

EMDR Evaluated Clinical Applications

EMDR is now widely recognized as a first line treatment of trauma (e.g., American Psychiatric Association, 2004; Bisson & Andrew, 2007; Bleich et al., 2002; CREST, 2003; DVA/DoD, 2004; Foa et al., 2009; INSERM, 2004; NICE, 2005)

EMDR clinical applications are based upon the adaptive information processing model (AIP; see Shapiro, 2001, 2002, 2006, 2007) which posits that the direct reprocessing of the stored memories of etiological events and other experiential contributors can have a positive effect in the treatment of most clinical complaints. This prediction has received support in a case studies and open trials with a variety of diagnoses. Expanding the standard protocols (Shapiro, 1995, 2001), additional applications have been developed in clinical practice by experts and consultants in a number of specialty areas. To-date, while numerous controlled studies have supported EMDR's effectiveness in the treatment of trauma and PTSD across the lifespan, other clinical applications are generally evaluated in case studies or open trials and are in need of further investigation.

As with all treatments for most of these disorders, little controlled research has been conducted, a state of affairs evident in an evaluation report by a task force set in motion by the Clinical Division of the American Psychological Association (Chambless, Baker, Baucom, Beutler, Calhoun, Crits-Christoph, et al., 1998). This report revealed that only about a dozen complaints, such as specific phobias and headaches had empirically well-supported treatments. Many of the treatments listed as empirically validated had not been evaluated for the degree to which they provided substantial long-term clinical effects. For the latest listing see: <http://therapyadvisor.com>

While EMDR protocols for PTSD have been widely investigated by controlled research, it is hoped that additional promising applications will be thoroughly investigated. Suggested parameters have been thoroughly delineated (Shapiro, 2001, 2002). To aid researchers in identifying protocols available for study, and to assist clinicians in obtaining supervision for proposed applications, published materials and conference presentations are listed below. Many presentations have been taped and are available from the conference coordinators. Presenters may also be accessed directly through the EMDR International Association <http://www.emdria.org>

Another excellent resource is The Francine Shapiro Library (FSL) developed by Barbara Hensley Ed.D. and hosted by Northern Kentucky University. It is the premier repository for scholarly articles and other important writings related to the Adaptive Information Processing (AIP) model and EMDR. The intent of the FSL is twofold: (1) to electronically house documents related to EMDR or AIP and (2) to maintain a comprehensive, accurate, and up-to-date list of citations related to AIP and EMDR. http://library.nku.edu/emdr/emdr_data.php

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 the Iraq Wars, the Afganistan War, 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, 1996; Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Daniels, Lipke, Richardson, & Silver, 1992; Lipke, 2000; Lipke & Botkin, 1992; Russell, 2006, 2008; Russell, Silver, Rogers, & Darnell, 2007; Silver & Rogers, 2001; Silver, Rogers, & Russell, 2008; Thomas & Gafner, 1993; Wesson & Gould, 2009; White, 1998; Young, 1995; Zimmermann, Güse, Barre, Biesold, 2005).
2. **Persons with phobias, panic disorder and generalized anxiety disorder who revealed a rapid reduction of fear and symptoms** (De Jongh & ten Broeke, 1998; De Jongh, ten Broeke & Renssen, 1999; De Jongh, van den Oord, & ten Broeke, 2002; Doctor, 1994; de Roos, & de Jongh, 2008; Feske & Goldstein, 1997; Fernandez & Feretta, 2007; Goldstein, 1992; Gauvreau, & Bouchard, 2008; Goldstein & Feske, 1994; Gros & Antony, 2006; Kleinknecht, 1993; Nadler, 1996; Newgent, Paladino, Reynolds, 2006; O'Brien, 1993; Protinsky, Sparks, & Flemke, 2001a; Schurmans, 2007). Some controlled studies of spider phobics have revealed comparatively little benefit from EMDR, (e.g., Muris & Merckelbach, 1997; Muris, Merckelbach, Holdrinet, & Sijenaar, 1998; Muris, Merckelbach, van Haften & Nayer, 1997) but evaluations have been confounded by lack of fidelity to the published protocols (see De Jongh et al., 1999; Shapiro, 1999 and Appendix D). One evaluation of panic disorder with agoraphobia (Goldstein, de Beurs, Chambless, & Wilson, 2000) also reported limited results (for comprehensive discussion per Shapiro, 2001, 2002; see also Appendix D).
3. **Crime victims, police officers, fire fighters, 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, 1993; Jensma, 1999; Kitchiner, 2004; Kitchiner & Aylard, 2002; Kleinknecht & Morgan, 1992; Lansing, Amen, Hanks, Rudy, 2005; McNally & Solomon, 1999; Page & Crino, 1993; Rost, Hofmann & Wheeler, 2009; Shapiro & Solomon, 1995; Solomon, 1995, 1998; Solomon, & Dyregrov, 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** (Lazrove et al., 1998; Puk, 1991a; Shapiro & Solomon, 1995; Solomon, 1994, 1995, 1998; Solomon & Kaufman, 2002; Solomon & Rando, 2007; Solomon & Shapiro, 1997; Sprang, 2001).
5. **Children and adolescents healed of the symptoms, including depression, caused by disturbing life experiences** (Ahmad et al., 2007; Bae, Kim, & Park, 2008; Chemtob, Nakashima, Hamada & Carlson, 2002; Cocco & Sharpe, 1993; Datta & Wallace, 1994, 1996; Fernandez, 2007; Fernandez, Gallinari, & Lorenzetti, 2004; Greenwald, 1994, 1998, 1999, 2000, 2002; Hensel, 2006, 2009; Jaberghaderi, Greenwald, Rubin, Dolatabadim, & Zand, 2004; Johnson, 1998; Jarero, Artigas, & Hartung, 2006; Korkmazler-Oral & Pamuk, 2002; Kraft, Schepker, Goldbeck, & Fegert, 2006; Lovett, 1999; Maxfield, 2007; Oras et al., 2004; Pellicer, 1993; Puffer, Greenwald & Elrod, 1998; Russell & O'Connor, 2002; Scheck, Schaeffer, & Gillette, 1998; Shapiro, 1991; Soberman, Greenwald, & Rule, 2002; Stewart & Bramson, 2000; Streeck-Fischer, 2005; Taylor, 2002; Tinker & Wilson, 1999; Tufnell, 2005; Wanders, Serra, & de Jongh, 2008; Zaghrou-Hodali, Alissa, & Dodgson, 2008).
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; Rothbaum, Astin, Marsteller, 2005; 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; Colelli, & Patterson, 2008; Fernandez, 2008; Fernandez, et al, 2004; Grainger, Levin, Allen-Byrd, Doctor, & Lee, 1997; Jarero, Artigas, Mauer, Lopez Cano, & Alcala, 1999; Jayatunge, 2008; Knipe, Hartung, Konuk, Colleli, Keller, & Rogers, 2003; Konuk, Knipe, Eke, Yuksek, Yurtsever, & Ostep, 2006; Shapiro & Laub, 2008; Shusta-Hochberg, 2003; Silver, Rogers, Knipe & Colelli, 2005).
8. **Accident, surgery, and burn victims who were once emotionally or physically debilitated and who are now able to resume productive lives** (Blore, 1997b; Broad & Wheeler, 2006; Hassard, 1993; McCann, 1992; Puk, 1992; Softic, 2009; Solomon & Kaufman, 1994).
9. **Victims of family, marital and sexual dysfunction who are now able to maintain healthy relationships** (Bardin, 2004; Capps, 2006; Errebo & Sommers-Flanagan, 2007; Keenan & Farrell, 2000; Kaslow, Nurse, & Thompson, 2002; Knudsen, 2007; Koedam, 2007; Levin, 1993; Madrid, Skolek & Shapiro, 2006; Moses, 2007; Protinsky, Sparks, & Flemke, 2001b; Shapiro, Kaslow, & Maxfield, 2007; Snyder, 1996; Stowasser, 2007; Talan, 2007; Wernik, 1993).
10. **Clients at all stages of chemical dependency, sexual deviation/addiction, and pathological gamblers, who now show stable recovery and a decreased tendency to relapse** (Amundsen & Kårstad, 2006; Besson, Eap, Rougemont-Buecking, Simon, Nikolov, Bonsack, 2006; Cox & Howard, 2007; Hase, Schallmayer, & Sack, 2008; Henry, 1996; Marish, 2009; Popky, 2005; Ricci, 2006; Ricci et al., 2006; Shapiro & Forrest, 1997; Shapiro, Vogelmann-Sine, & Sine, 1994; Vogelmann-Sine, Sine, Smyth, & Popky, 1998; Zweben & Yeary, 2006).
11. **People with dissociative disorders who progress at a rate more rapid than that achieved by traditional treatment** (Cohen, 2009; Fine, 1994; Fine & Berkowitz, 2001; Lazrove, 1994; Lazrove & Fine 1996; Marquis & Puk, 1994; Paulsen, 1995; Rouanzoin, 1994; Twombly, 2000, 2005; Young, 1994).
12. **People with performance anxiety or deficits in school, business, performing arts, and sport who have benefited from EMDR as a tool to help enhance performance** (Barker, & Barker, 2007; Crabbe, 1996; Foster & Lendl, 1995, 1996; Graham, 2004; Maxfield, 2000).
13. **People with somatic problems/somatoform disorders, including migraines, chronic pain, phantom limb pain, chronic eczema, gastrointestinal problems, CFS, psychogenic seizures, and negative body image, who have attained a relief of suffering** (Bloomgarden, & Calogero, 2008; Brown, McGoldrick, & Buchanan, 1997; Chemali & Meadows, 2004; Dziegielewski & Wolfe, 2000; Friedberg, 2004; Grant, 1999; Grant & Threlfo, 2002; Gupta & Gupta, 2002; Kelley, & Selim, 2007; Kneff & Krebs, 2004; Marcus, 2008; Mazzola et al., 2009; McGoldrick, Begum, & Brown, 2008; Ray & Zbik, 2001; Royle, 2008; Russell, 2008a, b; Schneider et al., 2007, in press; Tinker & Wilson, 2006; Van Loey & Van Son, 2003; Wilensky, 2006; Wilson et al., 2000).
14. **Adults and adolescents successfully treated for diagnosed depression** (Bae, Kim & Park, 2008; Broad & Wheeler, 2006; Gomez, 2008; Hogan, 2001; Manfield, 1998; Protinsky, Sparks, & Flemke, 2001a; Tanaka, & Inoue, 1999; Uribe, & Ramirez, 2006).
15. **Clients with acute trauma and wide variety of PTSD and trauma-based personality issues who experience substantial benefit from EMDR** (Allen & Lewis, 1996; Bisson, Ehlers, Matthews, Pilling, Richards, Turner, 2007; Brown & Shapiro, 2006; Carbone,

2008; Cohn, 1993; Fensterheim, 1996; Forbes, Creamer, & Rycroft, 1994; Gelinas, 2003; Hogberg, Pagani, Sundin, Soares, Aberg-Wistedt, Tarnell, et al, 2007; Kutz, Resnik, & Dekel, 2008; Ironson, et al., 2002; Kim & Choi, 2004; Kitchiner, 1999, 2000; Korn & Leeds, 2002; Lee, et al., 2002; Manfield, 1998; Manfield & Shapiro, 2003; Marcus, Marquis, & Saki, 1997; Marquis, 1991; Maxwell, 2003; McCullough, 2002; McLaughlin et al, 2008; Parnell, 1996; 1997; Pollock, 2000; Power et al., 2002; Protinsky, Sparks, & Flemke, 2001a; Puk, 1991b; Raboni, Tufik, & Suchecki, 2006; Renfrey & Spates, 1994; Rittenhouse, 2000; Sandstrom et al., 2008; Schneider, Nabavi, Heuft, 2005; Seidler & Wagner, 2006; Shapiro & Forrest, 1997; Shapiro & Laub, 2008; Spates & Burnette, 1995; Spector & Huthwaite, 1993; Sprang, 2001; van der Kolk, Spinazzola, Blaustein, Hopper, Hopper, Korn, Simpson, 2007; Vaughan, et al., 1994; Vaughan, Wiese, Gold, & Tarrier, 1994; Wilson, Becker, & Tinker, 1995, 1997; Wolpe & Abrams, 1991; Zabukovec, Lazrove & Shapiro, 2000).

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