GUIDELINE 8

Eye Movement Desensitization and Reprocessing

Description

Eye movement desensitization and reprocessing (EMDR) is a multistage treatment for posttraumatic stress disorder (PTSD). It entails eight stages, including history gathering, treatment planning, patient preparation, systematic assessment of trauma-relevant target(s), desensitization and reprocessing, installation of alternative positive cognitions, body scan for continuing discomfort or trouble spots, and closure designed to address constructive coping needs for future use by treated patients. First introduced in 1989, the treatment has benefited from a dramatic improvement in research quality over the past 15 years.

General Strength of the Evidence

Evidence supporting the efficacy of EMDR has advanced from case reports to well-controlled randomized trials and multiple, systematic meta-analytic reviews. Consequently, this critical review of the evidence is based exclusively on a review of randomized controlled trials (RCTs) of EMDR for PTSD published in peer-reviewed journals since publication of the guidelines in the first edition of this volume. The treatment has been compared to other front-line treatments, most recently including medications that target PTSD. It has performed comparably in all such trials. Additionally, several investigations have examined elements of the conceptual framework offered to explain the treatment's effectiveness. Compared to other treatments targeting PTSD,

the status of the evidence supporting EMDR is substantial and of high quality. The treatment warrants an Agency for Health Care Policy and Research (AHCPR) Level A rating for treatment of adults with a diagnosis of PTSD. EMDR applied to children warrants an AHCPR Level B rating.

Course of Treatment

Using EMDR requires extensive assessment to identify the range of traumatic event exposure across the patient's lifespan. Multiple aspects of each traumatic event also require assessment: affective and physiological response elements; negative self-representations; and alternative, desired positive self-representation. Treatment comprises eight stages. The length of treatment is based on the number of traumatic events identified and on the patient's response and potential. Sessions can vary in length depending on patient characteristics and response.

Recommendations

EMDR is widely applicable to civilian PTSD cases and also has some efficacy with combat-related PTSD. What is yet to be studied in the combat population is the degree to which "service-connected" disability status influences treatment outcome with EMDR, as acknowledged earlier by EMDR practitioners. Additionally, the literature is silent regarding the extent to which comorbid physical injury (a common occurrence in combat-related PTSD) complicates EMDR treatment. Finally the impact of chronicity of symptoms on EMDR treatment has not been specifically controlled in RCTs, although one 5-year follow-up investigation revealed a lack of long-term durability for chronic combat-related PTSD. These factors comprise important sources of "severity" among individuals with combat-related PTSD. Nonetheless, the success of EMDR in early trials with combat veterans warrants continued application and study with this population.

The treatment is relatively brief in terms of the functional duration, although the duration of treatment cannot be determined a priori and must be guided by the patient's needs. The treatment appears to be well tolerated by most patients, and possibly to a degree not characteristic of alternative psychological treatments, but this issue requires further systematic study. Children also seem to benefit to an adapted procedure. Existing data support the use of EMDR in children and adolescents; however, compared to adults, there have been considerably fewer RCTs evaluating EMDR in children and adolescents diagnosed with PTSD. Further research with this population is recommended. EMDR is robust in the face of some variations in procedure, while retaining its effectiveness (i.e., eye movements and other parallel stimulation).

Patient Characteristics

It is unknown what patient characteristics predict improvement, other than the observation that single-episode traumas appear to respond more favorably to treatment. Additionally, a recent pharmacological comparison revealed specifically that traumas originating during the developmental period are more resistant than those originating later in life when targeted for treatment during adulthood. As indicated in the previous edition of this volume, there remains little empirically based guidance for treating patients with comorbid disorders, other than that found in good clinical practice. In this connection, elevated depression scores do seem to respond favorably to EMDR, even when they are not targeted specifically for intervention.

Process Studies

Recent investigations suggest the possibility that the dosed exposure, combined with postexposure "mindful awareness" features contained in EMDR, might confer advantages over conventional exposure to trauma memories. In some ways, the treatment of panic disorder has similarly benefited from this approach entailing a specific focus on interoceptive sources of distress immediately following specific arousal induction procedures (Barlow, 2002).

Combination Treatment with Trauma-Focused Medication

Many patients seen in practice are either already taking FDA-approved medications for PTSD or may initiate a medication trial during treatment. As important as understanding individual efficacy is understanding the empirical basis for combined efficacy of medication and psychological interventions because their joint use is a likely reality in practice. More (drugs plus psychological therapy) is not always better in these matters, and practitioners should be informed by empirical findings concerning such combination treatments.

Tolerability and Acceptability

Finally, more information is needed on client acceptability of treatment in an effort to elucidate further the extent to which this treatment is suited to client preferences. The repeated finding of high dropout rates with PTSD treatment demands that we understand the role of patient and therapist tolerance and acceptability as they affect efficacious interventions.

Summary

EMDR is rated as a Level A treatment for its use with adults. Quality clinical trials support its use for patients with PTSD. More studies need to be com-

pleted with EMDR adapted for use with children and adolescents. It currently has a Level B rating for treatment with this population.

Suggested Readings

- Barlow, D. (2002). Anxiety and its disorders: The nature and treatment of anxiety and panic (2nd ed.). New York: Guilford Press.
- Shapiro, F. (2001). Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures (2nd ed.). New York: Guilford Press.
- Shapiro, F., & Maxfield, L. (2002). Eye movement desensitization and reprocessing (EMDR): Information processing in the treatment of trauma. *Journal of Clinical Psychology*, 58, 933–946.
- Tinker, R. H., & Wilson, S. A. (1999). Through the eyes of a child: EMDR with children. New York: Norton.