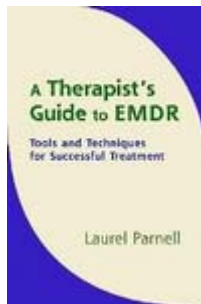


## What Makes EMDR Work?

A review of



### **A Therapist's Guide to EMDR: Tools and Techniques for Successful Treatment**

by Laurel Parnell

New York: Norton, 2007. 363 pp. ISBN 978-0-393-70481-5.

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Reviewed by

[Arnold R Bruhn](#)

Laurel Parnell notes that eye-movement desensitization and reprocessing (EMDR) has been around for over a decade and that more clinicians are seeking training to translate “theory” into practice as clients are encountered who do not fit what they learned.

Actually, Shapiro, its founder, has written about EMDR since at least 1989, or for nearly 20 years. What motivated Parnell to write *A Therapist's Guide to EMDR: Tools and Techniques for Successful Treatment*, she says, is to share her knowledge of EMDR as a “broader treatment approach” (p. xv). She shares that she herself brings a transpersonal approach that honors the therapeutic relationship to her role as an EMDR therapist and views EMDR as “an art, requiring

flexibility, creativity, and the use of intuition" (p. xv).

The author states that she has found four areas where "most EMDR-trained therapists need help: case formulation, ego strengthening, target development, and the ability to work with processing difficulties" (p. xv). She adds that she wanted to write a book that would present the information from the training she does but adds to that information.

Parnell reviews the theoretical basis for EMDR and includes new information on the neurobiology of trauma. The book is divided into four parts: EMDR Theoretical Overview; Using EMDR With Clients; The EMDR Session; and Clinical Applications. Each is rich. Each is creative and original. I found the second section most useful where she talks about specific interventions.

In her introduction, Parnell reviews "important theories and general principles" (p. 10) that should be remembered when dealing with traumatized people. For Parnell, a trauma is an experience that "causes one to develop erroneous beliefs about oneself or the world" (p. 10). Essentially, a trauma is an experience that cannot be integrated *healthfully*—however, one would wish for a definition of that term. What she does not talk about is what makes certain events traumatic. Does everyone respond identically? If not, why not? This question is key to diagnosing and treating "emotional problems." My impression is that Parnell is well aware of this conundrum and tries to explain it via the concept of "memory networks" (p. 10). Her contribution in this area is basically conceptual. Memory networks do not help us understand, specifically, who will become traumatized and who not.

The book is crafted by a seasoned clinician who has used EMDR with hundreds of diverse clients with many kinds of traumas. Her abundant examples are helpful and thought provoking and often leave one pondering with appreciation the intervention she describes. If one begins reading with a solid understanding of EMDR beforehand, Parnell will take her reader much further down a path toward integration and mastery of the technique. Her background as a teacher of EMDR and trainer is amply evident. She has struggled with the dual task of mastering the technique and also teaching it, which are very different tasks for anyone who has attempted both. She is the sole or lead writer

of eight articles in the References section, including two single-author books published by Norton. She writes with a clarity and thoughtfulness that appear deceptively simple, and elegant only after reflection. I found the book stimulating and would recommend it for graduate students and inquisitive mental health professionals—not just EMDR practitioners. However, I think it would be most useful to individuals who have at least a beginning familiarity with EMDR and how it can be used.

As I mentioned, the book stimulates many questions worth pondering. I will focus on one: What is the clinician actually treating in posttraumatic stress disorder (PTSD) cases? Parnell talks about stimulating the “memory network” in PTSD cases (p. 37). She elaborates, noting that the client can be asked for a picture that represents the worst part of an incident and other aspects that can activate the memory network. She notes that modifications of standard steps are necessary to treat individual patients.

The EMDR perspective can be questioned. For instance, what is it that makes us recall certain events in certain ways or, alternatively, fail to recall other important events at all or perhaps very differently from others who have witnessed the same event? Put another way, should we expect that everyone who witnessed a traumatic event will recall it and recall it in exactly the same way? Anyone who has shared a family gathering in which events of years past are recounted with other family members knows otherwise.

However, such questions lead us toward constructing a theory of autobiographical memory, an effort that was largely ignored before cognitive–perceptual theory (Bruhn, 1990a, 1990b). To state the problem in slightly different terms, is it the proximate trauma that causes PTSD, or is it the preceding life events and the individual's spin while processing them that make him or her vulnerable to later traumas that are believed to cause PTSD? Such questions amount to far more than idle speculation or woolgathering. For if the purported traumatic event serves an accidental role in PTSD and the real issue is the constructions that precede it, we may as clinicians be treating the wrong trauma. Worse, we may be failing even to understand the crux of the problem.

Permit me a brief case to illustrate my point. A woman came to

me for an evaluation in connection with PTSD of such severity that she had been put on disability for the preceding four years. She needed a reevaluation to continue her disability claim. What proximally occasioned her trauma five years previous was an episodic occurrence in her workplace. My client felt that she was qualified for a promotion to various positions that she interviewed for over a period of years but was rejected time and again. She filed an Equal Employment Opportunity (EEO) complaint, which took over a year to be adjudicated. Her complaint was upheld, despite the "lies" of various witnesses for the defense, and her employer (the federal government) was severely reprimanded by the court.

But the process was so debilitating that my patient eventually developed symptoms of PTSD, including serious depression, anxiety, and a sleep disorder. She was placed on disability, seen by a psychiatrist, and given psychiatric meds and individual therapy for about three years. When I saw her for a reevaluation, I started her with an early memories procedure (EMP; Bruhn, 1985, 1989), a pencil-and-paper procedure used to undertake a lifetime autobiographical memory assessment so, in this case, I could better understand the context of the presenting problem. The EMP requires about three hours of introspection and writing outside the office, and many clients report when they bring their protocols in for interpretation that they understand their presenting problem in much more depth. In short, the EMP attempts to teach clients to understand themselves better by working with their own memories. The procedure is described in detail in Bruhn (1990b). Many interpretive examples appear in the literature (e.g., Bruhn, 1992a, 1992b, 1995a, 1995b, 2006)

My client's PTSD-related memory dated to an incident when she was a teenager in a large family. A thrifty, planful person, she had been saving change in a glass jar; she wanted to use the money for a rainy day. Her older sister and an older brother stole her money and took delight in telling her they did and how they spent the money. She asserted herself and made the problem known to her father, who said (and did) nothing. Her stepmother was appropriately sympathetic and upset at her sibs' behavior and even spoke to her husband. Bottom line: Nothing happened.

How did the theft as a teen relate to her not getting a promotion? My client learned from her family of origin that she could not count on justice or fairness. The perpetrators gloated at what they had done and boasted of how they had gotten away with their misdeeds. Similarly, at work, her supervisors promoted men or cronies they wanted to advance, ignoring fairness, education, work history, and resumes. Even though her EEO claim was upheld, emotionally she could not continue working at her job. The lengthy legal process left her retraumatized time and again. She left on disability.

Was this client treated for PTSD? Not exactly. As a therapist, I served as a stand-in father and lamented, with metaphorical intent, the loss of her funds and expressed outrage that her interests had not been protected. I commented that it was bad enough that her funds had been stolen, but to allow the “perpetrators” to gloat and humiliate her—certainly there could be no excuse for that! In expressing my outrage at this injustice, I could validate her own feelings, which had not been validated by her father. As I did, she began to feel better almost immediately. Within three sessions she felt ready to return to work—just not at the same agency where she had been victimized. As it is said, prudence is the better part of valor.

I later asked her what helped her work through her feelings. She said the key for her was realizing, on her own as it turned out, that the amount taken was not that much. My surmise is that she could accept that after I became indignant, as her paternal replacement, about what had occurred. My indignation reassured her that she could be heard, just as the judge in her legal case heard her, and the feelings accepted and validated.

Could this client be treated with medications or insight-oriented therapy or with EMDR? In fact, she was treated with medications and psychoanalytically oriented psychotherapy; I think she gained from that relationship, just not what she needed to return to work. I think she might have profited also from some variant of EMDR had it been offered. However, sometimes the simplest and most direct approach should be considered first. I undertook an EMP evaluation to determine who she was before she was damaged by the government. Once she understood that what happened to her had historical antecedents, she was able to

let go of her feelings. She was ready to move on with her life.

The preceding clinical example illustrates well my biggest reservation with Parnell's book and with EMDR: What is it exactly that we treat when someone with a traumatic background presents for help? Are we treating a "trauma," or are we treating a construction of what seems like unrelated events that continues to cause trouble and psychological harm, much like an ill-fitting shoe with a pebble that causes injury as we travel along life's path?

EMDR appears to recognize that the past is alive in the present. Parnell talks about the importance of memory networks, but she provides few means to access or deconstruct these networks. And herein lies the rub. Bruhn and Last (1982) described four theories of early memories (Adlerian, ego psychological, Freudian, and cognitive–perceptual). Later, Bruhn (1990a, 1990b) offered an elaboration of cognitive–perceptual theory. If it is to advance, EMDR needs to familiarize itself with autobiographical memory theory and review methods to tap memory networks so that clinicians can more effectively understand how the past lives on in the present... and what we can do to put obsolete spirits to rest. In my judgment, it is here that we struggle as clinicians: What can we do to help our clients resolve the problems that have left them stuck in their own process and frustrated?

Life beckons, and the gifted therapist can help the client understand and move on. I think Parnell's book provides sufficient fodder to satisfy the inquisitive clinician. I recommend it.

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