EMDR for post-traumatic stress and other psychological trauma

In this article...
- An explanation of eye movement desensitisation reprocessing (EMDR)
- Case studies of when EMDR has been used successfully
- Arguments for more widespread use of EMDR as a powerful psychotherapy

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Eye movement desensitisation and reprocessing (EMDR) is a powerful psychotherapy with well-researched benefits for adults and children who are experiencing post-traumatic stress and post-traumatic stress disorder. There is a wealth of research and practice-based evidence demonstrating the effectiveness of EMDR in many differing clinical presentations but the true potential of this extraordinarily beneficial therapeutic approach has not been fully embraced by the mental health nursing profession.

Francine Shapiro developed eye movement desensitisation and reprocessing (EMDR) in the 1980s. Its somewhat unusual processes tend to be highlighted by the media as much as its extraordinary efficacy however, as demonstrated in an article describing the successful treatment of a nurse traumatised by her duties in the Iraq war, which was published in The Telegraph (Goldwin, 2012). The efficacy of EMDR in treating post-traumatic stress disorder (PTSD) is well researched and documented. The research evidence is sufficiently robust for recognition by the National Institute for Health and Clinical Excellence (NICE, 2005) and there is a wealth of additional research evidence confirming the effectiveness of EMDR in the treatment of children. For example, Rodenburg et al (2009) drew together the findings of seven randomised controlled trials and concluded that EMDR is as effective as cognitive behavioural therapy but requires fewer sessions.

How does it work?
It is not known exactly how any psychotherapy works but EMDR processes are believed to release and enhance the brain’s adaptive information processing system. Using eye movements while recalling distressing events appears to help integrate and process painful memories in a similar way to rapid-eye-movement sleep or dream sleep, which is understood to help process the events of our day and integrate them into our experience (Stickgold, 2002). Alternate tapping or auditory tones have been found to be similarly effective – this part of EMDR...
treatment is usually referred to as bilateral stimulation (BLS).

Some therapists employ devices such as a light bar, headphones or alternating tactile buzzers to deliver the BLS. It is worth mentioning here that EMDR cannot be compared to hypnosis. Electroencephalograph (EEG) readings show increased alpha, beta and theta waves during hypnosis associated with increased suggestibility; during EMDR, however, EEG readings show brainwaves within normal waking parameters. Anecdotally, EMDR therapists are aware that during EMDR “the person is actually less susceptible than usual to information that is not correct” (Lovett, 1999).

**EMDR therapy**

EMDR is a great deal more than eye movements or bilateral stimulation; it is a complex protocol with eight phases of treatment integrating many elements from a range of therapeutic approaches. The aim of EMDR therapy is to work with past memories and present symptoms in order to completely “digest” or “process” the experiences causing problems and to allow a new awareness or perspective necessary for full psychological and emotional health (Shapiro, 2001).

EMDR treatment starts with detailed history-taking, including a full trauma history and the development of a collaborative therapeutic relationship. Many clients who are traumatised are too distressed to begin work immediately on the traumatic material triggering their condition; if this is the case, they are taught EMDR-specific stress-management techniques and are supported to develop and/or access their own personal resources to help them feel strong and calm enough to begin work on their traumatic material. This prevents them from becoming overwhelmed and/or re-traumatised. When the groundwork has been done the client is invited to select a target from their list of adverse events.

Target selection requires proper training and skill, as well as a sound knowledge of the client, their history, their strengths, vulnerabilities and their issues. It may be necessary to address smaller contributory events first or use some distancing techniques to ensure the client is not overwhelmed as they begin to digest their troublesome experiences. The client selects an image (or other identifier, such as a sound or smell) that represents the worst part of the target event; they then identify the negative message (negative cognition) this event gives them in terms of their belief about themselves, particularly in relation to the event – for example, “I’m a bad person” or “I’m not safe”. The therapist also invites the client to select a preferred, more functional message or learning point that could be drawn from the target event; this is described as a positive cognition – for example, “I’m OK” or “I can learn to protect myself”. Positive cognitions enable the client and therapist to identify where they want to go, highlighting the desired psychologically healthy message the event can provide rather than the one that is fuelling the client’s distress.

The subjective severity of disturbance associated with the target event and the negative thought is recorded (subjective units of distress), as is the client’s assessment of the truthfulness of the more functional message. This is useful because the individual who is traumatised cannot believe the more-functional message to be intrinsically true when recalling their traumatic experiences. Their sense of its truthfulness is measured on a scale of 1-7 (validity of cognition) to enable changes or improvements in the functionality of their belief systems to be identified as treatment progresses. When the traumatic event no longer causes distress and the client can accept the positive, adaptive thought as true, the traumatic event has been integrated and treatment is complete.

The client will be invited to focus on the target image or other identifier and related negative cognition, notice the emotion(s) this evokes and where it is experienced in his/her body. The client then follows the associative chain of this disturbing material from the past while simultaneously focusing on the external stimulus provided by the BLS (given in short 25-30-second sets) and the therapist’s guidance; this is called dual attention focus. This process accesses the traumatic memory network so the target can be “reprocessed” in a more functional way with new associations being made between the disturbing memory and more adaptive material. In this way, emotional and physiological distress are alleviated and the client develops cognitive insights.

**Successful use of EMDR**

EMDR can be used to treat all manner of psychological and emotional problems, as noted in the literature (Shapiro, 2009; 2005; Shapiro and Kaslow, 2007) and published research papers (Wanders et al, 2008; Soberman et al, 2002).

The case studies supplied are derived from my experience of treating clients. Case study 1 illustrates the use of EMDR in a young person suffering from the intrusion, hyper-arousal and avoidance of their memory. Emily was aged 14 and living at home with her family when she was referred for treatment. She had been drugged at a party by someone she barely knew, and raped. The perpetrator received a custodial sentence.

Emily’s safe place was a tropical island paradise and resources were happy holiday memories, winning an important argument and academic success. The worst part of the trauma for her was becoming conscious, seeing her torn clothing, feeling the pain in her body and the realisation of what had happened. Her negative cognition spanned safety and control: “I cannot protect myself”, “I’m powerless”.

**Case study 1. EMDR and post-traumatic stress disorder**

Emily* was aged 14 and living at home with her family when she was referred for treatment. She had been drugged at a party by someone she barely knew, and raped. The perpetrator received a custodial sentence.

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Treatment was complicated by daily reminders of invasion due to her home situation where her need for privacy in the bathroom and in her bedroom while changing was disregarded by family members. Treatment involved persuading her parents to support Emily’s desire for privacy from them and her siblings, and to prioritise certain home improvements. The installation of a bedroom door and a lock on the bathroom door played a significant part in her recovery.

Emily required one desensitisation session and eight sessions of therapy in total. Name has been changed.

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*Emily* is a pseudonym.
phenomena associated with PTSD. Case study 2 illustrates my experiences of using EMDR to treat problems generated by multiple adverse events rather than the major trauma linked to post-traumatic stress or PTSD.

**Conclusion**

These case studies show some of the success stories obtained through EMDR. Of particular note is the psychological and emotional growth frequently seen as a by-product of successful treatment with EMDR. Clients report improved relationships; a large proportion also engage in further education or training, while others seek and obtain career advancement.

**References**


**CASE STUDY 2. EMDR AND MULTIPLE ADVERSE EVENTS**

Jenny is aged 15 and lives at home with her mother. Her 18-year-old brother lives with extended family. She is the youngest of her mother’s five children and the only female. There are three adult half-brothers with their own partners and children. Three of her brothers have been convicted for violent crime and drug-related offences.

Jenny presented with behaviour problems, aggression (physical and verbal) and difficulties regulating and managing her emotional responses (affect regulation). She was extremely bright but at risk of exclusion from school due to her escalating explosive and volatile behaviour towards peers and teaching staff. She was anxious to maintain her place in school as she had the ability and ambition to attend university and succeed in her goal of a well-paid professional career. She was expressing fear that she might follow the example of her brothers if she did not learn how to control her rages.

Jenny’s treatment involved stress management training using breathing techniques, visualisation and progressive muscle-relaxation exercises as well as resource development, before embarking on desensitisation of some of the disturbing formative experiences that had contributed to her current predicament.

Often people come for treatment feeling helpless, demoralised and with little or no belief in their potential for positive change. They need some help to remember the positive things they can do. One of Jenny’s resource-development sessions involved encouraging her to remember a time when she had managed a challenging situation without getting in a rage. She was supported to recall the event vividly with images and sounds alongside the sense of pleasure, pride and competency her success in this evoked. She was encouraged to notice how these positive feelings are experienced as physical sensations in her body and then the memory was “installed” by using two to three sets of very slow bilateral stimulation (as opposed to the longer, faster, multiple sets required during the reprocessing phase).

Using bilateral stimuli in this way has been found to be extremely effective at bringing positive memories into present consciousness and, along with them, an increased sense of competency and belief in one’s potential for healing. An essential resource that is established in everyone embarking on EMDR therapy is the ability to self-soothe and/or to create a psychological/imaginary safe place. Jenny needed a number of stress-management and resource-installation sessions before beginning to address some of the negative cognitions generated by a plethora of adverse life events and circumstances. Her safe place was an imaginary outdoor environment in the sunshine and her negative cognitions spanned responsibility, safety and control.

As a result of her treatment with EMDR Jenny became calmer, happier, avoided exclusion, did well in her GCSEs and is now doing her A-levels. She had six desensitisation sessions and 14 sessions in total.

*Name has been changed*