EMDR Consulting
BASIC TRAINING
Study Guide

Sources:

1. "EMDR Therapy-Basic Principles, Protocols, and Procedures"—Francine Shapiro
2. "Go With That Magazine", Fall 2020 Volume 25 / Issue 3.

HISTORY OF EMDR

Since 1987, EMDR therapy has been empirically supported by numerous randomized controlled trials (RCTs) and is internationally recognized as an effective treatment for trauma and a wide range of experientially based disorders.

Although the initials EMDR (Eye Movement Desensitization and Reprocessing) are still the designated name of the therapy, it should be viewed as a complex approach. Key points to remember:

- Bilateral dual attention stimulation is merely one component integrated with procedural elements unique to the therapy, as well as aspects synthesized from all the major psychological orientations.
- As a comprehensive approach, careful attention is given to images, beliefs, emotions, physical responses, increased awareness, internal stability, resiliency, and interpersonal systems in achieving the effects of EMDR therapy.
- Clinicians must use different EMDR protocols, depending on the types of pathology and follow therapeutic procedures customized to the need of the client.
- The purpose of the eight-phase EMDR therapy is to help liberate the client from the past into a healthy and productive present.

Francine Shapiro's first controlled study included working with 22 individuals who suffered from PTSD symptomology among victims of rape, molestation, or Vietnam combat. Francine utilized EMD with the treatment group.

EMDR therapy began as therapy specifically for the treatment of people with PTSD. The use of EMDR can be fully compatible with most of the known psychological orientations including psychodynamic approaches and cognitive-behavioral approaches. Exposure based CBT has demonstrated efficacy, but EMDR differs from this therapy in that EMDR does not require prolonged exposure and does not necessitate homework as in traditional CBT.

AIP MODEL

The AIP model provides a framework for treatment, understanding, development of pathology, making associations, coming to a resolution, and guiding future actions.

Psychological Trauma and AIP

- Psychological trauma is associated with numerous changes in the nervous system caused by cortisol release, spikes in adrenaline, fluctuations in neurotransmitters, the result of which is a loss of neural homeostasis.

- Due to the loss of this imbalance, the information processing system is unable to function optimally, and the information acquired at the time of the event, including images, sounds, affect, and physical sensations, are stored in their disturbing state.
- Stored in the distressing state, that original material can be triggered by internal and external stimuli and may be expressed in the form of nightmares, flashbacks, and intrusive thoughts (PTSD symptoms.)
- According to Shapiro, any event that has a lasting negative effect on the self or psyche is by its nature traumatic.

Inherent in the AIP model is the concept of psychological self-healing (i.e. the body has an intrinsic capacity for psychological self-healing.)

- For example, when you cut your hand, your body works to close and heal the wound. If something blocks the healing, such as a foreign object or repeated trauma, the wound will fester and cause pain. If the block is removed, healing will resume.
- A similar sequence of events seems to occur with mental processes; that is, the natural tendency of the brain's information-processing system is to move toward a state of mental health. However, if the system is blocked or becomes imbalanced by the impact of a trauma, maladaptive responses are observed.
- The information-processing system is adaptive when it is activated.
- Clinicians should be cognizant that limitations and distortions of memory may exist that could alter the accuracy of any memory that emerges during EMDR processing.

EMDR therapy unblocks adaptive information processing that would normally occur. Research strongly supports that EMDR has three mechanisms of change:

1. tax working memory
2. orienting response
3. REM processes

Research indicates that EMDR processing frequently leads to somatic de-arousal response associated with eye movements.

The clinical applications of EMDR therapy are not limited to PTSD. According to the AIP model, inadequately or unprocessed experiences are the basis of pathology across the clinical spectrum. Pathology is viewed in terms of maladaptive memory networks which have not been fully reprocessed and continue to be held in a state-specific form giving rise to maladaptive perceptions, behaviors, beliefs, and attitudes. Specifically, unprocessed/inadequately experiences can result in:

- Dysfunctional traits, behaviors, beliefs, affects, and body sensations
- Dysfunctional family of origin interactions and relationship issues throughout life
- Maladaptive personality traits

EIGHT PHASES OF EMDR

The three-pronged protocol refers to identify, target, and process: (1) the earlier memories causing the problems, (2) the present experiences triggering the disturbance, and (3) the behaviors needed for adaptive future functioning.

PHASE ONE-Client History
It is important to assess:

1. Client readiness
   - Because of the potential of EMDR for rapid destabilization, there are many client factors to consider prior to beginning EMDR including: (1) the client has good affect tolerance, (2) if the client has a stable life environment, (3) if the client can undergo temporary discomfort for long term relief.

2. Client Safety Factors
   - Level of Rapport
   - Emotional Disturbance-it is very important to take the necessary steps to assess whether clients can manage moderate to high levels of emotional disturbance and to practice self-control procedures.
   - Stability
   - Life Supports
   - General Physical Strength
   - Neurological Impairment
   - Drug and Alcohol Use
   - Legal Requirements-when memories that might be a part of a case involving a legal proceeding, informed consent should be used with all pertinent parties.
   - Systems Control
   - Secondary Gains
   - Timing
   - Medication Needs-so far, research has shown that no medications appear to completely block EMDR processing, although benzodiazepines have been reported to reduce treatment efficacy with some clients.
   - Dissociative Factors

3. Treatment Planning –to inform their treatment planning, clinicians should ascertain the following:
   - Symptoms
   - Duration of pathology
   - Initial cause
   - Additional past occurrences
   - Other complaints
   - Present constrains.
   - Desired state

PHASE TWO-Preparation

1. Forming a bond with client
2. Explaining the theory
3. Testing eye movements (or other DAS)
4. Creating a safe/calm place—this is recommended because it reassures clients that they have a way to recover emotional stability during disturbance.
5. Setting expectations
6. Addressing client fears

PHASE THREE-Assessment

1. Selecting a picture—the clinician should specifically ask "What picture best represents the experience to you?"
2. Identifying Negative Cognition—negative self-statement the client believes, at least to some extent, about themselves now when recalling the disturbing event and picture.
3. Developing a Positive Cognition
4. Rating the Validity of Cognition—this is a scale range from 1-7
5. Naming the Emotion—this is important because it identifies the emotion that the client feels now as they bring up the experience in present time.
6. Estimating the SUDS—ranging from 1-10
7. Identifying body sensations

PHASE FOUR-Reprocessing

1. Reprocessing can have different protocols
2. The clinician should ask the client to notice the image, the negative cognition, and where they feel it in their body.
3. During desensitization in **EMDR**-after the first set of BLS, it is advisable for the clinician to refrain from reminding client of the negative cognition.
4. If the client is having difficulty maintaining dual focus of attention and connection to present time, clinicians can (A) give verbal reassurance, (B) purposely change the direction of eye movements, (C) make slower movements or cover shorter range, and (D) change method of DAS.
5. If reprocessing is not progressing even after changing the nature or type of bilateral stimulation, the clinician should explore ancillary factors, such as feeder memories, blocking beliefs, or secondary gain.
6. Three primary themes of interweaves are responsibility, safety, and choices.

PHASE FIVE-Installation

1. Installation concentrates primarily on the full integration of a positive self-assessment with the targeted information.
2. When beginning Phase 5 installation, the first question to ask is: "Do the words (repeat the positive cognition) still fit, or is there another positive statement you would feel more suitable?"

3. When checking the VOC during installation Phase, the therapist should say: “Think about the original incident and those words (insert positive cognition), from 1 completely false, to 7, completely true, how true do they feel?”

PHASE SIX-Body Scan

1. The AIP model that guides EMDR practice posits that the dysfunctional material may have a physical sensation that correspond to processes and can be targeted.

PHASE SEVEN-Closure

1. Visualization
2. Safety Assessment
3. Debriefing and Log

PHASE EIGHT-Reevaluation

1. Reevaluation is vital and should open each reprocessing session after the first, assessing client’s progress and how well previously targeted material has been resolved.
2. Future template— (1) imagine a scene of acting effectively in the future, (2) if blocks, these can be targeted, (3) if there are no blocks and the client can visualize the future scene with confidence then have them focus on the image and positive belief and introduce several sets of BLS until the future template is strengthened.

SPECIFIC PROTOCOLS

- **Recent Event Protocol—**

1. Obtain a narrative history of event, noting the most disturbing moments.
2. Target the most disturbing aspect of memory first.
3. Target the remainder of the disturbing moments identified in the narrative in chronological order.
4. Have the client visualize the entire sequence of the event with eyes closed and reprocess disturbing moments as they arise. Repeat until the entire event can be visualized from start to finish without undue distress.
5. Have the client visualize the event from start to finish with eyes open and install the positive cognitions.
6. Conclude with the body scan.
7. Process the stimuli.
8. Incorporate positive future templates for each trigger.

- **Protocol for Phobias—**

1. Teach self-control procedures to handle the fear of fear.
2. Target and reprocess <u>all of the following</u>:
    - Antecedent/ancillary events
    - The first time the fear was experienced
    - The most disturbing experiences--<u>anxiety</u>
    - The most recent time it was experienced
    - Any associated present stimuli
    - Any current catastrophic thoughts involving <u>anticipatory fear,</u>
    - Physical sensations or other manifestations of fear, including hyperventilation.
3. Incorporate a future template for fear-free future action
4. If appropriate, arrange a contract for action
5. Run mental video of full sequence of action and reprocess disturbance
6. Complete reprocessing of targets revealed between sessions

- **<u>Protocol for Completed Grief—</u>**Following the death of a loved one, a person may first experience emotional shock accompanied by numbing. In these cases, psychological first aid, rather than EMDR processing is recommended.

1. The moment of realization of the loss which is often when the mourner received the news of the death. (could take place before)
2. Other actual events, including he loved one's suffering or death, or distressing events taking place after the death
3. Intrusive images may have images of what their loved ones suffered.
4. Nightmare images
5. Present triggers
6. Issues of personal responsibility, mortality, or previous unresolved losses
7. The Butterfly Hug

SPECIFIC POPULATIONS

- When working with military personnel and veterans, it is important to develop cultural competence on the effect of military values and training.

- When working with children: (1) children can create maps, timelines, and storybooks of their lives through which the clinician can identify potential targets and resources, (2) young children may use hands to indicate levels of disturbance, and (3) clinician may ask for a "mixed up thought" or a "bad thought" to help elicit the negative cognition.

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- According to Archer's article, when identifying adverse or traumatic experiences during history-taking with clients among Black, Indigenous, or People of Color it is especially important to consider how a client might have been racialized into disadvantage, since racism affects one's trauma history.

- Racial trauma is historical, multigenerational, and reinforced through implicit and explicit forms of discrimination and oppression. In addition to preverbal traumatic events, using EMDR helps to target second-generation trauma material.

- The EMDR therapist working with Black Americans should consider historical trauma and the reluctance, stigma, and shame when seeking help.

- Cultural competency informs the application of EMDR therapy throughout all phases: through race-related inquiry, culturally relevant cognitive interweaves, and awareness that successful desensitization may involve a higher level of SUDS due to ongoing threats related to racism.