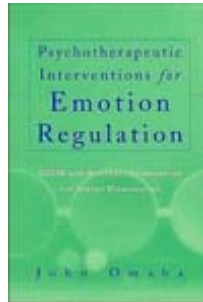


EMDR Variants, Pseudoscience, and the Demise of Empirically Supported Treatments?

A Review of



Psychotherapeutic Interventions for Emotion Regulation: EMDR and Bilateral Stimulation for Affect Management

by John Omaha

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— In the world of psychotherapy, clinicians always seem to be looking for the “latest and greatest” approach. Although there are a few notable exceptions (e.g., exposure therapies for anxiety disorders), current treatments leave much to be desired in terms of their specific efficacy, effectiveness, and efficiency. Furthermore, most therapists are acutely aware of the deficits found in traditional approaches. This leaves fertile ground for enterprising clinicians proposing new techniques that they claim will address some, if not all, of psychotherapy’s shortcomings. In recent years, there has been an upsurge of new therapies, each claiming to offer a breakthrough in psychotherapy. These new approaches have been referred to as “power therapies” due to their putatively increased effectiveness, efficiency, and wide applicability (Rosen, Lohr, McNally, & Herbert, 1998). Each of the power therapies has its own acronym to set it apart from the other, which has led some

to term them the *alphabet interventions* (Gist, Woodall, & Magenheimer, 1999). Popular examples include eye movement desensitization and reprocessing (EMDR), thought field therapy, emotional freedom techniques, critical incident stress debriefing, traumatic incident reduction, neurolinguistic programming, Tapas acupuncture technique, be set free fast, and energy diagnostic and treatment methods.

— In recent history, perhaps no one has been more successful at promoting a novel psychotherapy than Francine Shapiro, the creator of EMDR. EMDR uses alternating eye movements, body taps, or tones that are theorized to aid in the desensitization of traumatic memories and in the amelioration of symptoms associated with posttraumatic stress disorder (PTSD). According to Shapiro (1995), the technique was inspired by a serendipitous occurrence during a walk, and she began offering training seminars in the procedure shortly after publishing a small pilot study in 1989. Since that time, EMDR has expanded in popularity, and the EMDR Institute, Inc., now claims to train over 4,500 clinicians each year in the method (Colwell, 2000). However, EMDR has garnered equal amounts of critics and supporters. For example, many argue that the treatment's efficacy has been grossly exaggerated and that its development and dissemination exemplify many of the characteristics of pseudoscience (Herbert et al., 2000).

— Even though rigorous clinical trials support the use of EMDR only for PTSD, proponents routinely promote it for a diverse array of clinical conditions. In *Psychotherapeutic Interventions for Emotion Regulation*, John Omaha describes his new adaptation of EMDR, which is combined with a myriad of other traditional and nontraditional therapy techniques, for treating emotion regulation problems associated with a variety of Axis I

and II disorders. The author begins by claiming that his work represents a “new phase in a profound revolution in psychotherapy” (p. 1) because it specifically targets emotions in addition to behaviors and cognitions. Omaha calls his approach affect-centered therapy or ACT (not to be confused with acceptance and commitment therapy and assertive community treatment, which also share this acronym). Phase I of ACT is called affect management skills training (AMST), and it includes a set of seven techniques developed to teach clients how to regulate their emotions. After Phase I skills are learned, Phase II skills involve “uncovering and resolving the causes of emotion dysregulation” (p. 347). The relationship between emotion regulation and psychiatric disorders is a timely topic, and efficacious techniques created to help clients better manage their emotions could be immensely useful to clinicians. Unfortunately, Omaha’s book does not deliver on its initial promises.

☞ EMDR has been criticized extensively for exhibiting many of the features of pseudoscience, which is when something is presented to look scientifically supported and credible even though it is not (Herbert et al., 2000). Similar questionable practices are found in Omaha’s presentation of ACT. The author briefly discusses the research literature on EMDR first to build the case for his own variant but completely ignores negative outcome findings and all other valid criticisms. Furthermore, he asserts “The eye movements appear to be an active treatment component” (p. 9). However, this grossly exaggerates the state of the evidence. For example, a recent meta-analysis concluded that there is no evidence to support the claim that eye movements, arguably the only unique feature of EMDR, are responsible for the treatment’s effects (Davidson & Parker, 2001). It is not surprising that Omaha takes this stance given that ACT is inextricably linked to

the sensory stimulation component of EMDR.

☰ It also is interesting to note that ACT uses alternating hand taps during skills training instead of the more traditional eye movements used in EMDR. Hand tapping and other forms of nonvisual sensory stimulation were used as control conditions in early studies of EMDR to examine the specific efficacy of eye movements (e.g., Bauman & Melnyk, 1994). When these studies failed to identify the superiority of eye movements relative to various control conditions, proponents asserted that the real mechanism behind the treatment must be any form of "bilateral" stimulation. This post hoc reasoning, or the reinterpretation of negative findings in a favorable light after the fact, has been criticized as one of the hallmarks of pseudoscience (Herbert et al., 2000). To assist in the hand tapping, Omaha sells a TheraTapper for \$95 (www.theratapper.com), which "delivers a light, tactile," buzzing "sensation to the palms of the hands" (p. 9). Although not essential to the treatment, the device is referred to so frequently in the book that it is difficult to imagine conducting ACT without purchasing it. Similar electronic devices have been promoted by EMDR proponents for inducing eye movements.

☰ ACT and EMDR share more than just a propensity for unusual electronic therapy aids. Similar to Shapiro (1995), Omaha frequently uses neurobiological explanations to describe the processes through which his therapy is hypothesized to work. For example,

The reader will realize how AMST has built a kernel of structure to this point through development of the safe place visualization and its consciously elaborated visual, auditory, olfactory, and tactile elements. Based on what is known of neurobiology, we may conjecture

that we have primarily activated declarative memory and involved the sensory cortex, all right-side temporal lobe structures. The next step of the safe place skill enlarges this structure and involves the left hemisphere as a cognitive appraisal is invoked. (p. 245)

☰ Similarly speculative, overly simplistic, and overstated neurobiological descriptions of EMDR by Shapiro have been criticized by some as merely inaccurate “neurobabble” that provides the veneer of science through technical jargon (Rosen et al., 1998).

☰ Not only is Omaha’s explanation of therapy process highly speculative, but he also provides scant evidence in general to support his claims about ACT. Not one randomized controlled trial of ACT has been conducted and published in a scientific peer-reviewed journal. Omaha cites a few unpublished pilot studies but does not provide enough detail for evaluating their methodology or the significance of their findings. The nonexistent empirical support for ACT is not surprising given that Omaha reports that the AMST protocol was first developed in 2000 (p. 11). Omaha later states that the aim of his book is to “stimulate empirical research” (p. 305) on ACT. However, this appears to be putting the cart before the horse as the book promotes the use of a recently developed clinical intervention without extensive prior clinical use or any published research.

☰ Perhaps Omaha is comfortable promoting the use of the treatment because it borrows quite heavily from other traditional approaches. Unfortunately, Omaha only clearly acknowledges some of ACT’s many influences, which include EMDR, Eriksonian hypnosis, and Gestalt therapy. What is inexplicably absent from the book is a discussion of the similarities between ACT and an empirically supported and

well-known treatment called dialectical behavior therapy (DBT; Linehan, 1993). Most of the AMST techniques presented in the book are very similar to those used in DBT. For example, AMST Skill IV is "sensation-affect identification," which is nearly identical to the first step in the emotion regulation module of DBT. During this skill, the client learns to identify and label emotions and their accompanying physical sensations as experienced. Furthermore, Skill V, "grounded and present," and Skill VI, "noticing," are very similar to the core mindfulness skills taught in DBT. However, Linehan is only cited twice briefly in the book, but neither instance relates to the influence of DBT in the development of the AMST protocol. This is perplexing because in earlier writings Omaha clearly acknowledges that AMST is based on Linehan's work: "Affect Management Skills Training, which is derived from work by Leeds⁴, Leeds and Korn⁵, and Linehan⁶, teaches a skills set to recognize, cope with, and decrease disturbing affects" (p. 3, Omaha, 2000). The major difference between Linehan's DBT and Omaha's ACT is the use of hand tapping during skills training. Omaha hypothesizes that this procedure accelerates and consolidates learning, even though no evidence supports this assertion.

☞ Unfortunately, Omaha mixes DBT skills with other approaches that may be cause for concern due to their potential for producing iatrogenic effects. If a client is not satisfactorily learning an AMST technique, Omaha proposes various interventions to facilitate skill acquisition. One such technique is the "ego state intervention," in which the client is hypnotized and asked to formulate a part of the "self" responsible for the resistance:

Adapting Watkins and Watkins (1997), I ascertain that the ego state can speak to me. I ask the ego state to validate that it is in fact the

ego state we intended to "bring forward." I do this by asking, "Are you indeed 'The One Who is Preventing the Container From Filling?'" I then ask the ego state for a name that it would like to be called. It is important to elicit a name that distinguishes the ego state from the client. (p. 228)

☰ Such suggestive procedures have been noted to be highly influential in the etiology of dissociative identity disorder (Lilienfeld et al., 1999). During Phase II of ACT, Omaha uses similar hypnotic techniques in an attempt to identify and resolve the "causes" of emotion dysregulation by regressing the client back to childhood to recall traumatic events. However, such procedures are known to facilitate false memories, in which an individual can develop a strong belief in the validity of an induced recollection even though it may be inaccurate or entirely fictional (Loftus & Ketcham, 1994).

☰ In 1998, EMDR found its way onto a list of empirically supported treatments (ESTs) for PTSD (Chambless et al., 1998). This development surprised many because controlled studies failed to show that the bilateral stimulation component (even when compared with no stimulation at all) was responsible for the treatment's benefits. Critics have argued that without eye movements, EMDR is similar to other exposure-based therapies for PTSD, which are known to be among the most efficacious treatments for the disorder (Herbert et al., 2000). However, this potential "loophole" in the EST criteria opens the door for other therapies seeking to gain notoriety and credibility by adding potentially inert components to established techniques. Through this method, entrepreneurs can claim to be the creators of unique interventions deserving their own rightful place on EST lists. Omaha's ACT, and many others like it, may one day follow in EMDR's trail-blazing

footsteps. Perhaps the only way ultimately to stem this tide of brand-named psychotherapies will be to develop formal practice guidelines for psychotherapists. Such guidelines can be updated regularly to reflect the state-of-the-art and ever-changing knowledge base of the field to protect clients against potentially harmful or inert techniques (Herbert & Gaudiano, in press).

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