EMDR Institute, Inc. The Efficacy of EMDR

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Critiques of EMDR which question the "lack of research" are badly out of date, as you will see below. EMDR is now accepted as a treatment of choice by numerous mental health departments, and trauma organizations.

EMDR has a broad base of published case reports and controlled research which supports it as an empirically validated treatment of trauma. The Department of Defense/Department of Veterans Affairs Practice Guidlines have placed EMDR in the highest category, recommended for all trauma populations at all times. In addition, the International Society for Traumatic Stress Studies current treatment guidelines have designated EMDR as an effective treatment for PTSD (Chemtob, Tolin, van der Kolk & Pitman, 2000) as have the Departments of Health of both Northern Ireland and Israel (see below), which have indicated EMDR to be one of only two or three treatments of choice for trauma victims. Most recently, the American Psychiatric Association Practice Guideline (2004) has placed EMDR in the category of highest level of effectiveness.

See **Shapiro (1999, 2001, 2002)** for procedures, protocols, theories, and discussion of clinically valid research criteria. See **Shapiro & Forrest (1997)** for a comprehensive narrative of cases, and in-session transcripts, and "EMDR for Trauma" in APA Psychotherapy Videotape series. For a comprehensive review of areas of debate see **Perkins and Rouanzoin (2002)**. For discussion of studies investigating the eye movement and other bilateral stimulation, please see **Commonly Asked Questions.**

Efficacy/Validation Overviews

International Treatment Guidelines

American Psychiatric Association (2004). *Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder.* Arlington, VA: American Psychiatric Association Practice Guidelines

EMDR given the same status as CBT as an effective treatment of ameliorating symptoms of both acute and chronic PTSD

Bleich, A., Kotler, M., Kutz, E., & Shalev, A. (2002) A position paper of the (Israeli) National Council for Mental Health. Guidelines for the assessment and professional intervention with terror victims in the hospital and in the community.

EMDR is one of only three methods recommended for treatment of terror victims.

Chambless, D.L. et al. (1998). Update of empirically validated therapies, II. The Clinical Psychologist, 51, 3-16.

According to a taskforce of the Clinical Division of the American Psychological Association, the only methods empirically supported for the treatment of any post-traumatic stress disorder population were EMDR, exposure therapy, and stress inoculation therapy.

CREST (2003). The management of post traumatic stress disorder in adults. A publication of the Clinical Resource Efficiency Support Team of the Northern Ireland Department of Health, Social Services and Public Safety, Belfast.

Of all the psychotherapies, EMDR and CBT were stated to be the treatments of choice for trauma victims

Department of Veterans Affairs & Department of Defense (2004) VA/DoD Clinical Practice Guideline for the Management Of Post-Traumatic Stress. Washington, DC.

EMDR was one of four therapies given the highest level of evidence and recommended for treatment of PTSD.

Dutch National Steering Committee Guidelines Mental Health Care (2003). Multidisciplinary Guideline Anxiety Disorders. Utrecht: Quality Institute Heath Care CBO/Trimbos Intitute.

EMDR and CBT are both treatments of choice for PTSD

Foa, E.B., Keane, T.M., & Friedman, M.J. (2000). Effective treatments for PTSD: Practice Guidelines of the International Society for Traumatic Stress Studies New York: Guilford Press.

In the Practice Guidelines of the International Society for Traumatic Stress Studies, EMDR was listed as an efficacious treatment for PTSD.

Sjöblom, P.O., Andréewitch, S . Bejerot, S., Mörtberg, E. , Brinck, U., Ruck, C., & Körlin, D. (2003) Regional treatment recommendation for anxiety disorders. Stockholm: Medical Program Committee/Stockholm City Council

Of all psychotherapies CBT and EMDR are recommended as treatments of choice for PTSD.
United Kingdom Department of Health. (2001). Treatment choice in psychological therapies and counselling evidence based clinical practice guideline. London, England.

Best evidence of efficacy was reported for EMDR, exposure, and stress inoculation.

Meta-analyses

Davidson, P.R., & Parker, K.C.H. (2001). Eye movement desensitization and reprocessing (EMDR): A meta-analysis. Journal of Consulting and Clinical Psychology, 69, 305-316.

EMDR is equivalent to exposure and other cognitive behavioral treatments. It should be noted that exposure therapy uses one to two hours of daily homework and EMDR uses none.

Maxfield, L., & Hyer, L.A. (2002). The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. Journal of Clinical Psychology, 58, 23-41

A comprehensive meta-analysis reported the more rigorous the study, the larger the effect.

Van Etten, M., & Taylor, S. (1998). Comparative efficacy of treatments for post-traumatic stress disorder: A meta-analysis. Clinical Psychology and Psychotherapy, 5, 126-144.

This meta-analysis determined that EMDR and behavior therapy were superior to psychopharmaceuticals. EMDR was more efficient than behavior therapy, with results obtained in one-third the time.

Randomized Clinical Trials

Carlson, J., Chemtob, C.M., Rusnak, K., Hedlund, N.L., & Muraoka, M.Y. (1998). Eye movement desensitization and reprocessing (EMDR): Treatment for combat-related post-traumatic stress disorder. Journal of Traumatic Stress, 11, 3-24
traumatized combat veterans studied. Effects were maintained at follow-up. This is the only randomized study to provide a full course of treatment with combat veterans. Other studies (e.g., Macklin et al.) evaluated treatment of only one or two memories, which, according to the International Society for Traumatic Stress Studies Practice Guidelines, is inappropriate for multiple-trauma survivors. The VA/DoD Practice Guideline also indicates these studies (often with only two sessions) offered insufficient treatment doses for veterans.

Chemtob, C.M., Nakashima, J., & Carlson, J.G. (2002). Brief-treatment for elementary school children with disaster-related PTSD: A field study. Journal of Clinical Psychology, 58, 99-112.

EMDR was found to be an effective treatment for children with disaster-related PTSD who had not responded to another intervention. This is the first controlled study for disaster-related PTSD, and the first controlled study examining the treatment of children with PTSD.

Edmond, T., Rubin, A., & Wambach, K. (1999). The effectiveness of EMDR with adult female survivors of childhood sexual abuse. Social Work Research, 23, 103-116.

EMDR treatment resulted in lower scores (fewer clinical symptoms) on all four of the outcome measures at the three-month follow-up, compared to those in the routine treatment condition. The EMDR group also improved on all standardized measures at 18 months follow up (Edmond & Rubin, in press, Journal of Child Sexual Abuse).

Ironson, G.I., Freund, B., Strauss, J.L., & Williams, J. (2002). Comparison of two treatments for traumatic stress: A community-based study of EMDR and prolonged exposure. Journal of Clinical Psychology, 58, 113-128.

Both EMDR and prolonged exposure produced a significant reduction in PTSD and depression symptoms. Study found that 70% of EMDR participants achieved a good outcome in three active treatment sessions, compared to 29% of persons in the prolonged exposure condition. EMDR also had fewer dropouts.

Jaberghaderi, N., Greenwald, R., Rubin, A., Dolatabadim S., & Zand, S.O. (In press). A comparison of CBT and EMDR for sexually abused Iranian girls. Clinical Psychology and Psychotherapy.

Both EMDR and CBT produced significant reduction in PTSD and behavior problems. EMDR was significantly more efficient, using approximately half the number of sessions to achieve results.

Lee, C., Gavriel, H., Drummond, P., Richards, J. & Greenwald, R. (2002). Treatment of post-traumatic stress disorder: A comparison of stress inoculation training with prolonged exposure and eye movement desensitization and reprocessing. Journal of Clinical Psychology, 58, 1071-1089.

Both EMDR and stress inoculation therapy plus prolonged exposure (SITPE) produced significant improvement, with EMDR achieving greater improvement on PTSD intrusive

symptoms. Participants in the EMDR condition showed greater gains at three-month follow-up. EMDR required three hours of homework compared to 28 hours for SITPE.

Marcus, S., Marquis, P. & Sakai, C. (1997). Controlled study of treatment of PTSD using EMDR in an HMO setting. Psychotherapy, 34, 307-315

Funded by Kaiser Permanent. Results show that 100% of single-trauma and 80% of multiple-trauma survivors were no longer diagnosed with post-traumatic stress disorder after six 50-minute sessions.

Power, K.G., McGoldrick, T., Brown, K., et al. (2002). A controlled comparison of eye movement desensitization and reprocessing versus exposure plus cognitive restructuring, versus waiting list in the treatment of post-traumatic stress disorder. Journal of Clinical Psychology and Psychotherapy, 9, 299-318.

Both EMDR and exposure therapy plus cognitive restructuring produced significant improvement. EMDR was more beneficial for depression and required fewer treatment sessions.

Rothbaum, B. (1997). A controlled study of eye movement desensitization and reprocessing in the treatment of post-traumatic stress disordered sexual assault victims. Bulletin of the Menninger Clinic, 61, 317-334.

Three 90-minute sessions of EMDR eliminated post-traumatic stress disorder in 90% of rape victims

Scheck, M., Schaeffer, J.A., & Gillette, C. (1998). Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. Journal of Traumatic Stress, 11, 25-44.

Two sessions of EMDR reduced psychological distress scores in traumatized young women and brought scores within one standard deviation of the norm.

Soberman, G. B., Greenwald, R., & Rule, D. L. (2002). A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problems. Journal of Aggression, Maltreatment, and Trauma, 6, 217-236.

The addition of three sessions of EMDR resulted in large and significant reductions of memory-related distress, and problem behaviors by 2-month follow-up.

Taylor, S. et al. (2003). Comparative efficacy, speed, and adverse effects of three PTSD treatments: Exposure therapy, EMDR, and relaxation training. Journal of Consulting and Clinical Psychology, 71, 330-338.

The only randomized study to show exposure statistically superior to EMDR on two subscales (out of 10). This study used therapist assisted "in vivo" exposure, where the therapist takes the person to previously avoided areas, in addition to imaginal exposure and one hour of daily homework (@ 40 hours). The EMDR group used only standard sessions and no homework.

Vaughan, K., Armstrong, M.F., Gold, R., O'Connor, N., Jenneke, W., & Tarrier, N. (1994). A trial of eye movement desensitization compared to image habituation training and applied muscle relaxation in post-traumatic stress disorder. Journal of Behavior Therapy & Experimental Psychiatry, 25, 283-291.

All treatments led to significant decreases in PTSD symptoms for subjects in the treatment groups as compared to those on a waiting list, with a greater reduction in the EMDR group, particularly with respect to intrusive symptoms. In the 2-3 weeks of the study, 40-60 additional minutes of daily homework were part of the treatment in the other two conditions.

Wilson, S., Becker, L.A., & Tinker, R.H. (1995). Eye movement desensitization and reprocessing (EMDR): Treatment for psychologically traumatized individuals. Journal of Consulting and Clinical Psychology, 63, 928-937.

Three sessions of EMDR produced clinically significant change in traumatized civilians on multiple measures.

Wilson, S., Becker, L.A., & Tinker, R.H. (1997). Fifteen-month follow-up of eye movement desensitization and reprocessing (EMDR) treatment of post-traumatic stress disorder and psychological trauma. Journal of Consulting and Clinical Psychology, 65, 1047-1056.

Follow-up at 15 months showed maintenance of positive treatment effects with 84% remission of PTSD diagnosis.

Non Randomized Studies

Devilly, G.J., & Spence, S.H. (1999). The relative efficacy and treatment distress of EMDR and a cognitive behavioral trauma treatment protocol in the amelioration of post-traumatic stress disorder. Journal of Anxiety Disorders, 13, 131-157.

The only EMDR research study that found CBT superior to EMDR. The study is marred by poor treatment delivery and higher expectations in the CBT condition. Treatment was

delivered in both conditions by the developer of the CBT protocol.

Fernandez, I., Gallinari, E., Lorenzetti, A. (in press) A School- Based EMDR Intervention for Children who Witnessed the Pirelli Building Airplane Crash in Milan, Italy. Journal of Brief Therapy.

A group intervention of EMDR was provided to 236 schoolchildren exhibiting PTSD symptoms 30 days post-incident. At four-month follow up, teachers reported that all but two children evinced a return to normal functioning after treatment.

Grainger, R.D., Levin, C., Allen-Byrd, L. , Doctor, R.M. & Lee, H. (1997). An empirical evaluation of eye movement desensitization and reprocessing (EMDR) with survivors of a natural catastrophe. Journal of Traumatic Stress, 10, 665-671.

A study of Hurricane Andrew survivors found significant differences on the Impact of Event Scale and subjective distress in a comparison of EMDR and non-treatment condition

Puffer, M.; Greenwald, R. & Elrod, D. (1997). A single session EMDR study with twenty traumatized children and adolescents. Traumatology-e, 3(2), Article 6.

In this delayed treatment comparison, over half of the participants moved from clinical to normal levels on the Impact of Events Scale, and all but 3 showed at least partial symptom relief on several measures at 1-3 m following a single EMDR session.

Silver, S.M., Brooks, A., & Obenchain, J. (1995). Eye movement desensitization and reprocessing treatment of Vietnam war veterans with PTSD: Comparative effects with biofeedback and relaxation training. Journal of Traumatic Stress, 8, 337-342.

One of only two EMDR research studies that evaluated a clinically relevant course of EMDR treatment with combat veterans (e.g., more than one or two memories; see Carlson et al., above). The analysis of an inpatient veterans' PTSD program (n=100) found EMDR to be vastly superior to biofeedback and relaxation training on seven of eight measures.

Solomon, R.M. & Kaufman, T.E. (2002) A peer support workshop for the treatment of traumatic stress of railroad personnel: Contributions of eye movement desensitization and reprocessing (EMDR). Journal of Brief Therapy, 2, 27-33,

60 railroad employees who had experienced fatal grade accident crossing accidents were evaluated for workshop outcomes, and for the additive effects of EMDR treatment. Although the workshop was successful, in this setting, the addition of a short session of EMDR (5-40 minutes) led to significantly lower, sub clinical, scores which further decreased at follow up.

Sprang, G. (2001). The use of eye movement desensitization and reprocessing (EMDR) in the treatment of traumatic stress and complicated mourning: Psychological and behavioral outcomes. Research on Social Work Practice, 11, 300-320.

In a multi-site study, EMDR significantly reduced symptoms more often than the CBT treatment on behavioral measures, and on four of five psychosocial measures. EMDR was more efficient, inducing change at an earlier stage and requiring fewer sessions.

Additional Information

Shapiro, F. (2001). Eye movement desensitization and reprocessing: Basic principles, protocols and procedures (2nd ed.). New York: Guilford Press.

Shapiro, F. (2002). (Ed.). EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism. Washington, DC: American Psychological Association Books.
EMDR for trauma: Eye Movement Desensitization and Reprocessing. American Psychological Association Psychotherapy Videotape series II

Shapiro, F. & Maxfield, L. (2002). Eye movement desensitization and reprocessing (EMDR). In M. Hersen, & W. Sledge (Eds.), Encyclopedia of Psychotherapy (vol. 1, pp. 777-785). New York: Elsevier Science.
EMDR is an eight-phase treatment approach that brings together aspects of all the major psychological orientations. It has been validated by controlled research to be both effective and efficient in the treatment of post-traumatic stress disorder.

Perkins, B.R. & Rouanzoin, C.C. (2002). A critical evaluation of current views regarding eye movement desensitization and reprocessing (EMDR): Clarifying points of confusion. Journal of Clinical Psychology, 58, 77-97.
http://www.perkinscenter.net/

There are numerous instances in the literature in which misconceptions of about EMDR have been developed and maintained. This article provides a full critique.

Rogers, S., & Silver, S. M. (2002). Is EMDR an exposure therapy? A review of trauma protocols. Journal of Clinical Psychology. 58, 43-59.

Detailed comparison of theory, practices and procedures

Stickgold, R. (2002). EMDR: A putative neurobiological mechanism of action. Journal of Clinical Psychology, 58, 61-75.

Exposition of the neurobiological concomitants and relevant memory systems.

Since the initial efficacy study (Shapiro, 1989a), positive therapeutic results with EMDR have been reported with a wide range of populations including the following:

1. Combat veterans from Desert Storm, the Vietnam War, the Korean War, and World War II who were formerly treatment resistant and who no longer experience flashbacks, nightmares, and other PTSD sequelae **(Blore, 1997a; Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Daniels, Lipke, Richardson, & Silver,1992; Lipke, 2000; Lipke & Botkin, 1992; Silver & Rogers, 2001; Thomas & Gafner, 1993; White, 1998; Young, 1995).**

2. Persons with phobias and panic disorder who revealed a rapid reduction of fear and symptomatology **(de Jongh & ten Broeke, 1998; de Jongh, ten Broeke & Renssen, 1999; De Jongh, van den Oord, & ten Broeke,2002; Doctor, 1994; Feske & Goldstein, 1997; Fernandez & Feretta, in press; Goldstein, 1992; Goldstein & Feske, 1994; Kleinknecht, 1993; Nadler, 1996; O'Brien, 1993; Protinsky, Sparks, & Flemke, 2001a).** Some controlled studies of spider phobics have revealed comparatively little benefit from EMDR, **(e.g., Muris & Merckelbach, 1997; Muris, Merkelbach, Holdrinet, & Sijsenaar, 1998; Muris, Merckelbach, van Haaften, & Nayer, 1997)** but evaluations have been confounded by lack of fidelity to the published protocols **(see De Jongh et al., 1999; Shapiro, 1999).** One evaluation of panic disorder with agoraphobia **(Goldstein, de Beurs, Chambless, & Wilson, 2000)** also reported limited results (for comprehensive discussion per **Shapiro, 2001, 2002**)..

3. Crime victims and police officers and field workers who are no longer disturbed by the aftereffects of violent assaults and/or the stressful nature of their work **(Baker & McBride, 1991; Dyregrov, A., 1993; Jensma, 1999; Kitchiner, 2004; Kitchiner & Aylard, 2002; Kleinknecht & Morgan, 1992; McNally & Solomon, 1999; Page & Crino, 1993; Shapiro & Solomon, 1995; Solomon, 1995, 1998; Solomon, R. & Dyregrov, A., 2000; Wilson, Becker, Tinker, & Logan, 2001).**

4. People relieved of excessive grief due to the loss of a loved one or to line-of-duty deaths, such as engineers no longer devastated with guilt because their train unavoidably killed pedestrians **(Puk, 1991a; Solomon, 1994, 1995,1998; Shapiro & Solomon, 1995; Solomon, 1994, 1995, 1998; Solomon & Kaufman, 2002).**

5. Children and adolescents healed of the symptoms caused by the trauma **(Chemtob, Nakashima, Hamada & Carlson, 2002; Cocco & Sharpe, 1993; Datta and Wallace, 1994, 1996; Fernandez, Gallinari, & Lorenzetti, 2004; Greenwald, 1994, 1998, 1999, 2000, 2002; Jaberghaderi, Greenwald, Rubin, Doaltabadim, & Zand, in press; Johnson, 1998: Korkmazler-Oral & Pamuk 2002; Lovett, 1999; Pellicer, 1993; Puffer, Greenwald & Elrod, 1998; Russell & O'Connor, 2002; Scheck, Schaeffer, & Gillette, 1998; Shapiro, 1991; Soberman, Greenwald, & Rule, 2002; Stewart & Bramson, 2000; Taylor, 2002; Tinker & Wilson, 1999).**

6. Sexual assault victims who are now able to lead normal lives and have intimate relationships **(Edmond, Rubin, & Wambach, 1999; Hyer, 1995; Parnell, 1994, 1999; Puk, 1991a; Rothbaum, 1997; Scheck, Schaeffer, & Gillette, 1998; Shapiro,1989b, 1991, 1994; Wolpe & Abrams, 1991).**

7. Victims of natural and manmade disasters able to resume normal lives. **(Chemtob et al, 2002; Fernandez, et al, 2004; Grainger, Levin, Allen-Byrd, Doctor, & Lee, 1997; Jarero, Artigas, Mauer, Lopex Cano & Alcala, 1999; Knipe, Hartung, Konukk, Colleli, Keller, & Rogers, 2003; Shusta-Hochberg, 2003).**

8. Accident, surgery, and burn victims who were once emotionally or physically debilitated and who are now able to resume productive lives **(Blore, 1997a; Hassard, 1993; McCann, 1992; Puk, 1992; Solomon & Kaufman, 1994).**

9. Victims of marital and sexual dysfunction who are now able to maintain healthy relationships **(Keenan & Farrell, 2000; Kaslow, Nurse, & Thompson 2002; Levin, 1993; Protinsky, Sparks, & Flemke, 2001b; Snyder, 1996; Wernik, 1993).**

10. Clients at all stages of chemical dependency, and pathological gamblers, who now show stable recovery and a decreased tendency to relapse **(Henry, 1996 ; Shapiro & Forrest, 1997; Shapiro, Vogelmann-Sine, & Sine, 1994; Vogelmann-Sine, Sine, Smyth,& Popky, 1998).**

11. People with dissociative disorders who progress at a rate more rapid than that achieved by traditional treatment **(Fine, 1994; Fine & Berkowitz, 2001; Lazrove, 1994; Lazrove & Fine, 1996; Marquis & Puk, 1994; Paulsen, 1995; Rouanzoin, 1994; Twombly, 2000; Young, 1994).**

12. People engaged in business, performing arts, and sport who have benefited from

EMDR as a tool to help enhance performance **(Crabbe, 1996; Foster & Lendl, 1995, 1996; Graham, 2004).**

13. People with somatoform problems/somatoform disorders, including chronic pain, who have attained a rapid relief of suffering **(Brown, McGoldrick, & Buchanan, 1997; Dziegielewski & Wolfe, 2000; Grant, 1999; Grant & Threlfo,2002; Gupta & Gupta, 2002; Ray & Zbik, 2001; Wilson et al., 2000)**

14. Clients with a wide variety of PTSD and other diagnoses who experience substantial benefit from EMDR **(Allen & Lewis, 1996; Brown, McGoldrick, & Buchanan, 1997; Cohn, 1993; Fensterheim, 1996; Forbes, Creamer, & Rycroft, 1994; Gelinas, 2003; Ironson, et al., 2002; Kitchiner, 1999, 2004; Korn & Leeds, 2002; Lee, et al., 2002; Manfield, 1998; Manfield & Shapiro, 2003; Madrid, Skolek, Shapiro, in press; Marcus, Marquis, & Saki, 1997; Marquis, 1991; McCullough, 2002; Parnell, 1996; 1997; Pollock, 2000; Power et al., 2002; Protinsky, Sparks, & Flemke, 2001a; Puk, 1991b; Renfrey & Spates, 1994; Ricci, in press; Rittenhouse, 2000; Shapiro & Forrest, 1997; Spates & Burnette, 1995; Spector & hutwaite, 1993; sprang, 2001; Vaughan, et al., 1994; Vaughan, Wiese, Gold, & Tarrier, 1994; Wilson, Becker, & Tinker, 1995, 1997; Wolpe & Abrams, 1991; Zabukovec, Lazrove & Shapiro, 2000).**