
Brief Report

EMDR Minus Eye Movements Equals Good Psychotherapy

Lee Hyer¹⁻³ and Jeffrey M. Brandsma^{1,2}

Eye Movement Desensitization and Reprocessing (EMDR) is a therapy roughly equal in efficacy to others currently available. It is argued that this treatment method is efficacious independent of the value of its component parts (e.g., eye movements) and is successful because it applies common and generally accepted principles of psychotherapy. Ten curative principles of this procedure are discussed as reflective of sound psychotherapy practice. It is hoped that an understanding of this therapy from the perspective of the practice and theory of psychotherapy will assist in its study.

KEY WORDS: EMDR; psychotherapy.

Eye Movement Desensitization and Reprocessing (EMDR) is a form of exposure/desensitization psychotherapy that requires clients to reexperience and cognitively (re)process their trauma in imagination, while at the same time moving their eyes (Shapiro, 1993). Above all, EMDR involves the processing of information that includes a self-directed search of identified targets (by the client) which uses several accepted psychotherapy components, including free association, desensitization, and both cognitive and emotional reprocessing. These processes are guided by rules in a basically nondirective therapy format. The goal is to move information non-obtrusively, or with assistance when natural processes are blocked (Shapiro, 1995).

We argue that, while the general effects of EMDR have not been separated from the putative effects of the components of EMDR, the applica-

¹Augusta, Veterans Administration Medical Center.

²Medical College of Georgia.

³To whom correspondence should be addressed at Department of Veterans Affairs, Medical Center, 1 Freedom Way, Augusta, GA 30910.

tion of the unique procedures of EMDR is providing therapeutic changes. EMDR has yet to receive consideration within the context of more accepted principles or theories of psychotherapy. If EMDR can be "explained" using reasonably accepted concepts of psychotherapy, then perhaps it can be more fairly viewed and seen as efficacious when the data support it. In this paper we argue that EMDR practices common (and sound) principles of psychotherapy. We have identified 10.

Review

Several reviews have found EMDR to be no more effective than other treatments (Acierno, Hersen, Van Hasselt, Tremont, & Meuser, 1994; Herbert & Meuser, 1992; Lohr et al., 1992; Lohr, Klienknecht, Tolin, & Barrett, 1995; Page & Crino, 1993). These reviews note design flaws, especially poor sample definition, unreliable measures, non-blinded evaluations, a lack of quality control on the treatments, as well as a surprising absence of a rigorous comparison with an established therapy. They also point to a few "mini-conclusions" regarding EMDR; (1) eye movements (as well as other component parts), the center piece of this therapy, appear unimportant as related to outcome; (2) changes, when they do occur, apply to verbal reports (mostly SUDS ratings); and (3), despite nonsignificance in many results, there are no negative results. In fact, these reviews support the proposition that, while EMDR is not superior to other methods, the methods of EMDR have produced positive changes along with or relative to controls. And, evidence exists that this method may be more effective with less chronic patients (e.g., Levin et al., 1994; Wilson et al., 1994) and involve less time than other methods (e.g., Renfrey & Spates, 1994; Vaughn et al., 1994). Importantly too, EMDR applies its treatment in what appears to be a user-friendly manner (Boudewyns & Hyer, in press).

From perhaps the most accepted perspective, learning theory, Foa and colleagues (Foa & Kozak, 1986, 1991) believe that the client must bring up the "bad" information, experience concomitant arousal, and be exposed to new information. This group (Foa, Steketee, & Rothbaum, 1989; Foa, Zimbarg, & Rothbaum, 1993) also noted the importance of accessing necessary stimulus characteristics, organismic response patterns, and the unique cognitive aspects of the whole learned response. The therapeutic response must be corrective to the poorly learned response. Sweet (1995) further outlined these arguments and applied them to EMDR. He argued that EMDR presented the best "context" for the holding of images that reduce avoidant responses typical of the trauma victim. This author outlined several areas (specified by Foa & Kozak, 1986) that represent critical

ingredients for emotional processing—exposure (to the conditioned stimulus), the stimulus, response and meaning propositions activated simultaneously, within and across session habituation, and corrective cognitive and physiological information. EMDR was, according to the author, responsive to all conditions.

It is worth noting too that, despite the efforts of several theories on the processes of EMDR (e.g, Accelerated Information Processing; Shapiro, 1995), little data exist to support any formulation (Boudewyns & Hyer, in press; Page & Crino, 1993). As we argue, EMDR may work because its “theory” involves the curative components of other therapies in one package.

Psychotherapy Principles Applied to EMDR

EMDR applies what appears to be central for change with trauma victims. Based on our experience (Boudewyns & Hyer, in press) and the reviews above, it is argued that the core of trauma processing involves both the reexperiencing of the trauma and the reprocessing of a newly assembled set of perceptions, emotions, and reattributions from the past (Smyth, 1995). In this format, therapy maximizes exposure, in a client friendly way, and does so applying other principles of therapy. EMDR does this in the application of its central feature, the pursuit of movement. It also respects the position of the client with the application of a non-directive and phenomenological method and by so doing empowers the client. It fosters what is natural, and therapeutically borrows from other forms of therapy what is required in more difficult instances. It also checks the process as it unfolds.

The first principle is accessing associative networks which are unique for each person: Each person protects the self differently. Each has established a personal profile of traits, defenses, and resistances that are over-learned. Jacobson (1964) noted that “the individual learns to run his organism according to what he believes are its best interests.” An important task of any effective therapy is to access (target) these unique associative networks (prototypical exemplars of the person) to help unblock problem processing. “EMDR is not a cookie cutter” (Shapiro, 1993). Based on the position and method of EMDR, flexibility is provided to target problems of the client (Shapiro, 1995). Shapiro (1993) labels this synclitic (synthetic eclecticism), the natural concatenation of various modes of therapy that individuate, then blend their tributaries to form a river of movement.

A second principle involves a time-honored belief of psychotherapy: the positive, growth motives within the person will ultimately be greater than the negative ones. EMDR rests on a principle of psychotherapy (that dates back at least to Carl Rogers) in which the client is said to move

toward positive growth, given the right environment. Just as many believe that older people experience a biographical impulse (given the right circumstances), Shapiro believes that in EMDR information is only processed in a positive direction (Shapiro, 1995). Similar to Rogers (1951) and modern constructivists (who advocate positive reframes), the position of EMDR is that when imbalances or stuck memories link up with other networks or nodes, the dysfunctional material that is held hostage in state-specific or state-dependent form will be allowed to move and be assimilated, often at a fast rate. The curative feature of concentrating on a negative event within a different context now allows the client to experience the differences in a positively assimilative manner.

A third principle is that movement is central for change. According to EMDR theory the person is always processing (even in conversation), and the task is to allow access to all relevant "nodes" of information (Shapiro, 1995). The enemy here is avoidance. EMDR presents an environment that allows movement to appear attractive. If not, a clear understanding that a less appealing choice is being followed is noted. Resistance is not a useful construct in this therapy. Given the "right" therapeutic presentation, the client should be able to understand that the processing of the trauma is in his/her best interest, and be able to find a way to continue it.

During abreaction (the fastest type of movement), the ideal is to keep the eyes moving until a new plateau is reached, often taking several minutes. The intent is to keep the client processing in present time, and allow the natural healing processes of assimilation and accommodation to function. Worked properly, other information presumably becomes linked with emotions, which are usually the real governor of processing. Again, the therapist has only one rule in this process—to keep it moving.

A fourth principle is that the therapist is most effective when "nondirective" with regard to content; it is preeminently the client's therapy. The client is requested to instigate a dialogue with self and then to "stay with that." The focus of the action is internal for the client. In fact, the client is told that the therapist does not need to know the content or details of the trauma, just what is happening during the EM processing. EMDR has been labeled a less threatening form of exposure, a free association with desensitization (Hyer, 1994). Shapiro (1995) believes that this procedure provides opportunity for a dual focus of attention to occur, the melding of past and present as well as the conscious and physiological.

The fifth principle affirms the importance of treatment expectations. In review studies that comment on the salient components of treatment, preparation for treatment or the inculcation of treatment expectations are singularly powerful. Importantly EMDR respects and enhances this. To start with, EMDR provides an efficient protocol for the assessment of the

learning history of the client (Shapiro, 1995; Sweet, 1995). Necessary ingredients for an understanding of the client are provided. Beyond the information, however, EMDR readies the client for therapy. The client is given general expectations (powerful procedure, access negative target memories, associate freely to the target, fast processing, keep a log) and EMDR-specific expectations (use SUDS, cognition ratings, tell what goes on).

Sixth, clean language is applied (Grove & Panzer, 1991). Clean language involves the therapist's use of nonleading language that keeps the focus on the target in an uncontaminated way. Much of traditional therapy is a participatory experience that gives full recognition to what the client says and how it is said. Clean language is an added method of giving full credit to the client. It keeps the client on the target in a useful and friendly way. It respects the power of words, how they create an environment for the client. To borrow from Grove and Panzer (1991), by the mere act of the "clean" loosening the infrastructure of the trauma (as with penetrating oil), the stuck symbol, idea, sensation, or feeling evolves—if enough components are involved, an epiphanic moment results.

One other feature of EMDR is clean: the metacommunication and EM sections of the EMDR procedure combine a "just right" mix for processing. During the processing itself (EMs), the client may be in a "trance" (a state shorthandedly characterized as "alpha") when the rhythm of the saccades proceeds. In this state if clean language is used with the client, the focus is where it needs to be (inside the client); the client can go anywhere inside to get the answer or another piece to the puzzle. Between saccades the client metacommunicates on this trance. In this way the client is fully involved at many levels, doing the experiencing during the EMs and placing (other) words on feelings, or conditioning sensations with the experiences between the saccades. This is what Rennie (1994) believed to be the best in storytelling in psychotherapy—the client mixing nonreflexive ("just doing" in the story, not aware of activity) and reflexive (intending and reflecting on the "doing").

A seventh principle involves the important role of cognition. It has been argued that at base EMDR is a cognitive therapy; it highlights negative and positive anchoring cognitions. This frames the reprocessing part of EMDR. In EMDR the client is requested to identify a negative, self-referenced belief that is current and has affective resonance about the target event. The client is also asked to identify positive cognitions that, if true, would remove the offensive influence of the target event. This cognition is brought back to the life of the therapy at various times and installed when there is a low SUDS (at the end of the therapeutic sessions of therapy). In effect, the client is requested to process negative thoughts,

accept and relearn a healthy cognition, and do it now or in the future, or both.

An active cognitive intervention, a cognitive interweave, is employed when resistance, looping, or no change is present. This is a present-oriented, cognitive re-look at a stuck position. It is cognitive reconstruction to help the client reauthor or reassess the rigid position. It is a “common sense” view that upsets the tendentious and fictive beliefs of the client. Of interest, the cognitive interweave punctuates the self-narrative with a blend of language and experiencing that seems to allow healing. It is done sparingly and only when the subjective side of experiencing welcomes this.

While cognitions are kept in the foreground both as operational and understandable contributors and monitors of the EMDR change process, more central to the person are feelings and sensations, which allow this process to unfold naturally and honestly (eighth principle). In fact, cognition plays off and enhances the role of affect; affect recruits cognitions. It may be that the level of affect stimulates cognitive content of equivalent valence resulting in change (Shapiro, 1995). Affect has a strong influence on change, both goal-directing the process and increasing the processing. In fact, no change seems possible without concomitant emotions (Safran & Segal, 1990).

Sensations are first cousins of affect, representing an experiential component. Bacon noted that sensations do not lie, giving a “true snapshot” of the situation (Guidano, 1991). In effect, sensations become the governor of the change process. When problems exist, EMDR depends on both for indications and for change. As the process of EMDR explores a situation fully, information is processed most richly when attending to and generating emotionally tuned data, often anchored to the physiology of the person (sensations).

EMDR does something that very few other therapies do—it reduces the need for security operations on the part of the client (ninth principle). If done well, the client basically has only self with whom to do battle. Defenses and maneuvers to parry the interpersonal intrusions of the therapist are reduced to their lowest level. As has been noted, the content of therapy focuses on the internal state of the client, the action of therapy is always on the target within. In this regard too, an advantage of EMDR may be that it does not seek to increase exposure beyond what the client volunteers and therefore does not engender as high a level of anxiety during the treatment as do direct exposure methods (Boudewyns & Hyer, in press).

One other principle (the tenth) is provided: The role of the therapist is liberated. In traditional psychotherapy therapists are listeners: Clients always feel good when they are heard (Hyer & Associates, 1994). The therapist, on the other hand, may be effective as a listener (Kahn, 1991),

but also feels the urge to “do” something, to have rules at the ready that facilitate the change process (when needed). In EMDR, both appear to apply: The therapist functions as a real “blank screen,” and, when necessary, has a manualized set of rules to create movement.

The role of the therapist is, however, important. The therapist is far from a nonperson. In the practice of EMDR the therapist acquires referent and contextual power as he/she is forced to do what is natural and therapeutic (i.e., be nondirective and facilitative). By being nondirective the therapist is “directing” the client more than is possible in any other way—the client becomes empowered to act on self. Many therapists like to “do something” in therapy and give the client something (Mahoney, 1991). EMDR provides the therapist with this luxury, but in a highly circumscribed and disciplined way.

Conclusion

In sum, we believe that EMDR is on to something important. We believe that the methods of EMDR are important, whatever the eventual merits and impact of its component parts. Arguably, we believe that EMDR is efficacious because it applies sound psychotherapy principles. The structure and process of this technique are sufficiently unique in its practice and sufficiently common in the proferring of accepted principles of psychotherapy as to be uniquely impactful. Only comparative data will bear this out.

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