

Assessing the Effectiveness of EMDR in the Treatment of Sexual Trauma

Shanika Paylor
North Carolina Central University
and
Chadwick Royal
North Carolina Central University

Abstract

The authors provide a critical review of eye movement desensitization and reprocessing (EMDR) as an effective means of clinical treatment for female survivors of sexual abuse. The authors reviewed selected research findings, assessing strengths and limitations of each work. The authors present themes and patterns regarding the use of EMDR with female sexual abuse victims and offer suggestions of best practice for applying EMDR as a complimentary intervention to other behavioral approaches.

Keywords: Sexual abuse, sexual trauma, trauma, EMDR, PTSD

Assessing the Effectiveness of EMDR in the Treatment of Sexual Trauma

Mental health practitioners depend on research literature to govern the development of therapeutic treatments and the design of programming in mental health agencies. Practitioners' reliance on research findings is particularly important when providing treatment for clients with a significant history of trauma. Implementing treatment methods for survivors of trauma is challenging because of the pervasive nature of the trauma experience. This complexity, combined with the factors that contribute to the psychological aftermath of trauma and one's experience of sexual abuse or assault may make sexual trauma more detrimental than any other type of trauma.

Though the prevalence of sexual trauma is particularly difficult to quantify, Leserman (2005) notes that anywhere between 15 and 25 percent of women are impacted by a history of sexual abuse. Based on those findings, at worst, one out of every four females is said to be a survivor of at least one act of sexual victimization. This point is particularly salient for all professionals who are in any way invested in the physiological or psychological care of women. Empirical data has linked sexual trauma to a host of medical and psychiatric conditions, ranging from gastrointestinal issues, gynecological ailments, and headaches to Post Traumatic Stress Disorder (PTSD), Major Depressive Episode, and Generalized Anxiety Disorder (Leserman, 2005).

Of all treatment modalities used in current practice, clinical findings support that eye movement desensitization and reprocessing (EMDR) therapy has a significant impact on the

symptoms associated with the aforementioned psychological disorders. In some instances, EMDR has been found to rid study participants of a DSM-IV diagnosis of PTSD and has rendered more than half of those clients asymptomatic after a six-month follow-up (van der Kolk et al., 2007). To best assess the effectiveness of EMDR, particularly in the treatment of clients with histories of sexual trauma, clinicians must consider the finer points of research findings related to the treatment of this population.

This review seeks to present findings highlighting the effectiveness of EMDR when working with female survivors of sexual victimization. Several studies were considered based on their methodology and results. This review (a) objectively summarizes the studies' strengths and limitations and (b) presents guidelines around best practices for clinicians and future researchers of EMDR as a therapeutic intervention in clinical practice.

Eye Movement Desensitization and Reprocessing (EMDR)

Eye Movement Desensitization and Reprocessing (EMDR) is a technique that is used to help ease or lessen symptoms brought about by previous trauma. The technique attempts to combine sensory stimulation with memories (emotional memories) to manipulate the brain's processing scheme and relieve affective distress (Meyer, 2014). When applying the technique, a clinician will have a client address negative or traumatic emotional memories while focusing their attention on a concrete external stimulus. The most common stimuli are (clinician-directed) lateral eye movements, but hand-tapping and audio stimuli are also used (EMDR Institute, 2014).

Reoccurring Themes in Research

The authors discovered reoccurring themes and findings throughout the body of research concerning the use of EMDR when treating survivors of sexual trauma. Most notably, there is limited research relating to the application of EMDR in clinical practice that specifically addresses the effectiveness of it when working with victims of sexual trauma. While extensive research has been conducted on EMDR for use with treating PTSD, the search for sources regarding the use of EMDR specifically for sexual trauma has yielded works that were published only in the last 15 years. Additionally, many of these studies are said to be limited in their reliability due to several factors. These elements range from (a) the limited number of participants in the samples of these studies, to (b) the prevalence of research methods without controls, or (c) the use of case studies as a means of assessing the effectiveness of EMDR. Though each study presents with its own flaws, they all speak to the efficacy of EMDR as a successful treatment modality for symptoms deriving from sexual trauma.

What Selected Research Indicates

The study of EMDR as a treatment method for various types of trauma yields promising long-term psychological results. Van der Kolk and others (2007) applied EMDR, fluoxetine (a psychotropic drug, in the selective serotonin re-uptake inhibitors class), and a placebo pill as separate interventions to three groups of randomly assigned participants ($n=88$). Both EMDR and fluoxetine yielded positive results for their respective participants, more than the participants in the placebo group. However, EMDR was found to be significantly more helpful in reducing PTSD symptoms than fluoxetine. Immediately following the intervention phase, participants who were treated with EMDR no longer met the criteria for PTSD, and 58% of those who

received EMDR were still asymptomatic after the final, 6-month follow-up (van der Kolk et al., 2007).

Participants who were treated with EMDR also reported a reduction in depressive symptoms (van der Kolk et al., 2007). It can be assumed that the use of EMDR made a significant impact on the clients who were placed in the group in which the treatment was employed. When comparing the results from the EMDR group to those results from the fluoxetine group, the EMDR participants continued to improve post-treatment, while it appeared that the participants in the latter group only experienced an immediate improvement that was achieved after the fluoxetine therapy began.

When comparing this study to others that focus on this population and the treatment, it is notable that the researchers managed to secure a sound sampling of participants (van der Kolk et al., 2007). Following initial and subsequent screenings, 88 participants took part in the study. Additionally, the study's researchers considered the concern of concurrent therapeutic treatment. One of the exclusion criterion of the study required that participants not be currently engaged in any trauma-focused therapeutic treatment while participating in the study. Addressing this matter served to differentiate any of the results from other factors that could potentially affect the clients' therapeutic progress.

While the strengths for this study (van der Kolk et al., 2007) were significant in their own right, in light of considering best practices for the use of EMDR in research, it is important to consider the weaknesses as well. Concerning the sample of participants, the study did not have exclusion criteria that restricted clients with other types of trauma from participating in the study (e.g., childhood physical abuse or intimate partner violence). A breadth of experiences widens the scope of the participants' trauma histories and subsequently places limitations on the generalizability of research findings.

Additionally, researchers allowed participants to take part in the study whether they (the participants) experienced their trauma during childhood or adulthood (van der Kolk et al., 2007). The trouble with including participants who were impacted by trauma either during their childhood or as adults lies in the fact that the treatment modalities may impact the client in differing manners, depending on how recently the trauma occurred and the client's age during the first incident of sexual victimization. A child may process and internalize a trauma in a much different way than an adult. Van der Kolk et al. (2007) noted that a small number of participants dropped out of the study and that the majority of these clients were those who experienced childhood sexual abuse and were also assigned to the EMDR group. Considering that a portion of the EMDR participants left the group and were not replaced, it is possible that the results could have been swayed in favor of either EMDR therapy or the SSRI treatment had the withdrawn participants continued with treatment.

The most considerable limitation concerns the duration of treatment for each of the three groups. Eight weeks of treatment with EMDR did not appear to be sufficient for some participants, particularly those who were survivors of childhood-onset chronic sexual trauma. The short time frame may have been limiting to the therapeutic process, and van der Kolk et al.

(2007) suggest that future studies consider the use of EMDR for more than 8 weeks, as opposed to considering it a brief solution treatment.

Conversely, Edmond, Rubin, and Wambach (1999) compared EMDR to what they considered as “routine individual treatment” with adult female survivors of childhood sexual abuse. “Routine individual treatment” was comprised of over 20 different treatment interventions, ranging from cognitive behavioral techniques to psychodynamic therapy to the Gestalt approach. After roughly 10 weeks of EMDR treatment and 11 weeks of routine therapy, researchers noted a positive outcome for the EMDR clients. They all scored significantly better on posttests, which included a reduction in trauma-specific anxiety, depression, and PTSD symptoms. However, unlike the van der Kolk et al. study (2007), posttest results did not reveal EMDR to be significantly superior to the routine interventions that were applied in the other group (Edmond et al., 1999).

A reasonable sample of 59 participants completed the treatment and reported their experiences during follow-up (Edmond et al., 1999). The research is focused, including a diverse, yet homogenous sample of clients. While the women that were included in the study derived from various socio-economic backgrounds and varied in age, they all experienced similar histories of trauma. The inclusion criteria included similar abuse-specific variables, such as the age of initial onset of abuse, the duration of victimization, the frequency of sexual abuse, and the gender of the abuser (Edmond et al., 1999).

When considering Edmond et al.’s (1999) methodology, each of the clinicians received training in EMDR therapy. However, one of the intervention providers had prior experience with EMDR and was later found to have a treatment bias in favor of the technique. By comparison, another practitioner was not in favor of EMDR’s proposed outcomes and was negatively biased against the treatment. In addition to the therapists’ biases, there was a large variance of experience in working with the given population. One clinician had worked with survivors of sexual trauma for only two and half years, while another clinician had nearly 25 years of experience (Edmond et al., 1999).

Due to limited resources, Edmond et al. (1999) provided clients with 6 sessions of either EMDR therapy or traditional psychotherapy. Because of the short-term nature of the treatment, clients from all groups were not restricted from seeking therapy with other clinicians following the end of the treatment period. Therefore, when the researchers contacted participants for a follow-up assessment, a large portion of the participants reported receiving additional treatment after the end of the study’s intervention. Considering that the clients sought services from professionals who practiced using various modalities, it would be nearly impossible to distinguish the effects of either EMDR or other therapies when reviewing follow-up results. This limitation reduces the validity of the results (Edmond et al., 1999).

A third study focused on a sample of 12-13 year old girls, all of whom were victims of sexual abuse (Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004). Researchers divided the participants into two sample groups to compare the effectiveness of EMDR to cognitive behavioral therapy on psychological and behavioral symptoms following trauma. The study found that both modalities were effective for young survivors of sexual trauma. However, it was

reported that EMDR was more efficient -- it required fewer sessions to yield significant results (Jaberghaderi, et al., 2004).

The Jaberghaderi, et al., (2004) study particularly focused on sexual trauma and excluded participants who were actively experiencing abuse. All of the participants attended the same school and were from identical socio-economic statuses and similar ethnic-religious backgrounds. Although this provides some strength of validity, the small sample and lack of heterogeneity limit the generalizability of the results. In addition, researchers based their results on one two-week follow-up, which is not a sufficient amount of time to support the effectiveness with this population (Jaberghaderi, et al., 2004).

Conclusions

Each of the studies speaks to EMDR's effectiveness across various cases of sexual trauma. The studies note EMDR's overall effectiveness in comparison to other "best practice" modalities such as CBT and psychotropic medications. Results indicated several key points that lead to successful EMDR implementation:

- a) When identifying clients who might benefit from the treatment, EMDR has potential adverse effects for clients due to its focus on recalling traumatic memories.
- b) It is in the clinician's best interest not to use EMDR when working with a client who is currently experiencing abuse or has recently experienced some form of sexual victimization – and has not yet had separation/processing of the abuse.
- c) The duration of EMDR treatment may vary. It is wise to not set an expectation of how quickly or slowly EMDR will impact symptoms associated with trauma.
- d) Clinicians should prepare clients by arming them with psychoeducational information on the process of the treatment.
- e) The best way to evaluate the effectiveness of an EMDR intervention is through assessing symptoms before, during, and after treatment. Various assessment tools should be employed to monitor clients' progress.

Further research within the field should focus on the use of EMDR alongside other "best practice" modalities, such as CBT or Mindfulness Based Stress Reduction therapy. Though the intervention is potentially effective when used alone, the modality is designed for use within an integrative method of treatment. Perhaps a plan of treatment for female survivors of sexual trauma should include a course of psychotropic medications for stabilization (if warranted), and a skills-based, behavioral approach, which would be complimented by the use of EMDR. In research, comparing this integrative method of treatment alongside single interventions such as a trial of psychotropic medication (and nothing else) may speak volumes about the efficacy of the technique. Previous results all point to the value of applying EMDR with other treatment approaches when working with clients who have experienced sexual trauma.

References

- Edmond, T., Rubin, A., & Wambach, K. G. (1999). The effectiveness of EMDR with adult female survivors of childhood sexual abuse. *Social Work Research, 23*(2), 103-116.
- EMDR Institute. (2011). *What is EMDR?* Retrieved from: <http://www.emdr.com/general-information/what-is-emdr/what-is-emdr.html>
- Jaberghaderi, N., Greenwald, R., Rubin, A., Zand, S. O., & Dolatabadi, S. (2004). A comparison of CBT and EMDR for sexually-abused Iranian girls. *Clinical Psychology & Psychotherapy, 11*(5), 358-368.
- Leserman, J. (2005). Sexual abuse history: prevalence, health effects, mediators, and psychological treatment. *Psychosomatic medicine, 67*(6), 906-915.
- Meyer, J. L. (2014). EMDR for the co-occurring population. *Counseling Today, 56*(12), 54-59.
- Van der Kolk, B. A., Spinazzola, J., Blaustein, M. E., Hopper, J. W., Hopper, E. K., Korn, D. L., & Simpson, W. B. (2007). A randomized clinical trial of eye movement desensitization and reprocessing (EMDR), fluoxetine, and pill placebo in the treatment of posttraumatic stress disorder: treatment effects and long-term maintenance. *Journal of Clinical Psychiatry, 68*(1), 37-46.