From: Shapiro, Francine (1995) *Eye Movement Desensitization and Reprocessing, 1st Edition*. New York: Guilford

APPENDIX D

• • •

EMDR Clinician Survey

This appendix includes the unpublished results of a survey conducted on the work of the first 1,200 clinicians trained in EMDR with over 10,000 clients. This extensive report was instrumental in the decision to continue the training programs while awaiting the publication of more rigorous controlled studies.

Preliminary results of the survey were presented at the 1992 annual conference of the International Society for Traumatic Stress Studies and the final results were reported in a paper presented at the 1994 annual conference of the American Psychological Association. The survey results are included in this text in order to expedite its availability because it has been extensively referenced at a variety of professional presentations, in a number of published articles, and throughout this text.

Please note that not all of the clinicians surveyed had completed the two-part course, and specific protocols for a number of target populations had not yet been incorporated into the EMDR methodology at the time of the study.

Eye Movement Desensitization and Reprocessing (EMDR): A Quantitative Study of Clinician Impressions of Effects and Training Requirements

Howard Lipke, Ph.D.
DVA Medical Center, North Chicago
Finch University of Health Sciences/Chicago Medical School

While controlled studies are absolutely essential to examine the effectiveness of EMDR, or any other method of psychotherapy, another kind of research—extensive clinical reporting—may also be of vital importance. Controlled treatment outcome studies have practical drawbacks in that the number and type of cases examined must be limited and the use of the treatment must be carefully prescribed. This means that much could be missed about the effects of a therapeutic method in true clinical situations, about the breadth of its applicability, and, of preeminent importance, about the dangers or limitations

to its use. Putnam and Loewenstein (1994) made similar points in describing their survey of treatment for multiple personality disorder (MPD).

This study of EMDR, based on methodology used by Shipley and Boudewyns (1980) to examine whether flooding and implosion procedures were as dangerous (i.e., as likely to promote decompensation) as many clinicians feared, looked for danger in general but also asked subjects to comment on a wide variety of possible problems during therapy and attempted to ascertain the types of cases in which there were beneficial results. Structured questions were used to enhance objectivity in interpretation and were supplemented by unstructured questions to allow for maximum expression. Because EMDR training policies have been a center of controversy recently, a specific question on the need for training was also included.

METHOD

Subjects and Procedure

At the time this study was initiated, over 1,500 clinicians had been trained in EMDR by Francine Shapiro. Identifying information was available for all but approximately 25 of these trainees, who participated in small training meetings for researchers at two sites. Between August 15 and September 1, 1992, an extensive survey on EMDR was sent to all 1,295 trainees for whom there was a record of training before February 1, 1992; this date was chosen so that all subjects included in this study would have had at least 6 months to gain experience with EMDR. For trainees at each of the two sites where identification information was not obtained, a representative was asked to distribute surveys to clinicians who took the training.

Because a number of the therapists to whom surveys were sent failed to respond (a typical problem with any survey), it is legitimate to question the representativeness of the sample obtained. Thus, it could be claimed with some justification that people who did not respond are different in some significant way from those who did, rendering the sample nonrepresentative of the population as a whole. Nonresponders might, for example, tend to have an extreme attitude (negative or positive) about EMDR, but for whatever reasons do not wish to make such feelings public. In order to determine if any differences exist between responders and nonresponders, a random sample from this group was mailed a second request.

Therefore, in November 1992, 89 surveys were sent a second time to a randomly chosen 10% of the clinicians who had not responded to the initial mailing. Subjects who did not respond were telephoned at least once (and if not reached, a message was left) to encourage them to participate, if possible, in the study.

To sum up, of the original population of 1,295 EMDR therapists to whom surveys were sent, 408 (31%) responded and, of the random sample of 89 out

of 887 initial nonresponders who were mailed a second request, 35 (39% of the sample) responded. Because there were no obvious differences in survey results between the initial responders and second-mailing responders (see Tables 1, 8, 11, 12, below), it is reasonable to combine the results of the two mailings and to conclude that, by means of both direct and random sampling, 58% of the original population is represented by the current sample of 443 individuals. In addition, the similarity between the responses of the two groups also supports the reliability of the present survey instrument. On key questions the two samples are analyzed separately.

Tables 1, 2, 3, and 4 summarize the professional background of the subjects. Table 1 lists all of the subjects once. Tables 2, 3, and 4 include subjects in more than one catagory.

Licensed doctoral level psychologists (LP) subjects are the most highly represented group. The subsample of LP subjects is heavily weighted toward therapists in private practice. The amount of experience, as well as theoretical orientation reported, suggests that subjects had wide-ranging clinical backgrounds. It is interesting to speculate that there is some relationship between work in the private sector and a clinician's awareness of or willingness to investigate innovative treatment.

Materials

The survey contained 26 items, some of which called for multiple responses. Subjects were asked to identify their profession, level of professional training, membership in professional organizations, level of EMDR training, theoretical orientation, type of employment, overall frequency of EMDR use, comfort with the procedure, reasons for lack of use, and recent changes in frequency of use. Item 13 asked subjects to rate EMDR on 13 dimensions and to compare it to other treatment procedures they had used. After responding to this item, subjects were asked to give the specifics of any serious side effects. Item 13 was phrased so that

TABLE 1. Profession of Subjects

	First mailing		Second mailing	
	N	%	*N*	%
Licensed doctoral psychologists	198	49	10	29
Licensed marriage family child counselors	64	16	10	29
Licensed social workers	53	13	6	17
Nonlicensed psychologists	46	11	4	11
Students	14	3	3	9
Psychiatrists	13	3	1	3
Registered nurses	11	3	0	0
Others	8	2	1	3
Total	407	100	35	100

TABLE 2. Subjects' Organizational Membership

Professional organization	*N*
American Psychological Association	205
Association for Advancement of Behavior Therapy	68
National Association of Social Workers	42
International Society for Traumatic Stress Studies	31
American Society of Clinical Hypnosis	30
American Association of Marriage and Family Therapists	18
American Psychiatric Association	9
American Nursing Association	6

TABLE 3. Number of Years in Practice

Years	*N*
0–10	136
11+	246

TABLE 4. Subjects' Employment

Type of practice	*N*
Private practice	296
Veterans Administration	59
State or mental health agency	46
University affiliate	28
Other	25

clinicians would use their non-EMDR practice as an informal control group, thus allowing their responses to be interpreted in a meaningful context.

Items 14 to 16 asked subjects to list populations for which EMDR had been generally harmful, generally ineffective, and generally beneficial. Subjects were allowed unstructured response space to convey their impressions. In Item 17 subjects were asked to report on their results with obsessive–compulsive disorder, seizure disorders, multiple personality disorder, and posttraumatic stress disorder.

On Item 18 subjects were asked to rate their personal experience in the client role in EMDR training (it is been clear that practice sessions in these workshops have a powerful impact on some trainees). On Item 19 subjects were asked to rate the importance of supervised practice in EMDR training, an item developed in response to therapists who have questioned the necessity for practicum training in EMDR (Baer et al., 1992).

Item 20 asked clients to describe the effects of medication or illicit drugs on EMDR results, Item 21 asked about the frequency of use and effectiveness of self-generated eye movements by therapists and clients, and Item 22 asked

Problems. Based on reports concerning eye damage from an unstructured inquiry it appears that all but two positive incidents of eye damage referred to transitory discomfort. There were approximately 70 other notable (it is a matter of judgment whether an incident is considered notable) negative incidents reported by subjects during the unstructured inquiry. These included three cases of emergence of alter personalities in clients not previously diagnosed with MPD, out-of-session dissociative episodes, violence (a rock thrown at an abuser's car), increased auditory hallucinations in a previously diagnosed psychotic depression, serious suicide gestures, and severe headaches. Some of these responses resulted in hospitalization. In the case of some clients, such incidents were seen as precursors to therapeutic breakthroughs; for others, the course of treatment appeared to be negatively affected.

Limits of Effectiveness. To an unstructured question about problems for which EMDR generally had no effect, obsessive-compulsive disorder (OCD) was clearly the most cited. Responses to a later unstructured question on OCD indicated that about half the subjects reported some positive outcomes, with the remainder indicating little success. One subject reported deterioration in a client and the resumption of self-threatening behavior. It was specifically suggested that EMDR was most effective with OCD patients when combined with other behavioral methods. Personality problems were also frequently cited (about 25 times in the LP group) as nonresponsive to EMDR. These nonresponders were generally reported to have problems with avoidance, hostility, and issues of control.

Beneficial Effects. Posttraumatic stress disorder was listed over 120 times by the LP group alone in a response to an unstructured question about problems for which EMDR was generally beneficial. Often, responses were extremely enthusiastic. Phobias, anxiety, panic, depression, and MPD were each listed by 10 to 25 subjects in the LP group as responding positively to EMDR.

Seizure Disorders. Subjects were asked to summarize the effects of EMDR in treating patients with seizure disorders. One subject reported that EMDR may have led to a mild seizure (the client may have been dissociating); another reported EMDR led to a petit mal seizure. No other subject reported any role of EMDR in eliciting seizures, and one subject reported a decrease in frequency and intensity of seizures. Five subjects reported not attempting EMDR in seizure patients because of the clients' fears. Ten subjects reported having done EMDR with at least one diagnosed seizure patient with no seizure induction. No subject reported seizure activity elicited in a client with previously undiagnosed seizure disorder. These findings suggest EMDR is not contraindicated for seizure patients; however, caution should be exercised.

Medication and Drug Use. All subjects were asked, "From your experience, what effects does the use of medication or illicit drugs have on EMDR results?". Subject responses indicated that the interaction between EMDR and medication is complex. In general, antidepressants did not appear to interfere with EMDR effectiveness, and in some cases were seen to enhance effectiveness. Four subjects singled out benzodiazepines as decreasing effectiveness, while one reported that anxiolytics improved effectiveness. Overall, subjects' reports suggest that medication does not rule out the use of EMDR, and that in some cases, perhaps those with severe depression, medication might provide sufficient stabilization to begin EMDR treatment.

Self-Use. In EMDR workshops it is suggested that clients not attempt self-use of EMDR until the end of treatment. The survey did not inquire into the timing of self-use but in a nonstructured item asked subjects about their own self-use and that of their clients. Seventy-five subjects reported using eye movements themselves, and 61 reported at least some self-use by clients. Three subjects reported that these eye movements elicited new memories and problems. We do not know how many of the self-users used eye movements outside workshop guidelines, so it is difficult to interpret what the three bad experiences mean in terms of potential problems, if self-use was indiscriminate. In general, the reports suggest that the effects from self-use are milder than those elicited by standard EMDR treatment. Sixty-five subjects reported results to be at least mildly positive, especially in promoting relaxation.

Comparison to Exposure Treatments. As Keane (1992) has pointed out, there has been a paucity of controlled research on treatment of posttraumatic stress disorder (PTSD). Most of the treatment studies that have been published are on the use of exposure. In addition, in discussing EMDR, researchers often point to the exposure aspect of the method. For these reasons—and because the design of this study was chiefly influenced by a study on the exposure procedures of flooding and implosion (Shipley & Boudewyns, 1980)—it was decided to include questions directly comparing EMDR with flooding and implosion procedures. It should be noted that there are significant differences between the exposure aspects of EMDR and flooding and implosion procedures. Most salient are the far shorter exposure periods during most EMDR sessions and the use of cognitive restructuring interventions in EMDR, rather than increased exposure to the target scene, in the face of client failure to progress.

The items on flooding and implosion allowed for a comparison of treatment approaches by clinicians experienced in both methods.

TABLE 9. Comparison between EMDR and Exposure (in %)

	N	EMDR more	Equal effects	EMDR less	Variable effects
Effectiveness	91	57	19	19	5
Stress to client	90	11	24	59	6
Stress to therapist	86	21	24	47	8

Note. In percent of subjects selecting each response.

These results reflect an advantage for EMDR in terms of treatment effectiveness and extent of stress for clients (and, to a lesser extent, extent of stress for the therapist). This finding is notable in light of the fact that the subjects are likely to have had more experience with exposure procedures than with EMDR. The experience of subjects who did not often use EMDR and who did not find it generally more effective and less distressing than flooding and implosion may have been due to one or more of the following factors: therapist discomfort with a new procedure, the likelihood of repressed material emerging in EMDR sessions, muscle fatigue from the arm movements, and the lack of relative advantage of EMDR over flooding and implosion in the treatment of severe OCD. Another hypothesis that must also be considered is that flooding and implosion may in fact be more effective than EMDR, or equally effective, but that the subjects in this survey who found EMDR more effective were those who had not been able to effectively implement the exposure procedures.

Subject reports on changes in their use of EMDR are shown in Table 10, where subject use of EMDR appeared to be fairly stable in that a majority of the subjects had not changed use in the past 3 months. Responses to the open-ended part of this item suggest that the most common reason for decreasing the use of EMDR was a change in client load or work situation. Other reasons, in approximate descending order of frequency, were therapist preference of other procedures owing to their success or EMDR's failure, need for more training to feel comfortable using EMDR, client rejection of the procedure, and lack of supervision.

TABLE 10. Change in Clinical Use of EMDR by Subjects

Use of EMDR over past 3 months	*N*
Increased	95
Decreased	77
Stayed the same	207

Therapists' Personal Experiences. During the practicum portion of EMDR workshops trainees participate in both the therapist and client position. This activity is not role-played: Target events are those that trainees find uncomfortable (and sometimes traumatic). The final measure in this study of EMDR's effectiveness was subjects' report of the therapeutic benefit they themselves received in the client role in the workshops.

The results in Table 11 strongly suggest positive effects of EMDR reported by the clients themselves. The fact that the pool of subjects corresponding to this item consists of psychotherapists limits any generalization from this population to a clinical population. On the other hand, the fact that psychotherapists, who presumably have had the opportunity to resolve difficulties from their past, could benefit so much from the EMDR practicum suggests substantial effectiveness for the method.

TABLE 11. Subjects' Ratings of Personal Experience in the Client Role in Practice Sessions of the EMDR Workshop (in %)

		Very harmful						Very helpful
	N	-3	-2	-1	0	1	2	3
First mailing	365	1	2	4	7	28	26	32
Second mailing	30	0	0	0	7	30	27	37

Note. In percent of subjects selecting each position along harmful–helpful continuum.

Need for Training

Some of the controversy surrounding EMDR has related to training criteria. Several clinicians (Baer et al., 1992) have criticized the insistence that training could not be completed in a 3-hour workshop, as well as the implication that it is inappropriate to practice EMDR without extensive training. A question was included in the survey to obtain the opinions of EMDR-trained clinicians on the need for extensive training (i.e., training that includes supervised practice) in order to use this method with clients (see Table 12).

These results overwhelmingly indicate that clinicians who have had Shapiro's EMDR training believe that supervised practice with the method is of significant value, a finding that disputes the Baer et al. (1992) criticism concerning the viability of 3-hour training.

TABLE 12. Importance of Supervised Practice (in %)

"How important is it for EMDR training to include supervised practice?"	*N*	Extremely important	Somewhat important	Not important
First mailing	377	77	20	3
Second mailing	32	78	22	

Note. In percent of subjects selecting each response.

GENERAL DISCUSSION

At the time Shipley and Boudewyns collected their data, flooding and implosion were being taught at a number of sites, thus making it extremely difficult to take a representative sample of clinician-subjects. They sent 132 surveys and received responses from 70 subjects, who reported using flooding and implosion on 3,493 cases (with a range of 1 to 500). The present study took advantage of the fact that EMDR was initially developed by one person, Shapiro, who had at the time of this survey overseen all training in EMDR. Sampling was not necessary inasmuch as almost the whole population of trained clinicians could be surveyed. An advantage in interpreting this research is that the training for EMDR, unlike the training for flooding and implosion, is standardized. The

for comments on any other matter related to EMDR. Items 23 to 26 asked subjects how frequently they use exposure therapy and had them compare exposure with EMDR on effectiveness, client distress, and therapist distress in administration of the procedure.

RESULTS

Extent of Use

Tables 5, 6, and 7 summarize the extent to which subjects have used EMDR.

The strength of an extensive survey of clinicians is that information is made available about a greater number of clients (in this case, over 10,000)—who represent a greater variety of problems and who are treated in a more naturalistic manner—than is possible with controlled studies.

A sufficient number of clients are reported on here to warrant the belief that the conclusions reached by this survey on the possible negative effects of EMDR on target populations are valid.

TABLE 5. Approximate Number of Clients Treated with EMDR

	First mailing	Second mailing
Total	10,756	633
Licensed doctoral psychologists	4,683	

TABLE 6. Number of EMDR Clients Treated per Therapist

Number of EMDR clients in total client load	*N*
0	27
1–10	144
11–50	167
50+	56

TABLE 7. Comfort Level of Therapists Using EMDR

Description of comfort level	*N*
As comfortable as with any procedure	239
Somewhat uncomfortable	86
Very uncomfortable	17
Total	342

Effectiveness

Tables 8, 9, 10, and 11 summarize subject evaluation of the effects of EMDR from various perspectives.

some of these are temporarily uncomfortable experiences that are part of many successful psychotherapies. The rarity of many of these responses with EDMR is suggested by the fact that so many subjects invented the "not applicable" category for many of the items.

Activity not uncommon to fragile psychotherapy clients—such as suicidal ideation (with and without activity), violence, postsession dissociation, physical illness, cancellation of the next session, and premature termination of treatment—are reported considerably less often with EMDR than with other treatments. The reports of eye damage were difficult to interpret (see problems below). For two items—extreme agitation or panic and in-session dissociation—EMDR was somewhat more likely to be associated with these responses than were other treatments, and EMDR was so overwhelmingly more often associated with emergence of repressed material that this effect could be considered a cardinal feature of the method. Perhaps the most parsimonious reading of the overall pattern of findings is that during EMDR sessions repressed material surfaces and is often accompanied by strong negative affect and/or dissociation. However, these negative effects are limited to the session itself (perhaps because the material is successfully integrated), and therefore there is less suicidal ideation and activity, physical illness, and violence associated with EMDR than with other procedures.

TABLE 8. Subjects' Comparison of EMDR to Other Procedures (in %)

"Compared to other treatment procedures you have used, how often have EMDR sessions led to . . . "	*N*	More often	As often	Less often	NA
Suicidal ideation	363	6	36	39	20
Suicidal ideation and activity	324	2	38	49	12
Extreme agitation or panic	341	31	31	34	4
Emergence of repressed material	357	86	10	3	2
In-session dissociation	353	29	41	20	10
Postsession dissociation	330	14	46	32	9
Eye damage	329	4	42	23	31
Physical illness	330	8	41	31	21
Violence	322	1	42	36	21
Cancellation of next appointment	326	12	43	33	12
Premature termination of treatment	326	10	49	33	8
General negative side effects					
First mailing	326	8	39	46	7
Licensed psychologists	169	11	43	39	8
Second mailing	23	4	48	30	17
General beneficial therapeutic effects					
First mailing	354	76	20	4	1
Liscensed psychologists	178	76	21	3	1

homogeneity of trainings, however, does have a disadvantage in that these results can only be generalized to similarly trained clinicians; similar results may not be obtained by clinicians who learn EMDR by other means.

Shipley and Boudewyns (1980) used slightly different phrasing when they asked subjects about negative side effects of treatment. Since they were chiefly concerned with exploring the dangers of imaginal exposure, they asked subjects to compare this procedure to others in current use. The present study asked subjects to compare EMDR to procedures subjects had used. This phrasing allowed for the possibility that EMDR treatment had supplanted other forms of therapy for similar problems in a clinician's practice.

To briefly summarize, the data in the present study indicate that a majority of clinicians trained in EMDR consider the procedure to be of considerable value for clients with PTSD and other psychological problems. Subjects reported that negative effects were no more common with EMDR than with other procedures. However, given the reported tendency for emergence of repressed material and subjects' endorsement of the need for practicum training, it may be inferred that there is potential for countertherapeutic results if caution is not displayed. Both the number of respondents to the first round of surveys and the consistency between overall ratings by first round responders and nonresponders who responded to the second mailing suggest that these results are reasonably representative of the whole population.

This study's findings are consistent with the call for continued aggressive research into EMDR. In addition, they are seen as supportive of continued clinical use and training in this method of psychotherapy.

ACKNOWLEDGMENT

This study was approved by Medical Research Service, DVA Medical Center, North Chicago, and partially funded by that medical center. However, this report should not be taken as a reflection of the policy of that medical center or the Department of Veterans Affairs. The author wishes to thank James Alexander, Lynn Lipke, Robbie Dunton, A. J. Popky, William Zangwill, and Francine Shapiro for their assistance.

REFERENCES

Baer, L., Hurley, J. D., Minichiello, W. E., Ott, B. D., Penzel, F., & Ricciardi, J. (1992). EMDR workshop: Disturbing issues? *Behavior Therapist, 15*(5), 110–111.

Keane, T. (1992, October). Keynote address for the Annual Convention of the International Society for Traumatic Stress Studies, Los Angeles.

Putnam, F. W., & Loewenstein, R. J. (1994). Treatment of multiple personality disorder: A survey of current practices. *American Journal of Psychiatry, 150*(7), 1048–1052.

Shipley, R. H., & Boudewyns, P. A. (1980). Flooding and implosive therapy: Are they harmful? *Behavior Therapy, 11*, 503–508.

• • •

Index