

EMDR: Implications of the Use of Reprocessing Therapy in Nursing Practice

Susan McCabe, EdD, APRN, BC

TOPIC. *Eye movement desensitization and reprocessing (EMDR).*

PURPOSE. *To examine the available evidence base for EMDR treatment in psychiatric nursing practice.*

SOURCES. *Evidenced-based research findings, published case and anecdotal reports, and primary source documents on the development of the treatment method.*

CONCLUSIONS. *EMDR use remains controversial. Although it is safe, little is known regarding the mechanism of action of any therapeutic effect; more rigorous empirical establishment of efficacy is needed.*

Search terms: *Clinical efficacy, eye movement desensitization and reprocessing (EMDR)*

Susan McCabe, EdD, APRN, BC, is Associate Professor, University of Wyoming, Laramie, WY.

Trauma, and the associated disturbing memories that can result, are a common reason why individuals seek mental health care. While many treatment modalities can provide relief to patients experiencing traumatic memories, perhaps none is so acclaimed, so scorned, or so steeped in controversy as eye movement desensitization and reprocessing (EMDR). Reasons why this therapeutic intervention is gaining popularity include the apparent simplicity of the procedure and reports of dramatic, rapid improvement after only brief treatment with EMDR. Yet while volumes of case and anecdotal reports attest to the value of EMDR in reducing complex patient symptoms, questions linger regarding the scientific bases and empirical evidence supporting rational use of the modality.

In surprisingly polarizing fashion, EMDR is touted as either science or wizardry, with little middle ground. As EMDR continues to attract attention, nurses in clinical practice need a basis for deciding if this treatment is a neurobiological-based repatterning of neuronal information storage, or if it is a mesmeric, placebo-based, ineffective treatment. This article attempts to wade through the rhetoric and reports and examine the available evidence base for the use of EMDR treatment in psychiatric nursing practice. It examines the known and hypothesized scientific bases for the treatment, the levels of empirical evidence regarding efficacy, and the indications and counterindications for its use. This knowledge is essential for psychiatric nurses who want a framework for decision making to allow accurate discussion of this treatment with patients and/or for deciding to use or refer patients for EMDR treatment.

EMDR: What It Is and Where It Came From

A patient is troubled by intrusive and disturbing memories of past traumatic events and is feeling a significant level of distress. He seeks help from a therapist,

who quickly moves a finger back and forth in front of the patient's face, all the while asking him to hold traumatic images and memories in mind, and then asking the patient to shift associated memories to positive thoughts. After this activity, the patient self-rates his level of distress, and treatment is continued until significant improvement is noted. That is the core of EMDR treatment. While it appears simplistic, some proponents have reported serious disabling symptoms being extinguished in patients with as little as one 90-minute EMDR session. Such reports of almost miraculous recovery have been widely circulated and have fueled the almost legendlike belief among supporters of the value of EMDR.

EMDR, a form of psychotherapy, was originated in 1989 by psychologist Francine Shapiro after a chance observation while walking in the woods. She noticed that moving her eyes rapidly from side to side appeared to lessen the intensity of her own disturbing thoughts and related anxiety (Blore, 1996; Davidson & Parker, 2001; Shapiro, Vogelmann-Sine, & Sine, 1994). Shapiro tested her notion on post-traumatic stress disorder (PTSD) patients and reported significant improvement in their subjective distress levels after the treatment she called EMDR. Despite original reports that EMDR is a complex technique requiring extensive training (Shapiro, 1996a), it is now being taught in brief workshops and used by a wide array of practitioners in diverse settings.

While perhaps complex in its actions, EMDR can be described in deceptively simple terms. It is perhaps best described as the intentional induction of rapid, rhythmic, saccadic eye movement in order to assist an individual to desensitize linkages between experienced events and emotionally loaded memories (Blore, 1996). EMDR shares goals common to other desensitization therapies, with a chief aim of making individuals so accustomed to the traumatic memories that these lose their distress-inducing capacity (EMDR, 2002). As the therapist moves her finger in front of the patient, and as the patient tracks the movement with his eyes, the patient is asked to concentrate on traumatic memories (Figley, Leeds, Tinker-Wilson, & van der Kolk, 2000). While traditionally using

the therapist finger, EMDR practitioners have increasingly experimented with other processes, including hand or toe tapping, alternating sounds, and mechanized visual fixation props as alternatives to finger movement (Bridgeman, 1999; Figley et al.). Integral to the EMDR process is the use of a cognitive component that attempts to transform negative thoughts of traumatic events to more cognitively positive thoughts. The typical procedural steps that constitute EMDR treatment are outlined in Table 1.

Supporters of EMDR contend it should be undertaken only by licensed mental health providers who have been adequately trained in its use (Peterson, 2000; Shapiro & Maxfield, 2002; Smyth, Greenwald, de Jongh, & Lee, 2000). To date, more than 20,000 mental health professionals have been formally trained. Standards set by the EMDR International Association (Smyth et al.) require a minimum of 18 hours of lecture content accompanied by 13 supervised clinical hours, with 31 hours of training seen as the minimal training before a provider should attempt EMDR with patients. While some trainers have provided less rigorous workshop trainings, the EMDR International Association (EMDRIA 2000) criteria are widely accepted (Shapiro, 2001b). Additional stringency for approved trainers, consultants, and supervisors has been identified by the EMDR International Association, but there continues to be no legislative or regulatory restriction on untrained clinicians performing this procedure with patients.

EMDR shares obvious theoretical and procedural commonalities with cognitive behavioral therapy (CBT), hypnosis, and other desensitization psychotherapies. During the EMDR procedure, patients are asked to confront negative perceptions and to alter cognitive beliefs. In fact, many believe that shifts in cognitive perceptions rather than any effects of eye movement are the basis for positive outcomes reported with EMDR (Keenan & Farrell, 2000). In addition to CBT, EMDR shares commonalities with hypnosis, guided imagery, exposure-desensitization therapy, and neurolinguistic programming as treatment modalities because of its high reliance on visual fixations, visual image replacement, and eye-cognitive linkages as therapeutic strategies.

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Table 1. Overview of the Steps of an EMDR Session

Treatment Phase	Therapeutic Actions
Desensitization phase	<ol style="list-style-type: none">1. Patients rate their subjective level of distress.2. Ask patient to think about the traumatic memory and related negative beliefs, emotions, or somatic sensations.3. Therapist, using a hand wand or finger, asks the patient to self-reference the memory and to visually track the rapid back and forth movement made in front of the patient's face.4. The finger movements proceed from right to left in sets of 12–24 strokes, at a speed of approximately 12–14 strokes per second.
Installation phase	<ol style="list-style-type: none">1. Patient is asked to block out the negative image and to think of positive thoughts while repeating the eye movements.2. After each set, the patient again rates his/her subjective level of distress, reporting any changes in the image, memory, feeling, or somatic sensations.3. Sets continue until the subjective level of distress decreases, approaching normal, usually within 12–24 sets.4. Patient imagines a scene or event and associates it with comforting thoughts, again while following the therapist's finger movements.
Ongoing	<ol style="list-style-type: none">1. Treatment is repeated for each distressing memory, until subjective distress falls below 3 on the 1–10 self-rated scale with an EMDR session lasting typically an average of 90 minutes.

Source: Adapted from Bower, 1995; DeMeo, 1996; Herbert & Muese, 1995; Shapiro, 2001; Smyth et al., 2000.

Indications for and Use of EMDR

EMDR has most consistently been used as a treatment modality for PTSD, a common disorder usually treated in outpatient settings. PTSD is a disabling condition that has been associated with significant negative health outcomes, including diminished self-reported sense of well-being, obesity, substance abuse, fibromyalgia, polycystic ovary disorder, cancer rates, and asthma (Dobie et al., 2004). Because of the disabling nature of PTSD symptoms, and the common co-morbid syndromes associated with chronic PTSD, effective and rapid treatment of symptoms is essential. By far, the largest volume of case reports and research about EMDR examines it as a treatment for PTSD, with many sources seeing EMDR as a practical, cost-effective, noninvasive, and, therefore, appropriate treatment for PTSD (Macklin et al., 2000; McCullough, 2002; Shapiro, 2002). While most commonly used in treating PTSD, EMDR is one of many useful treatments for this disorder. Table 2 compares EMDR to other commonly available treatments for PTSD.

EMDR is increasingly being used as a psychotherapeutic treatment for a growing multitude of disorders in addition to PTSD, including such diverse problems as addictions, pain management, panic disorder, dental fears, phobias, body dysmorphic disorder, fear of public speaking, eating disorders, morbid jealousy, chronic pain, depression, and anxiety (Blore, 1997; Carrigan & Levis, 1999; De Jongh, Ten Broeke, & Renssen, 1999; Goldstein, de Beurs, Chambless, & Wilson, 2000; Grant, 2000; Protinsky, Sparks, & Flemke, 2001; Shapiro et al., 1994). Table 3 references scholarly works that report these extensions of suggested indications for EMDR treatment beyond PTSD.

The increasing utility of this treatment has once again fueled the debate about the procedures and whether it is scientifically sound or defensible. Some have linked the growth of EMDR to aggressive marketing rather than scientific evidence of efficacy (EMDR, 2002). Whether or not one believes EMDR has been aggressively marketed, EMDR has spawned a growth market of Internet sites, training seminars, manuals

Table 2. Commonly Available Treatments for PTSD

	Cognitive Behavioral Therapy (CBT)	Psycho/pharmacotherapy	EMDR	Group Therapy	Individual Therapy
Core aspect of therapy	Working with cognitions to change emotions, thoughts, and behaviors	Medications targeted at discrete symptoms clusters	Eye movements, hand taps, sounds used to create an alteration in distress level of intrusive memories	Using group factors of cohesion, safety, universality, and problem solving to reduce symptoms through shared experiences	Focus on emotional conflicts caused by traumatic event, often as they relate to earlier life experiences
Level of evidence on efficacy	High	High	Low to moderate	High	Moderate
Level of acceptance	High	High	Moderate	Moderate	High

Source: Adapted from National Center for Post-Traumatic Stress Disorder, 2004.

available for purchase, and the marketing of expensive treatment equipment, including eye scanners and other visual mechanized devices.

Because of the wide use of EMDR and the polarizing nature of claims of clinical efficacy, it is not easy to identify when EMDR would be most appropriate or when it would be contraindicated. It is clear that very limited data exist identifying any negative effects from EMDR therapy, leading to a general acceptance that it is an overall safe treatment. Only one study could be found (Kaplan & Manicavasagar, 1998) that identified case specific negative consequences of EMDR use. EMDR should be used with caution in special populations because of the very limited available data regarding its use with children, pregnant women, the elderly, comorbid, or other vulnerable populations. It is also unclear if it is a safe treatment in neurologically compromised patients such as those at serious risk for seizure. With a growing list of suggested conditions for which EMDR can be used—and a growth market of training and equipment—the obvious question becomes, how does EMDR work and is EMDR a clinically effective treatment?

Science, Integration, or Placebo: How EMDR Works

Much of the intuitive appeal of EMDR for clinicians relates to the apparent simplicity of the treatment procedures and the speed at which clinical improvement is reported. It has an intuitive mystical appeal that is in many ways similar to factors that have assisted hypnosis to flourish (Beere, Simon, & Welch, 2001). Even the most enthusiastic supporters of EMDR cannot say, in cogent bioscientific terms, how it works; how EMDR actually produces the purported outcomes remains an issue of intense speculation and theorization.

Shapiro, the therapy's founder, has elaborated on two theoretical models to explain the action of EMDR, both evoking elements of *integration* as the scientific basis of action. These models, first called the Accelerated Information Processing model (Shapiro, 1996b) and now revised to the Adaptive Information Processing model (Shapiro, 2001a), conceptualize memory and its affective storage as an integration of *mind* and *brain*. Shapiro argues that EMDR, while affecting psychological aspects of functioning, has a clear neurophysiologic impact that is responsible for the therapeutic benefits (Shapiro & Maxfield,

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Table 3. Conditions and Disorders for Which EMDR Has Been Reported as Helpful

PTSD	<ul style="list-style-type: none"> ■ Lazrove, Triffleman, Kite, McGlashan, & Rounsaville, 1998 ■ Devilly & Spence, 1999 ■ Beere, Simon, & Welch, 2001 ■ Bisson et al., 2002 ■ Korn & Leeds, 2002 ■ Macklin, Metzger, Lasko, Berry, Orr, & Pitman, 2000 ■ Edmond, Rubin, & Wambach, 1999
Panic disorder	<ul style="list-style-type: none"> ■ Goldstein, de Beurs, Chambless, & Wilson, 2000
Dermatologic disorders	<ul style="list-style-type: none"> ■ Gupta & Gupta, 2002
Eating disorders	<ul style="list-style-type: none"> ■ Hudson, Chase, & Pope, 1998
Couples work	<ul style="list-style-type: none"> ■ Protinsky, Sparks, & Flemke, 2001
Complicated bereavement/stress	<ul style="list-style-type: none"> ■ Sprang, 2001
Chronic pain	<ul style="list-style-type: none"> ■ Grant & Threlfo, 2002 ■ Grant & Threlfo, 2002 ■ Grant, 2000
Conduct disorder	<ul style="list-style-type: none"> ■ Soberman, Greenwald, & Rule, 2002 ■ Rubin et al., 2001
Morbid jealousy	<ul style="list-style-type: none"> ■ Blore, 1997 ■ Keenan & Farrell, 2000
Jail-related aggression	<ul style="list-style-type: none"> ■ Kitchiner, 2000
Body image disturbance	<ul style="list-style-type: none"> ■ Dziegielewski & Wolfe, 2000
Dental anxiety	<ul style="list-style-type: none"> ■ McGoldrick, deJongh, Durham, Bannister, & Levitt, 2002
Public speaking anxiety	<ul style="list-style-type: none"> ■ Carrigan & Levis, 1999
Phobias	<ul style="list-style-type: none"> ■ De Jongh, Ten Broeke, & Renssen, 1999

2002). What those neurophysiologic impacts are, however, is as yet unexplicated.

Shapiro asserts that asynchronous electrical activity in cerebral hemispheres is at the pathogenic heart of symp-

toms seen in PTSD (Shapiro, 2002; Shapiro & Maxfield, 2002). She contends that EMDR somehow synchronizes electrical activity, thereby altering conditioned fear responses to memories of the original trauma. While accepted by many, the integrative mind-brain component theory proposed by Shapiro has led to skeptics believing that as a treatment, EMDR's theoretical models of action are vague at best and foolish at worst. Others have speculated that any benefit is either placebo based or related to the therapeutic interpersonal relationship between patient and therapist, rather than any eye movement or information reprocessing (Lipke, 2003; Lohr, Lilienfeld, Tolin, & Herbert, 1999; McNally, 1999; Rosen, 1997; Smith, 2003).

While models of how EMDR works remain hypothetical and have not been fully tested, they have been criticized for lacking correlation to known brain structures. Additionally, as EMDR is used for more and more diverse health problems, many of which have well-identified neurophysiologic etiologies having little to do with information reprocessing, it is hard to find a physiologically based theoretical model of EMDR's action that would explain equal efficacy for such diverse problems (Herbert et al., 2000; Hudson, Chase, & Pope, 1998). Additionally, as EMDR procedures are expanded to replace saccadic eye movement with finger tapping and/or auditory focus on sound, some of the original theories pertaining specifically to eye movement "freeing up" memory displacement become even harder to understand. It has been suggested by some that the real benefit of EMDR reported in some studies may be linked more to its ability to distract and/or relax the patient rather than any ability to free trapped memories (Heber, Kellner, & Yehuda, 2002; Hyer & Brandsma, 1997).

One of the first studies to examine how EMDR affected neurophysiology employed neuroimaging techniques, examining subjects diagnosed with PTSD using single-photon emission computed tomography (SPECT) studies prior to and following three EMDR sessions (Levin, Lazrove, & van der Kolk, 1999). The authors concluded that patients experienced subjective improvement in distress levels, while SPECT scanning suggested

two areas of the brain, the anterior cingulate gyrus and the frontal lobe, were hyperactive post-EMDR. It is the function of the cingulate gyrus to shift attention from one thing to another, whereas the frontal lobe is involved in associative and affective aspects of cognition. This study is limited by a very small sample size and its lack of a control group, but it provides a starting point for models hypothesizing the action of EMDR. The cingulate gyrus has been identified in other studies as the area of impact for desensitization therapies, including hypnosis (McNeal, 2001) and, therefore, a logical area of hypothesized EMDR action (Hudson et al., 1998; Smith, 2003; Stickgold, 2002).

More recent work has looked at stress chemicals and neuroendocrine responses as a window into measuring the impact of EMDR and identifying its actions. Studies have shown that EMDR increases basal cortisol levels and produces more attenuated cortisol hypersuppression in response to dexamethasone suppression tests in PTSD sufferers (Heber et al., 2002). This suggests that neuroendocrine measures may be of some assistance in future studies in the assessment of EMDR treatment outcomes. Having known biological markers of EMDR actions would allow for objectification of treatment procedures' impact on the clinical outcomes of the patient over time and may well lead to a clearer understanding of the neurobiological basis of reported efficacy.

Perhaps the most complete, logical, and parsimonious theory on how EMDR works is contained in the work of Stickgold (2002). This theoretical model attempts to explain the therapeutic benefits of the saccadic eye movements of EMDR. Proposing that the induced eye movements in EMDR mimic rapid eye movements (REM) of sleep, the model attempts to identify the neurological pathways of the cortical integration of traumatic memories that was alluded to in Shapiro's early works (Shapiro, 1996a, 1996b; Shapiro & Maxfield, 2002). This emerging model provides a reasonable explanation for EMDR that is consistent with modern neurobiological understanding and is a first step toward a more universally acceptable, neurologically logical theory. Stickgold's model suggests that REM states are facilitative of

memory integration, and EMDR may cause cholinergic activation on the brainstem that jump starts the REM-induction mechanisms of memory induction in associative cortical areas. One limitation of this theory is the assumed causality between eye movement and clinical improvement, and its examination only of EMDR done using eye movements. It is much less helpful in explaining reports of EMDR's efficacy in other health states or when done with hand motions or sounds rather than with eye movements. But it begins to provide a clear, and testable, neurobiological theory of EMDR action.

How does EMDR work? No one can say with any degree of certainty. Without this knowledge, it is difficult to decrease the controversy over this treatment or to assure clinicians and patients that it is an effective treatment. As cogent models of EMDR's actions emerge, testing will advance our understanding of this therapy. While work continues on developing such a cogent, parsimonious, and logical theory, there remains the lingering question of its efficacy as a treatment.

Does EMDR Work: Clinical Efficacy and the Nature of "Evidence"

Marano (1994) touted EMDR as the "wave of the future" (p. 22). This promise has failed to materialize, largely because of lingering questions regarding the efficacy of EMDR treatment in mediating targeted symptoms. This is not for want of trying, and there is a plethora of studies examining the efficacy of EMDR as a treatment modality. Yet despite the extensive literature, there remains no consensus about the efficacy of EMDR.

Studies can be found that conclude EMDR works, many written by ardent supporters (Shapiro, 1996b; 2002). Just as many can be found that conclude little or no benefit from EMDR (Figley et al., 2000; Greenwald, 1999; McNally, 1999). Rubin et al. (2001), for example, found no effect from EMDR treatment for children with PTSD. Much of the debate over efficacy is centered on whether a true, measurable "effect" exists consistently because of EMDR treatment (Devilly & Spence, 1999; EMDR, 2002; Rosen, 1997; 1999; Sack, Lempa, & Lamprecht,

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2001; Taylor et al., 2003). Effect is most often, and most compellingly, established by controlled clinical trials, where EMDR would be compared to other standard treatments, to no treatments, or to a placebo treatment. These studies are largely absent, and the few studies that purport to be controlled trials *and* found EMDR effects, have been repeatedly cited as being significantly methodologically flawed (Maxfield & Hyer, 2002). Identified flaws in studies that have found an EMDR effect include small sample size, lack of randomization, lack of diagnostic similarity among subjects, lack of standardized instruments to measure clinical improvement, and serious lack of control of other treatments that subjects were concurrently receiving (Davidson & Parker, 2001; Herbert et al., 2000; Hudson et al., 1998).

All these limitations make it very difficult to say with any certainty that a clinical effect occurs with EMDR or that EMDR is efficacious in the treatment of PTSD or other related disorders (Perkins & Rouanzoin, 2002). One of the most thorough recent reviews of existing studies on the efficacy of EMDR was conducted in 2001 using meta-analysis (Davidson & Parker, 2001). This meta-analysis concluded, after review of extant studies, that EMDR appeared to be no more effective than other exposure therapies and that the eye movement, the procedure for which it is named and which is the hallmark of the therapy, is "unnecessary" and that patients derive similar benefit no matter what physical action the therapist performed. Such findings, juxtaposed to continued anecdotal and case reports of almost miraculous improvement, continue to fuel the controversy surrounding EMDR.

Some of the controversy over efficacy of EMDR can be framed within the debate over what constitutes evidence of efficacy, an issue of growing concern in this era of evidence-based care. While the debate regarding evidence-based care is beyond the scope of this article, supporters of EMDR continue to contend strongly that it works, dismissing the failure to establish effect through rigorous controlled clinical trials as an issue for scientists, not clinicians (Lampropoulos & Spengler, 2002). This schism over what is acceptable evidence is further exem-

plified by the reality that EMDR is most often embraced and used by practitioners with formal research training and who are less programmed to believe randomized clinical trial data are necessary to establish efficacy. These clinicians have more comfort accepting *evidence* at the level of personal experiences, responses of known patients, and other case and anecdotal reports as sufficient to support their use of the therapy (Beutler, Moleiro, & Talebi, 2002).

Is EMDR clinically effective? The answer to this question is as unclear as the answer to how EMDR works. Critical evaluation of empirical data regarding the efficacy of EMDR is difficult and is influenced by one's own stance on the debate over what is evidence of efficacy. The literature on EMDR suffers from lack of a cogent theoretical, biologically based model explaining the effects of EMDR. The lack of a theoretical model explaining how EMDR works makes it difficult to reproduce PTSD or other symptom cluster for experimental controlled research studies. In addition to lack of theory model and the identified methodological flaws, many believe there has been overt biased dissemination of study findings by a small number of authors (Perkins & Rouanzoin, 2002), making final conclusions concerning the efficacy of EMDR very difficult.

EMDR and Nursing Practice

For a therapy now more than 20 years old, EMDR remains unusually controversial. The evidence base for EMDR is confusing, clinicians remaining divided into camps of believers and nonbelievers. It is difficult for nurses to determine whether they should incorporate EMDR into their clinical practice. It should be remembered that even the most ardent supporters of EMDR assert it is most effective on the anxiety and distress subjectively experienced by patients but is not a panacea for all PTSD-related symptoms (Koppel, 2002; Korn & Leeds, 2002).

One of the few nursing publications that can be found pertaining to EMDR describes the treatment and supports the use of EMDR (Barron, Curtis, & Grainger, 1998). This work typifies the complexities surrounding

EMDR and the confusion that exists regarding efficacy of this controversial treatment. Barron et al. discuss in their summary that as a result of EMDR treatment, "EMDR processes images, memories, associations, thoughts, and emotions" (p. 143). Their conclusion is fully supportive of nurses using or referring patients for EMDR because after use of EMDR, "a 'neurological' event" has occurred. They recommend EMDR for a wide array of patients, including those suffering from "PTSD, anxiety, phobia, depression, or any neurotic symptom" (p. 143). They base these recommendations on a stated belief that traumatic events "upset the balance of the brain's information-processing center" and go on to discuss how this imbalance "prevents the information from proceeding to an adaptive resolution, and perceptions of the trauma incident are locked into the nervous system" (p. 140).

Such nonspecific, unscientific, non-evidence-based mumbo jumbo becomes an indefensible rationale for the inclusion of a treatment into a nurse's clinical practice. Psychiatric nursing is a science-based practice, and nurses must carefully weigh the scientific evidence and rationales for practice treatments. That is not at all to say we should avoid all as yet unexplained treatment (Smith, 2003). Health care often uses unproven treatments or treatments supported solely by untested theory or unclear efficacy data. What is important is to acknowledge the degree of available evidence and our limitations in current understanding. This allows one to be open to emerging explanation and evidence of efficacy, including the possibility that unproven treatments may be highly effective or have placebo effect only, or at worst, prove to be unhelpful and dangerous. Patients have a right to a balanced discussion of available information, an understanding of the rigor of evidence, and nurses must be able to defend clinical decision based on science.

Conclusion

It is the conclusion of this author that clinicians should approach EMDR with a degree of caution until more rigorous conclusive models of action are devel-

oped and until stringent empirical establishment of efficacy occurs. EMDR is by most standards seen as an overall safe treatment, most appropriately used for PTSD-related treatment. The decision to use EMDR in clinical practice needs to be personal, based in thoughtful clarification by individuals of what, for them, constitutes the necessary and sufficient evidence that must be present in order to adopt the use of a treatment strategy. The interface of clinically meaningful findings and research-driven evidence will most likely remain a contentious professional issue for the foreseeable future. The decision to use or reject EMDR as a clinically meaningful treatment modality should be based within the science of our profession. While tempting to be swayed by urban legend-level reports of miraculous cures, the evidence is less persuasive and cannot be ignored. EMDR is controversial. It has no proven basis of action. It has no strong empirically sound base supporting its consistent efficacy. These realities must be mediated by our understanding that this is how many of our best treatments started. Caution is warranted. Hope is appropriate.

Author contact: smccabe@direcway.com, with a copy to the Editor: mary@artwindows.com

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