects of EMDR therapy on trauma-related syndromes are summarized in Chapter 2. A rapidly expanding number of papers in recent years have explored psychological, psychophysiological, and neurological explanations for EMDR therapy’s effects (Aubert-Khalfa, Roques, & Blin, 2008; Barrowcliff, Gray, Freeman, & MacCulloch, 2004; Barrowcliff et al., 2003; Bergmann, 2001, 2008; Bossini et al., 2011; Christman, Garvey, Propper, & Phaneuf, 2003; El Khoury-Malhame et al., 2011; Elofsson et al., 2008; Frustaci, Lanza, Fernandez, di Giannantonio, & Pozzi, 2010; Grbesa, Simonovic, & Jankovic, 2010; Gunter & Bodner, 2008; Harper, Rasolkhani-Kalhorn, & Drozd, 2009; Hornsveld et al., 2010; Kapoula, Yang, Bonnet, Bourtoire, & Sandretto, 2010; Kavanagh, Freese, Andrade, & May, 2001; Kristjánsdóttir & Lee, 2011; Kuiken, Bears, Miall, & Smith, 2001–2002; Landin-Romero et al., 2013; Lansing et al., 2005; Lee et al., 2006; Lilley et al., 2009; Nardo et al., 2009; Oh & Choi, 2004; Ohtani, Matsuo, Kasai, Kato, & Kato, 2009; Pagani et al., 2011, 2012a, 2012b; Richardson et al., 2009; Sack, Hofmann, Wizelman, & Lempa, 2008; Sack et al., 2008; Schubert, Lee, & Drummond, 2011; Stickgold, 2002; van den Hout & Engelhard, 2012; van den Hout et al., 2010a, 2010b; van den Hout, Muris, Saleminik, & Kindt, 2001). These papers build on earlier studies and theoretical papers from the 20th century (Andrade, Kavanagh, & Baddley, 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 therapy 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 with 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 single photon emission computed tomography, electroencephalography, near-infrared spectroscopy, functional magnetic resonance imaging (Pagani, Hogberg, Fernandez, & Siracusano, 2013), as well as psychophysiological measures (Bergmann, 2010; Gunter & Bodner, 2009), in several case reports, case series, and one controlled study cited previously.

A growing number of case reports and case series support the view that EMDR therapy can be viewed as a general model for psychotherapy for a wide range of conditions where environmental factors play a role—that is, learning, conditioning, or stress. Notable among the conditions where EMDR therapy is emerging as a potentially helpful treatment are depression (Bae, Kim, & Park, 2008; Hofmann et al., 2014; Rosas Uribe, López Ramírez, & Jarero Mena, 2010; Song & Wang, 2007), complex PTSD and dissociative disorders (van der Hart, Groenendijk, Gonzalez, Mosquera, & Solomon, 2013, 2014), substance abuse and addictive-compulsive behaviors (Amundsen & Kårstad, 2006; Bae & Kim, 2012; Besson et al., 2006; Brown & Gilman, 2007; Brown, Gilman, & Kelso, 2008; Hase, Schallmayer, & Sack, 2008; Miller, 2010, 2012; Popky, 2005; Vogelmann-Sine, Sine, Smyth, & Popky, 1998), obsessive compulsive disorders (Böhm & Voderholzer, 2010; Marr, 2012; Nazari, Momeni, Jarani, & Tarrahi, 2011), a range of somatoform disorders including chronic pain and migraine (Gauvry, Lesta, Alonso, & Pallia, 2013; Grant, 2009; Grant & Threlfo, 2002; Konuk, Epozdemir, Hacimeroglu Atceken, Aydin, & Yurtsever, 2011; Marcus, 2008), phantom limb pain (de Roos et al., 2010; Flik & de Roos, 2010; 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), body dysmorphic disorder, and olfactory reference syndrome (Brown et al., 1997; Dziegielewski & Wolfe, 2000; McGoldrick, Begum, & Brown, 2008). In addition, early case reports and strategies have appeared describing the application of EMDR therapy to the treatment of personality disorders (Bergmann, 2008;
Section One: The Conceptual Framework for EMDR Therapy

Brown & Shapiro, 2006; de Jongh, ten Brocke, & Meijer, 2010; Egli-Bernd, 2011; Grand, 2003; Korn & Leeds, 2002; Knipe, 2003; Mosquera & González-Vázquez, 2012; Mosquera & Knipe, 2015; Mosquera, Leeds, & Gonzalez, 2014). A growing number of books describe applications of EMDR therapy to couples and family systems (Shapiro, Kaslow, & Maxfield, 2007), integration of EMDR therapy with a range of well-accepted psychotherapy approaches (Shapiro, 2002b), and a role for EMDR therapy in the treatment of complex PTSD and borderline personality and dissociative disorders (Forgash & Copeley, 2008; Gonzalez & Mosquera, 2012; International Society for the Study of Trauma and Dissociation, 2011; Knipe, 2014; Lanius, Paulsen, & Corrigan, 2014).

Summary

In less than 20 years, EMDR therapy 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. Although some controversies and misleading myths about EMDR therapy’s empirical status persist, primarily in the United States, EMDR therapy has achieved a global acceptance as an empirically supported treatment offering a new paradigm to alleviate human suffering. More than 175,000 clinicians worldwide have been trained in EMDR therapy. 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 serious or terminal illness; phantom limb pain; chronic substance abuse; and a range of somatoform disorders. EMDR therapy professional associations exist on five continents. EMDR therapy conferences are held in 20 countries annually. These achievements reflect the vision and persistence of Francine Shapiro. She has personally taught EMDR therapy 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 therapy 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 therapy trainers and consultants. How she accomplished all this in less than 20 years is a remarkable story that deserves to be told in its own right (Luber & Shapiro, 2009).

The inspiration of Francine Shapiro’s dedication and vision led to the formation of EMDR therapy professional associations in more than 20 countries around the world. The achievements of these professional associations could fill another chapter and include more than 90% of Dutch psychologists being trained in EMDR, a dramatic number of clinicians being trained in Italy and Spain, a steady stream of published European research—on children; on those with psychosis and PTSD; a multisite, multicountry research project on the treatment of major depression—humanitarian projects in developing countries that span the globe, and much more. A recent proposal by Rolf C. Carriere, UNITAR fellow and retired UNICEF country director, calls “for launching an ambitious global trauma therapy plan” with EMDR therapy as “a potentially scalable intervention” to overcome the “four violences.” In the United States, where government research funding for EMDR therapy became constrained at the start of the 21st century, the EMDR Research Foundation has emerged as a major source of support for EMDR research due to the consistent financial support of EMDR-trained clinicians and other donors.

However, the story of EMDR therapy’s remarkable evolution and growth is more than the story of what Francine Shapiro has personally achieved or the achievements of a global network of EMDR therapy professional associations. It is a story of the thousands of researchers, clinicians, and graduate students, as well as the millions of patients who have experienced EMDR therapy in training programs and individual therapy and been transformed by the human experience of a change in consciousness (Krystal et al., 2002). This shift in consciousness does not happen to everyone during EMDR therapy, but it does occur.
with a significant percentage of those who experience EMDR reprocessing. For those who experience this transformation, EMDR reprocessing reveals something compelling about our human potential to evolve and grow as individuals and as a species. The experience of EMDR therapy’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.