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POWER THERAPIES: EVIDENCE VERSUS EMOTION A REPLY TO ROSEN, LOHR, McNALLY AND HERBERT

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Abstract. Rosen, Lohr, McNally and Herbert's (1998) arguments directed at the so-called "Power Therapies" and, in particular, Eye Movement Desensitization and Reprocessing (EMDR) are examined. It is suggested that their paper does not adequately review the available research data and, therefore, draws unwarranted conclusions. Based on published controlled studies it is concluded that there is evidence to support the use of EMDR in the treatment of post traumatic stress disorder (PTSD).

Keywords: EMDR, PTSD, outcome research, treatment effectiveness.

In their paper entitled "Power Therapies, miraculous claims and the cures that fail" Rosen, Lohr, McNally and Herbert (1998) conclude that the various treatment procedures that have been grouped together and termed "Power Therapies" (Figley, 1997) are supported by little empirical evidence and should be treated with "sceptical caution among today's cognitive behaviour therapists". While agreeing that empirical validity of treatment effects is an essential feature of the behavioural approach to psychotherapy, Rosen et al. (1998) fail adequately to address the available literature.

Included within the methods labelled "Power Therapies" are Thought Field Therapy (TFT, Callahan, 1985), Trauma Incident Reduction (TIR, Gerbode, 1988), Eye Movement Desensitization and Reprocessing (EMDR, Shapiro, 1989, 1995) and Emotional

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Freedom Techniques (EFT, Craig, 1997). With regard to TFT, TIR and EFT there are no controlled studies, with independent evaluation, appropriate outcome measures or follow-up, showing stability of treatment effects. Consequently, claims for these procedures are, at best, premature. However, Rosen et al. (1998) address their criticisms primarily against EMDR, but by accepting Figley's (1997) linking together of these so-called Power Therapies they seek to discredit them all.

In fact, the theoretical foundations of these procedures have no common ground. For example, in contrast to TFT and EFT, EMDR incorporates well established principles of exposure, cognitive restructuring and self-control procedures, combined with the use of eye movements. In addition, Shapiro (1995) has emphasized that EMDR should be viewed as part of an overall treatment process rather than as a "one-off" treatment method.

While Rosen et al. (1998) suggest that the theoretical foundation of EMDR "approaches the limits of neurobabble", Shapiro (1995) has acknowledged that her Acclerated Information Processing Model is simply that – a model. Various authors (e.g. Andrade, Kavanagh, & Baddeley, 1997; Armstrong & Vaughan, 1996; Dyck, 1993; MacCulloch & Feldman, 1996) have offered alternative theoretical explanations. Research by Van der Kolk, Burbridge and Suzuki (1997) suggests that EMDR produces effects at the neurobiological, as well as at the psychological level, while Stickgold (1998), drawing upon findings from research on sleep, dreaming and memory, has also provided an explanation for the mechanisms underlying the role of eye movements within the procedure. However, whether or not Shapiro's theoretical model is correct is irrelevant to the issue of treatment effectiveness, in the same way, for example, that criticism of Wolpe's (1958) theory of reciprocal inhibition did not undermine the effectiveness of systematic desensitization.

Rosen et al. (1998) imply that clinicians who have been trained in EMDR are gullible. They claim that several studies find that "eye movements add nothing to treatment outcome" and that "effects of the technique are largely limited to verbal report indices". In support of these statements they cite two papers that have as the lead author a member of their own group (Lohr, Kleinknecht,Tolin, & Barrett, 1995; Lohr, Tolin, & Lilienfeld, 1998).

While not denying that some studies have produced equivocal findings on the role of eye movements and have relied on verbal reports, this does not adequately reflect the research literature. To date there are 13 controlled studies on EMDR and post traumatic stress disorder (PTSD) (Boudewyns & Hyer, 1996; Boudewyns, Stwertka, Hyer, Albrecht, & Sperr, 1993; Carlson, Chemtob, Rusnak, Hedlund, & Maraoka, 1998; Jensen, 1994; Marcus, Marquis, & Sakai, 1997; Pitman et al., 1996; Renfrey & Spates, 1994; Rothbaum, 1997; Scheck, Schaeffer, & Gillette, 1998; Shapiro, 1989; Vaughan et al., 1994; Wilson, Becker, & Tinker, 1997; Wilson, Silver, Covi, & Foster, 1996). In fact, there are currently more published randomized controlled studies supporting the effectiveness of EMDR than for any other psychological method for treating trauma (see Table I).

In claiming that outcome is "largely limited to verbal report indices" Rosen and his colleagues choose to ignore that the effects of treatment with EMDR, in common with studies on other behavioural treatments, such as exposure, have been reported as improvements on standardized psychometric measures of PTSD (Boudewyns & Hyer,

Table 1. Comparison of controlled studies of PTSD

Treatment method	Total number of published studies	Total number of participants treated	Mean number of treatment sessions
EMDR	13	286	4
Exposure	8	120	16
Cognitive therapy	2	37	11
Psychodynamic therapy	1	29	16
Exposure and cognitive therapy combined	1	19	10
Cognitive behavioural treatment	1	9	9

1996; Carlson et al., 1998; Marcus et al., 1997; Rothbaum, 1997; Scheck et al., 1998; Wilson et al., 1996). Also omitted from mention are demonstrated changes on psychophysiological measures (Boudewyns & Hyer, 1996; Pitman et al., 1996; Vaughan et al., 1994; Wilson et al., 1997) as well as the findings on changes in brain activity following EMDR treatment reported by Van der Kolk et al. (1997).

Another issue that Rosen et al. (1988) have chosen to disregard is the apparent greater rapidity of treatment effects compared to exposure methods. Considering the recent published controlled studies using EMDR with single trauma subjects (Marcus et al., 1997; Rothbaum, 1997; Scheck et al., 1998; Wilson et al., 1997) and comparing these with the sole published report on the use of imaginal exposure (Foa, Rothbaum, Riggs, & Murdock, 1991) and those employing a combination of imaginal and *in vivo* exposure (Richards, Lovell, & Marks, 1994; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998) some interesting findings are apparent.

At post-test 55% of the patients in Foa et al.'s (1991) study were reported to no longer have PTSD. In the Richards et al. (1994) study 100% no longer met the criteria for PTSD, and this figure for the Marks et al. (1998) study was 80%. While these results are impressive Foa et al.'s (1991) patients required approximately 25 hours of exposure, those of Richards et al. (1994) 50 hours, and the patients in Marks et al.'s (1998) study received over 100 hours of exposure, including homework assignments. Across the four studies employing EMDR, mentioned above, the data indicate that after only approximately 4 hours of treatment the number of single trauma subjects no longer diagnosed as PTSD ranged from 84% to 100%.

These findings not only indicate that treatment of single incident trauma using EMDR is much more rapid than treatment by exposure methods, it also suggests that mechanisms other than habituation, which is assumed to be the basis of exposure, operate in the case of EMDR.

Further, an important issue in assessing treatment effectiveness and efficiency is that of client acceptability and satisfaction (see Seligman, 1995). There are strong indications that EMDR is less anxiety provoking, better tolerated, and therefore more acceptable to patients, than are exposure methods (Boudewyns & Hyer, 1996; Pitman et al., 1996).

As regards the alleged "striking parallels between EMDR and Mesmerism" referred to by Rosen and his colleagues, and documented by one of them (McNally, in press), these, like the criticism of the theoretical basis of EMDR, are entirely irrelevant to the

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issue of treatment effectiveness, which should be determined on the basis of research evidence alone. EMDR is certainly not a miraculous cure and even if exaggerated claims have been made on its behalf this should not be used as a reason to dismiss, or distort, the data that do exist. Given that EMDR has been assessed as ''probably efficacious'' for the treatment of civilian PTSD (Chambless et al., 1998) it would not appear to be a cure that has failed. This assessment is, in fact, the same as that assigned to exposure methods.

As with any new treatment procedure, healthy scepticism is appropriate. However, the appropriate response is to undertake further and better controlled studies, both to test effectiveness and to identify and enhance the active elements. Such aims are best served by empirical research rather than unbalanced reviews and emotive argument.

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