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Traumatic Memories, Eye Movements, Phobia, and Panic: A Critical Note on the Proliferation of EMDR

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Abstract—In the past years, Eye Movement Desensitization and Reprocessing (EMDR) has become increasingly popular as a treatment method for Posttraumatic Stress Disorder (PTSD). The current article critically evaluates three recurring assumptions in EMDR literature: (a) the notion that traumatic memories are fixed and stable and that flashbacks are accurate reproductions of the traumatic incident; (b) the idea that eye movements, or other lateralized rhythmic behaviors have an inhibitory effect on emotional memories; and (c) the assumption that EMDR is not only effective in treating PTSD, but can also be successfully applied to other psychopathological conditions. There is little support for any of these three assumptions. Meanwhile, the expansion of the theoretical underpinnings of EMDR in the absence of a sound empirical basis casts doubts on the massive proliferation of this treatment method. © 1999 Elsevier Science Ltd. All rights reserved.

In the last 7 years or so, Eye Movement Desensitization and Reprocessing (EMDR) gained popularity as a treatment method for a broad range of psychopathological and even medical conditions. For example, more than 14.000 therapists have now attended the international workshops on EMDR (Lohr, Kleinknecht, Tolin, & Barrett, 1995) and it is said that the vast majority of them report "positive clinical results" (Shapiro, 1995, p. 6). As another example, more and more clinicians who treat survivors of war or disaster-related traumas are trained in the basic principles of EMDR (e.g., *APA Monitor*, August 1995; Levin, Grainger, Allen-Byrd, & Fulcher, 1994). As to the clinical status that therapists ascribe to EMDR protocols for PTSD, one review paper claims that "it is already considered a treatment of choice by many"

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(Greenwald, 1994, p. 67). Thus, it is fair to say that the career of EMDR is quite impressive in terms of the enthusiasm it has evoked and its expansion (see also, Acierno, Hersen, Van Hasselt, Tremont, & Mueser, 1994; Lohr et al., 1995).

In *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*, Shapiro (1995) gives a lively description of how she accidentally discovered EMDR: "I noticed that when disturbing thoughts came into my mind, my eyes spontaneously started moving very rapidly back and forth in an upward diagonal. . . . At that point I started making the eye movements deliberately while concentrating on a variety of disturbing thoughts and memories, and I found that these thoughts also disappeared and lost their charge" (p. 2). On the basis of this experience, Shapiro (1989a) elaborated EMDR and explored its efficacy in Vietnam veterans and molestation victims. All patients had chronic difficulties with their traumatic memories, but EMDR appeared to be an effective treatment. That is, after treatment, patients reported that their traumatic memories were less disturbing and that they functioned better in daily life. A cascade of case studies on EMDR and trauma followed. Most (e.g., McCann, 1992; Puk, 1991; Wolpe & Abrams, 1991), but certainly not all (e.g., Oswalt, Anderson, Hagstrom, & Berkowitz, 1993) suggested that EMDR is a fruitful treatment approach for this type of psychopathology. Since that time, two major changes have taken place in the development of EMDR. To begin with, the techniques underlying EMDR have become more liberal in the sense that the eye movement component of EMDR is no longer considered as a *conditio sine qua non* for obtaining treatment effects. Shapiro (1995) admits that ". . . even without the eye movements, EMDR has shown itself to be an efficient and structured approach to pathology that offers positive therapeutic benefit" (p. 26). Secondly, although originally developed to treat PTSD symptoms, EMDR is now increasingly extended to other mental disorders, such as obsessive-compulsive disorder (Rosenthal, 1993), dissociative disorders (Paulsen, 1995), nightmares (Pellicer, 1993), specific phobias (Marquis, 1991), and panic disorder (Feske & Goldstein, 1997; Goldstein & Feske, 1994). This expansion is largely guided by case material.

Basically, EMDR and its career can be brought back to three assumptions. The first assumption is that traumatic or aversive memories that underlie psychopathological conditions reside in a fixed and stable format in the brain. The second assumption is that lateral eye movements, or more generally lateralized, rhythmic movements, inhibit the negative affect associated with these memories and in this way contribute to the resolution of the trauma. The third assumption is that PTSD, on the one hand, and conditions such as phobias and panic disorder on the other, share sufficient features so that EMDR can be applied to all these conditions (see Shapiro, 1999 [this issue]).