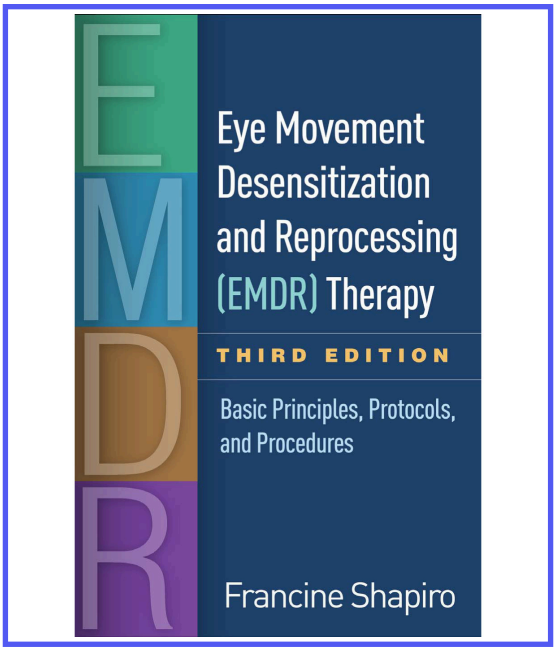


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In memory of my grandparents,
Charles and Lena Sumner;
my parents, Daniel and Shirley Shapiro;
and my sisters, Debra and Marion

With gratitude for the
guiding lights of each generation
and for the loving support of my husband,
Bob Welch, one of my life's greatest blessings

Freedom is what you do with what's been done to you.
—Jean-Paul Sartre

About the Author

Francine Shapiro, PhD, the originator and developer of EMDR therapy, is Senior Research Fellow Emeritus at the Mental Research Institute in Palo Alto, California; Executive Director of the EMDR Institute in Watsonville, California; and founder and President Emeritus of the Trauma Recovery/EMDR Humanitarian Assistance Programs, a nonprofit organization that coordinates disaster response and pro bono trainings worldwide. She is a recipient of the International Sigmund Freud Award for distinguished contribution to psychotherapy, presented by the City of Vienna in conjunction with the World Council for Psychotherapy; the Award for Outstanding Contributions to Practice in Trauma Psychology from Division 56 of the American Psychological Association; and the Distinguished Scientific Achievement in Psychology Award from the California Psychological Association. Dr. Shapiro was designated as one of the "Cadre of Experts" of the American Psychological Association and the Canadian Psychological Association Joint Initiative on Ethnopolitical Warfare and has served as advisor to a wide variety of trauma treatment and outreach organizations and journals. She has been an invited speaker at psychology conferences worldwide and has written and coauthored more than 90 articles, chapters, and books about EMDR.

Preface

Blessed is he who has found his work;
let him ask no other blessedness.
—THOMAS CARLYLE

THE PATH OF DISCOVERY

The opportunity to introduce another edition brings to mind again a statement by the early philosopher Heraclitus: "You cannot step twice into the same river, for different and ever different waters flow down." This edition marks 30 years since I made the initial observation that led to the development of Eye Movement Desensitization and Reprocessing (EMDR) therapy, which is now internationally recognized as an empirically supported treatment for trauma. Since the early days of controversy over the effects of the eye movements, more than 30 randomized studies have verified their effects, and hundreds of published peer-reviewed articles have documented positive treatment effects for a wide range of populations. Given the ever-changing nature of health care, life, and thought, it is gratifying to see that most of the book has remained relevant to clinical practice. It has aged well.

At the same time, this revision has given me an opportunity to offer the latest theory and research governing EMDR therapy practice, to expand information on the treatment of various populations, and to describe additional procedures and protocols that have proven to be valuable additions to clinical practice. The extensive controlled research on EMDR therapy has been updated, and additional areas of potentially useful investigation are suggested. New appendices include a variety of clinical aids for both the practicing therapist and researcher, including questionnaires, forms, checklists, and treatment transcripts.

It has also been gratifying, over the last 15 years, to witness throughout the professional community practicing EMDR therapy the sustained international commitment to the healing of suffering. In fact, the first edition of this text appeared only a few days after the Oklahoma City bombing. At the request of an FBI agent who had undergone EMDR treatment, volunteers traveled at their own expense to offer assistance to the traumatized community. Those Oklahoma clinicians who had already been trained in EMDR opened their offices and spread word of the opportunity throughout the area. Over the subsequent 4-month period, two to three EMDR clinicians per week traveled to Oklahoma and offered pro bono services to those in need, starting with the traumatized mental health professionals, who then requested services for the frontline providers and survivors. At the end of the 4 months, a pro bono course of training was offered to all licensed mental health professionals in Oklahoma City, enabling them to continue the work. This spontaneous outpouring of service marked the inauguration of the Trauma Recovery/EMDR Humanitarian Assistance Programs (see Appendix F), emphasizing the need to combine scientifically evaluated treatments with heartfelt clinical service worldwide. Additionally, over the last decade, humanitarian projects from numerous local and national EMDR organizations have offered pro bono treatment after natural and human-made disasters. Research has supported the efficacy of the protocols used in these efforts, and they are described in later chapters. Clinicians are urged to learn the procedures and protocols to aid in relief efforts both domestically and internationally. As we join together and expand our efforts in this global commitment, we can truly fulfill our obligation as a profession.

To repeat my statement from the previous edition: We went from Kitty Hawk to the moon in little more than 50 years. Yet despite such monumental technological advances, millions of people suffer unremitting pain, and a cycle of violence continues unchecked worldwide. Surely, as a society, we need to redirect more of our vast resources and pay greater attention to the alleviation of global suffering. Surely we need to change our level of expectations regarding the potential for healing and interpersonal development. But part of the problem may also be caused by a variety of attitudes inherent within our profession. Although the integration of knowledge in the hard sciences has allowed for continued developments and refinement of applications, which have moved rapidly from Edison to the Internet, the field of psychotherapy has somehow not kept pace. The reason may be an insufficient sharing of information across disciplines. For despite the advent of many new psychological orientations, each has remained relatively distinct over this past century, with little cross-fertilization even between science and practice. A lesson may be that the psychological treatment of individuals demands a composite of knowledge from various approaches. I align myself fully with those who

believe that we strengthen clinical repertoires through integration, not through displacement or exclusion (Beutler, 2009; Beutler, Someah, Kimpara, & Miller, 2016; Norcross & Goldfried, 2005; Norcross & Shapiro, 2002; Stricker, 2010).

In this spirit, the development of EMDR therapy over the past 30 years has moved it from a simple technique to an integrated psychotherapy approach. Therapeutic applications have expanded from the treatment of posttraumatic stress disorder to a wide range of clinical complaints. Also, as we shall see, the emphasis is on not only the elimination of overt suffering, but also attention to the comprehensive clinical picture that incorporates multifaceted personal growth and integration into the wider social systems. For that reason, clinicians of all orientations will find commonalities between EMDR therapy and their clinical practices, as well as complementary aspects of other disciplines that may enhance their work. I believe it is in this synthesis that clients can best be served.

I made the initial observation that led to the development of EMDR therapy in 1987. However, the path to that discovery had begun nearly 10 years earlier. In 1979, I was completing a doctorate in English literature at New York University and had already published extensively in that field. I felt that this was important work; to be one of those who shed light on our culture and literature—with its delicate nuances, rich textures, and the intricate lives of characters—held me in constant fascination.

At the same time, I had long been interested in behavior therapy, owing to my early readings of Andrew Salter and Joseph Wolpe. The idea of a focused, predictable, cause-and-effect approach to human psychology seemed fully compatible with the concepts of literary character and plot development. After all, many well-known authors had intimated that if characters are drawn true to life and set loose, they then create their own plots. I had fascinating discussions with my English professors on the interaction between the multifaceted texts I was reading and the physiological cause-and-effect implications of behavioral formulations. But psychology was only a side interest of mine. I held staunchly with those authors who believed in the perfectibility of humankind. I reveled in the glory of human suffering transformed into art via the masterworks of English literature, and I looked forward to a long and fruitful career as a literary critic and scholar. Then, right before launching into my dissertation on the poetry of Thomas Hardy, I was diagnosed with cancer.

When a potentially fatal disease strikes, it can be a watershed that marks a change in the course of one's life. For me, time took on a new dimension. Life no longer stretched out endlessly before me. Suddenly, the behaviorists' "physiological cause and effect" took on new meaning. I became focused on the interplay of mind and external stressors. I also wondered why we had come so far technologically yet seemed unable to advance in ways to master our own minds and bodies.

Fortunately, I discovered the works of Norman Cousins and others in the field of psychoneuroimmunology, which was just emerging. The idea that there is a connection between disease and stress seemed obvious to me, but what to do about it was another matter. By this time, according to my physicians, my cancer was cured, but there was no guarantee it wouldn't happen again. I remember their communication to me as something like this: "Your cancer is gone, but *X* percent get it back. We don't know who and we don't know how, so good luck."

Now the question of which psychological and physiological methods actually worked to enhance physical health became primary. I believed there had to be some useful psychological and physiological approaches already developed, but why weren't they well known? Suddenly, finding these methods and disseminating information about them to others with life-threatening illnesses became more important to me than studying and communicating about 19th-century literature. I left New York in search of workshops and seminars on mind, body, and psychological methods to enhance physical and mental well-being.

After a while, I sponsored workshops myself for the general public on everything I found that offered tangible ways to help people lead less stressful lives. During that time, I also enrolled in a doctoral program in clinical psychology to complete my formal education. The eventful walk in the park that led to the discovery of the effects of the eye movements occurred just as I was beginning to look for a dissertation topic. In that single moment, my cross-country search for mechanisms of mental change and my need for a doctoral research project neatly converged.

The rest of the story of the development of EMDR is covered in Chapter 1. For now, suffice it to say that my discovery of the effects of the eye movements was followed by the development of a methodology that grew rapidly in complexity and application. Over the past three decades, positive clinical results with EMDR therapy have been reported consistently by the clinicians who have been trained in its use. Our clinical work with EMDR therapy shows us that suffering can be transformed—not only into art but into life.

This book is a product of 30 years of personal experience refining and teaching EMDR, as well as input from numerous seasoned clinicians and researchers; it includes research-based recommendations and case histories, as well as cautions derived from the experience of EMDR-trained practitioners.

THE NEED FOR TRAINING

Because the emphasis of my life since 1979 has been on learning, developing, and disseminating procedures that work to enhance mental health, it is no surprise that my primary concern now is with the client. Clients

are best served by clinicians who are guided by research and are willing to learn, expand their skills, and experiment with innovative methods. They are also clearly best served when clinicians are licensed in the field of mental health and trained in the therapies they are using, and when adequate research is done to validate and improve upon those methods. These beliefs are at the heart of EMDR therapy and are the foundation on which EMDR therapy's success—as well as its training policies—has been built. I have been blessed to have met many clinicians and researchers who share these beliefs.

EMDR therapy trainings are available worldwide through universities and freestanding postgraduate organizations. Clearly, they are not all equally thorough, so clinicians should refer to Appendix F for guidance. An explanation of EMDR training policies is the subject of a position paper of the original EMDR Professional Issues Committee, included in Appendix E, and specific parameters can be reviewed on the website (*www.emdria.org*) of the EMDR International Association (an independent professional association that oversees training and clinical practice in North America). EMDR research has demonstrated a correlation between treatment fidelity and positive clinical effects (Maxfield & Hyer, 2002) and, clearly, supervised training is the best way to achieve that goal. The rest of the rationale for these policies springs from logic and compassion. A survey of the first 1,200 clinicians trained in EMDR therapy indicated that only 2% considered the supervised training unnecessary. Moreover, results of this survey (which were reproduced in Appendix D of the 1995 edition; Lipke, 1994, 1995) indicated that 85% of the clinicians found that clients had more highly charged and previously forgotten memories emerge with EMDR than with any other methodology practiced at the time. The reasons for this phenomenon, which helps illuminate the very nature of psychopathology, are fully explained in this text, and when appropriately handled, the memories are quickly resolved. However, it seems reasonable to conclude that if dysfunctional memories emerge from EMDR sessions, complete with a possibly high level of disturbance, clinicians should be fully educated in the methodology that precipitates these memories and has the potential to resolve them. To reiterate more succinctly, clients are best served if their clinicians are trained. The clear objective is helping people.

Of course, training does not ensure success with every client. EMDR therapy is not a cure-all; treatment failures occur, as they do with any form of psychotherapy. However, the American Psychological Association ethics code states that training and supervision are necessary for a clinician to achieve competency before treating clients or doing research. Adequate training means greater likelihood of success—and less likelihood of harm. Therefore, although this book provides the necessary written instructions to begin using EMDR therapy, it should be employed in conjunction with appropriate supervision and training. I repeat this refrain throughout the text.

PRINCIPLES AND PROCEDURES

To paraphrase a well-known proverb, it is better to teach a hungry man how to fish than to give him a fish. Likewise, it is better to provide practitioners with a conceptual framework or model to serve as a guide to their clinical practice than merely to give them inflexible, step-by-step procedures for implementing EMDR therapy. Therefore, along with step-by-step directives, this text offers clinicians a new way of thinking about pathology and therapeutic treatment, in addition to a comprehensive set of therapeutic procedures that have evolved from clinical applications consistent with the theory. Understanding these principles will allow the clinician to customize treatment to the individual needs of each client. This applies whether a client is in the need of rapid treatment for an isolated trauma or comprehensive treatment that addresses the full clinical picture.

One of the basic premises of EMDR therapy is that most psychopathologies are based on early life experiences. The goal of EMDR treatment is to rapidly metabolize the dysfunctional residue from the past and transform it into something useful. Essentially, with EMDR therapy, the dysfunctional information undergoes a spontaneous change in form and meaning—incorporating insights and affect that are enhancing rather than self-denigrating to the client. Clinicians will find that the information covered in this book describes the components and strategies needed to provide effective treatment. These standardized procedures were developed to ensure optimal activation of the client's innate information-processing system and thus achieve full resolution of the presenting problem. The procedures have been widely tested in clinical trials, with consistent results demonstrating their value. A comprehensive meta-analysis (Maxfield & Hyer, 2002) indicated that the more rigorous the EMDR study, the larger the effects. In addition, there was a positive correlation between treatment fidelity and effect size. An important element of rigorous research is the fidelity check, which provides verification that the standardized procedures were properly applied. To that end, a fidelity checklist is included in Appendix C. However, understanding the principles on which the therapy procedures are based fosters appropriate and flexible application.

THE NAME OF THE THERAPY

Although EMDR was initially named for the eye movements, which in 1987 appeared to be the most salient part of the methodology, over the years, the name has appeared to unduly limit the appreciation and application of the approach. As this book indicates, EMDR therapy is a complex methodology that includes many components; in addition, other stimuli besides the eye movements have proven useful. If I had it to do over again, I would name it simply "Reprocessing Therapy." Nonetheless, because of