

# From nightmare to memories

Eye movement desensitisation and reprocessing (EMDR) is achieving positive outcomes with an ever-increasing breadth of trauma-related mental health problems, as *Robin Logie* reports

'EMDR has managed to take a trauma that I have endured for so many years, turned it from a living nightmare into a simple picture book of memories that never trouble my life again.'

This description by a client of eye movement desensitisation and reprocessing (EMDR) may sound too good to be true but is typical of many comments from clients following experience of this form of therapy.

I have used EMDR for 15 years and am still sometimes astounded and slightly disbelieving about how it works. However there is no magic or hocus-focus involved. It has a sound theoretical framework based on an understanding of neurology, uses a systematic protocol, has a structured training programme that is internationally agreed and has a body of published research to demonstrate its effectiveness for trauma and, increasingly, other forms of psychological disorder such as depression and anxiety. It is one of only two forms of treatment recommended for post-traumatic stress disorder (PTSD) by the National Institute for Health and Clinical Excellence (NICE).<sup>1</sup>

EMDR was developed by American clinical psychologist Francine Shapiro in the 1980s. She had recently been diagnosed with cancer and noticed that bilateral eye movements seemed to calm her when she thought about her illness. Initially she assumed she had discovered a technique for desensitisation only and she developed it into a therapy that she first named eye movement desensitisation (EMD).<sup>2</sup>

However she then discovered that, in addition to desensitising the client to their traumatic memory, her new therapy promoted spontaneous cognitive changes. Her clients were reprocessing their 'frozen' traumatic memories so that the trauma became integrated with their other experiences. So she added 'reprocessing' to the title, giving it the rather unwieldy name it now has. In some ways it is unfortunate that the words 'eye movement' have become part of its name as subsequent research and experience has shown that the crucial component appears to be the bilateral stimulation of the two hemispheres of the brain. We now know this can also be achieved by similar alternating techniques using the other senses, such as sounds in the ears, tapping each side of the body and holding alternately vibrating buzzers in each hand.

After Shapiro's discovery of the reprocessing function of EMDR, a theory was developed to make sense of what occurs. Adaptive information processing (AIP)<sup>3</sup> explains how new experiences are assimilated into existing memory networks. As Shapiro has written: 'For instance, when handed a cup, one needs previous "cup" experiences in order to know what to do with it. Likewise, a failed love experience is assimilated into memory networks associated with relationships, and adds to the knowledge base regarding such things as expectations and potential warning signs. In a healthy individual, as new experiences are processed, they are "metabolised" or "digested" and what is useful is learned,

stored with appropriate emotions, and made available to guide the person in the future.'<sup>3</sup>

If the event is traumatic, the information processing system stores the experience without adequately processing it to an adaptive resolution. For example, in PTSD<sup>4</sup> – the first disorder for which the effectiveness of EMDR was clearly demonstrated – individuals continue to re-experience the trauma 'as if it's happening now'. So they understandably seek to avoid anything connected to the trauma and tend to be hyper-aroused by anything that recalls it. EMDR uses dual attention stimuli to help the client recall the trauma safely, while keeping 'one foot in the present'. In this way, the client is able to access the dysfunctionally stored experience and the body's innate processing system can then spontaneously transform, assimilate and store it as useful learning within the brain's memory structures. The client will be able to recall and describe the event and what has been learned but the distressing emotions and physical sensations have been discarded.

## EMDR therapy

In an EMDR session, the therapist will first conduct a very careful and detailed assessment, paying particular attention to the client's trauma history. Sometimes the trauma is obvious, such as a road traffic accident or a rape. With more complex problems, the individual may have suffered multiple traumas dating back to early childhood. Sometimes the therapist must search for a 'touchstone

event' that is crucial to unlocking the client's dysfunctional processing.

The therapist also needs to ensure that the client is sufficiently psychologically robust to undertake EMDR reprocessing; it can be a very powerful experience, emotionally, cognitively and physically. For some clients it may be necessary to use EMDR to first build up their resilience – for example, by ensuring that they have a 'safe place' and have the ability to 'self soothe' when necessary.

Once it has been established that the client is ready to work on their past, they are asked to identify the 'worst moment' of their trauma. They are then asked: 'When you think of that incident, what negative thoughts do you have about yourself now?', and to describe the emotions that are produced by the memory and where they feel them in their body.

The actual processing of the trauma then starts with the therapist saying something like: 'I'd like you to bring up that image, those negative words "I'm not safe", and notice where you are feeling it in your body and then follow my hand with your eyes.' The therapist will then pass their hand to and fro in front of the patient. After about 20 to 30 seconds of bilateral eye movements (or tactile or auditory stimulation with buzzers and/or headphones), the therapist will check progress using a very open question such as, 'What are you getting now?'

Often the change occurs spontaneously and all the therapist needs to say is, 'Go with that' and

continue the processing with more bilateral stimulation. If the client becomes stuck the therapist may need to use a 'cognitive interweave' to move things along. For the most part, however, the therapist is advised to let the processing occur naturally.<sup>5</sup> Positive change and reprocessing usually happens naturally as the brain's built-in meaning-making circuitry reworks the memory and the client begins to see and feel their trauma in a wider context.

From the client's perspective, the process might feel like this.

'It starts with a gently spoken lady moving her hand from left to right in front of my eyes and asking me to focus on her hand and think of only one of my many past events. This movement of the hand only lasts for around 20 or 30 seconds, after which I am asked if any images or maybe an emotion linked with the event has become clearer. As strange as it may sound, after a few more hand movements, images and emotions do become clearer. A state of panic ensues as the whole event from years before suddenly feels as though it is happening to me again here and now. A gentle voice reassures me that everything is OK and nothing will bring me to harm and I'm in a safe place... This is now becoming really uncomfortable for me. I feel confused, insecure yet safe at the same time... As each session progresses, images and memories become confused and somewhat cloudy, even finding it difficult at times to recall the event.'

Once the stage has been set, EMDR is one of the most client-centred forms

of therapy, following where the client spontaneously goes. It could be described as a kind of turbo-charged psycho-analytic free association but with the difference that, after tracking a sequence of memories and associations, the client is always brought back to the 'target memory', the urgency of which can very rapidly begin to fade as the EMDR continues.

### **Beyond trauma**

Because it is a therapy that focuses on traumatic events, the obvious starting place for the application of EMDR has been the treatment of PTSD,<sup>4</sup> and it is now well established in this field. However, EMDR has since evolved into a comprehensive psychological treatment for any psychological disorder whose origins can be traced back to earlier experiences that are still negatively affecting their emotional functioning. I have chosen three areas – depression, obsessive compulsive disorder (OCD) and pain – to illustrate the diversity of the applications for EMDR.

#### *Depression*

In my experience, most individuals with depression have early experiences that have created a blueprint for the way they see themselves in relation to the world. With EMDR, rather than starting with a specific traumatic experience, the therapist identifies a 'touchstone event'. For example, a client's belief that they are 'worthless' may relate to the expectation in their childhood that they take responsibility for others in the

## References

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family – perhaps a parent with alcohol problems. They may remember a specific occasion when their mother said, 'You never think of others. Can't you see that your dad's poorly?' This specific memory might represent the client's relationship with their family.

The touchstone memory forms the focus for the EMDR therapy, from which current negative cognitions, emotions and somatic responses are identified. These are not traumas with a capital 'T', as in PTSD. But the process is the same: the client needs to be helped to experience and reprocess their childhood experiences in the present; otherwise these memories will stay in the trauma-related circuitry of their brain and continue to infect and negatively inform, often outside consciousness, their emotional responses and how they are.

With depression, EMDR thus appears to be a more integrative approach, in that it works simultaneously on several levels (cognitive, emotional and somatic) instead of just one.

### *Obsessive compulsive disorder*

I have a particular interest in the use of EMDR for the treatment of OCD.<sup>4</sup> OCD is known to have a strong genetic component<sup>6</sup> and you might legitimately question how a therapy that focuses on unresolved past events can help someone with this disorder. More than half of those with OCD have experienced at least one traumatic life event;<sup>7</sup> EMDR can help the client by targeting these traumas, and this can go some way towards ameliorating the OCD symptoms.

However, some people with OCD do not have an identifiable trauma or, when the trauma has been resolved, the obsessive compulsive way of coping with life's stresses remains ingrained and they need further help to overcome this.

I am having some success with using the EMDR approach to target not a past event but a future feared event. For example, I might ask the client to imagine that they do *not* engage in a specific compulsive ritual. Following the usual EMDR protocol, I will then ask them to say what this makes them believe about themselves now, what emotions they are experiencing and where they feel them in their body. We then process the event as usual. Sometimes this naturally resolves the distress. Sometimes it brings up past events that we had not previously identified and that remain unresolved. We can then do some further therapeutic work on these events. There is some research evidence to support the use of this 'flashforwards' technique.<sup>8</sup>

### *Pain*

EMDR is becoming increasingly recognised as an effective approach to the amelioration and management of pain. Chronic pain can continue after there is no longer any identifiable physical injury to explain it. Pain may be directly or indirectly related to traumatic or stressful events or situations. However, because of avoidance, denial or simple lack of understanding, the client may not consciously make this association. A careful and thorough

history taking is often necessary to elicit traumatic, stress-related antecedents of chronic pain disorders.

The primary target for EMDR processing will be the original incident in which the injury occurred or the first time that the pain was experienced. The basic EMDR trauma protocol is used in this application. EMDR can also be used to target the sensation of pain and the distress about symptoms and related disabilities.<sup>9</sup>

When EMDR is used to transform the pain experience, the client is asked to focus on the pain while attending to short sets of bilateral stimulation, after which they report what, if any, changes have occurred, and the therapist facilitates the cognitive interpretation of these changes. Patients typically report that they feel more relaxed and that the sensation of pain has changed. This is often a decrease in pain severity but it may also be a change in location, type or quality of the pain, or a sense of relief or relaxation.

In order to cognitively integrate the reported changes in physical sensations, the therapist asks specific questions designed to facilitate cognitive associations. For example, a client might be asked, 'What does this feeling of relief remind you of?' and might reply that his pain feels softer, 'like cotton wool'. The therapist will then reinforce this imagery by using further bilateral stimulation. The client is then shown how to use this same process to manage their pain themselves. For example, clients are instructed that, when they

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have pain in the future, they should recall their antidote imagery and simultaneously attend to bilateral stimulation, and then try to just let whatever happens happen, as they were instructed to do in the therapy session.<sup>10</sup>

### Does EMDR work?

EMDR is now well established as an effective treatment for PTSD. A survey of 38 randomised control trials (RCTs) has established that EMDR and trauma-focused cognitive behaviour therapy (TFCBT) are the two most effective treatments for this disorder.<sup>11</sup> A review of seven studies of EMDR for children with PTSD has found that EMDR and cognitive behaviour therapy (CBT) are superior to all other treatments and that EMDR is slightly more effective than CBT.<sup>12</sup>

The current treatment guidelines of the International Society for Traumatic Stress Studies state that EMDR is an effective and empirically supported 'A' rated treatment for PTSD in adults.<sup>13</sup> The American Psychiatric Association's practice guideline for acute stress disorder and post-traumatic stress disorder recommends EMDR as one of three first-line treatments.<sup>14</sup> As previously reported, in the UK EMDR is one of the two psychological treatments for PTSD recommended by NICE.<sup>1</sup>

Research into the application of EMDR with other disorders is developing. There are published RCTs showing the effectiveness of EMDR with survivors of sexual abuse.<sup>15</sup> In one study, approximately half the number of EMDR

sessions were needed to achieve results comparable with CBT.<sup>16</sup> In another RCT, EMDR resulted in large and significant reductions in memory-related distress and problem behaviours in boys with conduct problems.<sup>17</sup> A recent RCT found that EMDR is more effective than medication in the treatment of OCD.<sup>18</sup>

Many non-randomised studies have been published showing that EMDR is an effective treatment for other disorders. These include borderline personality disorder,<sup>19</sup> body dysmorphic disorder,<sup>20</sup> generalised anxiety disorder,<sup>21</sup> pain management,<sup>22</sup> paedophilia,<sup>23</sup> phantom limb pain,<sup>24, 25, 26</sup> bulimia nervosa<sup>27</sup> and phobia.<sup>28</sup>

EMDR is likely to become established as a treatment of choice for depression. Many EMDR clinicians currently use it to great effect with this condition and a pan-European clinical trial of EMDR in this application is currently being conducted. Change in depressive symptoms has often been a secondary measure in studies of EMDR for post-traumatic stress, and many of these trials have achieved reductions. Some studies have specifically demonstrated that EMDR is an effective treatment for depression.<sup>29, 30</sup>

### Training in EMDR

To train in EMDR, you need to be a qualified mental health professional with some experience in the field. Several hundred people complete the training each year in the UK.

When selecting a course, first check that the trainer is accredited by the

EMDR Europe Association. The initial seven days of training are usually spread over several months. Once you have completed the initial training you can work towards accreditation as an EMDR Europe practitioner through supervision of your EMDR practice. There is a requirement to attend for supervision but accreditation is based on the clinician's competence in all areas of EMDR practice. EMDR consultants are accredited to provide supervision and consultation to therapists who are working towards becoming accredited practitioners. EMDR consultants have completed an additional consultants' training and have been assessed on their supervising skills and have considerable further supervised experience of using the therapy. ■

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*For further information about EMDR and details of training courses, please visit [www.emdrassociation.org.uk](http://www.emdrassociation.org.uk)*

*The Humanitarian Assistance Programme (HAP) is a registered charity that provides training in EMDR to local mental health professionals in communities that have experienced major trauma. For more information, please visit [www.hapuk.org](http://www.hapuk.org)*