

DIFFERENCES BETWEEN EMDR AND ART

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As the Founder and Developer of Accelerated Resolution Therapy® (ART), I have frequently been asked through the years how ART differs from EMDR. In this document, I explain these differences by drawing on the descriptions and guidance of Francine Shapiro, PhD, Founder and Developer of Eye Movement Desensitization and Reprocessing (EMDR), as presented in what is widely considered her definitive work on the therapy.

The book used for this comparison is *Eye Movement Desensitization and Reprocessing (EMDR) Therapy: Basic Principles, Protocols, and Procedures*, third edition (2017), by Francine Shapiro, PhD. All page numbers below refer to this book. The quotations are excerpts from the cited passages.

On How Much a Therapist Should Be Involved with a Client's Processing

EMDR: Shapiro describes processing as following the client's own associations, with deliberate clinician intervention primarily when processing becomes blocked (pp. 148, 355).

"The activation of the client's innate self-healing processing system should be done with minimal clinical intrusion." — p. 84

ART takes a much more directive approach. The clinician actively guides the client throughout the protocol, keeps attention on the presenting issue, and helps the client change distressing imagery and sensations. The client chooses the changes and does not need to disclose the details of the trauma for the clinician to guide the process.

On How Regimented a Therapy Should Be

EMDR: Shapiro describes EMDR as responsive to the individual material emerging in treatment rather than following a regimented session structure.

"Because EMDR is not a regimented approach, no two treatment sessions will be the same." — p. 82

ART deliberately uses a systematic, scripted framework. That structure helps the clinician maintain focus and move toward resolution, while the client's memories, images, and choices make every session unique. ART can be highly individualized without giving up a consistent procedure.

On Whether the Speed of the Therapy Matters

EMDR: Shapiro emphasizes adapting treatment to the client's needs and cautions clinicians against rushing the process.

"... they must refrain from viewing EMDR as a race to achieve treatment effects." — pp. 82–83

ART is also attentive to the client's needs, but it is intentionally goal-oriented and designed to reach resolution as quickly as possible. Many clients experience substantial relief from a targeted problem in one session, while others need additional work. Why keep clients in pain any longer than necessary when the problem can be resolved sooner?

On What to Do If a Client Gets “Stuck”

EMDR: Shapiro presents the cognitive interweave as a selective intervention for blocked processing. She also discusses supervision or consultation when persistent distress or looping continues (pp. 256–257, 346).

“... use the cognitive interweave selectively so that the client's own processing system can do the work ...” — pp. 256–257

ART clinicians actively guide treatment from the beginning and have multiple ways to respond when a client feels stuck. Questions, imagery, metaphors, Gestalt-based interventions, and further eye-movement processing can be used to help the client move through an obstacle and continue toward resolution.

On the Focus on Cognitions

EMDR: Shapiro describes assessing a negative cognition, the accompanying emotion, and the client's current disturbance when working with a memory.

“The client is asked to hold in mind the picture of the memory and the negative cognition ...” — p. 59

ART puts primary emphasis on changing the distressing image and the sensations connected to it. As those change, clients often find that their thoughts about the experience change as well. Cognitions can certainly be discussed when useful, but they do not have to be the central focus of treatment.

On How Much to Process for Success

EMDR: Shapiro explains that successful processing involves addressing the dysfunctionally stored material across the memory channels associated with a target (pp. 30–31, 142). She also emphasizes that EMDR is not a one-session therapy (p. 112).

“EMDR is not a one-session therapy” — p. 112

ART is designed to resolve the presenting problem without requiring the therapist to deliberately work through every associated memory channel. ART reduces negative sensations and uses Voluntary Image Replacement to change the distressing scene itself. In my experience, resolving the central target can also reduce the emotional impact of related triggers, often in a single session.

On Establishing a Relationship with the Client

EMDR: Shapiro emphasizes the need for adequate trust and therapeutic alliance before EMDR processing begins; she notes that establishing that trust can take from one or two sessions to many months.

“Unless the client and clinician have established a sufficient level of trust, EMDR should not be initiated.” — p. 114

ART clinicians also assess safety, readiness, and whether the client can participate appropriately. However, ART's structured process can often begin without a lengthy preliminary period devoted to relationship-building. Clients can develop trust in the process as they experience how it works, without first having to tell the therapist every detail of what happened.

On the Safety of the Therapy

EMDR: Shapiro discusses the possibility of intense emotional reactions and disturbance between sessions, including circumstances when trauma processing should be delayed.

"There is no way to predict accurately these reactions before processing begins." —

pp. 93–94

ART is designed to help clients move through strong emotional reactions during the session rather than remain caught in distressing sensations. The clinician guides processing and helps the client replace disturbing imagery with changes of their own choosing, aiming for relief before the session ends. Other issues may still need treatment, but completing the work on the target is a central ART goal.

In Summary

EMDR and ART both use eye movements, but they put them to work in very different ways. As Shapiro describes it, EMDR places substantial emphasis on the client's own unfolding processing, with limited therapist intrusion. ART uses a consistent, directive protocol to address distressing sensations and images and move toward resolution of the presenting problem as efficiently as possible. The client controls the images and changes, and does not need to disclose the details of the trauma.

I am grateful to Francine Shapiro for her pioneering work with eye movements. I invite EMDR therapists and other clinicians to see what ART makes possible when eye movements are combined with active guidance, image replacement, and a clear goal of relief.