

Effects of eye movement versus therapist instructions on the processing of distressing memories

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Abstract

The effectiveness of components of eye movement desensitization and reprocessing (EMDR) was tested by randomly assigning 48 participants to either an eye movement or an eye stationary condition and to one of two types of therapist instructions (reliving or distancing). Participants were university students (mean age 23) who were asked to recall a personal distressing memory with measures of distress and vividness taken before and after treatment, and at follow-up. There was no significant effect of therapist's instruction on the outcome measures. There was a significant reduction in distress for eye movement at post-treatment and at follow-up but overall no significant reduction in vividness. Post hoc analysis revealed a significant reduction in vividness only for the eye movement and distancing instruction condition. The results were consistent with other evidence that the mechanism of change in EMDR is not the same as traditional exposure.

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1. Introduction

EMDR has been acknowledged as an evidence-based form of treatment for post-traumatic stress disorder in the United Kingdom by the [National Institute for Clinical Excellence \(2005\)](#), in America by the [American Psychiatric Association \(2004\)](#), in Australia by the [Australian Centre for Posttraumatic Mental Health \(2007\)](#), and in the Netherlands by the [Dutch National Steering Committee for Guidelines for Mental Health Care \(2003\)](#). However, the mechanism of action for the

success of EMDR remains controversial ([Rogers & Silver, 2002](#); [Smyth & Poole, 2002](#)).

Previous studies of traditional exposure techniques have emphasized that 'reliving' is a key process in recovery during treatment ([Jaycox, Foa, & Morral, 1998](#)). However, reliving was not associated with improvement in a study of key processes during EMDR for 44 participants with post-traumatic stress disorder ([Lee, Taylor, & Drummond, 2006](#)). Instead the greatest improvement occurred when clients gave distancing responses. 'Distancing' involved focusing on the trauma material but from an observational or detached perspective. Furthermore, cross-lagged panel correlations were consistent with the proposition that distancing was a consequence of the EMDR procedure rather than a response that covaried with improvement.

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Although the findings from this study suggested that distancing during EMDR is related to improvement, they did not provide any evidence as to what ingredients of EMDR cause the distancing. Distancing could be promoted by two distinct mechanisms: therapist instructions or eye movement (Lee et al., 2006). For example, in the introduction to the desensitization phase, Shapiro (1995) recommended that the client be instructed to “Imagine you are on a train and the scenery is passing by. Just notice the scenery without trying to grab hold of it or make it significant” (p. 107). The emphasis in the process is “Let whatever happens happen” and “To just notice . . . whatever arises” (Shapiro, 1995: pp. 127–128). Smyth and Poole (2002) also observed that the therapist instructions during EMDR may encourage ‘mindful observation’ of the traumatic experience which is similar to the distancing concept described above. They likened the instructions during EMDR to the practice of mindful acceptance which has been recommended as an important process in facilitating treatment in traditionally difficult-to-treat populations (Segal, Williams, & Teasdale, 2002).

Alternatively, eye movements themselves might generate distancing, perhaps by disrupting the “visuospatial sketchpad” (Andrade, Kavanagh, & Baddeley, 1997) or by producing a de-arousal effect through initiating an orienting response (Barrowcliff, Gray, Freeman, & MacCulloch, 2004). That eye movements do indeed promote distancing received empirical support from a study on the effects of eye movements, finger tapping, and a control condition not involving eye movement or finger tapping on the emotive memories of undergraduate students (van den Hout, Muris, Salemink, & Kindt, 2001). The memories were rated as less aversive after an exposure intervention accompanied by eye movements, but not after the other interventions. In addition, eye movements led to a greater reduction on a vividness measure. Similarly, the degree of aversiveness and degree of vividness of personal memories decreased significantly more during an exposure task accompanied by eye movement than by spatial tapping (Andrade et al., 1997).

A greater reduction in arousal and vividness for memories associated with fear and anxiety was also found for eye movement over an eye stationary condition using physiological measures of arousal (Barrowcliff et al., 2004). Finally, Kavanagh, Freese, Andrade, and May (2001) found that eye movement resulted in reduced ratings of distress and vividness compared to a no eye movement condition and a passive visual interference task.

The present study attempted to find which of the two ingredients of EMDR linked to the distancing response

– eye movement or instructions – produce the most improvement in a non-clinical sample. Participants were randomly assigned to either an EMDR treatment, which involved eye movement, or an identical procedure that did not involve eye movement. In addition, therapists were instructed either to encourage the participant to take a distancing perspective on the traumatic memory or to maximize reliving in a manner similar to that which occurs during traditional exposure treatments. The objective was to test the effects of eye movement and distancing instructions on changes in vividness and emotional response immediately after treatment and at 1-week follow-up.

2. Method

2.1. Participants

Study participants were recruited from psychology undergraduate courses at an Australian University and received course credit for participating in the research. Of the 59 recruited, 10 were excluded because their distress at pretest was so high that the intervention might have been harmful. Another participant was excluded because the level of distress was too low. The 14 men (29.2%) and 34 women (70.8%) who completed treatment ranged in age from 18 to 38 years (mean age 23, median 21). Apart from four participants, who were international students, the sample was predominantly Caucasian Australian. All participants were given an information sheet on the study and were asked to sign a consent form approved by the Murdoch University human research ethics committee.

2.2. Measures

2.2.1. Dissociative experiences scale (DES-II: Carlson & Putnam, 1993)

This is a 28-item questionnaire designed for screening dissociative tendencies in both non-clinical and clinical samples. High scorers in college student samples have been identified as those scoring above 30 (Zingrone & Alvarado, 2001). The DES-II appears to have satisfactory internal consistency with coefficient alpha values for college students ranging from .92 to .94 (Gibbs & Rude, 2004; Zingrone & Alvarado, 2001).

2.2.2. Impact of event scale (IES: Horowitz, Wilmer, & Alvarez, 1979)

This is one of the most widely used self-report measures of post-trauma symptomatology. The original IES assesses the extent of avoidance, numbing and

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