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Treatment of Specific Phobias with Eye Movement Desensitization and Reprocessing (EMDR): Protocol, Empirical Status, and Conceptual Issues

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Abstract—This paper considers the current empirical status of Eye Movement Desensitization and Reprocessing (EMDR) as a treatment method for specific phobias, along with some conceptual and practical issues in relation to its use. Both uncontrolled and controlled studies on the application of EMDR with specific phobias demonstrate that EMDR can produce significant improvements within a limited number of sessions. With regard to the treatment of childhood spider phobia, EMDR has been found to be more effective than a placebo control condition, but less effective than exposure *in vivo*. The empirical support for EMDR with specific phobias is still meagre, therefore, one should remain cautious. However, given that there is insufficient research to validate any method for complex or trauma related phobias, that EMDR is a time-limited procedure, and that it can be used in cases for which an exposure *in vivo* approach is difficult

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to administer, the application of EMDR with specific phobias merits further clinical and research attention. © 1999 Elsevier Science Ltd. All rights reserved.

Behavioral therapy has proven to be of great practical value in the treatment of fears and phobias. This approach involves systematic desensitization, imaginal exposure, and real-life exposure. Research on specific phobias has shown equivalent effectiveness for systematic desensitization and flooding in imagery (e.g., Marks, Boulougouris, & Marset, 1971), while imaginary procedures were generally found to be less effective than exposure *in vivo* (e.g., Barlow, Leitenberg, Agras, & Wincze, 1969). It is a widely accepted notion that exposure *in vivo* (i.e., graded and prolonged exposure to the phobic stimuli) is the treatment of choice for specific phobias (e.g., Emmelkamp, Bouman, & Scholing, 1989).

A typical example of the exposure *in vivo* procedure is the treatment of spider phobia, which can be roughly described as follows. First, the client is introduced to a spider in a sealed container at what the client considers to be a safe distance. After much of the client's anxiety has subsided, the client is asked to either approach the container or pull it closer. After the client looks at the container closely, it is opened. Next, the client touches the spider with a pencil, later with a finger, and finally allows the spider to creep on the client's bare fingers and hands. Further, the client is encouraged to practice approaching the phobic objects between sessions while refraining from avoidance and escape behaviors as much as possible. Exposure *in vivo* is often combined with other techniques, including modelling by the therapist, cognitive interventions to correct catastrophic misinterpretations (e.g., De Jongh et al., 1995), and applied tension to prevent fainting in the case of blood-injury-injection phobias (Öst & Sterner, 1987).

It appears that certain types of circumscribed phobias can be effectively treated in one session, often lasting no more than 3 hours (Öst, 1989, 1997). These rapid treatment results may leave the impression that specific phobias *in general* can be successfully treated within a few sessions. However, single-session treatments of 3 hours or less have been found effective only in relation to a limited range of monosymptomatic phobias, particularly snake, spider, and injection phobias (see Öst, 1997 for an overview). This raises the question as to whether the available outcomes can be generalized toward more complex phobias. As a matter of fact, there are a variety of phobias for which controlled outcome studies are totally lacking, such as phobias of choking, vomiting, and driving. Clinical observations suggest that other specific phobias, such as thunderstorm phobia and extensive claustrophobia, generally require more elaborate treatment (see e.g., Emmelkamp et al., 1989 for a case report

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