



**EMDR Institute Inc.**

**WEEKEND 1 TRAINING MANUAL**

**OF**

**THE TWO PART**

**EMDR BASIC TRAINING**

# **AGENDA**

## **DAY 1**

|               |                                      |
|---------------|--------------------------------------|
| 8:00-8:30am   | REGISTRATION                         |
| 8:30-10:15am  | Lecture                              |
| 10:15-10:30am | BREAK                                |
| 10:30-12:00   | Lecture                              |
| 12:00-1:00pm  | LUNCH                                |
| 1:00 -5:00pm  | Practice Session 1                   |
| 1:15-2:15     | Groups of 9-10                       |
| 2:15-4:45pm   | Triads<br>(15 minute break in Triad) |
| 4:45-5:00pm   | Debrief-Groups of 9-10               |

## **DAY 2**

|               |                                      |
|---------------|--------------------------------------|
| 8:00-8:30am   | REGISTRATION                         |
| 8:30-10:00am  | Lecture                              |
| 10:00-10:15am | BREAK                                |
| 10:15-12:00   | Lecture                              |
| 12:00-1:00pm  | LUNCH                                |
| 1:00-5:00pm   | Practice Session 2                   |
| 1:15-2:15pm   | Groups of 9-10                       |
| 2:15-4:45     | Triads<br>(15 minute break in Triad) |
| 4:45-5:00pm   | Debrief-Groups of 9-10               |

## **DAY 3**

|               |                                      |
|---------------|--------------------------------------|
| 8:00-8:30am   | REGISTRATION                         |
| 8:30-10:30am  | Lecture                              |
| 10:30-10:45am | BREAK                                |
| 10:45-11:30am | Lecture                              |
| 11:30-12:30pm | LUNCH                                |
| 12:30-3:45pm  | Practice Session 3                   |
| 12:45-1:45pm  | Groups of 9-10                       |
| 1:45-3:45m    | Practice Assignments                 |
| 1:45-3:45pm   | Triads<br>(15 minute break in Triad) |
| 3:45-4:00pm   | Getting Started, Wrap-up/Closure     |

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## **INTRODUCTION AND TRAINING GOALS**

### **BASIC TRAINING-50 hours**

- 20 hours of lecture
- 20 hours of practice
- 10 hours of consultation

### **WEEKEND 1 TRAINING 20 HOURS**

#### **Goals**

- To provide an understanding of the EMDR Approach
- To provide sufficient knowledge and practice using EMDR

#### **Day 1**

- Overview of EMDR
- Adaptive Information Processing Model (AIP)
- Practice Session Day 1-Preparation and History-Taking

#### **Day 2**

- In-depth discussion of reprocessing procedures
- Practice Session Day 2-EMDR Reprocessing of selected memory

#### **Day 3**

- Recent Trauma
- Eight Phases with Children
- Practice Session Day 3-Reevaluation of selected memory

### **CASE CONSULTATION WITH EMDR INSTITUTE FACILITATOR**

See EMDR Institute Facilitator/Consultant Listing in back of manual

- 5 hours completed between Weekend 1 and Weekend 2
- 5 hours after completion of Weekend 2

### **WEEKEND 2 TRAINING-20 HOURS**

#### **Expand knowledge of EMDR to include:**

- Additional Treatment Plan strategies
- Case Conceptualization for more complex presentations
- Expand Resource Development interventions
- Application of Cognitive Interweave
- Introduce using EMDR with:
  - Recent trauma
  - Dissociation
  - Phobias
  - Somatic disorders
  - Special populations

### **CERTIFICATE OF COMPLETION ISSUED**

- Upon completion of the Basic Training Course

## **THE EMDR COMMUNITY**

### **EMDR INSTITUTE INC-[www.emdr.com](http://www.emdr.com)**

- Training Institute
- Founded by Francine Shapiro, Ph.D.
- Domestic and International Training Schedules
- Continuing Education
- Research Summaries
- Listing of EMDR Institute-trained Clinicians
- Resource for Frequently Asked Questions & Answers
- EMDR Bookstore and Clinical Aids
- Electronic Discussion List for EMDR Institute-trained Clinicians
- International Organizations

### **EMDR INTERNATIONAL ASSOCIATION (EMDRIA)-[www.emdria.org](http://www.emdria.org)**

- Non-Profit Professional Association
- Training Standards
- Certification
- EMDR International Conference
- Regional Meetings
- Membership Directory
- Newsletter
- Peer reviewed [Journal of EMDR Practice & Research](#)
- Research Summaries
- Special Interest Internet Discussion Groups
- Francine Shapiro Library

### **EMDR HUMANITARIAN ASSISTANCE PROGRAMS (HAP) [www.emdrhap.org](http://www.emdrhap.org)**

- Non-Profit Programs
- Volunteer Based
- Disaster Response Network (Domestic and International)
- Low Fee EMDR Trainings for Non-Profit Agencies/Organizations
- Bookstore

# **BACKGROUND OF EMDR**

## **Chapter 1 (Shapiro, 2001)**

### **DISCOVERY**

#### **1987**

- Discovery of the effects of spontaneous eye movement
- Developed procedures around effects of eye movement

#### **1989**

- First controlled treatment outcome study of EMDR for PTSD published in the *Journal of Traumatic Stress*
- First controlled studies of prolonged exposure therapy, psychodynamic therapy, and hypnosis for treatment of PTSD

#### **1990**

- **EMD** becomes **EMDR**
- Discovered other forms of bilateral stimulation (tactile taps, tones)

### **RESEARCH-SEE APPENDIX**

#### **CONTROLLED OUTCOME STUDIES (See Appendix)**

- Over a dozen randomized controlled treatment outcome studies of PTSD
- Typically 3-6 sessions; 77-100% remission of PTSD with single trauma victims
- 12 or more sessions needed for multiple trauma victims, such as combat veterans
- EMDR compared to Prozac indicates EMDR superior with patients becoming improved even after termination of therapy, while many Prozac patients again became symptomatic (van der Kolk et al., 2007)
- While 90 minute sessions are suggested, 50 minute sessions can also be used (Marcus et al., 1997, 2004)
- For positive results there is a need for adequate fidelity and treatment dose
- Meta-analysis (Maxfield & Hyer, 2002) indicated that the more rigorous the study, the larger the effect sizes

## **COMPONENT ANALYSES**

- Clinical component analyses have been equivocal due to variety of methodological problems
- Component studies testing variety of neurobiological hypotheses have supported theories of working memory, orienting response, reciprocal inhibition and REM (read Chapter 12 for comprehensive review)

## **META-ANALYSES (See Appendix)**

- Combination of all controlled studies
- Equal treatment effect sizes when measuring overt symptoms of PTSD for EMDR and exposure therapies (although EMDR studies include those with insufficient treatment doses for combat veterans)
- EMDR uses no homework to treat the trauma while exposure therapies use 1-2 hours of daily imaginal and/or *in vivo* homework

## **ACUTE ONGOING TRAUMA IN CHILDREN**

- Outcome: increased resiliency  
Zagrout-Hodall, Alissa & Dodgson (2008)

## **INTERNATIONAL TREATMENT GUIDELINES (See Appendix)**

- American Psychiatric Association (2004). EMDR recommended as effective in the treatment of trauma
- Bleich, Kutz & Shalev (Israeli National Council for Mental Health, 2002)  
EMDR is one of only three methods recommended for treatment of terror victims
- Department of Veterans Affairs & Department of Defense (2004). EMDR was placed in the A category for the treatment of intense trauma
- National Institute for Clinical Excellence (2005). Trauma-focused CBT and EMDR were stated to be empirically supported treatments of choice for adult PTSD

## **MECHANISM, MODEL AND METHODOLOGY**

### **MECHANISM**

- Neurobiological underpinnings-unknown for any form of psychotherapy
- Eight studies indicated eye movements have effects on memory (retrieval, vividness, emotional arousal, etc.)
- Orienting response/working memory, REM
- See Appendix

### **MODEL**

- Information Processing Model
- Independent of any particular neurobiological mechanism
- Interprets clinical phenomena
- Predicts successful application
- Guides clinical practice
- PTSD scores higher after life events (t) than after traumatic events (T) (Mol, Metsemakers, Dinant, Vitters-Van Montfort, 2005)  
Survey of 832 people for events within past 30 years
- “T”-meet Criteria “A” for PTSD
- “t”-life event with equal or greater impact on presenting problem/ pathology

### **METHODOLOGY**

- Eight Phases of EMDR Treatment
- Standard procedures guided by articulated principles
- Largest treatment effects were shown in studies with rigorous designs that maintained fidelity to the EMDR procedures (Maxfield & Hyer, 2002)

# **THE EMDR APPROACH TO PSYCHOTHERAPY**

## **Chapter 2 (Shapiro, 2001)**

Bilateral stimulation (eye movements, tactile taps, auditory tones) is merely one component of EMDR.

EMDR is a distinct integrative treatment approach with eight-phases that is compatible with all the major orientations to psychotherapy.

Different diagnoses require different, often customized EMDR procedures which incorporate the three-pronged protocol of past, present, and future.

EMDR is used to address disturbing life experiences that contribute to clinical problems and health.

EMDR is a comprehensive psychotherapy approach (distinct from psychodynamic, CBT, experiential, etc.) guided by an information processing model of learning.

### **THE ADAPTIVE INFORMATION PROCESSING MODEL**

**(see also Shapiro, 2001, 2006)**

- The cornerstone of the EMDR approach: memory networks are the basis of clinical symptoms and of mental health
- Excluding situations caused by inadequate information/organic deficits, unprocessed memories are the primary basis of pathology
- Foundation of all EMDR phases, procedures and protocols
- Basis of understanding developmental and clinical phenomena
- Guides case conceptualization and treatment planning
- Predicts positive treatment outcomes

### **COMPONENTS OF THE ADAPTIVE INFORMATION PROCESSING MODEL**

- Physical information processing system, like other body systems, is geared toward health
- Physical example: cut closes and heals unless blocked
- Emotional example: The information processing system moves disturbances to an adaptive resolution, thereby creating functional memories and memory networks

- Disruptions to the information processing system result in disturbing memories that are dysfunctionally stored as they were experienced and perceived at the time of the event 
- As the perceptions of the present link to the memory networks, various components of the previously unprocessed memories are experienced (e.g., emotions, physical sensations, thoughts/beliefs) –Triggers
- “The past is present”: Perceptions of current situations link into the networks of physically stored memories in order to be interpreted. If a memory network contains an unprocessed memory, the current perceptions are informed by the earlier dysfunctional emotions, thoughts/beliefs, sensations of the past event(s) 
- Processing is viewed as the forging of adaptive associations between networks of information stored in the brain
- EMDR facilitates an associative process that allows the relevant connections to be made
- The unprocessed components/manifestations of memory (image, thoughts/sounds, emotions, physical sensations, beliefs) change/transmute during processing to an adaptive resolution 
- What is useful is stored, available to inform future experiences; what is no longer adaptive is discarded (e.g., physical sensations, irrational beliefs)
- Memory networks are viewed as the underlying basis of pathology and mental health
- Disruptions of processing may be caused by high levels of disturbing emotions—can block experiences from being adaptively processed

Examples:

Early childhood attachment issues:

- Childhood trauma or neglect
  - “t” life events
  - “T” criterion “A”
1. Childhood humiliation experiences
  2. Accidents/Injuries/Illness
  3. Loss of parent/sibling or significant other
  - 4.
  - 5.

## EXPERIENTIAL CONTRIBUTORS

We use the term “trauma” to refer to the ubiquitous life experiences that have a lasting, ongoing impact on people in order to sensitize clinicians to this notion. 

EMDR targets the memories that contribute to dysfunction and to health.

## COMPONENTS OF MEMORY=STORED INFORMATION

- Sensory Input (images, sounds, smells, tastes)
- Thoughts
- Emotions
- Body Sensations
- Beliefs

### Memory Networks:

- Memories with similar information (senses, thoughts, emotions, body sensations and beliefs) are linked by their channels of association
- Adaptive memory networks are the primary basis of learning, self-esteem, and other positive resources and behaviors
- Maladaptive/dysfunctional memory networks are the primary basis of pathology
- Maladaptively stored memories are etiological to client’s presenting concerns

### Memory networks form the basis of:

- Perceptions
- Emotions
- Attitudes
- Behaviors

### Node/Target

- The node is the memory designated for therapeutic targeting. It is a biologically stored experience, which represents a memory network
- Touchstone Memory—earliest recalled experience that laid the foundation for the client’s presenting problem
- Memories are considered “dysfunctional” because they are physiologically stored in a way that does not allow them to link to any positive/adaptive networks

## **EMDR PROCEDURES ACTIVATE THE TARGET MEMORY AND STIMULATE THE ADAPTIVE INFORMATION PROCESSING SYSTEM**

- Negative, disturbing memories that are inadequately processed are reprocessed
- Processed memories are integrated into adaptive memory networks

## **ENHANCEMENT AND DEVELOPMENT OF POSITIVE NETWORKS**

- Positive memory networks need to be present and accessible for reprocessing to occur
- Positive life experiences and adaptive memories (senses, thoughts, emotions, physical sensations, beliefs), when accessed, are strengthened and enhanced through the addition of BLS
- Therapeutic relationship as a positive memory network

## **REPROCESSING**

- Maladaptive/dysfunctional memory networks, when accessed and processed, link with existing positive, adaptive, and functional memory networks
  - Accessing experiences (positive and negative) allows for the linkages between consciousness and where information is stored.
  - EMDR- activated processing is metaphorically like moving down a train track towards a more adaptive/functional resolution.
  - Each stop allows linkage to existing adaptive positive networks.

## **BY-PRODUCTS OF EMDR- ACTIVATED ADAPTIVE INFORMATION REPROCESSING**

- Desensitization of emotional and physical disturbance
- Emergence of insight and positive changes in physical and emotional responses
- Integration: new learning becomes available in the current life context

## **EMDR IS AN INTEGRATIVE PSYCHOTHERAPY APPROACH**

Interventions, such as, self-soothing techniques or the development of new skills can be included in EMDR therapy using the precepts of the AIP Model. Additional interventions may be needed to provide comprehensive treatment or to fully assimilate changes that occur during EMDR reprocessing. They are all applied through an understanding of the AIP model. Dysfunctional memory networks are reprocessed and positive ones are integrated and enhanced.

- Self-regulation skills - external and internal challenges to emotional stability and current level of functioning (add or enhance access to positive networks)
- Skills building - fill in developmental deficits or learning specific skills (develop positive memories which incorporate new learning)
- EMDR is compatible with elements of other clinical approaches. However, it is a distinct form of psychotherapy which directly addresses the physiologically stored memories. Changes in the present occur because of the reprocessing of the targeted memory networks.
- EMDR therapists come from various theoretical approaches and backgrounds. Practitioners from all orientations can successfully integrate EMDR principles and procedures into their clinical practice.

### **GOAL OF THE EMDR APPROACH TO PSYCHOTHERAPY**

- To achieve the most effective and efficient treatment effects while maintaining client safety
- To achieve appropriate, adaptive and ecological resolution of presenting problems
- To incorporate new skills, behaviors and beliefs about self, optimizing clients' capacity to respond adaptively in the current context of their lives

### **EMDR ACTIVATING COMPONENTS**

- **Access** "frozen" dysfunctional memory
- **Stimulate** the information processing system (keep it dynamic)
- **Move** information to adaptive (appropriate/positive) resolution

### **REPROCESSING = LEARNING**

## **EIGHT PHASES OF EMDR TREATMENT**

- **Phase One:** History
- **Phase Two:** Preparation
- **Phase Three:** Assessment
- **Phase Four:** Desensitization
- **Phase Five:** Installation
- **Phase Six:** Body Scan
- **Phase Seven:** Closure
- **Phase Eight:** Reevaluation

# **PHASE ONE: HISTORY-TAKING**

## **Chapter 4 (Shapiro, 2001)**

### **GOALS**

To gather customary information about the client via the therapist's usual history-taking and to provide the client with all information typically required for informed consent.

To consider special EMDR criteria related to client selection and readiness

To identify potential treatment targets from positive and negative events in the client's life (past, present, future).

### **OVERVIEW**

EMDR Treatment Plan as part of a comprehensive treatment plan

Evaluate:

- Client's integrative capacity
- Affect tolerance
- Current internal and external resources
- Attachment history
- Readiness for change
- Current psychosocial factors
- Level of complexity/resources determine pace

### **AIP- INFORMED CASE CONCEPTUALIZATION**

- Current symptoms are caused by earlier experiences that were not adequately processed due to trauma or insufficient information.
- What experiences have set the groundwork for pathology? Trace present reactions to past experiences.
- Assess strengths as well as developmental deficits and establish the necessary conditions to move the client toward health.
- What memories need to be targeted that will fill in deficits and bring the client to health? Identify needed skills and behaviors.
- Is the client able to access the experiences and allow reprocessing to occur?
- Conduct Psychosocial/Diagnostic Intake Interview to evaluate the clinical landscape, self-soothing skills, and readiness for EMDR processing. When clinically appropriate, gather information necessary for EMDR case conceptualization and Treatment Planning.
  - Information may include early childhood strengths and resources as well as negative events—abuse and/or neglect, problems with significant attachment figures, developmental milestone deficits.

- Develop collaboratively with the client, a Treatment Plan consistent with their treatment goals.

### **POSSIBLE CLINICAL PRESENTATIONS (in order of complexity):**

- Single Incident Presentations:
  1. Acute Stress Response: An acute traumatic event (“T”) that occurred within a few days and is represented by a set of symptoms that are directly related to a single event.
  2. Recent Event: A traumatic event that occurred within a two-to-three month period.
- Single Dominant Issue/Symptom:
  1. A disturbing life event or a series of events that are organized around one dominant theme represented by a single symptom such as, a core negative belief, pervasive emotional state, body sensation, pattern of behavior, etc. May be exacerbated by ‘t’ events from early childhood.
  2. Posttraumatic Stress Disorder (PTSD): A disturbing life event (“T”) or series of events over a prolonged period that meets DSM Criterion A for PTSD. Client suffers from intrusions, hyper arousal, and/or avoidance of stimuli that trigger negative symptoms. Origin may be in adulthood or early childhood experiences to include:
    - a. Accident(s)
    - b. Major life changes (e.g., loss of loved one, serious illness or injury to self or other)
    - c. Physical or sexual assault
    - d. War
    - e. Natural disasters
- Multiple Issues/Symptoms Presentations:
  1. Depression, anxiety, panic reactions, interpersonal problems, some dissociative processes, less severe characterological issues. Numerous experiences over time have produced pathology, but client does not meet the full diagnostic criteria for PTSD.
  2. Complex PTSD: Complex presentation of traumatic life events, extreme stress over a prolonged period of time. Symptoms may include more severe personality and dissociative phenomena. More preparation required. *Note: Complete EMDR Basic Course with specialty training in the field.*

- Depth and comprehensiveness of history-taking determined by the client's internal and external resources (i.e., emotional regulation, affect tolerance, social supports, etc). Evaluate need for resource development and stabilization.
- Use clinical judgment when inquiring about earlier events by evaluating the client's ability to maintain dual awareness without flooding or dissociating during interviewing.
- Important to titrate history-taking over time while preparing for memory processing work with EMDR.
- Use clinical judgment to determine what memories to process and in what order
- Ongoing reevaluation of overall treatment plan and targeting sequence strategies may be necessary as treatment evolves.

## THREE-PRONGED PROTOCOL

- **PAST**

- What etiological incident(s) set the groundwork for pathology (Touchstone memory, or other experiential contributor)? Link present reactions/symptoms to past contributing experiences.
- What skills and behaviors are needed to stabilize and resource the client sufficiently to begin reprocessing and adaptive learning?

- **PRESENT**

- What present experiences are causing disturbing symptoms and reactions?

- **FUTURE**

- What is the client's positive vision for the future?
- What is the client's capacity to allow a positive, more adaptive set of responses to be developed and acted upon?
- What are the potential future challenges that could occur?

## PROCEDURES TO IDENTIFY MEMORIES FOR REPROCESSING

**AIP:** To access a memory or memories in a memory network that is the basis of the client's current dysfunction.

**GOAL:** Identify earlier memories within the identified memory network; can be used during History-taking; to identify a feeder memory during processing; to bring to awareness a memory causing a blocking belief, etc.,

Asking clients to access a current experience of the problem; identifying earlier experiences that are similar or relate in some way that can be targeted for reprocessing.

### **DIRECT QUESTIONING**

#### **FLOAT BACK TECHNIQUE** (Browning & Zangwill)

Uses the associational processes of the brain to access other memories that are connected to the client's current experience of the problem. Best to use during History-taking with more highly resourced clients. Use caution with clients who have pervasive history of abuse or neglect or who may be dissociative. 

*"As you bring up the recent experience of \_\_\_\_\_, notice the image that comes to mind, the negative belief you're having about yourself along with any emotions and sensations, and let your mind float back to an earlier time in your life when you may have felt this way before and just notice what comes to mind..."*

**AFFECT SCAN** (Shapiro, 1995: independently developed and without the hypnotic/reliving component contained in Watkins and Watkins, 1971).

**Note:** Affect Scan is particularly useful to apply when the NC is unclear, when an early memory is not accessible by other means, and during reprocessing sessions when client's process is stuck and you are checking for an earlier feeder memory.

*"Bring up that experience, the emotions and the sensations that you're having now, and allow yourself to scan back for the earliest time you experienced something similar..."*

## **EMDR PSYCHOSOCIAL INTERVIEW AGENDA** **(Client Selection Criteria)**

### **ADAPTIVE INFORMATION PROCESSING**

Excluding situations caused by insufficient information/organic deficits, the cause of present dysfunction is based in physiologically stored memories. Evaluate history accordingly.

What targets have set the groundwork for pathology? Trace present reactions to past experiences.

What targets will fill in deficits and bring the client to health-identify needed skills and behaviors?

Is the client able to access the experiences and allow processing to occur?

### **PRESENTING COMPLAINT (ISSUE)**

### **CLIENT-CLINICIAN RELATIONSHIP**

Trust and safety have been established in the clinical relationship. Client agrees to give clinician accurate feedback about client's private internal experiences regarding the reprocessing of the memory.

### **CLINICAL LANDSCAPE**

Use clinical judgment regarding the timing and pacing of gathering information about early childhood attachment and development; life experiences, family of origin, peer relationships; cultural, gender, ethnic and religious influences.

**CHECKLIST:** The following may be treated as a clinical checklist or worksheet:

- OK** Has been addressed and is favorable for EMDR use
- P** Problem: Wait until completion of course or until further preparation and stabilization has occurred.
- C** Consultation indicated with EMDR clinician with expertise in area of concern.

## **CLINICAL CONCERNS**

### **CLIENT STABILITY / DEVELOPMENTAL DEFICITS / ABILITY TO MANAGE STRESS**

OK PROBLEM CONSULTATION

Client has been screened for Dissociative Disorder. DD rules out use of EMDR by Weekend 1-trained clinicians. See *Clinical Signs of Dissociative Disorders and DES* in Appendix. In addition to a Mental Status Exam, the DES should be used for every client. Special preparation for DD clients is needed to establish their capacity to maintain dual awareness in order for reprocessing to occur. Indicators of poor psychic development include but are not limited to:

- Years of unsuccessful psychotherapy
- Depersonalization and/or derealization
- Memory lapses
- Flashbacks and intrusive thoughts
- Somatic symptoms
- Chronic instability at home and/or at work

Secondary gain issues identified and appropriately addressed.

Clinician and client have considered severity of issues which may be exacerbated based on history and clinical diagnosis.

## **ACUTE PRESENTATIONS**

OK PROBLEM CONSULTATION

The following situations require caution and case consultation:

- Life threatening substance abuse
- Serious suicide attempts
- Self-mutilation
- Serious assaultive behavior
- Dissociative disorders

## **STABILIZATION**

OK   PROBLEM   CONSULTATION

- Adequate stabilization/self-control strategies in place
- Client must have a workable means of dissipating disturbance if necessary during or between sessions
- Client has adequate life supports (friends, relatives, etc.)
- Systems/issues that might endanger client have been addressed
- Client able to call for help if indicated

## **MEDICAL CONSIDERATIONS**

OK   PROBLEM   CONSULTATION

- General physical health/medical condition/age considered (possible exacerbation with stress)
- Medications
- Inpatient if necessary to manage danger to client or others
- Eye pain contraindicates EMs until cleared by physician (use alternate forms of stimulation)
- Any neurological impairment or physical complication inappropriate for Weekend 1/Part 1 clinicians

## **TIMING CONSIDERATIONS/READINESS**

OK   PROBLEM   CONSULTATION

- Timing of life events (projects, demands, work schedules, vacations, etc)
- Availability of both therapist and client for support and/or follow-up
- Willingness/ability to continue treatment as indicated
- 90 minute sessions (if possible)

## DEVELOPING AN AIP-INFORMED TREATMENT PLAN

### SYMPTOM CLUSTERS THAT CAN BE USED TO ORGANIZE A TREATMENT PLAN:



- Irrational negative beliefs about self (Part One focus)
- Behaviors
- Emotions
- Body sensations
- Senses (tastes, odors, sounds)
- People, places, or things
- Other

### THREE-PRONGED PROTOCOL

- **Past**
  - First experience (Touchstone Memory)
  - Worst experience
  - Other contributing past experiences
- **Present Triggers**
  - Current triggers that remain due to second-order conditioning (may need to be targeted separately)
  - Recent experiences that occur such as accidents, injuries that do not have a historical component but have generated symptoms that need to be treated
- **Future Templates**
  - Desired outcomes for the future; preparation for potential challenges
  - Anticipatory anxieties
  - Develop alternative patterns of response that are more adaptive to the client



### IRRATIONAL BELIEFS ABOUT THE SELF

Distorted conclusions about the self are based on the disturbing affects and the incomplete or inaccurate *information* that was available at the time of the experience (usually based in childhood).

These “*informational plateaus*” are a result of experiences where the adaptive information is missing. These experiences are considered inadequately processed and maladaptively stored.

## NEGATIVE BELIEFS ABOUT THE SELF

- Are the meta-perception (or conclusion) of the maladaptively stored experiences.
- Are the symptom, not the cause of the client's distress about themselves.
- Are the verbalization of the stored affect; a conclusion about the self, based on the "felt sense" of the experience.
- Can be used to organize the treatment plan (Part One focus).

## CHARACTERISTICS OF NEGATIVE BELIEFS

(referred to as Negative Cognitions in EMDR):

- Negative, irrational, self-referencing (an "I" statement)
- Presently held belief (when focusing on the picture/incident)
- Accurately reflects the client's presenting issue
- Generalizable to related events or areas of concern
- Resonates with client's associated affect

## DEVELOPING APPROPRIATE NEGATIVE BELIEFS (COGNITIONS-NC)

- Negative Cognitions (NCs):
  - Are **not** descriptions of the client's experience, disturbing circumstances, attributes of self or others;
  - Are **not** a simple statement of emotion;
- To generate an appropriate negative cognition (NC), ask:

*"When you think of (repeat description of memory) what negative belief do you have about yourself? If client doesn't understand, ask: "What does that say about you as a person?"*

*"What negative belief about you goes with that (repeat the named emotion)?"*

*"In your worst moment, what negative belief do you have about yourself when you think of the experience?"*

## NEGATIVE COGNITION CATEGORIES

- Negative beliefs are organized into the following categories reflecting the nature of the client's distortions about themselves due to the inaccurate or incomplete information at the time of the experience:

- **Responsibility/Defectiveness**

*"The cause of the problem stems from me."*

Self-Worth/Shame (*"I am something wrong."*)

*"I am not good enough."*

*"I am unlovable."*

*"I am worthless/unimportant/invisible."*

*"I am bad."*

*"I am defective."*

*"I am incompetent."*

Action/Guilt (*"I did something wrong."*)

*"I should have..." (What does this say about you?)*

*"I have to..." (What does this say about you?)*

*"I cannot..." (What does this say about you?)*

*"It's my fault." (What does this say about you?)*

- **Safety/Vulnerability**

*"I am vulnerable."*

*"I am going to die."*

*"I am unsafe."*

*"I am in danger."*

- **Power/ Control (Choices)**

*"I am helpless."*

*"I am powerless."*

*"I am not in control."*

*"I can't protect myself."*

## **POSITIVE BELIEFS (COGNITIONS-PC)**

Positive self-referencing belief: *"I am\_\_\_\_" statement*

## **CHARACTERISTICS OF POSITIVE BELIEFS**

(referred to in EMDR as a Positive Cognition:

- Has an internal locus of control : *"I'm okay as I am."*
- Accurately focuses the client's desired direction of change
- Is initially acceptable/somewhat believable as a desired goal
- Generalizable to related events or areas of concern
- Addresses same issue presented in the negative belief

## **DEVELOPING APPROPRIATE POSITIVE COGNITIONS**

- Positive cognitions are not negation of negative cognitions  
For example, *"I am NOT weak."*
- Positive cognitions are not absolute statements
- Avoid the use of *"always"* or *"never"*
- Positive cognitions are not magical thinking  
Example: Changing actual events, attributes of others or self

## EXAMPLES OF NEGATIVE AND POSITIVE COGNITIONS

### NEGATIVE COGNITIONS

#### **RESPONSIBILITY/DEFECTIVENESS**

*I'm not good enough*  
*I don't deserve love*  
*I am a bad person*  
*I am incompetent*  
*I am worthless/inadequate*  
*I am shameful*  
*I am not lovable*  
*I deserve only bad things*  
*I am permanently damaged*  
*I am ugly/my body is hateful*  
*I do not deserve.....*  
*I am stupid/not smart enough*  
*I am insignificant/unimportant*  
*I am a disappointment*  
*I deserve to die*  
*I deserve to be miserable*  
*I am different/don't belong*  
*I have to be perfect (out of inadequacy)*

#### **RESPONSIBILITY: Action**

*I should have done something\**  
*I did something wrong\**  
*I should have known better\**  
*\*What does this say about you?*  
*(e.g. therefore, I am...)*  
*I am shameful/I am stupid/I bad person*  
*I am inadequate/weak*

#### **SAFETY/VULNERABILITY**

*I cannot trust anyone*  
*I cannot protect myself*  
*I am in danger*  
*I am not safe*  
*I am going to die*  
*It's not OK (safe) to feel/show my emotions*

#### **POWER/CONTROL**

*I am not in control*  
*I am powerless/helpless*  
*I cannot get what I want*  
*I cannot stand up for myself*  
*I cannot let it out*  
*I cannot be trusted*  
*I cannot trust myself*  
*I cannot trust my judgment*  
*I am a failure/will fail*  
*I cannot succeed*  
*I have to be perfect/please everyone*  
*I can't handle it*

### POSITIVE COGNITIONS

*I am good enough/fine as I am*  
*I deserve love; I can have love*  
*I am a good (loving) person*  
*I am competent*  
*I am worthy; I am worthwhile*  
*I am honorable*  
*I am lovable*  
*I deserve good things*  
*I am/can be healthy*  
*I am fine/attractive/lovable*  
*I can have/deserve...*  
*I am intelligent/able to learn*  
*I am significant/important*  
*I am OK just the way I am*  
*I deserve to live*  
*I deserve to be happy*  
*I am OK as I am*  
*I am fine the way I am*

*I did the best I could*  
*I learned/can learn from it*  
*I do the best I can/I can learn*

*I'm fine as I am*  
*I am adequate/strong*

*I can choose whom to trust*  
*I can learn to protect myself*  
*It's over; I am safe now*  
*I am safe now*  
*I am safe now*  
*I can safely feel/show my emotions*

*I am now in control*  
*I now have choices*  
*I can get what I want*  
*I can make my needs known*  
*I can choose to let it out*  
*I can be trusted*  
*I can/learn to trust myself*  
*I can trust my judgment*  
*I can succeed*  
*I can succeed*  
*I can be myself/make mistakes*  
*I can handle it*

## **PHASE TWO: PREPARATION**

### **Chapter 5 (Shapiro, 2001)**

#### **GOAL**

To prepare clients for EMDR processing of traumatic targets.

Establish therapeutic alliance with distinct characteristics

Education of EMDR mechanics and procedures; obtain informed consent

#### **AIP**

- Positive/adaptive memory networks are necessary in order for processing to take place
- To develop and enhance positive memory networks in which maladaptively stored target memories will be integrated
- Increase access to positive memory networks to ensure that the client can change state if the reactivation of the negative memory network is unduly distressing

#### **CLIENT STABILIZATION**

- Preparation Phase interventions may be needed before being able to safely complete Phase 1: History-Taking (psychosocial and development of the Treatment Plan)

#### **PSYCHOSOCIAL**

- Relationship – rapport, establish emotional safety
- An appropriate clinical relationship -- a strong therapeutic alliance, specific truth-telling agreements, and a therapist who can convey a message of safety, flexibility, and unconditional regard
- Meets Client Selection Criteria

#### **EMDR EDUCATION AND EXPECTATIONS**

- Education of EMDR mechanics and procedures

## **INFORMED CONSENT**

Client agrees to EMDR treatment with the understanding of the following:

- “Nature of memory” related to EMDR and court involvement:
  - Memory image can fade or disappear (forensic issues)
  - Legal counsel consulted if indicated
  - Initial investigative notes, deposition completed as indicated
  - Client may no longer exhibit high emotion when recounting the incident
  - More information may be recalled (information recalled during reprocessing is always valid, but not necessarily accurate)
- High level of disturbing emotions may occur while reprocessing
- Appropriate safeguards in place to help prevent relapse in cases where there is a history of substance abuse. Urge to use can be activated by EMDR
- AIP-informed Treatment Plan

## **TEACH IN-SESSION/BETWEEN SESSIONS COPING SKILLS**

(State change coping strategies)



- Calm/Safe Place or other resources
- Resource development
- Container exercise
- Relaxation, stress reduction strategies and exercises
- Affect management and stabilization skills
- Life management skills
- Positive behavior change skills

## **PLEASE NOTE**

See Appendix for extensive Resource Development and Installation Strategies. *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (Shapiro, 2001).

## EXPLANATION OF EMDR AND THE ADAPTIVE INFORMATION PROCESSING MODEL

*“When a disturbing event occurs, it can get locked in the brain with the original picture, sounds, thoughts, feelings and body sensations. EMDR seems to stimulate the information and allows the brain to reprocess the experience. That may be what is happening in REM or dream sleep. The eye movements (tones, tactile) may help to process the unconscious material. It is your own brain that will be doing the healing and you are the one in control.”*

### MECHANICS

- Sitting position
- Distance
- Eye movement
  - Preferred method of BLS for reprocessing
  - “A pass” = one round-trip, centerline to centerline
  - Range 
  - Speed
  - Direction(s)
  - Bifocals, glasses, contacts
  
- Tactile and auditory
  - Introduce options to client
  - Use only when necessary
  
- Bilateral stimulation
  - Stabilization and resource development (slower, 4-8 passes)
  - Reprocessing (fast, BLS generally 20 or more passes/customized to need of client).
    1. Desensitization
    2. Installation
    3. Body Scan
    4. Future Templates (Third-prong)

## REPROCESSING AIDS

- Metaphors
  - Train: *“In order to help you ‘just notice’ the experience, imagine riding on a train and the feelings, thoughts, etc., are just the scenery going by.”*
  - Movie: *“Imagine that you’re going to see a movie; you know what the movie is about, but you don’t know what is going to happen from one scene to the next, so let yourself be curious about it...”*
- Stop signal/keep going signal
- In-session/between sessions state change resources
  - Calm/Safe Place or other resources
  - Relaxation, stress reduction strategies and exercises
  - Container strategy

## **CALM/SAFE PLACE EXERCISE**

- One technique to help prepare client for processing
- Introduces bilateral stimulation without the demand of distressing affect
- Evaluate the client's ability to effectively shift from one state to another
- To close down an incomplete session when time is running out
- Manage high level of distress during reprocessing (when solicited by client)
- Calm/Safe Place can be used as a temporary state-change technique as distinguished from trait change (permanent reprocessing effects of EMDR)

### **Cautions**

1. Developing a Calm/Safe Place may increase levels of distress in more debilitated clients.
2. Bilateral stimulation paired with the development of the Calm/Safe Place may quickly bring the client to intense negative affect.
3. The Calm/Safe Place development may activate the client's negative associations if a memory spontaneously links with the Calm/Safe place.

**PLEASE NOTE:** Clients who are unable to use self-control techniques to shift out of states of distress should not be considered for memory reprocessing until after the clinician has completed the second part of the EMDR Basic Training. These clients need to be evaluated for sufficient ego strengths and self-soothing skills and may need advanced EMDR procedures in order to begin memory reprocessing.

## DEVELOPING AND ENHANCING A CALM/SAFE PLACE

### **IMAGE**

"I'd like you to think about a place you have been or imagine being that feels very calm or safe. Perhaps being on the beach or sitting by a mountain stream. What image represents your place?"

### **EMOTIONS AND SENSATIONS**

"As you think of that calm/safe place, notice what you see, hear, and feel right now. What do you notice?"

### **ENHANCEMENT**

"Focus on your calm/safe place--its sights, sounds, smells, and body sensations. Tell me more about what you are noticing."

### **EYE MOVEMENTS**

"Bring up the image of that place. Concentrate on where you feel the pleasant sensations in your body and allow yourself to enjoy them. **Concentrate on those sensations and follow my fingers.** (4-8 slow BLS) How do you feel now?"

#### **If positive**

"Focus on that. (BLS) What do you notice now?"

**If negative** – redirect attention to identify another calm place or consider some other self-soothing strategy such as a container, mindfulness, or a breathing exercise

### **CUE WORD**

"Is there a word or phrase that represents your safe place? Think of \_\_\_\_\_ and notice the positive feelings you have when you think of that word. Concentrate on those sensations and the word \_\_\_\_\_ and follow my fingers. (4-8 BLS) How do you feel now?" Repeat and enhance positive feelings with BLS several times.

### **SELF-CUING**

"Now I'd like you to say that word \_\_\_\_\_ and notice how you feel."

### **CUING WITH DISTURBANCE**

"Now imagine a **minor** annoyance (SUD 1-2) and notice how you feel. Bring up that word \_\_\_\_\_ and notice any shifts in your body. What did you notice?"



### **SELF-CUING WITH DISTURBANCE**

"I'd like you to think of another mildly annoying incident (SUD 2-3), notice how you feel then bring up that word \_\_\_\_\_ by yourself, especially noticing any changes in your body when you focus on your cue word."

## **DAY 2 REVIEW**

### **QUESTION-PRACTICE SESSION 1**

#### **REVIEW DAY 1**

#### **EMDR APPROACH BASED ON AIP MODEL**

- Inadequately processed memories are the basis of current pathology
- Past unresolved memories color the experience of the present
- Information processing system-adaptive and moves toward health
- Bilateral stimulation
- The EMDR Eight Phases and standard procedures
- Three-Pronged Protocol, Targeting Sequence
  - Reprocess in order:
    1. Past events (Touchstone Memory then additional past events)
    2. Present triggers
    3. Future templates

#### **ADAPTIVE INFORMATION PROCESSING MODEL**

- Physical processing system of the brain
- EMDR Components
  - Access
  - Stimulate
  - Move

#### **AIP-INFORMED TREATMENT PLAN**

- Understand clinical landscape
- Psychosocial history
- Needs, skills, education
- Informed consent
- Client selection

- Information gathering for developing EMDR Treatment Plan
  1. Recent event or single incident PTSD
  2. Dominant issue (problematic behavior, belief, emotion, affect)
  3. Past events, present triggers, future anxieties

## **PHASE TWO-PREPARATION**

- Therapeutic relationship
- Educate
- Treatment expectations
- Informed consent
- EMDR mechanics
- Stabilization skills

# PHASE THREE: ASSESSMENT

## Chapter 5 (Shapiro, 2001)

### GOALS

To access the target memory experience for EMDR reprocessing by stimulating the primary aspects of the memory as they exist in present time. 

To take baseline measurements in a safe, structured manner in preparation to reprocess the memory.

### ADAPTIVE INFORMATION PROCESSING MODEL

- Access and delineate components of the selected target
- Activate the memory networks associated with the target memory experience

### ASSESSMENT PHASE PROCEDURE

**TICES** (Target = Image, Cognition, Emotions, Sensations)

#### 1. IMAGE

Representative: *“What picture represents the incident?”*   
or

Most disturbing: *“What picture represents the **worst part** of the incident as you think about it now?”*

or,

If no picture: *“When you think of the incident what do you get?”*  
(baseline to assess how memory is currently encoded)

#### 2. NEGATIVE COGNITION

*“What words go best with that picture that expresses your negative belief about yourself now?”* 

A negative belief is:

- Negative
- Irrational
- Self-referencing
- Generalizable
- Resonates as true



## **PHASE FOUR: DESENSITIZATION**

### **Chapter 6 (Shapiro, 2001)**

#### **GOAL**

Reprocess experiences toward an adaptive resolution (SUD should be 0 for completed treatment).

#### **ADAPTIVE INFORMATION PROCESSING**

- Information is accessed and reprocessed as it is currently stored without clinical interventions (to the extent that is possible).
- Target experience is accessed and memory network is fully reprocessed.
- SUD should be 0 for complete treatment.
- Information reprocessing (learning) takes place as targeted memory links to more adaptive networks.
- Feedback regarding changes occurs after each set of bilateral stimulation.
- Make certain that all available channels are accessed and fully reprocessed (returning to target and taking a SUD).

Begin Desensitization Phase:

*“I’d like you to bring up that image, those negative words (repeat the negative cognition), notice where you are feeling it in your body, and follow my fingers (or alternative bilateral stimulation).”*

#### **BILATERAL STIMULATION (BLS)**

- Sets are generally 15-30 seconds (try starting with 24 passes) and then lengthen or shorten as needed by the client. The number of the eye movements is customized to the client.  
*Note: The starting point may be 24 as that is the average to get the processing moving. However, remain attentive to client response and use shorter or longer sets as needed. Some clinicians find that most of their clients will do fine if the initial BLS is 24 (or 35 or 40). Others find that some of their clients cannot tolerate that amount, but could initiate EMDR processing if they began with fewer, sometimes many fewer, BLS movements. Whatever number of BLS the clinician chooses to begin with can be refined through attention to the response of/and consultation with the client.*
- Rate of speed of eye movements should be as fast as the client can comfortably manage without strain. When coming to a stop, bring your fingers to the client’s mid-line.
- EMs versus tapping/auditory

- Client instruction: *“Just notice, there are no supposes to’s. Let whatever happens, happen.”*
- Pacing
- Body language/non-verbal cues

## FEEDBACK AFTER EACH SET OF BILATERAL STIMULATION

**Clinician:** *“Take a breath, let it go...what are you noticing now?”*

**Client:** Gives brief feedback about what they’re experiencing

**Clinician:** *“Go with that.”* or *“Notice that.”*

## CHANGES INDICATING REPROCESSING

- **Individual Memory**
  - Image
  - Cognitions-insights, polar
  - Emotions-ecological
  - Sensations-release, shifts, retracing 
- **Memory Network: Channels of Associations**
  - Participants
  - Stimuli
  - Events
  - Physical sensations
  - Emotions
  - Beliefs

## INFORMATION NOT MOVING

- Adjust bilateral stimulation (BLS)
  - Change direction, speed or modality
- Focus on the body
- Return back to target i.e., “Go back to the memory we started with; what are you noticing now?” Note: Direct the client’s attention to the memory itself, not any particular component of their experience, such as image.
- **Caution:** Returning to target memory can activate the next channel of associations. If there is insufficient time to deal with material that may emerge do not return to target until the next session. Instead, go to instructions for “Closing an Incomplete Session.”

## WHEN TO RETURN TO TARGET MEMORY:

- Client reports repeated neutral or positive responses (signifying the end of a channel)
- Client reports no change after two consecutive sets of BLS
- Client's reported associations are too vague or remote from original target (signifying need to refocus processing to original target)
- Returning to target will identify any remaining channels associated with this node.
- After returning to target and client reports no change and no additional channels of association after two sets of BLS, then take a SUD

*"When you think of the original experience, what are you noticing now? (Wait for client response). Go with that."*

**TAKING A SUD (0-10)** Client continues to report neutral or positive material after two sets of BLS in a row.

- To check client's progress or to identify end of desensitization (SUD=0)  
*"When you think of the original incident (issue), on a scale from 0-10, where 0 is no disturbance and 10 is the highest disturbance you can imagine, how disturbing is the incident (issue) to you now?"*

Add another set of BLS after client's response: *"Go with that."*

- If SUD becomes stuck at 1 or 2:
  - Focus on the body sensation and add BLS  
If still no change, ask:  
*"What makes it a \_\_\_\_ (1 or 2 SUD)?"*  
If they have difficulty, ask:  
*"What prevents it from becoming a zero?"*
  - Once identified, add BLS  
If still no change:
  - Probe for additional blocking beliefs or feeder memories:

## FEEDER MEMORIES

Feeder memories are earlier memories that are not spontaneously emerging into conscious awareness, but are in the memory network blocking the processing.

(Note: These should be immediately investigated if processing is blocked on an adolescent or adult memory.)

Feeder memories can block complete resolution during the desensitization and installation phases.

The clinician may invite the client to focus on the aspects of their experience that they are aware of and scan back to an earlier time in an attempt to bring the feeder memory into consciousness in order to be processed:

- **Affect Scan** (Shapiro, 1995: independently developed and without the hypnotic/reliving component contained in, Watkins and Watkins, 1971. The affect bridge: A hypnoanalytic technique. *International Journal of Clinical and Experimental Hypnosis*, 19, 21-27.)

*Strategy to access feeder memories through client's affective experience by asking the client to scan back to an earlier time that may be similar. Clinician asks:*

*“ Focus on your experience, the emotions and the sensations that you are having now, and allow yourself to scan back an earlier time when you may have experienced something similar...”*

## BLOCKING BELIEFS

Blocking beliefs are distorted conclusions that the client arrived at about themselves, others or life circumstances that may or may not emerge in the memory network during processing, but may impede the client's ability to continue processing towards a successful resolution.

Examples:

- It's not safe to get over this problem
- If I feel better, I will forget about what happened
- I will be disloyal to my fallen comrades ( or my family) if I get over this problem
- I don't deserve to get over this problem
- I will never get over this problem
- It's not ok to get over this problem

Blocking beliefs may spontaneously process; if, however the processing is blocked, the clinician may invite the client to explore when they may have arrived at this conclusion:

*“Would you be willing to go back in time to explore where you might have learned this belief (or arrived at this conclusion)?”*

Blocking beliefs may be blocking the complete resolution of the memory (SUD=0) or a complete installation (VOC=7). If the SUD>0 or VOC<7, ask:

*“What keeps it from becoming a 0 (or 7)?”*

Note: The memory/memory network that is responsible for the blocking belief may be too large to be processed within the existing session, and may have to be set aside and tagged to be targeted separately.



## EMOTIONAL RESPONSES DURING REPROCESSING

- Information is being released.
- Client is experiencing an underlying emotion, or is having an appropriate response to a memory or a new understanding for the first time.
- An emotional response has a beginning, middle and end.
- In most instances, the emotional response is occurring as information is being reprocessed.
- The client will move through the emotional responses more effectively, efficiently and safely if BLS is maintained until the client's emotions have peaked and reached a plateau. The clinician evaluates the movement by observing the client's facial expressions, breathing, and body language.
- Clinician should maintain position of detached compassion.
- To increase client's sense of safety and maintain dual awareness use voice tone to communicate your attention and support.
- Calm/Safe Place and other self-control strategies practiced in Preparation Phase are available if one needs to stop.
- Observe non-verbal cues to determine plateaus of change.
- Pause if necessary from intense reprocessing.
- Assess need for additional interventions.

## BASIC STRATEGIES

- Continue bilateral stimulation (consider changing to tactile or auditory stimulation should client be crying, closing or covering eyes, etc). 
- Maintain dual focus of awareness with periodic supportive statements:

*"That's it.*

*"Stay with it. You're doing fine."*

*"It's old stuff."*

*"Just notice it."*

*"It's in the past."*

*"It's over. You're safe now."*

## **METAPHORS**

- Tunnel: *“You are in the tunnel, just keep your foot on the pedal and keep moving.”*
- Train: *“It’s just old information. Watch it like scenery going by.”*

## **IF CLIENT ASKS TO STOP DURING THE PROCESSING**

- Inquire as to what happened that made the client want to stop
  - Do they need to slow down or take a break?
  - Do they need to share their experience because they’re confused or feeling overwhelmed?
  - Do they have concerns? If so, what are they?
  - What do they need in order to continue?
- If client does not want to continue:
  - Calm/Safe Place or other self-soothing technique
  - Access Calm/Safe Place through guided imagery
  - NO BLS
  - Explore with client what needs to be in place in order to resume reprocessing

## **RETURN TO EMDR REPROCESSING WHEN CLIENT IS READY**

## **PHASE FIVE: INSTALLATION**

### **Chapter 6 (Shapiro, 2001)**

#### **GOAL**

To check the validity of the selected Positive Cognition and strengthen the positive effects of the PC by linking it with the original target memory.



#### **ADAPTIVE INFORMATION PROCESSING**

- Strengthen connections to positive memory networks
- Increase generalization effects within the associated network

#### **CHECKING THE INITIAL POSITIVE COGNITION**

*“When you bring up that original incident, does your original positive cognition (repeat the PC) I am \_\_\_\_\_ still fit or is there now a better statement?” (Is the client now able to see further down the tracks?)*

#### **CHECK THE VOC**

*“Think about the original incident and those words \_\_\_\_\_ (repeat the selected positive cognition). From 1, completely false, to 7, completely true, how true do they feel now?”*



#### **LINK THE PC AND THE TARGET AND ADD BLS**

*“Think about the original incident and those words \_\_\_\_\_ (repeat the selected positive cognition) and follow my fingers.”*

Do sets of BLS (same speed and approximate duration as in Desensitization) as long as the client reports new positive associations, sensations or emotions and install the PC until the VOC=7.

Check VOC after each set of BLS until the PC is fully installed (VOC=7).

## **WHEN THE VOC IS LESS THAN 7: CHECK FOR A BLOCKING BELIEF**

Ask, *“What prevents this from going to a 7?”*

Reprocess with BLS whatever client reports until VOC=7.

Consider:

- Ecological soundness
- New skills needed
- Tag the blocking belief and address it as a separate target at another time to make sure it is fully processed.
- Develop a Treatment Plan to address additional issue(s).

## **PHASE SIX: BODY SCAN**

### **Chapter 6 (Shapiro, 2001)**

#### **GOALS**

To complete reprocessing by checking for any residual body sensations associated with the target memory.

To ensure that the somatic responses (body sensations) are congruent with the neutralized memory and the positive cognition.

#### **ADAPTIVE INFORMATION PROCESSING**

Dysfunctionally stored material often manifests through physical (somatic) sensations.

#### **BODY SCAN PROCEDURES**

*“Close your eyes and keep in mind the original memory and the (repeat the positive cognition). Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find tension, tightness, or unusual sensation, tell me.”*

Reprocess any negative sensation or strengthen positive sensation with standard sets of bilateral stimulation.

- Sensations associated with dysfunctional information should dissipate.
- New associations may emerge which should be completely reprocessed.
- Reprocessing of chosen target is not considered complete until body scan is clear of all negatively associated sensations.   
Positive sensations should be reinforced with standard sets of BLS

**CAUTION:** Proceed with body scan only if sufficient time is available. If not, resume at following session. 

## **PHASE SEVEN: CLOSURE**

### **Chapter 6 (Shapiro, 2001)**

#### **GOALS**

To ensure client stability at the completion of an EMDR session.

To maintain client stability between sessions.

#### **ADAPTIVE INFORMATION PROCESSING**

- Shift focus away from memory network
- Focus toward neutral or other positive associations (memory networks).

#### **INSTRUCTIONS FOR CLOSING A COMPLETED TARGET SESSION**

(SUD=0, VOC=7, clear Body Scan)

- ~~Tell client it is time to stop.~~
- Give encouragement:  
*“You have done very good work today. How are you feeling?”*
- Debrief:  
*“As you review your experience in our session today, what positive statement (about yourself) can you make to express how you feel or what you have learned about yourself or the situation?”*

#### **INSTRUCTIONS FOR CLOSING AN **UNFINISHED TARGET** MEMORY SESSION**

(SUD>0, VOC<7, no clear Body Scan)

- Tell client it is time to stop 
- DO NOT take SUD, check PC, take VOC or do Body Scan

- Stabilization:
  1. When client shows significant disturbance, take special care to stabilize client, emphasizing possibility of continual processing.
  2. Assure client of your availability.
  3. Use one or more of following strategies and instruct client to use between sessions:
    - a. Calm/Safe Place
    - b. Relaxation exercise such as progressive relaxation or breathing exercise
    - c. Container exercise
  
- Closing down (once stabilized):
  1. Give encouragement:
 

*“You have done some good work today. How are you feeling?”*
  2. Debriefing:
 

Use clinical judgment to debrief client with special attention to reorienting to the present, not discussing details of the session.

*“As you consider your experience today, what positive statement can you make to express what you have learned or gained?”* 
  3. Use clinical judgment regarding client’s ability to manage emotions that may emerge due to incomplete reprocessing.

### **SELF-MANAGEMENT TECHNIQUES BETWEEN SESSIONS:**

- Practice self-control techniques that have been established
- Use TICES Grid to keep track of associations:  
**Target = Images, Cognitions, Emotions, Sensations**

### **INSTRUCTIONS FOR CLOSING ALL SESSIONS**

*“Processing may continue after our session. You may or may not notice new insights, thoughts, memories, physical sensations or dreams. Please make a note of whatever you notice. We will talk about that at our next session. Remember to use one of the self-control techniques as needed.”*

## **DAY 3 REVIEW**

### **PRACTICE SESSION 2: QUESTION & ANSWER**

**PHASE ONE: HISTORY-TAKING**

**PHASE TWO: PREPARATION**

**PHASE THREE: ASSESSMENT**

**PHASE FOUR: DESENSITIZATION**

**PHASE FIVE: INSTALLATION**

**PHASE SIX: BODY SCAN**

**PHASE SEVEN: CLOSURE**

# FACILITATING BLOCKED PROCESSING

## Chapter 7 (Shapiro, 2001)



### GOALS

To recognize three types of client responses.

To facilitate the client's processing experience when they are not responding in a way that appears conducive to adaptive resolution

To use specific strategies to facilitate processing based on specific strategies designed to address the client's particular difficulty.

### THREE KINDS OF CLIENT RESPONSES TO BE CONSIDERED:

#### 1. Normal processing

- Phase Three: Assessment phase works the majority of the time to activate the client by accessing the memory
- No additional interventions required by the clinician
- Allows for spontaneous processing to occur

#### 2. **Over-accessing** (when the client may be having difficulty managing the information being accessed)

- Client appears to be upset at a level that is higher than they can maintain
- Clinician uses strategies designed to slow or contain the process
- Objective is to allow client to continue processing with greater containment and emotional safety
- Goal is to keep the client in the process by limiting the speed and intensity of the processing itself (unless client uses stop signal)



#### 3. **Under-accessing** (when the client's affect may not be consciously available)

- Client appears blocked
- Clinician uses strategies to accelerate and deepen the processing
- Allows the client to access traumatic events more fully

**Note: The client in the second category is merely accessing the information as it is currently stored without the resources/affect tolerance to comfortably deal with it.** Clients may, at times "over-access," under-access and/or respond normally given the context of the memory network.

## **STRATEGIES FOR “OVER-ACCESSING” CLIENTS**

Examples of strategies for a clinician to use when a client is displaying an uncomfortably high level of emotions that is unchanged after two sets of eye movements:

### **First – Dual Awareness**

- Ask the client how s/he is doing and remind them of their stop signal.
- Speak to the client during the processing offering support and compassion in order to help maintain dual awareness throughout the processing by reminding them of your continued presence.
- Remind the client about the reality of the situation, such as, “It’s over, it’s in the past,” “You’re here now, looking back on the experience.”

### **Second – Narrowing the Focus of Attention**

- See if concentrating only on body sensations helps during the set of BLS, particularly if they’re highly disturbed by other aspects of their experience
- Have the client concentrate on their thoughts about the event as a counterpoint to their intense emotional response.

### **Third – Mechanics Strategies**

- If the client has closed eyes, ask the client to open his/her eyes to maintain contact with their immediate surroundings as well as the clinician.
- Change the length of the set (shorter or longer), change the speed (slower or faster), change direction of the BLS (from horizontal to diagonal), or change modality of BLS (from EM to tactile, etc.).

Note: Any time the clinician changes the form of the BLS (except for speeding up or slowing down within the same modality), stop in between sets offering a brief explanation, so as not to startle the client.

### **Fourth – TICES Strategies**

- Image (for visual modification)
  - Suggest the client change the vivid image from color to black and white
  - Suggest the client visualize the perpetrator without action so as to limit the impact of the memory work on the client
  - Use a hierarchy, beginning with visualizing the disturbing event from a distance, then gradually seeing it closer and closer, at their won pace
  - Have the client imagine an invisible barrier to protect the client visually from part of the memory, then slowly removing the barrier at their will.
- Cognition (for verbal or sound interventions)
  - Focus on one at a time
- Emotional or sensory interventions

- Suggest that the client concentrate on only one emotion at a time or one sensation at a time so they're not feeling overwhelmed

It is important to use clinical judgment to assess the situation:

- At times, the client can respond best if the stimulation is reduced to a small number of passes and then gradually increase the length of the set.
- At other times, it is best to increase the length of the set in order to move through the block
- At other times, it will be best to apply a state change intervention and pause the processing until client is ready to continue.

## **STRATEGIES FOR UNDER-ACCESSING CLIENTS**

Using the same mechanics and TICES interventions, the strategies suggested can be used to restart processing for those who are blocked, or to amplify processing for clients who report feeling too little, or are maintaining too great a distance from the target memory.

### **First – Initial Strategies**

- Increase the length and/or speed of the set to see if this unblocks or produces a greater emotional reaction
- Focus only on body sensations
- Change the mode of BLS to increase the emotional response, i.e., from eye movements to tactile, noting the response.
- Check for a feeder memory or a blocking belief (next section)

### **Second – TICES strategies**

These interventions are intended to mimic spontaneous processing. Try the strategies in the order listed:

- For blocked processing or to increase access:
  - Return to the target event and suggest that the client scan for new visual data to stimulate a greater response, or to access additionally disturbing events that have not arisen spontaneously.
  - Check if tension in jaw or throat indicates “unspoken words” and have the client speak during BLS
  - Check if muscle tension indicates the need to move or act and have the client do this during BLS
  - Scan the original target for disturbing sounds or smells

- Scan the original target for disturbing conversations
- To increase feeling and responsiveness:
  - Redirect the client to the negative cognition in order to access disturbance
  - Add color to a black and white image, or suggest the client brighten it to increase emotional impact
  - Visualize an actionless perpetrator with action
  - Have the client imagine getting visually closer to the event so as to feel it more intensely
  - Change the client's seating or offer some other behavioral stimulus so the client can experience the original event more actively
  - Ask the client to focus on several sensations at once
  - Ask the client to focus on several emotions at once

**IMPORTANT:**

- All targets must be re-accessed and processed in undistorted form.
- Any changes in stimulation should be done only after first informing the client of the upcoming change, including a brief explanation of the rationale, and then only with the client's consent.

**FEARS** 

Going crazy

Losing good memories

Change

Worst case scenario

Losing respect of clinician

Losing contact with clinician

# **STABILIZATION AND RESOURCE DEVELOPMENT INTERVENTIONS**

## **RESOURCE DEVELOPMENT INTERVENTIONS**

- Stabilization
- Affect Management
- Behavior (State) change

## **RESOURCE DEVELOPMENT STEPS (Affect Management and Behavior Change)**

### **1. RESOURCE**

Client identifies the needed resource or affect management skill.

Examples: calm place, container, breathing technique, courage, focus, etc.

### **2. IMAGE**

Client imagines a time, activity or place (real or imagined) when that resource had been successfully used.

### **3. EMOTIONS AND SENSATIONS**

Client focuses on image, feelings, and identifies location of positive sensations associated with the resource.

### **4. ENHANCEMENT**

Clinician verbally enhances the resource with guided imagery stressing its positive behaviors, feelings and sensations.

### **5. BILATERAL STIMULATION**

Once enhanced, add several brief sets of bilateral stimulation (BLS 6-8 slow passes).

*“Bring up your resource and those pleasant sensations.”* (BLS 6-8 slow passes).

Repeat several times if process has enhanced client’s positive feelings and sensations. If not positive, consider returning to step 1 and identify another resource.

### **6. CUE WORD**

Have client identify a word or phrase that represents the resource.

Use that word/phrase to verbally enhance the pleasant feelings and sensations. Once fully accessed, further enhance by using a short set (BLS 4-8 slow passes). If positive, repeat several times. If negative, return to step 1 and consider an alternative coping skill.

### **7. In order to avoid premature linkages with trauma material, no BLS is used from this point on.**

**8. SELF-CUING**

Instruct client to repeat procedure on her own, bringing up the image of the resource and its positive emotions and sensations.

**9. CUING WITH DISTURBANCE**

Have client think of a recent, mild disturbance then instruct her to imagine how using her resource would have helped in managing the situation. Guide client through process until able to experience positive emotions and sensations.

**10. SELF-CUING WITH DISTURBANCE**

Without any help from clinician, have client think of another mild, recent disturbing event, imagining using the resource and experiencing positive emotions and sensations.

**11. KEEP A TICES LOG**

To evaluate effectiveness of the Calm/Safe Place or any other stress management strategy being used by client.

## **ADDITIONAL STRESS MANAGEMENT STRATEGIES**

(For incomplete sessions or additional stabilization)

-

### **A. LIGHT STREAM TECHNIQUE**

- Ask client to concentrate on upsetting body sensations.
- Identify the following by asking, *"If it had a \_\_\_\_\_, what would it be?"*
  - a. shape      d. temperature
  - b. size        e. texture
  - c. color       f. sound (high pitched or low)

Ask, *"What is your favorite color you associate with healing?"*

- Say, *"Imagine that this favorite colored light is coming in through the top of your head and directing itself at the shape in your body. Let's pretend that the source of this light is the cosmos so the more you use, the more you have available. The light directs itself at the shape and resonates, vibrates in and around it. And as it does, what happens to the shape, size or color?"*
- If client gives feedback that it is changing in any way, continue repeating a version of the underlined portion and ask for feedback until the shape is completely gone. This usually correlates with the disappearance of the upsetting feeling. After it feels better, bring the light into every portion of the person's body, and give her a positive statement for peace and calm until the next session. Ask client to become externally aware at count of five.

### **B. SPIRAL TECHNIQUE**

- Client is asked to bring up a disturbing memory and to concentrate on the body sensations that accompany the disturbance. Client is told this is an imaginal exercise and there are no right or wrong responses.

*"When you bring up the memory, how does it feel from 0-10?"*

*"Where do you feel it in your body?"*

- Clinician then asks client to concentrate on body sensations.

*"Concentrate on the feeling in your body. Pretend the feelings are energy. If the sensation was going in a spiral, what direction would it be moving in, clockwise or counterclockwise?"*

- Whatever the client answers, respond, “Good,” and instruct him/her to move the spiral in the opposite direction.

*“Now with your mind, let’s change direction and move the spiral (state clockwise or counterclockwise to indicate the opposite direction). “Just notice what happens as it moves in the opposite direction.”*

Ask, “What happens?”

- If the technique works the client will report that moving in the opposite direction will cause the feelings to dissipate and the SUD to drop. Teach it to the client for self-use. If the client says the spiral doesn’t change, doesn’t move, nothing happens, then choose another technique.

### **C. BREATHING SHIFT**

- Ask the client to bring up a good, happy or positive memory. Try to use whatever affect is most useful. Ask him to notice where his breath is starting and to put his hand over that location in his body. Let him breathe a moment or two and instruct him to notice how it feels. Now ask him to bring up a memory with a low level of disturbance and notice how his breath changes. Ask him to put his hand over that location in his body. Now ask him to change his hand to the previous location and deliberately change his breathing pattern accordingly. This should cause the disturbance to dissipate. Teach it to the client for self-use.

### **D. DIAPHRAGMATIC BREATHING**

- Ask the client to take a deep breath and fill lungs completely so they get the most out of breathing. You may suggest that they scoot forward in their chair and place one hand over their abdomen and the other hand over their chest (Demo for client).
- *“Start by exhaling and then breathe in all the way with your abdomen for a count of two and then breathe in all the way with your chest for a count of two. Hold that for a count of seven and then breathe out all the way with your abdomen for a count of four and breathe out with your chest for a count of four.”*
- Demo for the client and/or do it together. Repeat the sequence four times.

## **PHASE EIGHT: REEVALUATION**

### **Chapter 8 (Shapiro, 2001)**

#### **GOALS**

To follow-up after an EMDR reprocessing session.

Ensure precise clinical attention to changes the client is experiencing as a result of the previous reprocessing session.

Evaluate client progress internally, and systemically.

Evaluate the specific target memory.

Identify other relevant associations that may have developed as a result of the reprocessing.

Identify other relevant associations that may have developed as a by-product of the processing.

To review and/or reprocess remaining targets in the Treatment Plan.

#### **GOALS PRIOR TO TERMINATION**

To ensure complete reprocessing of relevant material associated with the client's overall treatment plan before termination.

To ensure that the client is successfully integrated into the larger social systems.

#### **ADAPTIVE INFORMATION PROCESSING**

- Reprocessing will continue between sessions.
- Not all relevant channels will be accessed in each session.
- New experiences will stimulate previously dormant networks.
- New information may need to be supplied in order for changes to be successfully integrated in the client's life

## **CHECKING RESULTS OF THE PREVIOUS TREATMENT SESSION**

### **General Treatment Plan Issues**

- Changes in symptoms
- Changes in behaviors
- Reactions to present triggers
- New thoughts, insights or information
- Dreams

### **Target Specific Issues – Unfinished versus Completed Target Memory**

- New aspects of the target memory
- Activation of other associated memories
- Present triggers associated with the targeted memory
- If completed, did the SUD remain 0 and the VOC remain a 7?

## RESUMING REPROCESSING OF AN UNFINISHED TARGET MEMORY

**SUD>0:** Procedures for restarting an unfinished target memory:

**Memory:** *“Bring up the memory we have been working on. What is the image that represents the worst part of it as you think about it now?”*

**Emotions:** *“What emotions are you experiencing now?”*

**SUD:** *“On a scale from 0-10, how disturbing is it?”*

**Body Location:** *“Where do you feel it in your body?”*

**Reprocessing:** *“Focus on the experience, where you feel the sensations in your body and follow my fingers.” (BLS)*

If the Target Memory is a SUD = 0 and the Positive Cognition for the Target Memory is VOC<7: resume the Installation Phase. Follow procedural steps through Closure.

If the Target Memory is SUD=0, the Positive Cognition for the Target Memory is VOC=7 and the Body Scan was not clear: Go directly to Body Scan and complete.

Continue until Phases 4-6 are completed (SUD=0 VOC=7, clear Body Scan)

### **ONCE TARGET IS FULLY REPROCESSED**

Proceed to the next identified target within Treatment Plan to determine if the memory still needs to be targeted (due to generalization effect) and reprocess using Phases 3-8.

### **REEVALUATION BEFORE TERMINATION**

**Symptom Resolution:** Have the client’s symptoms been reduced or eliminated in a way that is ecological to the client?

**Comprehensive Treatment:** Evaluation of the overall progress on the main themes and to the extent that they have successfully integrated in the client’s current life context:

### **PAST**

- **Primary Events**

Primary events are the stand alone disturbing experiences reported during history-taking and over the course of treatment.

- **Past Events**

Hold each of the main Negative Cognitions in mind and scan for other unresolved memories.

Scan chronologically through life for other unresolved memories.

- **Progressions**

Other events may be disclosed during processing of a primary target. Clinical judgment may lead to returning to and reevaluating these memories.

- **Clusters**

Each cluster of related memories that were grouped together during treatment planning should be scanned to identify any memories that were not resolved through generalization of treatment effects.



- **Participants**

Significant individuals in client's life should be targeted to determine if memories or issues regarding them remain disturbing.

## **PRESENT**

- Target current conditions, situations, or people that continue to evoke avoidant or maladaptive behaviors or emotional distress.
- Address physical sensations and urges that can be residual sources of maladaptive patterns of response as a by-product of second-order conditioning.

## **FUTURE**

- Target and reprocess desired outcomes and potential challenges in the future
- Help the client optimize their ability to successfully integrate the positive changes from the reprocessing work by ensuring that they are able to apply these changes in their daily lives in a meaningful and productive way.

## COMPLETING THE TREATMENT PLAN

### GENERALLY, COMPLETE ONE TREATMENT PLAN SEQUENCE BEFORE ADDRESSING ANOTHER

#### Exceptions:

- Feeder memory emerges that is preventing completion of original targeting sequence
- Blocking belief arises that is preventing completion of original targeting sequence. 
- Current life stressors that require a temporary shift in focus.

### TREATMENT PLAN

#### Past

- Confirm that the original target (first or worst) has been reprocessed (SUD=0, VOC=7, clear body scan).
- Address the remaining (still disturbing) experiences identified during history or reprocessing.
- Reprocess each incident using Phases 3-8.

#### Present

- Target remaining present triggers having distress (SUD>0) using Phases 3-8.

#### Future Templates

- As each trigger is reprocessed (SUD=0, VOC=7, clear Body Scan), proceed with appropriate future templates.

## **REPROCESSING PRESENT TRIGGERS**

Second Step of Three-Pronged Protocol: Process current situations that cause the disturbance.

### **REPROCESS CURRENT SITUATIONS THAT RESONATE WITH PRESENTING PROBLEM THAT ARE STILL CAUSING DISTURBANCE, SUCH AS:**

- Current conditions, situations, or people that evoke avoidant or maladaptive behaviors or emotional disturbance
- Physical sensations and urges can be residual sources of avoidant or non-adaptive behaviors or emotional disturbance

### **TARGET AND REPROCESS PRESENT TRIGGERS IDENTIFIED**

- During History-Taking
- During Reprocessing
- During Reevaluation

### **IDENTIFY RECENT EVENTS THAT HAVE CAUSED THE SYMPTOMS (NEGATIVE EMOTIONS, SENSATIONS, BELIEFS, BEHAVIORS) TO EMERGE**

These recent/current situations have been identified during history-taking, and from client feedback over the course of treatment.

- Once the earlier events that set the foundation for the current disturbance have been reprocessed, most triggers will no longer be active.
- The reprocessing of the earlier events will have transformed the “traumas” into an adaptive learning experience, thus resolving the current triggers.
- Some triggers, however, will still be active because of second-order conditioning. That is, the stimuli in the present are now independently disturbing. The triggered distress may also be activating another memory network that has not been accessed yet. Therefore, a full generalization effect has not yet been achieved.
- These triggers will need to be targeted separately for complete resolution.

Assessing the recent/current events that have caused distress allow the client and clinician to evaluate whether it is still disturbing:

“Bring up the last time you remember feeling/behaving\_\_\_\_\_.”

If any disturbance remains, the full assessment procedures are applied and the experience is reprocessed to an adaptive resolution.

The recent situation (trigger) is reprocessed until the client feels no disturbance and the VOC is 7.

The Future Template is then applied for each trigger (e.g., imagining encountering the same situation in the future with an adaptive response on the part of the client).

## **FUTURE TEMPLATES**

### **Third Step of the Three-Pronged Protocol**

#### **GOALS**

To develop the client's repertoire of skills and strengthen their confidence by rehearsing future situations related to the presenting issue (complaint).

Address anticipatory anxieties as well as explore new, more adaptive patterns.

#### **AIP**

- Incorporate and strengthen positive memory networks including (imaginal) experiences of adaptive functioning

#### **PURPOSE**

- To develop templates of desired actions that are adaptive to the client's current life context
- To strengthen adaptive skill, behavior, emotional/sensory response within memory system
- To prepare client for adaptive response *in vivo*
- To reveal hidden fears, negative beliefs, and inappropriate responses
- Utilizes behavioral rehearsal (teach, model, visualize, feel)

#### **PROCEDURES**

- Explore how the client would like to be perceiving, feeling, acting, and believing in the present and into the future.
- Identify any additional education and/or skills the client might need and assist the client in learning these skills.
- Address each trigger with a future template after trigger has been successfully reprocessed.

Once the client has appropriate education (e.g., about assertiveness, social customs & norms, other skills), s/he is asked to imagine the optimal behavioral responses, along with an enhancing PC. The clinician then leads the client in successive sets of EMs to assist him/her in assimilating the information and incorporating it into a positive template for future action.

## **PROCEDURAL STEPS FOR INSTALLING FUTURE TEMPLATES**

### **INTRODUCTION**

*“We have worked on the past experiences relating to your issue, as well as the current situations that triggered your distress. Let’s now work on how you would like to be able to respond to similar situations in the future.”*

### **IDENTIFY DESIRED OUTCOMES**

#### Steps

1. Identify the future situation (identified previously as a recent experience or a present trigger) the client would like to have a more adaptive response to:

*“Identify a future situation and a positive belief (PC) you would like to have about yourself in that situation.”*

2. Run the movie

*“While holding the positive belief about yourself in mind, run the movie of the situation as you would like to be able to respond, from beginning to end. Let me know if there is any part or parts of the movie that are uncomfortable or challenging.”*

3. *“What are you noticing?”*

If client’s response is POSITIVE: run movie of adaptive response(s) adding sets of BLS as long as positive response is strengthening.

If client’s response is NEUTRAL, ask for clarification (lack familiarity, need for a plan). Generate with client desired response; run movie of desired response with sets of BLS until client has achieved a positive response.

If client’s response is NEGATIVE: focus on body sensations; add sets of BLS until client response is neutral. Elicit from client desired response and run movie with sets of BLS until client’s response is positive. Note: if negative associations open up, you may need to return to reprocessing.

3. Install PC (from recent experience/present trigger) to VOC=7

*“Hold your positive cognition with that situation. On a scale from 1-7, how true does it feel?”* Install to VOC of 7 with BLS.

## GENERATE CHALLENGE SITUATIONS

1. Create multiple scenarios where there is an unanticipated or undesirable outcome and generate an adaptive response:

*“I’d like you to think of a challenge situation that could occur.”*

2. *“What are you noticing?”*

Positive: add BLS sets as long as additional positives are reported.

Negative: focus on body sensation with BLS until sensations dissipate.

3. Install PC to VOC=7 with each situation.

## **RECENT TRAUMATIC EVENTS**

### **ADAPTIVE INFORMATION PROCESSING MODEL**

Recent traumatic events often have not had the time to fully consolidate on all levels. Therefore, it is necessary to target each aspect of the traumatic event separately. Each aspect of the event needs to be assessed for its own image, negative cognition, positive cognition, VOC, emotions, SUD, and body sensations.

### **PHASE ONE: HISTORY**

Obtain a narrative of the event

### **PHASE TWO: PREPARATION**

- Client selection
- EMDR education
- Mechanics
- Self-soothing strategy (Calm Place, container, breathing, etc.)

### **PHASE THREE: ASSESSMENT**

- Identify each “T” (Frame)
- Image, NC, PC, VOC, emotion, SUD, location of physical sensation for the worst part (if necessary). If not, start at the beginning of the event.

### **REPROCESSING SEQUENCE**

- Desensitization: Target and reprocess:
  - Worst part first (if necessary to avoid distraction)
  - Remaining event in chronological order
- Have client visualize the entire sequence of the event with eyes closed and reprocess any new disturbing frame as it arises-up through installation.
- Repeat until the entire event can be visualized from start to finish without disturbance

- Extended Installation Phase: Develop a representative positive cognition of the entire event and have client visualize the event from start to finish with eyes open and install positive cognition
- As an additional check, review the entire event with eyes closed with the PC to ensure that the VOC is at a 7 for the entire event. If not, target that part of the memory until VOC is 7.
- Body Scan
- Closure

### **THREE-PRONGED PROTOCOL**

- Reprocess all present triggers
- Apply future templates of desired response(s) for future scenarios

# **WORKING WITH CHILDREN USING EMDR**

## **Chapter 11 (Shapiro, 2001)**

### **APPROACH**

- Children respond very well to EMDR
- Reprocessing often more rapid with children
- Children do not appear to have as many complex memory networks
- Standard EMDR procedures may be used with developmentally appropriate modifications
- Use child-related psychotherapy interventions (art and play therapy, etc)

### **PHASE ONE: HISTORY-TAKING**

- Parents
- Counselors/foster care/case workers
- Child
- Comprehensive Treatment Plan
  1. EMDR Targeting Sequence
  2. Needed skills and education

### **PHASE TWO: PREPARATION**

- Eye movement
  - Fingers
  - Wands
  - Puppets
- Tactile
  - Mechanical devices
  - Patty-Cake
  - Butterfly Hug
- Tones
  - Music
  - Mechanical devices
- Safe Place-real or imagined

### **PHASE THREE: ASSESSMENT**

- Image
  - Drawings
  - Sand tray
  - Puppets/toys
- Cognitions (NC and PC)
  - Developmentally appropriate
  - Faces (HAP Card)
- VOC Measurements
- Emotions
  - Faces
- SUD
  - Scales
  - Faces
- Body Location

### **PHASE FOUR: DESENSITIZATION**

- Reprocessing
  - Targets
  - Channels of association
  - Storytelling 
  - Emotional response
  - SUD

### **PHASE FIVE: INSTALLATION**

- Developmentally appropriate
- Faces
- Scales

### **PHASE SIX: BODY SCAN**

- Developmentally appropriate

## **PHASE SEVEN: CLOSURE**

- Safe Place
- Stabilizing
- Closure statement

Child  
Parents/counselors, etc.

## **PHASE EIGHT: REEVALUATION**

- Changes
- Behaviors

## **THREE-PRONGED PROTOCOL**

# APPENDIX

## **CERTIFICATE OF COMPLETION**

**THE EMDR INSTITUTE WILL SEND A CERTIFICATE OF COMPLETION UPON RECEIPT OF CONSULTATION SIGN OFF FORMS (WITH ALL 10 HOURS SIGNED)**

- 5 Consultation hours must be from an EMDR Institute Facilitator prior to Weekend 2 and 5 hours post Weekend 2
- Consultation may be one-on-one or in a group setting
- Consultation may be face-to face or by telephone

**IT IS REQUIRED TO RECEIVE 5 HOURS OF CONSULTATION PRIOR TO ATTENDING WEEKEND 2 OF THE INSTITUTE BASIC TRAINING AND 5 HOURS POST WEEKEND 2**

## **FINDING AN EMDR INSTITUTE APPROVED CONSULTANT**

- A listing of EMDR Institute facilitators/approved consultants by state and specialty is included in the back of this training manual.
- EMDR Institute web site: [www.emdr.com](http://www.emdr.com) Put in ONLY the state and then do a search. The facilitators will appear first on the listing.

## **EMDRIA (EMDR International Association) CERTIFICATION**

- After completion of the Basic Training (completion of Weekend 1 and 2 + 10 hours of case consultation), trainees are eligible to become EMDRIA certified. See [www.emdria.org](http://www.emdria.org) for further details
- For a listing of EMDRIA approved consultants providing certification visit [www.emdria.org](http://www.emdria.org)

## **CONSULTATION FOR BASIC TRAINING** **Participant Guidelines**

### **THE PURPOSE OF EMDR BASIC TRAINING CONSULTATION**

- To enhance your understanding and skills in using EMDR.
- To support you as you begin to apply EMDR in your clinical setting.

We want you to be comfortable using these skills by the end of your basic training. During the first five hours of consultation, and before returning for Weekend 2, your consultant will work with you to help you achieve the specific objectives listed on the following Skills Checklist and those listed on the Consultation for Basic Training-Consultant Guidelines. We ask that both you and your consultant assess your progress in these areas. **Give the Consultant Guidelines and Skills Checklist to your consultant.**

Since consultation is a new addition to EMDR training, we want to evaluate its usefulness in our program. **Please fill out and send or fax the following Evaluation and Consultation Sign-Off Form to the EMDR Institute.** We want consultation to be as productive and beneficial as possible. Your feedback and self-evaluation will determine what is most helpful in understanding and learning to use EMDR effectively.

### **FINDING AN EMDR INSTITUTE FACILITATOR/CONSULTANT:**

Please refer to Consultation Listing in the back of this manual for a facilitator. Also, go to <http://www.emdr.com/clinic.htm> and put in ONLY the state, then do a search. All facilitators will be listed first in each state.

### **SUGGESTIONS FOR FINDING A FACILITATOR/CONSULTANT:**

- PLEASE NOTE: The required 10 of hours of case consultation to complete the Basic Training must be with an EMDR Institute Facilitator. All approved Facilitators are EMDRIA approved consultants.
- Speak to the facilitators at the training about availability for group or individual consultation
- Call the EMDR Institute office (831-761-1040) for a list of facilitators who are doing affordable group consultation by phone and/or face to face

### **CERTIFICATE OF COMPLETION:**

A Certificate of Completion indicating completion of the EMDR Basic Training will be sent to you upon receipt of both Consultation Sign Off and Evaluation Forms (one is in this manual and you will receive another one in the Weekend 2 manual). All 10 hours of consultation are required to receive the certificate. In addition, upon completion of the Basic Training, which includes the 10 hours, you will be listed on the EMDR Institute Website Referral Listing.

**EVALUATION AND CONSULTATION SIGN-OFF FORM**

**Please return or fax this signed form to the EMDR Institute  
PRIOR to attending Weekend 2 of the Basic Training**

**EMDR Institute  
PO Box 750 Watsonville CA 95077  
Phone: 831-761-1040 Fax: 831-761-1204**

Name of Consultee (Please print): \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_

email: \_\_\_\_\_

Date and Location of Weekend 1 \_\_\_\_\_

Name of Consultant (Please print): \_\_\_\_\_

Consultant Phone Number: \_\_\_\_\_

**CONSULTATION SESSIONS:**

| <b>DATE</b>      | <b># of Hours</b> | <b>CONSULTANT SIGNATURE</b> |
|------------------|-------------------|-----------------------------|
| 1 ____/____/____ | _____             | _____                       |
| 2 ____/____/____ | _____             | _____                       |
| 3 ____/____/____ | _____             | _____                       |
| 4 ____/____/____ | _____             | _____                       |
| 5 ____/____/____ | _____             | _____                       |

**CONSULTEE:** When you have completed at least 5 hours of consultation, please evaluate your consultation experience with your consultant.

**Rate the following from 1 (least) to 5 (most).** Thank you for your feedback.

- \_\_\_ Usefulness of consultation in attaining the stated goals    1 2 3 4 5
- \_\_\_ Your confidence in using EMDR with your clients            1 2 3 4 5
- \_\_\_ Consultation increased that confidence                        1 2 3 4 5

Your suggestions to improve this aspect of the program:

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# **PARTICIPANT SKILLS CHECKLIST**

**SCALE: 1=Not at all confident 3=Somewhat confident 5=Totally confident**

## **Knowledge of the Adaptive Information Processing Model**

Able to describe the AIP model

## **Three-Pronged Protocol**

Able to describe the three-pronged protocol

Able to apply all 8 phases of EMDR

Completes all 3 prongs in history-taking, target sequencing, and reprocessing

## **Case Conceptualization and Treatment Planning**

Able to conceptualize and discuss a case using the AIP

Has submitted \_\_\_\_\_ Treatment Summary Forms from clinical cases

## **Eight-Phases of EMDR Treatment**

**1. History-Taking.** In addition to an appropriate general history, you should be able to:

Obtain a history informed by the AIP model

Determine if client meets EMDR selection criteria

Conceptualize the case within the AIP model

Determine target sequencing and appropriate target selection

Identify a Touchstone Memory that relates to the client's problem

**2. Preparation**

Able to introduce EMDR to your client

Able to prepare your client for treatment with EMDR

**3. Assessment**

Obtain an appropriate image (sound, smell, etc.)

Identify the central Negative Cognition (NC)

Identify the Positive Cognition (PC)

Rate the PC on the Validity of Positive Cognition (VOC)

Obtain the associated emotions

Appropriately rate the SUD

Obtain the location of the sensations in the body

**4. Desensitization** You should be able to:

Begin correctly with the Image, NC, and location of sensation

Maintain good mechanics with BLS

Use appropriate speed and length of set

Avoid distortions (for example, talking and/or interpreting)

Return to the target appropriately

Respond appropriately to abreactions

Manage under and over accessing of material

Appropriately ask for a SUD rating

Determine when desensitization phase is complete (SUD=0)

**5. Installation** You should be able to:

Check the PC to see if still fits

Pair PC with the target image

Continue BLS as long as positive material continues to emerge or strengthen

Identify and address any blocking belief

Continue installation until VOC 7 or ecological

**6. Body Scan**

Able to introduce body scan and reprocess any unresolved sensations

Continue until clear body scan

**7. Closure**

Able to close a complete session

Able to appropriately close an incomplete session

**8. Reevaluation**

Able to re-evaluate the target memory at the beginning of each subsequent session and make appropriate determination about next step (continue reprocessing or move to next target).

## **CONSULTATION FOR BASIC TRAINING**

### **Consultant Guidelines**

The purpose of consultation during EMDR Basic Training is to enhance the trainees' understanding and skills in using EMDR, and to support them as they begin to use EMDR in a clinical setting. These guidelines can be used to focus consultation on the topics that should be addressed before Weekend 2 of training, and reviewed before completion of Basic Training. It can be used to highlight teaching points, common errors, and to provide specific feedback to trainees in areas that may still need more attention. This should be done in a supportive and collaborative spirit that will help trainees meet the training goals of the first weekend of training.

During the first 5 hours of consultation, the trainee should be working towards a good understanding of the Adaptive Information Processing Model, application of AIP to case conceptualization, and have a working knowledge of the basic 8 phases and the three-pronged protocol.

Trainees will have the Participant's version of this checklist from the training manual, including an embedded evaluation of the consultation process. Please use their checklist to develop their skills and understanding and to assess their progress. This checklist can also track continued progress during consultation following the 2nd weekend of training.

**Please work with participants to complete their self-assessment checklist and evaluation of consultation. Have them return it to the EMDR Institute. They will need documentation of five hours of consultation prior to returning for Weekend 2. You may verify this by your signature on the Evaluation and Consultation Sign Off Form (Consultee received form in the Weekend 1 manual). If you are interested in group consultation (phone or face to face) for an affordable fee for each participant, please contact the EMDR Institute at 831-761-1040 for more information.**

**Thank you for your help in making consultation as productive and beneficial as possible.**

# **SKILLS CHECKLIST FOR CONSULTANT**

**SCALE: 1=Not at all confident 3=Somewhat confident 5=Totally confident**

## **Knowledge of the Adaptive Information Processing Model**

\_\_\_ Able to describe the AIP model

## **Three-Pronged Protocol**

\_\_\_ Able to describe the three-pronged protocol

\_\_\_ Completes all 3 prongs in history, target sequencing, and reprocessing

## **Case Conceptualization and Treatment Planning**

\_\_\_ Able to conceptualize and discuss a case using the AIP

\_\_\_ Has submitted \_\_\_ Treatment Summary Forms from clinical cases

## **Eight-Phases of EMDR Treatment**

### **1. History-Taking.** In addition to an appropriate general history, trainee is able to:

\_\_\_ Obtain and organize trauma history

\_\_\_ Determine if client meets selection criteria

\_\_\_ Conceptualize the case within the AIP model

\_\_\_ Determine target sequencing and appropriate target selection

\_\_\_ Identify the Touchstone Memory

### **2. Preparation**

\_\_\_ Able to introduce EMDR to client

\_\_\_ Able to prepare client for treatment with EMDR

### **3. Assessment**

\_\_\_ Obtain appropriate image (sound, smell, etc.)

\_\_\_ Identify the central Negative Cognition

\_\_\_ Identify the Positive Cognition

\_\_\_ Rate the Positive Cognition on the Validity of Positive Cognition (VOC)

\_\_\_ Obtain the relevant emotions

\_\_\_ Appropriately rate the SUD

\_\_\_ Obtain the location of the sensations in the body

### **4. Desensitization** Trainee is able to:

\_\_\_ Begin correctly with the Image, NC, and location of sensation

\_\_\_ Maintain good mechanics with BLS

\_\_\_ Use appropriate speed and length of set

\_\_\_ Avoid distortion (for example, by talking and/or interpreting)

\_\_\_ Return to the target appropriately

\_\_\_ Respond appropriately to abreactions

\_\_\_ Manage under and over accessing of material

\_\_\_ Appropriately ask for a SUD rating

\_\_\_ Determine when desensitization phase is complete (SUD=0)

### **5. Installation** Trainee:

\_\_\_ Checks Positive Cognition (PC) to see if still fits

\_\_\_ Is able to pair PC with the target image

\_\_\_ Continue BLS as long as positive material continues to emerge or strengthen

\_\_\_ Identify and address any blocking belief

\_\_\_ Continue installation until VOC 7 or ecological

### **6. Body Scan**

\_\_\_ Able to introduce body scan and reprocess any unresolved sensations

\_\_\_ Continue until clear body scan

### **7. Closure**

\_\_\_ Able to appropriately close an incomplete session

\_\_\_ Able to close an incomplete session

### **8. Reevaluation**

\_\_\_ Able to re-evaluate the target memory at the beginning of each subsequent session and make appropriate determination about next step (continue reprocessing or move to next target)

## **WEEKEND 1 FORMS FOR CLINICAL PRACTICE**

**THESE FORMS CAN BE DUPLICATED FOR USE**

**Client Selection Criteria Checklist**

**History-Taking and Treatment Planning Worksheet**

**Preparation Phase Checklist**

**Developing a Calm/Safe Place**

**Target Memory Assessment and Reprocessing Worksheet**

**Treatment Session Summary Notes**

**Reevaluation Phase Questionnaire**

**Procedural Steps for Installing Future Templates**

**Treatment Planning Considerations**

## **CLIENT SELECTION CRITERIA CHECKLIST**

**(A clinical checklist or worksheet to be used with clients in the office)**

- OK** Has been addressed and is favorable for EMDR use
- P** Problem: Wait until after Weekend 2 (or other) training or until further preparation and stabilization have occurred
- C** Consultation indicated with EMDR clinician with experience and expertise in the indicated area

### **CLINICAL CONCERNS**

#### **CLIENT STABILITY/ABILITY TO MANAGE STRESS**

**OK**    **PROBLEM**    **CONSULTATION**

Client has been screened for Dissociative Disorder. DD rules out use of EMDR by Weekend 1-trained clinicians. See *Clinical Signs of Dissociative Disorders and DES* in Appendix. In addition to a Mental Status Exam, the DES should be used for every client. Special preparation for DD clients is needed to stabilize and lay the groundwork for reprocessing memories with the ability to maintain dual awareness.

- Years of unsuccessful psychotherapy
- Depersonalization and/or derealization
- Memory lapses
- Flashbacks and intrusive thoughts
- Somatic symptoms

Secondary gain issues identified and appropriately addressed.

Clinician and client have considered severity of issues which may be activated based on history and clinical assessment.

#### **ACUTE PRESENTATIONS**

**OK**    **PROBLEM**    **CONSULTATION**

**The following situations require caution and case consultation:**

- Life threatening substance abuse
- Serious suicide attempts
- Self-mutilation
- Serious assaultive behavior
- Dissociative disorders

#### **STABILIZATION**

OK   PROBLEM   CONSULTATION

- Adequate stabilization/self-control strategies in place
- Client must have a workable means of dissipating disturbance if necessary during or between sessions
- Client has adequate life supports (friends, relatives, etc.)
- Systems/issues that might endanger client have been addressed
- Client able to call for help if indicated

**MEDICAL CONSIDERATIONS**

OK   PROBLEM   CONSULTATION

- General physical health/medical condition/age considered (possible exacerbation with stress)
- Medications
- Inpatient if necessary to manage danger to client or others
- Eye pain contraindicates EMs until cleared by physician (use alternate forms of stimulation)
- Any neurological impairment or physical complication inappropriate for Weekend 1/Part 1 clinicians

**TIMING CONSIDERATIONS/READINESS**

OK   PROBLEM   CONSULTATION

- Timing of life events (projects, demands, work schedules, etc)
- Availability of both therapist and client for support and/or follow-up
- Willingness/ability to continue treatment as indicated
- 90 minute sessions (if possible).

## History-Taking and Treatment Planning Worksheet

### PRESENTING ISSUE:

*“Let’s talk about the issue we have decided to work on. Tell me more about it.”*

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### RECENT EXAMPLE OF PRESENTING ISSUE:

*“What recent experience have you had that represents this issue?”*

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*“What other recent experiences have you had that represents this issue?”*

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### PAST EXPERIENCES:

You can use direct questioning or the Float back technique, as scripted below to identify the past experiences associated with the client’s current difficulties. Use the worst experience from the recent events described above:

*“As you focus on this recent experience, what is the image that represents the worst part for you as you think about it now?”*

*“What negative belief are you having about yourself?”*

*“What are the emotions?”*

*“What are the sensations?”*

*“Focus on the image, the negative belief about yourself, the emotions and sensations you’re experiencing right now, and just let your mind float back to an earlier time when you may have felt this way before and just notice what comes to mind...”*

Repeat Float back instructions using each experience the client identifies until they can’t access any more associations. Identify the first and worst experiences in the memory network. Write them down (next page).

**Experiences**

**Age**

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**PRESENT TRIGGERS:**

*“Are there other situations, people or places in your life now that bring up these negative reactions?”*

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**FUTURE TEMPLATE(S):**

*“How would you like to be able to handle these situations (present triggers) in the future?”*

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**DOMINANT INFORMATIONAL PLATEAU FOR THIS SEQUENCE (Circle One):**

Responsibility/Defectiveness

Safety/Vulnerability

Power/Control (Choices)

**POSSIBLE NEGATIVE/POSITIVE BELIEFS:**

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**TARGETING PLAN:**

Target memory selected for the first reprocessing session:

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Circle One: Touchstone Memory      Worst      Other Past Experience

Cue Word/Phrase for Calm/Safe Place \_\_\_\_\_

**(SHIFT CLIENT'S FOCUS TO SAFE PLACE TO BRING CLOSURE)**

## **PHASE TWO: PREPARATION CHECKLIST**

Check  when completed:

### **EMDR Seating Position**

- Seating arrangement (ships passing)

### **Eye Movements**

- Comfortable distance from client's face
- Comfortable speed (horizontal EMs)
- Alternative directions (- / \)

### **Alternative Bilateral Stimulation (to be used only if necessary)**

- Tapping
- Auditory

### **Explanation of EMDR**

- AIP/REM

*"When a disturbing event occurs, it can get locked in the brain with the original picture, sounds, thoughts, feelings and body sensations, EMDR seems to stimulate the information and allows the brain to reprocess the experience. That may be what is happening in REM or dream sleep--the eye movements (tones, tactile) may help to reprocess the unconscious material. It is your own brain that will be doing the healing and you are the one in control."*

### **Client Stability/Coping Strategies**

- Metaphor (train/video)

*"In order to help you 'just notice' the experience, imagine riding on a train or watching a video and the images, feelings, thoughts, etc., are just going by."*

- Stop signal

## **DEVELOPING AND ENHANCING A CALM/SAFE PLACE**

Use other coping skills if more appropriate (container, focus, courage, etc.)

### **IMAGE**

*"I'd like you to think about some place you have been or imagine being that feels very calm or safe. Perhaps being on the beach or sitting by a mountain stream. What image represents your place?"*

### **EMOTIONS AND SENSATIONS**

*"As you think of that calm/safe place, notice what you see, hear, and feel right now. What do you notice?"*

### **ENHANCEMENT**

*"Focus on your calm/safe place--its sights, sounds, smells, and body sensations. Tell me more about what you are noticing."*

### **EYE MOVEMENTS**

*"Bring up the image of that place. Concentrate on where you feel the pleasant sensations in your body and allow yourself to enjoy them. Concentrate on those sensations and follow my fingers. (4-8 slow BLS) How do you feel now?"*

#### **If positive**

*"Focus on that. (BLS) What do you notice now?"*

#### **If negative**

Redirect to identify another calm place or consider some other self-soothing strategy such as a container, mindfulness, or a breathing exercise.

### **CUE WORD**

*"Is there a word or phrase that represents your safe place? Think of \_\_\_\_\_ and notice the positive feelings you have when you think of that word. Concentrate on those sensations and the word \_\_\_\_\_ and follow my fingers. (4-8 BLS) How do you feel now?"*  
Repeat and enhance positive feelings with BLS several times.

### **SELF-CUING**

*"Now I'd like you to say that word \_\_\_\_\_ and notice how you feel."*

### **CUING WITH DISTURBANCE**

*"Now imagine a minor annoyance (SUD 1-2) and how you feel. Bring up that word \_\_\_\_\_ and notice any shifts in your body. What did you notice?"*

### **SELF-CUING WITH DISTURBANCE**

*"I'd like you to think of another mildly annoying incident (SUD 2-3), notice how you feel, then bring up that word \_\_\_\_\_ by yourself, especially noticing any changes in your body when you focus on your cue word."*



#### **PHASE FOUR: DESENSITIZATION: Processing and checking for new channels:**

*"I'd like you to bring up that picture, those negative words (repeat the negative cognition), and notice where you are feeling it in your body—and follow my fingers." (BLS generally 20 or more passes/customized to need of client).*

**A. REPROCESS:** *"Take a breath, let it go, what are you noticing now? Go with that." (BLS generally 20 or more passes/customized to need of client).*

Repeat: *"Take a breath; let it go, what are you noticing now? Go with that." (BLS generally 20 or more passes/customized to need of client) as long as client reports change or new information (as many sets of BLS as necessary) until the client stops reporting change for two consecutive sets of BLS, then ask (B).*

**B. BACK TO TARGET:** *"When you go back to the original experience, what are you noticing now? (Pause). Go with that." (BLS generally 20 or more passes/customized to need of client).*

Repeat: *"Take a breath; let it go, what do you notice now? Go with that." (BLS generally 20 or more passes/customized to need of client) as long as client reports change or new information (as many sets of BLS as necessary)*

When the client goes back to target for two consecutive sets of BLS and still reports no change check SUD (see C below).

#### **C. CHECK SUD:**

*"When you bring up the incident, on a scale of 0 to 10, where 0 is no disturbance and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now? (Pause for a response). Go with that." (BLS generally 20 or more passes/customized to need of client).*

If SUD is 1 or 2, ask, *"Where do you feel it in your body? Go with that." (BLS)*

REPEAT Steps A, B, and C until SUD is 0 (or ecologically sound).

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#### **PHASE FIVE: Installation:**

Linking the desired positive cognition with the original memory/experience:

1. *"Do the words (repeat the PC) still fit, or is there another positive statement that feels more suitable to you?"*
  2. *"Think about the memory and the words (repeat the selected PC). From 1 (completely false) to 7 (completely true), how true do they feel?"*
  3. *"Hold them together." Do BLS.*
  4. *"On a scale of 1 to 7, how true do those words (PC) \_\_\_\_\_ feel to you now?"*
  5. Continue installation as long as the material is becoming more adaptive. Continue sets of BLS until the VOC no longer strengthens. Once the VOC=7 (or ecological), go to Phase 6: Body Scan.
  6. If client reports a 6 or less, check appropriateness and address blocking belief (if necessary) with additional reprocessing.
- 

#### **PHASE SIX: Body Scan:**

*"Close your eyes and keep in mind the original incident and the (repeat the selected positive cognition). Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness or unusual sensation, tell me." If any sensation is reported, do BLS. If a positive/comfortable sensation, do BLS to strengthen the positive feeling. If a sensation of discomfort is reported—reprocess until discomfort subsides.*

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#### **PHASE SEVEN: Closure: Procedure for closing unfinished sessions:**

An unfinished session is one in which a client's material is still unresolved, i.e., s/he is still obviously upset or the SUD has not gone down to 0 or the VOC has not gone up to 7, or you have not had time to complete the Body Scan. The following is a procedure for closing down an unfinished session. The purpose is to acknowledge clients for what they have accomplished and for them to feel grounded before they leave the office.

##### **Steps:**

1. Give the client the reason for stopping. *"We are almost out of time and we will need to stop soon." Give encouragement and support for the effort made. "You have done some very good work and I appreciate the effort you have made. How are you doing?"*
2. Offer a relaxation or a container exercise. *"I would like to suggest we do a relaxation exercise before we stop. I suggest we \_\_\_\_\_" (can suggest Imagery, Safe Place, Light Stream, or a container to put unprocessed material in).*
3. Read the Closure/Debriefing the Experience section to the client.

##### **Closure: Debrief the experience**

*"The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If so, just notice what you are experiencing; make a note of it in your log (what you are seeing, feeling, thinking, sensing, and the trigger on the TICES grid). Use the Safe Place exercise to help manage your disturbance. Remember to use a relaxation technique daily. We can work on this new material next time. If you feel it necessary, call me."*

**TREATMENT SESSION SUMMARY NOTES**  
For Record-keeping Purposes

**CIRCLE APPROPRIATE ITEMS**

**NAME** \_\_\_\_\_ **DATE** \_\_\_/\_\_\_/\_\_\_

**PRESENTING ISSUE:**

\_\_\_\_\_

**TARGET:** Touchstone Memory    Past    Present Trigger    Future Template

Target Status now:            Completed            Unfinished

**Stabilization Exercise** used at the end of the session?

Safe Place    Light Stream    Breathing    Other \_\_\_\_\_

**Client Stabilization Status** when leaving session:

Poor            Fair            Good            Excellent

**Treatment Summary Notes:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Issues/associations of importance that arose during reprocessing to be reevaluated at later time:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## **PHASE EIGHT: REEVALUATION**

### **TREATMENT PLAN (Global)**

*“Tell me what you have noticed that is different in your life since our last session.”*

*“Any changes in how you respond to the issue we have been working on?”*

*“Any new insights?”*

*“Any dreams?”*

*“Changes in behavior?”*

*“Changes in your symptoms?”*

### **TARGET (Memory Specific)**

*“Now as you think about the incident (target) we focused on during our last session, what are you noticing now?”*

*“What has changed or is different about the incident now?”*

*“Any new insights or thoughts?”*

*“Any new connections?”*

*“When you think of the incident now, on a scale from 0-10, how disturbing is it now?”*

(Check client’s Treatment Plan to determine how to best proceed)

## TREATMENT PLANNING CONSIDERATIONS

### TREATMENT PLAN

- **Original target memory is complete (SUD=0, VOC=7, clear Body Scan)**
- 2. **Check remaining experiences identified during History-Taking as well as associations that emerged during reprocessing:**
  - a. **Past**  
Reprocess past experiences that are still disturbing  
Apply standard procedures for Phases 3-8 until fully reprocessed
  - b. **Present**  
Reprocess present triggers that are still disturbing  
Apply standard procedures Phases 3-8 for each trigger that did not generalize from reprocessing past experiences
- 3. **Future Templates**  
As past experiences and present triggers are resolved, proceed to developing and installing Future Templates.

### UNFINISHED TARGET MEMORY REEVALUATION (SUD>0)

1. **SUD>0:** Procedures for restarting an unfinished target memory:
  - Memory:** *“Bring up the memory we have been working on. What is the image that represents the worst part of it as you think about it now?”*
  - Emotions:** *“What emotions are you experiencing now?”*
  - SUD:** *“On a scale from 0-10, how disturbing is it?”*
  - Body Location:** *“Where do you feel it in your body?”*
  - Reprocessing:** Go to Desensitization page to continue reprocessing from previous session.
2. **If the Target Memory is a SUD = 0 and the Positive Cognition for the Target Memory is VOC<7:** Go directly to Phase 5 in your Assessment and Reprocessing Worksheet for resuming the Installation Phase. Follow procedural steps through Closure.
3. **If the Target Memory is SUD=0, the Positive Cognition for the Target Memory is VOC=7 and the Body Scan was not clear:** Go directly to Body Scan and complete.

# **PROCEDURAL STEPS FOR INSTALLING FUTURE TEMPLATES**

## **INTRODUCTION**

*“We have worked on past experiences relating to your issue, as well as the present situations that triggered your distress. Let’s now work on how you would like to be able to respond to similar situations in the future.”*

## **IDENTIFY DESIRED OUTCOMES**

### Steps

1. Identify the future situation (identified previously as a recent experience or a present trigger) the client would like to have a more adaptive response to:

*“Identify a future situation and a positive belief (PC) you would like to have about yourself in that situation.”*

2. Run the movie

*“While holding the positive belief about yourself in mind, run the movie of the situation as you would like to be able to respond, from beginning to end. Let me know if there is any part or parts of the movie that are uncomfortable or challenging.”*

3. *“What are you noticing?”*

If client’s response is POSITIVE: run movie of adaptive response(s) adding sets of BLS as long as positive response is strengthening.

If client’s response is NEUTRAL, ask for clarification (lack familiarity, need for a plan). Generate with client desired response; run movie of desired response with sets of BLS until client has achieved a positive response.

If client’s response is NEGATIVE: focus on body sensations; add sets of BLS until client response is neutral. Elicit from client desired response and run movie with sets of BLS until client’s response is positive. Note: if negative associations open up, you may need to return to reprocessing.

3. Install PC (from recent experience/present trigger) to VOC=7

*“Hold your positive cognition with that situation. On a scale from 1-7, how true does it feel?”* Install to VOC of 7 with BLS.

## GENERATE CHALLENGE SITUATIONS

1. Create multiple scenarios where there is an unanticipated or undesirable outcome and generate an adaptive response:

*“I’d like you to think of a challenge situation that could occur.”*

2. *“What are you noticing?”*

Positive: add BLS sets as long as additional positives are reported.

Negative: focus on body sensation with BLS until sensations dissipate.

3. Install PC to VOC=7 with each situation.

## **GLOSSARY OF EMDR TERMS**

### **EMDR Psychotherapy Approach**

Problems/issues are viewed as based in unprocessed physiologically stored memories impacting present thoughts, emotions, and behaviors.

### **Adaptive Information Processing**

The distinct information processing model that represents the cornerstone of the EMDR approach to psychotherapy and guides clinical practice.

### **Bilateral Stimulation (BLS)**

Eye movement, tapping or auditory alternating stimulus used as dual attention stimuli (external focus) as client simultaneously focuses on some aspect of the internal experience.

### **Channels of Associations**

Events, thoughts, emotions, etc., within the targeted memory network that spontaneously arise during reprocessing of the identified target (Touchstone Memory and/or node).

### **Eight Phases**

History, Preparation, Assessment, Desensitization, Installation, Body Scan, Closure, Reevaluation.

### **Negative Cognition (NC)=Negative Belief**

Negative belief of self associated with inadequately processed, maladaptively stored negative experiences.

### **Node**

The focused upon memory (Target) that represents the dysfunctional ( inadequately processed) memory within the Treatment Plan.

### **Original Target**

The selected memory/node that is the focus of the Assessment Phase, and out of which channels of associations from other relevant experiences emerge.

### **Positive Cognition (PC) = Positive Belief**

Positive belief is a more adaptive belief about the self that is identified in relation to the negative belief which is associated with the maladaptively stored negative memory/experience.

### **State Change**

Temporary shift in one's emotional state facilitated by a change in focus of attention. Example: use of safe place to shift from a state of relative distress to a state of calm.

### **Set**

20 or more round trip passes of eye movements or other forms of bilateral stimulation (taps, tones) generally used for most clients during reprocessing. Slower & shorter sets of 6-8 are used only during Preparation Phase for establishing Calm/Safe Place.

### **Subjective Units of Disturbance Scale (SUD 0-10)**

Scale used to measure the level of distress associated with a memory where 0 is no disturbance/neutral and 10 is the highest disturbance/distress.

### **Target**

Term used for the incident focused upon for reprocessing within the agreed upon treatment plan (Target focused upon during the Assessment Phase).

### **Back to Target**

Having the client redirect their focus of attention to the original memory/experience.

### **Three-Pronged Protocol**

Past Events, Present Triggers, and Future Templates – components of the EMDR approach to psychotherapy that ensures comprehensive EMDR treatment effects.

### **Touchstone Memory**

The earliest memory or experience a client can identify that represents the formation of the maladaptively stored memory network.

### **Trait Change**

Indicates a characteristic pattern of response that is permanently changed (versus a temporary shift in one's experience due to the application of an effective coping strategy).

### **Validity of Cognition Scale (VOC 1-7)**

Measurement of how valid or true the positive belief (PC) feels as one focuses on the target memory where 1 feels completely false and 7 feels completely true.

## OVERVIEW OF THE EIGHT PHASES OF EMDR TREATMENT

### EMDR Therapy and the Three-Pronged Protocol of Past, Present & Future

| <b>Phase</b>                  | <b>Purpose</b>   | <b>Procedures</b>  |
|-------------------------------|--|--|
| Phase One<br>Client History   | <ul style="list-style-type: none"> <li>Obtain background information</li> <li>Identify suitability for EMDR treatment</li> <li>Identify processing targets from positive and negative events in client's life</li> </ul>                                   | <ul style="list-style-type: none"> <li>Administer standard history-taking questionnaires and diagnostic psychometrics</li> <li>Review of criteria and resources</li> <li>Ask questions regarding (1) past events that have laid the ground-work for the pathology, (2) current triggers, and (3) future needs</li> </ul> |
| Phase Two<br>Preparation      | <ul style="list-style-type: none"> <li>Prepare appropriate clients for EMDR processing of targets</li> <li>Stabilize and increase access to positive states: (Calm/Safe Place)</li> </ul>  | <ul style="list-style-type: none"> <li>Educate regarding the symptom picture</li> <li>Teach metaphors and techniques that foster stabilization and a sense of personal self-mastery and control</li> </ul>   |
| Phase Three<br>Assessment     | <ul style="list-style-type: none"> <li>Access the target for EMDR processing by stimulating primary aspects of the memory</li> </ul>   | <ul style="list-style-type: none"> <li>Elicit the image, negative belief currently held, desired positive belief, current emotion, and physical sensation and baseline measures</li> </ul>   |
| Phase Four<br>Desensitization | <ul style="list-style-type: none"> <li>Process experiences toward an adaptive resolution (0 SUD level)</li> <li>Fully process all channels to allow a complete assimilation of memories</li> <li>Incorporate templates for positive experiences</li> </ul> | <ul style="list-style-type: none"> <li>Use standardized EMDR interactive procedures allowing the spontaneous emergence of insights, emotions, physical sensations and other memories</li> <li>Use "Cognitive Interweave" to open blocked processing by elicitation of more adaptive information</li> </ul>               |
| Phase Five<br>Installation    | <ul style="list-style-type: none"> <li>Increase connections to positive cognitive networks</li> <li>Increase generalization effects within associated memories</li> </ul>  | <ul style="list-style-type: none"> <li>Identify the best positive cognition (initial or emergent)</li> <li>Enhance the validity of the desired positive belief to a 7 VOC</li> </ul>   |
| Phase Six<br>Body Scan        | <ul style="list-style-type: none"> <li>Complete processing of any residual disturbance associated with the target</li> </ul>   | <ul style="list-style-type: none"> <li>Concentration on and processing of any residual physical sensations</li> </ul>  |
| Phase Seven<br>Closure        | <ul style="list-style-type: none"> <li>Ensure client stability at the completion of an EMDR session and between sessions</li> </ul>  | <ul style="list-style-type: none"> <li>Use of guided imagery or self control techniques if needed</li> <li>Brief regarding expectations and behavioral reports between sessions</li> </ul>   |
| Phase Eight<br>Reevaluation   | <ul style="list-style-type: none"> <li>Evaluation of treatment effects</li> <li>Ensure comprehensive processing over time</li> </ul>   | <ul style="list-style-type: none"> <li>Explore what has emerged since last session</li> <li>Reaccess memory from last session</li> <li>Evaluation of integration within larger social system</li> </ul>  |

## ANSWERS TO PROCEDURAL STEPS QUESTIONS

1. You complete your first set of BLS, then say:

*“Take a deep breath, let it go. What do you notice now? \_\_\_\_\_.  
Go with that.”*

**Teaching points:** Be generic in your initial questioning not mentioning “feeling” or “thinking” because that may shift client’s focus from what s/he is noticing.

2. After a set of BLS, ask client what s/he notices. If he reports something entirely different from the original incident, say: *“Go with that.”* Add set of BLS.

**Teaching points:** Reprocessing may bring up associated channels. Reprocessing does not have to stay on the original target.

*“Let whatever happens, happen; there are no suppose to’s.”*

3. Client reports nothing new or distressing after two consecutive sets of BLS.

Go back to the Target Memory. Ask: *“When you think of original experience, what do you notice now?”* Wait for client’s response. Add set of BLS.

**Teaching points:** Is likely the end of a channel where client is not making additional linkages to the original target memory. Clinician needs to bring client back to target in order to access the next channel of associations or begin closure of desensitization phase.

4. Client begins crying and having more vivid images of the past experience.

Continue with BLS until intense emotional response subsides. Maintain dual awareness. Be more actively encouraging and supportive. Remind client of distancing metaphor if needed. Assess for the need for additional interventions.

**Teaching points:** Client is having an intense emotional response; discharging stored affect or processing experience for the first time. Client has a stop signal if they need to stop.

5. Client continues to cry and gives you his/her stop sign. What do you do? Stop. How? Re-orient her to the present moment by talking and making contact with the client.

**Teaching points:** Always honor the stop signal. Reorient then stabilize. Ask client what is going on that makes them want to stop. Inquire as to what they might need. Options: resume reprocessing, take a break or stop for this session. Redirect client to Calm/Safe Place without BLS.

**Teaching points:** Always respect client. Some clients only need a breather. Others may have gone as far as they can for this session; use state-shift interventions to bring closure to the session until next time.

6. Client reports SUD of 1. Ask, *“Where do you feel it in your body?”*

**Teaching points:** The body sensations need more time than other components.

7. When desensitization is complete (SUD=0), what is the first thing you do when starting Installation Phase?

Ask, *“When you bring up that original incident, does your original positive statement (repeat the PC) still fit or is there now a better statement?”*

**Teaching points:** PC may have evolved since the Desensitization Phase. Now that the client has resolution (NC has been reprocessed), the PC may evolve to a more adaptive and declarative statement in the positive.

8. Installation is considered complete, when....? VOC=7 and PC no longer strengthens after at least two sets of standard BLS.

**Teaching points:** Even if client initially reports a VOC=7, use several sets of BLS to allow further strengthening of PC. BLS sets are administered at the same rate and speed as in the Desensitization Phase.

9. How do you complete the Body Scan?

**Procedures:** *“Hold the original experience and PC together. Close your eyes and scan your body from head to toe and report anything you are noticing.”*

**Teaching points:** Do body scan for any residual aspects of target still needing reprocessing. These are often residual body sensations. BLS sets are at the same rate and speed.

10. You have run out of time. How do you shut down the treatment session?

Tell client it is time to stop. Do stabilization or containment exercise if needed.

Give encouragement: *“You have done some good work today. What have you learned or gained today?”* Give instructions for closing session.

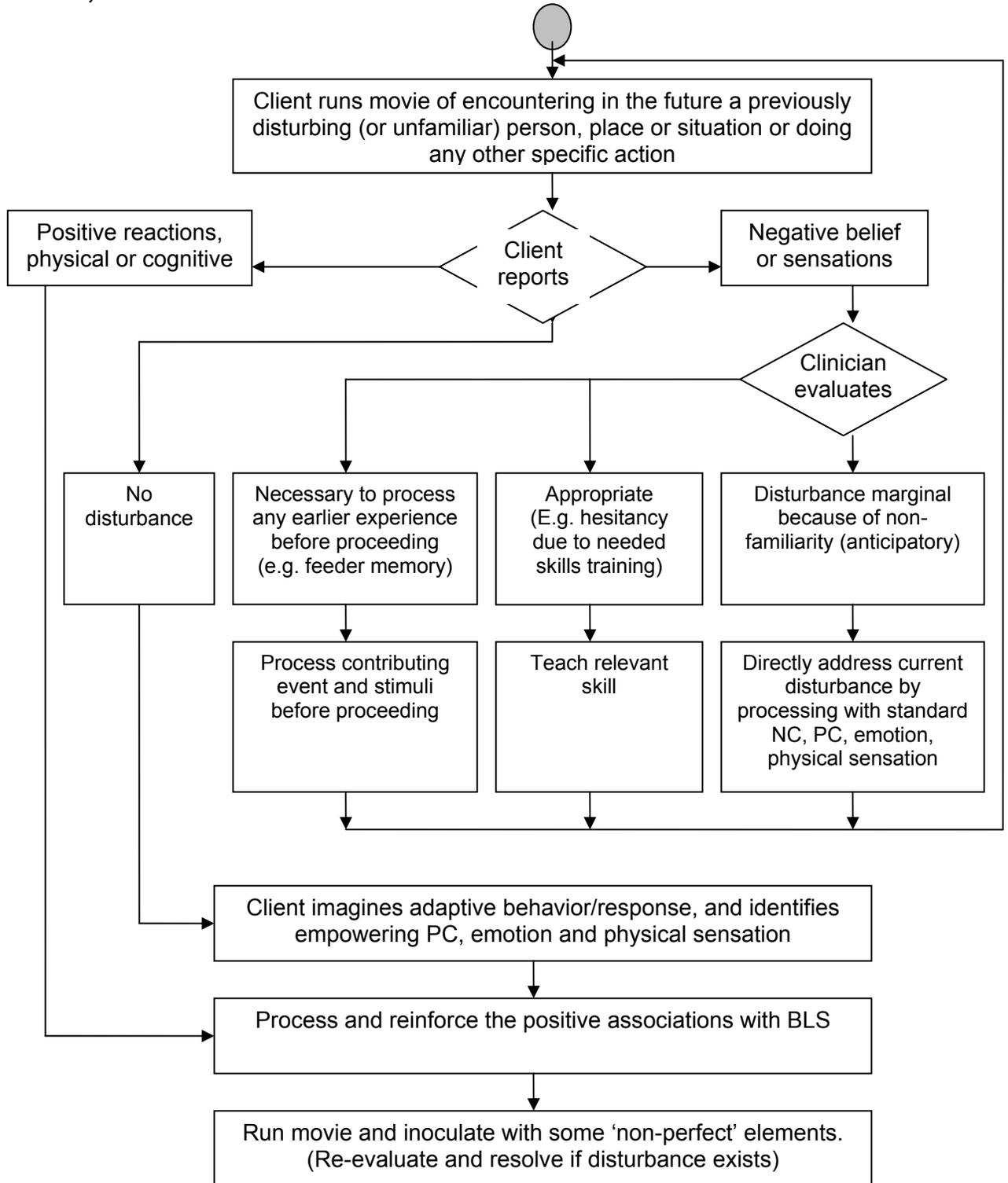
*“The processing may continue. Keep a log and we will talk about what you have experienced next session. Use self-control techniques as needed.”*

**Teaching points:** Ensure client stability before he leaves office. Inform client processing will continue and to keep a log.

# FUTURE TEMPLATE FLOW CHART

Michael Paterson, PhD

**Future: Process future templates (positive imagery plus stimulation) to address avoidance, actualization.**



## COMMON MISTAKES IN THE APPLICATION OF THE STANDARD EMDR PROTOCOL

### PHASE TWO: PREPARATION

With Development of Resources or State-Shift Skills such as Safe Place:

- Selection of a resource or safe place that is linked to disturbance
- Selecting a safe place that is a child's safe place (versus an adult)
- Doing sets of bilateral stimulation that are too long. It can stimulate channels of associations that can link to disturbing material
- Failing to ask for and install the cue-word
- Reinstalling the safe place when it's not necessary

It can also be useful to ask for a positive memory of a moment of well-being leading to a pleasant feeling when recalled. This association can also be reinforced and installed.

### PHASE THREE: ASSESSMENT

It is important to complete the assessment steps in the order given, since they build with increasing intensity from the cognitive to the emotions and sensations. Refrain from offering psychoeducation and cognitive restructuring during the assessment phase. Though some very important therapeutic issues may arise, the purpose of this phase is to access the dysfunctional information as it is currently stored. If the initial parts of the assessment (Image, NC and PC) were obtained in a previous session, it is worth checking them again since parts of the target may have already been processed or may have changed.

#### TARGET SELECTION

- Working on the distressing emotion(s) (anxiety, sadness, etc.) or on the symptom, without reference to a specific experience and without checking for the earlier experiential contributors
- Selecting a target memory that is too vague or diffuse
- Selecting a target memory that is unrelated to the presenting symptom(s)
- Selecting a target memory that is a recent event rather than an earlier relevant experiential contributor (except where the more recent experience(s) is/are causing intrusive symptomatology)

#### IMAGE

**Image:** *“What picture represents the worst **part** of this experience?”* (Remember, the image represents the most disturbing aspect of the experience)

- Targeting the whole narrative instead of the image that represents their current distress

- Investigating, exploring, asking for details, emotions, etc. after the client has identified the worst image
- Repeating back to the client their description of the image
- Not offering a description if the client cannot visualize the worst part

### NEGATIVE COGNITION

**Negative Cognition:** *“What words go best with that picture that expresses your negative belief about yourself now?”*

- Asking what the client thinks in general about him/herself, without reference to the image
- Investigating the NC and/or the PC in a complex and socratic way instead of following the script which directly links the negative belief to the image
- Immediately providing the sheet with the list of the NCs instead of allowing the client to discover their own negative self-talk
- Asking for the NC with reference to the past, instead of “what is alive now” with reference to the target
- Accepting a NC which is a description of emotions (e.g. “I am scared,” or “I can’t do it”) versus a belief that describes the *conclusion* the client has about themselves
- Investigating general issues, versus having an understanding about where the client is stuck (responsibility, safety, power) and focusing the client to that category
- Allowing a NC which doesn’t meet all of the requisite criteria
- Accepting more than one NC. Each one opens an associated memory network, so it’s important to work on only one NC at a time.

### POSITIVE COGNITION

**Positive Cognition:** *“When you bring up that picture, what would you prefer to believe about yourself?”*

- Directly suggesting the PC instead of using the question in the procedural steps
- Soliciting the PC by asking, “What would you have liked to think about yourself instead?” rather than using the script, which solicits the PC in the *present* tense and in reference to the disturbing image.
- Accepting a PC not on the same informational plateau as the NC and vice versa
- Unnecessarily exploring the PC (e.g., “Maybe you want to feel at peace?” Or, “You did all you could do?”)
- Accepting a PC such as “I can forget” or “They didn’t really mean it,” without reference to the self and with a magical connotation
- Accepting a PC that doesn’t meet all of the requisite criteria

### VOC

**VOC (Validity of Cognition):** *“When you think of that picture, how believable or true do the words (PC) \_\_\_\_\_, feel to you **now** on a scale of 1-7, where 1 **feels** completely false and 7 **feels** completely true?”*

- Asking for the VOC with reference to general situations, not to the image/target
- Asking for the VOC without pairing it with the image/target and repeating the PC.
- Asking for the VOC with the question “How true is it today?” instead of, *“When you think of that picture, how believable or true do the words (PC) feel to you **now**?”*
- Accepting a VOC of 5 or more in phase 3 without checking to see how true it feels on a gut level *“...as you focus on the image?”* If the VOC seems too high, it’s probably because they “know” it is true, but don’t “feel” it is true and they are not pairing it to the disturbing image.

### EMOTION

**Emotions/Feelings:** *“When you bring up that picture and those words (NC) \_\_\_\_\_, what emotion(s) do you **feel now**?”*

- Asking for the emotion while the client thinks of only the image or the NC, instead of pairing it with both the image and the NC.
- Naming and talking about the emotion (e.g., “Is it ‘anger’ instead of ‘disturbance?’”)
- Asking for the emotions as they were experienced then, not now.
- Not allowing more than one emotion. The client can list as many emotions as are presently associated with the target memory.
- Asking only about the physical sensations and not asking for the emotions, followed by the SUD.
- Not redirecting the client to the associated emotion when the client reports a physical sensation instead.

### SUD

**SUD:** *“On a scale from 0-10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does the incident feel to you now?”*

- Asking for the SUD on a 1 to 10 scale rather than a 0 to 10 scale.
- Asking for the SUD before obtaining the PC
- Assigning a SUD value to the emotion (e.g. “remorse”, “anger” or “failure”), instead of the disturbance of the entire memory.

## BODY LOCATION

**Location of Body Sensations:** *“Where do you feel that in your body?”*

- Asking “What do you feel.”
- Asking for the body location in a complex and convoluted way, instead of simply, “Where do you feel that (SUD) in your body?”

## PHASE FOUR: DESENSITIZATION

*“I’d like you to bring up that picture, those negative words (repeat the negative cognition), notice where you are feeling it in your body, and follow my fingers.”*

### BEGINNING THE DESENSITIZATION PHASE

- Teaching the stop signal or explaining that the client will be brought back to the “safe place” if there is disturbance. This is not necessarily true. Clinician should simply remind client of the selected metaphors and the stop signal.
- Starting the BLS without telling the client to bring up the image, the NC and the physical sensation.
- Suggesting the client should stay focused on the target image/experience instead of focusing on it for a few moments and then allowing associations to spontaneously emerge.
- Providing or repeating the description of the image or the details of the memory. This is contraindicated in the protocol.
- Starting the BLS by asking the client to concentrate on:
  1. The image, the NC and, for example, the stomach contraction instead of simply the location of the sensation
  2. The sensation, instead of the image, the NC and the location of the sensation
  3. The image, for example, the anguish and the rigidity, instead of the image, the NC and the location of the sensation.
  4. “All that”

### SETS

- Sets that are too long or too short. Generally, start with 20 or more passes. Watch your client’s face and body language to determine the best length of set for this client. There is no need to continue after the client indicates they are finished with the set.
- Passes that are too slow can stimulate a relaxation response. For optimal reprocessing, go as fast as the client can comfortably tolerate.
- Pausing too long between sets without a specific reason (client is complaining, overwhelmed, needs to talk). Most of the time you should only minimally or non-verbally acknowledge what the client has reported, and they reply, “Notice that.”

### INAPPROPRIATE THERAPIST INTERVENTIONS

- Commenting, summarizing, or restructuring the client's report of their experience.
- Initiating a conversation during a session while the client is processing. This can impede the processing and can confuse the client.
- Making unnecessary cognitive interweaves. This can bring the client back to a cognitive level when he/she is experiencing emotions and body disturbances. The goal is to allow spontaneous processing.
- Asking for more detail, or unnecessarily investigating a response even though the client's material is moving.
- Interpreting (e.g., "I think you are on the defensive even now, because you are sitting with your back against the chair..."). It is the client's experience and learning that is important, not the clinician's interpretation.
- Intervening with unnecessary questions and goals (e.g., "What could you do instead?" "You need to take care of yourself.")
- Distracting the client by bringing up issues unrelated to the target memory experience.
- Asking whether the "scene" described by the client is real or made-up, and how did things really happen (*this is not necessary nor called for by the protocol*). We are accessing what is stored in memory or what represents the client's distress. Whether actually true or not, it is the perception or the association that's important.
- Distancing the client from the memory (e.g., "see it from a distance", "train metaphor", or "it's in the past") when the client is reprocessing and is able to tolerate their emotions and remain present to their experience. Even with intense emotional responses, this is not necessary.
- Bringing the client back to the target memory while the client is still processing (e.g., "the client is reprocessing a memory of her father and of her feeling not protected by him"). Just continue reprocessing until there is no change two times before returning to the target.

### INTENSE EMOTIONAL RESPONSES

- Stopping the reprocessing when the client is experiencing intense emotions and is still processing. Continue BLS even though the client may be very distressed and emotional it will resolve more quickly.
- Talking during an intense emotional response to distract the client from their distress rather than offering support to tolerate their experience. Offer verbal support that facilitates dual awareness.
- Prematurely introducing a state-shift (breathing, safe place) rather than continuing the reprocessing.
- Stopping the reprocessing rather than just taking a break (if requested) and then returning to reprocessing as soon as the client is able.

## MEASURING SUD DURING DESENSITIZATION

*“When you bring up the original experience, on a scale of 0 to 10, where 0 is no disturbance or neutral, and 10 is the highest disturbance you can imagine, how disturbing does it feel to you now? (pause for a response). Go with that.”*

- Asking for the SUD on a 1 to 10 scale instead of on a **0 to 10** scale.
- Asking for the SUD without going back to the original target memory.
- Asking for the SUD after 2 sets of BLS (without going back to original target memory). When the client goes back to original target memory and reports no change after two consecutive sets of BLS, then check SUD.
- Proceeding with desensitization by asking how the client’s body feels rather than the experience in general. The correct way is to ask, *“As you recall the experience, how disturbing does it feel to you now?”*
- Asking, “What prevents it from being a zero?” each time the client is brought back to target, instead of asking what the client is noticing, and continuing with desensitization.
- Assuming the SUD is really zero (implying it only from the client’s presentation).
- Asking for the VOC in the middle of phase 4 (desensitization) without first making sure the SUD is 0 or going through the other steps (PC verification, etc.)
- Ending desensitization phase before reaching a SUD of zero (unless it is an incomplete session)
- Moving to the installation phase when the SUD is still high (e.g., 2 or more).
- Asking the client what prevents the SUD from being a 0 when it is still high (e.g., 5). This question should be asked only when the client is blocked with a SUD of 1 or 2. A high SUD level does not indicate that the client is blocked, but that more material needs to be processed. This question is asked when processing is stuck and you are looking for feeder memories or blocking beliefs.
- Remember to ask, “Where do you feel it in your body?” when the SUD is a 1 or 2.

## BETWEEN SETS

*“Take a breath; (pause) let it go, what are you noticing now?”*

- Not asking anything more (e.g. “what do you notice?”) when the client doesn’t say anything. Ask for particulars: changes in the image, thoughts, emotions or sensations.
- Suggesting the client go back to something in particular.
- Asking “How do you feel?” Or, “How are you?” Or “Any changes?” instead of, *“What are you noticing now?”*
- Initially asking for specific information (e.g. “Do you feel the tiredness in your legs?” “How is your body now?” “Is the image the same?” It is important to be deliberately vague and open-ended in your initial query.
- Focusing the client only to the body processing by regularly asking only for the sensations or feelings.

- Investigating and exploring client's reports for details.
- Repeating the client's words after each set, or encouraging a dialogue.
- Asking prematurely (e.g., "What prevents you from letting this go?") instead of saying, "Go with that."
- Failing to allow a report of all associations and instead focusing only on reducing the SUD (desensitization versus a reprocessing). Verification of SUD between sets is not called for until you return to the target memory and there are no more associations.

### AT THE BEGINNING OF A NEW SET

*"Go with that." "Just notice that."*

- Failing to say: "Just notice that" or "Go with that." The client loses concentration if he/she does not know what to do
- Saying "Let's start again from the image." Just begin from where they are rather than returning to the image or the target unless they got distracted or are having difficulty getting started. Note: some clients may have trouble getting started because they believe they should try and hold onto the target image. Instruct them to focus on it for a few moments and then release it, allowing for other associations to spontaneously emerge.
- Asking the client to take a deep breath before beginning a set rather than *at the end* as suggested by the procedural steps.
- Arbitrarily asking the client to focus on a particular sensation (e.g. "on the strong pain," "on your stomach"), because this leads to the client to consistently focus only on his/her body.
- Describing the situation reported by the client before starting a new set by repeating his/her words (e.g., "Think about the last thing you told me that your mother was always acting this way and that you noticed she had the same attitude with your brothers.")

### GOING BACK TO TARGET

*"When you go back to the original experience, what are you noticing now?"*

- Asking the client to go back to the image rather than to the original memory
- Asking what the client feels or thinks.
- Asking for the body disturbance or the SUD without going back to target
- Asking for the NC again
- Describing the target and/or the whole event again
- Asking, "How much anger are you experiencing?" instead of asking for the overall level of disturbance.
- Bringing the client back to the target memory when the channels of association are still in process.

- Saying, “Look back to that moment, does it still bother you?” or, “Look at the image for a moment,” instead of, “When you go back to the original memory, what are you noticing now?”
- Not returning to target when there is no change after two sets, when the associations feel too diffuse, or when the client or therapist is “lost” regarding the processing.

## **PHASE 5 – INSTALLATION**

*“Do the words (repeat the PC) still fit, or is there another positive statement you feel would be more suitable?”*

*“Think about the experience and those words (repeat the selected PC). From 1 (completely false) to 7 (completely true), how true do they feel?”*

*“Hold them together.” Do BLS.*

*“On a scale of 1 to 7, how true do those words (PC) \_\_\_\_\_ feel to you now?”*

- Starting phase 5 before completing phase 4.
- Failing to check if the PC is still appropriate before installing it.
- Failing to ask the client to link the PC with the target for the installation.
- Bringing the client back to the image instead of to the event or memory.
- Asking “What prevents it from being a 7?” after only one set of installation; it is too early and creates a demand.
- Asking again for the SUD after installing the PC with the VOC, etc.
- Installing the PC with a SUD of 1, unless it was determined to be ecological.
- Using the technical expression “Let’s install the positive cognition” with the client. Use client-friendly language such as, “...your positive belief about yourself.”
- Failing to check the PC and VOC and moving immediately to the body scan.

## **PHASE 6 – BODY SCAN**

*“Close your eyes and keep in mind the original memory and the words, (repeat the selected positive cognition). Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness or unusual sensation, tell me.”*

- Starting the body scan without linking it to the original memory and the PC.
- Asking only for the body sensations.
- Naming the body parts. Just ask to scan the body (so the client can proceed at his/ her own speed).
- Doing the body scan with open eyes.
- Doing eye movements during the body scan.
- Saying to the client, “Everything OK in your body?” or similar questions.

- Having the client concentrate on the positive feeling during the body scan to strengthen it, without stopping to notice any tension, disturbance, or negative sensation.

## **PHASE 7 – CLOSURE**

- Doing a complete session closure in an incomplete session.
- Forgetting to do any closure at all.
- Having the client concentrate on the distress in an incomplete session, then using BLS to bring the client to the safe place.
- Doing more BLS when the client is brought back to the safe place (*it is not only unnecessary, but it could stimulate more material, especially when closing an incomplete session*).
- Forgetting to inform of therapist availability should the client need it, especially in the beginning of an EMDR treatment.
- Asking the client to recall the image and the NC, and checking if it is still as disturbing as at the beginning of the session, or if it is lower. Going back to the target memory risks opening up more disturbing material during closure. If the session is incomplete, do not ask for SUD or go through the body scan or any other phase. Just go through the process for closing down an incomplete session. The purpose is to shift states away from reprocessing and into the present moment.
- Asking the client more questions about their distress (e.g. fear of dying, inadequacy, etc.) during the closure. Again, the goal is to shift states and close down the reprocessing.
- Even if the reprocessing session was completed, it is suggested that you refrain from debriefing with the client the specifics of their reprocessing experience. It is assumed that the processing will continue after the formal processing has been completed; it is more respectful to just allow for a complete resolution and revisit the reprocessing experience in the subsequent session.

## **EMDR IN CLINICAL PRACTICE: UNDERSTANDING AND MANAGING CLINICIANS' RESISTANCE AND BLOCKS**

During the EMDR Basic Training, participants learn not only about procedures and protocols, but about the theory and clinical practice that distinguish EMDR as a comprehensive psychotherapy approach. You learned about the research and the recognition of EMDR as an evidence-based treatment for PTSD, as well as its use in small “t” traumas, and the many disorders affecting daily life. During the basic training, trainees have likely had the opportunity to watch demonstrations by the trainer, as well as some videos, and experience at least 6 sessions during the three practice sessions, using it with themselves to treat their own personal memories as well as administering it as clinicians. By the end of the training experience, nearly all participants come away from their training experience excited and invigorated, having learned a new, surprisingly effective methodology that is far more than an added technique in one’s clinical toolbox. Their experience with EMDR is so remarkable that clinicians themselves go into EMDR therapy for their own personal work, even though they have already been in therapy in the past, perhaps several times before.

Despite the overwhelming positive feedback, we have noticed over the years that some colleagues find it difficult to successfully integrate EMDR in their clinical practice. The same trend is reported in European countries as well as in the US.

EMDR Institute and EMDR Italy have identified several issues which are described and reviewed below in the way that clinicians usually formulate them:

***“I feel I have a passive role when using EMDR with a client.”***

Actually, clinicians have a very active role in EMDR therapy. While it appears that the role of the therapist is incidental to the healing that is taking place, your presence, your positive intention for the client and your care and concern are an invaluable part of the process, just as with any form of psychotherapy, if not more. In addition you are working to help make meaningful connections between past and present, helping clients make sense of their difficulties. Finally, being there with them as they process disturbing life experiences helping to keep them safe and getting to the “other side,” is co-creating a positive, healing experience that you are actively participating in. It does take two people to make it happen; therefore clinicians have an **active as well as facilitating** role. EMDR sessions have often been compared to a dance, and it takes two people to dance...

***“I feel insecure and/or not capable.”***

This is an understandable if not common reaction; every time we learn something new we

feel insecure until the learning curve has been completed, which means tolerating practicing in new ways, receiving feedback and getting results, and finally consolidating our learning. Avoiding using it arrests the learning process initiated with the training, consultation, practice sessions, etc. Colleagues and consultants provide substantial, and sometimes real time support to help with the integration process. All participants learn the standard EMDR protocol during their training, and make mistakes or use it “imperfectly.” EMDR works well regardless of our procedural errors, because it is based on a natural proclivity we all have to move towards health given the opportunity. It is important to offer clients this opportunity.

***“EMDR may look a naive and easy methodology to clients.”***

Sometimes very experienced intuitive and skilled clinicians consider EMDR “silly” and “easy.” Actually we know it is a very complex process, in particular when we consider the richness, depth and personal value of the path our clients take with EMDR. This is why it is taught only to trained psychotherapy clinicians with clinical experience. Clients never give feedback saying that EMDR is too easy; on the contrary, their feedback on processing is very positive, and they are often surprised with the change in their experience and the insights that go along with it, in addition to the overall benefits to the quality of their lives.

***“I am afraid of losing control.”***

One of the fears felt by clinicians when they start using EMDR is the fear of losing control of the session and the client’s process. Stimulating our clients’ innate processing system means empowering them. This does not mean losing control over what happens in the therapeutic work, but providing clients the opportunity to unblock and resolve the issues that bring them into therapy in the first place. It also facilitates a greater awareness, self-confidence in themselves and an increased ability to manage their lives. During an EMDR session we are **empowering** the client by inviting them to trust themselves and the process: “...Just let whatever happens happen, and remember it is your brain that will do the healing.” A good clinician wants to empower their clients, rather than control their process.

***“I am afraid of losing my credibility as a clinician.”***

Using EMDR increases our credibility with our clients since we are using one of the most innovative and effective therapies according to the International Guidelines for clinical practice as well as the American Psychological Association, ISTSS, American Psychiatric Association, US Department of Defense, British National Health Service, etc. Clients are often very pleased with their EMDR treatment experience. EMDR treatment is known and sought after by the best informed clients who seek the latest innovations to treat their problem.

Additionally, fellow colleagues who are not trained in EMDR but appreciate its effectiveness will send you referrals. There is generally a greater acceptance of EMDR as an effective treatment among professional circles over the recent years.

The other variable to keep in mind is the clinician's attitude is one of the most important factors conveying trust, seriousness, etc., within the framework of a good therapeutic alliance and relationship. It is the clinician's confidence in the process that gives EMDR the credibility most people need.

***"I do not have specialized EMDR protocols for some of my clients."***

The important variable is to use EMDR within the scope of your clinical practice. If you have expertise in working with a specific disorder or clinical population, it is your responsibility to obtain whatever training and/or consultation is necessary to practice EMDR safely and effectively with that presentation. Regardless of the type of disorder, the underlying three-pronged protocol applies. We need to identify and reprocess the memories that are contributing to the client's current difficulties, and we need to ensure that the client is sufficiently prepared for the reprocessing of these experiences.

***"I am afraid of not being able to manage my emotions and those of my clients."***

Let us remember that during EMDR reprocessing, clients do not go out of balance, become crazy, etc...we can use the metaphor of the healing of a physical wound. The body will close and heal the wound after it has been cleaned and dressed... In EMDR, we as clinicians do not have control of our clients' healing capabilities; we set the conditions where healing becomes possible, stimulating the innate self-healing abilities we all possess. It, of course, is more complicated with clients that have a history of pervasive abuse and neglect, and particularly with clients whose basic sense of safety in the world was compromised; appropriate cautions are taken and preparations are made to ensure their readiness for processing when the time and the conditions are right.

As clinicians, it is likely that we, too, may have our own personal responses to some of our clients' experiences; either because some of their experiences are similar to our own; or, just the first-hand exposure to a level of psychic pain and human tragedy can cause us to have intense emotional responses of our own. It is important to recognize the source of those responses, so as not to inadvertently impose them on our clients or on their process. Seek appropriate consultation for your own support, as needed. At other times, however, just acknowledging the tragedy of their experience at the appropriate time can also be very validating to the client.

***"I am afraid of treating a client with a dissociative disorder and not being able to handle them."***

The EMDR Basic Training curriculum includes a section on this topic and an explanation of the DES to be administered before starting EMDR therapy whenever there is a question or concern about the degree of dissociation. Too often, clinicians can ask questions about DD through the discussion list, instead of seeking specific case consultation and/or additional training in this specialty area. For clinicians, it is important

to distinguish between clients who have dissociative responses in their memory network, versus clients who have a Dissociative Disorder, who have a more pervasive pattern of dissociation as part of what they manage in their daily lives. For our clients, we can provide psychoeducation on dissociative reactions, explaining that these responses developed at a time of high distress, where they were unable to process their experience. When reprocessing these overwhelming aspects of experience, the challenge is to be able to observe their response to it in the past while simultaneously recognizing that the current conditions of safety can allow the processing to take place. The Basic Training provides some specific strategies on how to handle these circumstances. For clinicians who have clients with a Dissociative Disorder, they need to have expertise in working with this presentation and, either seek additional training and consultation or refer the client to someone who does.

### ***“What if I don’t do it ‘right’?”***

EMDR is a robust methodology, based on the innate and natural mechanisms of our physiology. Just like other forms of psychotherapy, it is not about doing it “perfectly;” it is about using your positive intention for the client, coupled with your developing expertise in the use of the EMDR protocol and procedural steps to offer a comprehensive and robust treatment approach and apply it to the best of your ability, assuming that your clients will do okay even if you make mistakes. Consider your first practice experience in Part 1: even though the “clinicians” were nervous, had to read, do something they had never done before, do it with a lot of people around and observing them, most “clients” had a positive reprocessing experience. By comparison, doing an EMDR reprocessing session with a client we know and who knows us, in the safety, predictability and quietness of our therapeutic settings, provides an ideal set of conditions for healing to take place.

The past is present: We have observed that some colleagues are blocked in their training experiences and have difficulties learning and applying EMDR because it is something new and different, triggering small “t” traumas and dysfunctional cognitive schemas (“I’m not good enough,” “I am inadequate,” “I am not smart enough,” etc.) from school-based and performance-related experiences. These memory networks are common ones, especially considering how many school-based experiences we all have. Generally, learning something new can trigger feelings of insecurity and anxiety just based on the actual demand of the situation itself. (Think about your first driving lessons or interviews with clients, etc.). If some of those experiences were really negative and remain unprocessed, you are vulnerable to getting triggered either at the training, in your office or both. This reaction can also get triggered with clinicians who are “perfectionists,” and understandably developed this pattern of response in reaction to earlier experiences of being criticized or humiliated. Just as for your clients, you would benefit from some EMDR reprocessing sessions to resolve the earlier associations that are getting triggered. If you haven’t taken Part Two yet, consider using the training as an opportunity to resolve the issue.

Another issue that we have observed in the trainings that might be blocking the application of EMDR for some clinicians is the fear of dealing with intense emotions. Even experienced clinicians can feel this way especially if they are unaccustomed to treating intense emotional responses. One clinician, however, had an inordinate fear of seeing a client get upset and cry (to the point that she refrained from using EMDR). By doing a Float back herself, she discovered the connection to her childhood experience of seeing her mother crying and unable to console her. These small “t” traumas were being triggered every time she was supposed to do an EMDR session with a client. Her fear of the client getting upset was resolved by reprocessing the early associations with her mother. The clinician is now able to successfully manage intense emotional responses with her clients and stay present to their experience.

As with our clients, we too, have memory networks that can negatively affect our ability to learn and apply EMDR effectively. Consider one of the best learning experiences could be to pursue your own EMDR work as a means of optimizing your successful application of EMDR to your clinical practice.

***“I am afraid that EMDR will challenge my beliefs about therapy or change, and affect my personal and professional schemas about what works.”***

Your clinical knowledge, skills and expertise can only enhance your ability to successfully integrate EMDR into your clinical practice. It is our experience that there is a temporary cognitive and emotional dissonance for some clinicians between what you already know and do with competence and learning a new and comprehensive methodology such as EMDR. The challenge is to tolerate the temporary confusion and trust that, in time, you will be able to integrate it into your thinking and practice. The one challenge that some clinicians have is in relationship to change itself. It is well accepted in our profession that some clinical presentations and particularly personality disorders cannot “change,” but can only be managed. Consider the notion that these cluster of symptoms that we define as a personality disorder come from a constellation of early life experiences that, while formative, can also be changed, given adequate motivation for change that can alter one’s sense of who they are. For more information on this subject, you may want to read Brown & Shapiro’s study on the treatment of a Borderline Personality Disorder with EMDR (see References).

## **BASIC GROUNDING SKILLS FOR USE WITH CLIENTS WHO ARE DYSREGULATED AND DISSOCIATIVE**

When working with highly dysregulated and dissociative clients, it is helpful to have a repertoire of grounding techniques to assist clients with stabilization during any of the 8 phases. It is preferable to allow the client to process material unimpeded during Phases 4-6, including the processing through of high levels of emotion and sensations, as much as can be tolerated. However, some clients may have difficulty staying within their “window of tolerance” (Siegel, 1999; Ogden, 2006) while processing. These clients may show signs of overwhelm or freezing and may be unable to continue to track their experience. Others get panicky and can get disoriented, and have difficulty responding to your voice when attempting to reorient them to the current conditions of safety. Still others may start to go into flashbacks where suddenly the past becomes present and they are unable to observe their reactions, but rather are “in it.” All of these signs indicate that the client is having difficulty regulating their experience and are unable to maintain dual attention between past and present. When a client is unable to self-regulate and stay within their “window of tolerance,” the therapist needs to intervene to ground the client, reorienting him/her to present reality. The following are some simple stabilization techniques that can be utilized when needed, in increasing order of directedness; (use the strategies listed first):

### 1) Reorienting to the Therapist’s Face and Voice

You can say to the client (some or all of the following): “Come back to me (or to being here in the room). I’m right here with you. Notice that you’re in my office and you’re safe. Notice the familiarity of this space. Can you see me here with you? Can you feel me here with you? Look around and remember that you’re here with me, safe and sound. Notice it’s only a memory now.”

### 2) Breathing/Posture

Remind the client to breathe from the diaphragm, slowly and deliberately. Breathe with them, coaching them to simultaneously orient to you and to the room (see above). Invite him/her to straighten or lengthen his/her spine and to feel the support of chair/coach against his/her back and the bottom of their feet on the ground.

### 3) Comparison of Textures

Ask the client to feel the surface of the couch or chair, and describe; or feel his/her feet on the floor, or key ring or clothing, and describe the differences in textures.

### 4) Pillow Toss

Play “catch” with a soft object, such as a small pillow, stuffed animal or balled-up tissue.

### 5) Use of Anti-gravity Muscles

Have the client stand and raise his/her arms above their head, and move their arms up and down, as if flapping wings; or rise up on their toes; or do deep knee bends.

6) Simple Arithmetic Tasks:

Ask the client to count up or down by 3's, 4's etc. The idea is to create a task that is challenging enough to get his/her attention, but without being overly frustrating.

7) "5 times 5"

Ask the client to identify 5 items seen around the therapy office and describe each one (visual); then to identify 5 smells and describe (olfactory); then 5 sounds (auditory); then 5 textures. (kinesthetic); then 5 tastes, if necessary. If more time is needed to ground the client, the therapist can move to 4 new items of each sense. If more is required, however, it is suggested that the client may need more sophisticated stabilization methods.

8) Cross-crawl exercise

Ask the client to stand and take their elbow and opposite knee and bring them together alternating between the right and left sides of their body for about two minutes. This is a method from Applied Kinesiology to help regulate the nervous system.

All of these interventions require the client to shift states from an affective focus to a cognitive/perceptual/sensory focus, to attend to these tasks. They can help the client to feel more present in the room and dually aware, grounding them in the reality of their current conditions of safety. Note: it is important to resume reprocessing as soon as the client feels ready and sufficiently resourced to do so, whether in the same session or in a subsequent session. If these strategies are not sufficient, use the container exercise by asking them to take the memory and put it in the container to be brought out at a later time and/or the safe/calm place for further containment and stabilization.

## **EMDR: SYMPTOM REDUCTION OR COMPREHENSIVE TREATMENT**

The following summary may be helpful in case conceptualization and selection of the appropriate EMDR History-taking strategy for targeting treatment plan.

**Symptom reduction** is directed to specific symptoms or a disorder (such as impacting PTSD for time limited therapy or research); **comprehensive treatment** addresses the entire clinical picture.

| <b>Symptom Reduction<br/>Specific Symptoms/diagnosis<br/>Time Limited Therapy</b>   | <b>Comprehensive Treatment<br/>Entire Clinical Picture</b>   |
|---|--|
| Thorough history  | Thorough history   |
| Usually "T" – Single Incident,<br>or - Simple Phobia  | "T" or "t" / adult or childhood onset  |
| Not part of identity – external to<br>identity;   | Part of identity/pervasive belief of self  |
| <b>Past</b>   | <b>Past</b>  |
| Earliest related traumatic event<br>- Or worst event related to symptoms<br>(intrusive thoughts, avoidance,<br>hyper arousal) | Historical work<br>- Single Issue<br>- Multiple Issues<br>- Complex  |
| <b>Rule out earlier T/t onset</b>   | <b>Issue or time line driven history</b>   |
| Identify worst part of the traumatic<br>incident  | Use issues, themes, timeline or<br>symptoms to organize targeting<br>sequence  |
| Process incident, and all associated<br>channels using standard EMDR<br>procedures  | Identify Touchstone Events or T/ts<br>along timeline representative of<br>presenting problems – then establish<br>targeting sequence for processing of all<br>past, memories using standard EMDR<br>procedures |
| <b>Present</b>  | <b>Present</b>   |
| Target and process Present<br>Triggers/stimuli (use log)  | Target and process Present<br>Triggers/stimuli (use log)   |
|   |  |
| <b>Future</b>   | <b>Future</b>  |
| Anticipated fears   | Developmental needs/Anticipated fears  |
| Future projection   | Future projection  |

Personality is simply the configuration of characteristic responses. Each of these characteristics is based upon earlier experiential contributors interacting with genetics and organic propensities. EMDR is used to address the experiential contributors of dysfunction and health.

## **TREATMENT PLANNING GUIDE**

### **Simple PTSD**

“Simple” cases of PTSD involve a single event trauma or one cluster of events. These cases are generally addressed by targeting the primary event, the present manifestations of the problem (e.g., nightmares, flashbacks), the present triggers and future templates to overcome avoidance and consolidate learning with a greater degree of mastery. It is important for clinicians to investigate the aftermath of the identified trauma, as this may also be causing distress. For instance, the reaction of the police, medical personnel, or family and friends to a rape may also be traumatizing. If processing the rape itself does not clear these elements, they need to be targeted separately.

It is important in the History-taking Phase to identify if there have been previous losses or highly disturbing events (e.g., previous disaster situations, assaults) that may be feeding the present dysfunction. When appropriate, use direct questions, the Affect Scan or Float back to identify any touchstone memories that may be feeding the feelings (e.g., trapped, helpless). If these earlier events cause significant arousal, they should be processed before proceeding to the later event. Even if the current critical event is obviously horrific and is targeted first, it is still preferable to have sufficient information about the client’s history. In case of blocked processing, the clinician will be better prepared to access the earlier events as potential feeder memories.

### **Comprehensive Treatment**

For other diagnoses and issues (including complex PTSD), a more thorough understanding of the pathology is necessary. This is the case for comprehensive treatment (addressing the full clinical picture) or symptom focused treatment (discrete problems).

When working within a time-limited setting or restricted client contract, sometimes it is necessary to focus only on a particular diagnosis or issue(s). In this case it is imperative to identify the earlier memories that set the groundwork for each problem and to process this first, before proceeding to the present triggers. The present situations that cause disturbance are only a symptom. The cause is the dysfunctionally stored unprocessed touchstone memories. These events are identified through direct questioning, Affect Scan and/or Float back using a memory of a recent disturbing current situation (trigger) as the initial focal point. Future templates are incorporated for each trigger and anticipated future situation. This consolidates the learning, and gives the opportunity to incorporate skill development before the client engages in the real world. Feedback from the real world encounters then guides the therapy process to completion. The Three Pronged Protocol (past/present/future) is initiated to eradicate the symptom clusters and bring the client to the most adaptive level of response possible. For diagnoses (phobias, pain, substance abuse) it is also important to incorporate the steps of the specific EMDR protocol.

Even in cases of symptom focused treatment, it is preferable for the clinician to take a thorough and comprehensive history in order to educate clients about other aspects of their clinical picture and the potential for greater happiness and adaptive functioning in all areas of their lives. Once clients have been thoroughly informed, and see the myriad connections of their earlier history to their current life situations, they may decide to expand the clinical work. If the clinician does not do a comprehensive history, s/he will be unable to properly educate the client.

Comprehensive treatment can be accomplished by placing disturbing events (T and t) on a Time Line and processing them chronologically (1) past events, (2) present triggers, (3) future templates for each trigger and observed deficit. However, it is also crucial for the clinician to understand thoroughly how the client is currently affected, what issues s/he is dealing with, and the foundation of the pathology. In other words, each comprehensive history must be informed by the symptom focused clinical strategies. Each negative characteristic, symptom, behavior, affect, sensation, and belief stems from earlier experiences that are dysfunctionally stored. Time Lines will be most effective if the touchstone memories are identified and incorporated. As most presenting complaints stem from small “t” events, many are unlikely to be remembered by the client as memorable or significant until guided back to them through an Affect Scan or Float back.

### **Defining Targets for Treatment**

Different diagnoses indicate kinds of characteristics. Different characteristics stem from earlier unprocessed events. Simple PTSD has symptoms that stem from a critical incident and the treatment plan involves identifying that incident, any previous contributing ones, the triggers, current manifestations (e.g., nightmares, flashbacks), and future templates. Parts of the following form can be used for that purpose. Alternatively, most clients present with more complex diagnoses or “issues.” They are bothered by problems and aspects of their lives that need to be addressed by processing. However, processing can proceed only after the appropriate targets are identified. For instance, a client may have difficulty with relationships. That is the “issue.” However, each relationship difficulty has specific characteristics and these are targeted separately as the symptoms (e.g., being too clingy; being too judgmental; being attracted to unavailable people; believing people are untrustworthy; fear of self-disclosure; “defenses”). The present dysfunction is a symptom. The past event is the cause.

## **SAMPLE ACKNOWLEDGMENT AND CONSENT FORM**

Below you will find an example of the types of things that we think clients should know in order to have informed consent before initiating EMDR treatment. This sample format is not meant to be the definitive answer for an EMDR informed consent, nor is it endorsed by EMDR Institute, Inc.; it is offered here as one example of what can be included in such a document.

Because the laws governing the use and effect of such documents for any clinical treatment vary from state to state, it is **IMPERATIVE THAT YOU OBTAIN A LEGAL CONSULT BEFORE USING ANY SUCH DOCUMENT.**

### **SAMPLE CONSENT FORM FOR EMDR-DO NOT COPY AND USE**

I have been advised and understand that Eye Movement Desensitization and Reprocessing (EMDR) is a treatment approach that has been widely validated by research only with PTSD. Research on other applications of EMDR is now in progress.

I have also been specifically advised of the following?

Distressing, unresolved memories may surface through the use of the EMDR procedure. Some clients have experienced reactions during the treatment sessions that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.

Subsequent to the treatment session, the processing of incidents/ material may continue, and other dreams, memories, flashbacks, feelings, etc., may surface.

Before commencing EMDR treatment, I have thoroughly considered all of the above, I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having EMDR treatment, and by my signature below I hereby consent to receiving EMDR treatment. My signature on this Acknowledgment and Consent is free from pressure or influence from any person or entity.

Date: \_\_\_\_\_

Client Signature: \_\_\_\_\_

Each state has its own laws governing the use and effect of documents attempting to limit the liability of professionals, such as this CONSENT. Consult with an attorney regarding the laws applicable in your state BEFORE using any such document. This SAMPLE FORMAT is provided for your information only. EMDR Institute, Inc., does not warrant or represent the suitability of this document, and disclaims any liability stemming from its use. EMDR Institute, Inc., is not engaged in the practice of law and does not render legal services or give legal advice.

## **SAMPLE SINGLE INCIDENT-TRAUMA CLIENT HISTORY**

### **PRESENTING COMPLAINTS**

*“When we spoke on the phone, you mentioned having some problems related to an automobile accident. Tell me more about how it’s affecting you.”*

### **SYMPTOMS AT WORK**

**CLIENT:** *“Well, it’s affecting my work, my family life and my sleep. I mean, at the office my concentration is just not as good as before. People tell me I often seem distracted and just not as sharp. I’m worried that it’s going to affect my job review later this year. Sometimes I notice I just don’t catch the details, so I’ve been trying to make more notes to try to remember things.”*

**THERAPIST:** *“You said it’s affecting your family life too. Could you tell me about that?”*

### **SYMPTOMS WITH FAMILY, SLEEP AND NIGHTMARES**

**CLIENT:** *“I’ve been a lot more irritable with my wife and my kids. It may be because I’m not sleeping well. I seem to wake up a lot more often at night and have trouble getting back to sleep. Sometimes I dream about it too. When that happens, I don’t even want to go back to sleep because I’m afraid of dreaming about it again.”*

**THERAPIST:** *“Are there different dreams or does it seem like the same dream each time?”*

### **RECURRING NIGHTMARE**

**CLIENT:** *“It’s both. I mean, I have different kinds of dreams about it. Some of those aren’t even like the accident, just disturbing, strange dreams. But there’s this one nightmare . . . it’s hard to talk about it even now.”* [Client looks confused and sad with obvious tears that he wipes away on his sleeve.]

### **PRELIMINARY NEGATIVE COGNITION**

**CLIENT:** *“It’s so upsetting, I know I shouldn’t think this way, but it’s like it’s my fault those people died. Like I should have done something to stop it, but that’s crazy because I was so far behind those other cars. I know there was nothing I could do” . . .*

### **SPONTANEOUS ABREACTION**

[Client starts to cry again and briefly covers face with his hands. Then wipes face with tissue and looks at therapist.]

### **NORMALIZING AND PROVIDING INFORMATION**

**THERAPIST:** *“It’s not unusual or crazy to have those kinds of feelings and thoughts after what you experienced. Many trauma survivors tend to blame themselves for things that were beyond their control. Even though I know it’s painful for you to talk about this, I’m glad you are. Overcoming those thoughts and feelings of self-blame is one of the things that our work here together can help you with.”*

## **DURATION AND CHANGE IN SYMPTOMS**

**CLIENT:** *"It's reassuring to hear that, but it's hard to believe. What's strange is, it didn't seem to bother me as much when it first happened. Over the last 8 months, it's been getting worse."*

## **CLIENT FAMILIAR WITH EMDR BASICS**

**CLIENT:** *"Recently, when I told the EAP counselor at work about the nightmares and some of the other problems I've been having, she said that you'd helped some other employees after the explosion at the other plant. She gave me your brochure about trauma and EMDR. I checked it out on the Internet. At first it seemed kind of strange to use eye movements for therapy, but it does sort of make sense with how eye movements happen when you dream."*

## **INITIAL CAUSE OR INCIDENT**

**THERAPIST:** *"Can you give me a brief overview of what happened in the accident and how you were involved?"*

**CLIENT:** *"I'll try. I was driving to work later than usual one morning. I was on the highway. A sports car passed me on the right going well above the speed limit. The morning rush hour was starting to lighten up and the driver was weaving through the lanes like he owned the whole road. He was nearly out of my view when he cut right in front of a station wagon. The driver of the station wagon stepped on his brakes in time to make some room in front of him for the sports car, but the driver of the flatbed truck behind him didn't react as fast. He clipped the back of the station wagon and spun it around. The station wagon flipped over sideways and rolled several times. I managed to pull over into the emergency lane in the center without hitting anybody and ran over to station wagon. It was lying upside down. The mother was still buckled in on the passenger side, hanging upside down, yelling and crying, saying, "Where's Sammy? Where's Sammy?" The two other kids had undone their seat belts already and were sitting inside on the roof looking at their mom and crying and mostly in shock. The driver was unconscious. It turned out he'd been hit in the head by the kids' portable stereo. He was bleeding too. After they got him to the hospital, he came around. They all made it OK, except for one passenger who was thrown out the window." [Client cries and looks away.]*

**THERAPIST:** *"What happened after that?"*

**CLIENT:** *"Another driver came over. He and I got the woman and the two kids out. We were afraid to move the man because he was unconscious in case he had a spine injury. The dead person was covered up. About then the police and paramedics arrived and got the man out of the car and into the ambulance. They took him to the hospital. The woman rode to the hospital in the ambulance with the dead passenger and the police followed them with the two kids."*

## **AVOIDANCE OF MEMORY**

**CLIENT:** *"I gave the police a statement and then I went on to work. After I got there people could tell I wasn't myself and my supervisor walked me over to the EAP*

counselor. I talked to her for a while and then she sent me home for the rest of the day. It was sort of embarrassing being sent home like that. So I just decided I'd act like it was Sunday. I did some chores in the yard and went back to work the next day. I did OK in spite of not sleeping very well, but as the weeks went by I kept not sleeping, started having bad dreams and my concentration has been getting worse."

**THERAPIST:** "Have you spoken to anyone else beside the EAP counselor about what happened?"

### **BLOCKED WORDS**

**CLIENT:** "Just the police that day and I mentioned it to my wife. Actually I haven't really told her about the details. At first, I didn't want to upset her. Then later, well, I just couldn't talk about it without starting to cry. What's weird is that I really couldn't talk about it. I'd want to tell her, but I mean the words just went away and that's when I started to feel like I was sort of crazy, cause we've usually talked about most everything."

### **NORMALIZE**

**THERAPIST:** "It's understandable that you would feel strange not being able to talk about something that really upset you, but it's really not uncommon after a traumatic event to feel that way."

### **EXPLORE FOR OTHER TRAUMA HISTORY**

**THERAPIST:** "Have you ever seen or been involved in any other event like this where you or someone else was seriously hurt or someone was killed?"

**CLIENT:** "I broke my arm once as a kid, but that didn't really scare me. I knew it was broken right away and I didn't have any problems afterwards like with this. I can't think of anything else."

### **CURRENT STIMULI-HOW AFFECTED**

**THERAPIST:** "Since you witnessed this accident, what have you noticed as far as any changes in your driving or your feelings when driving?"

### **AUTONOMIC REACTIVITY-FEAR OF RECURRENCE**

**CLIENT:** "I'm more careful to keep enough distance between me and the cars up front, which is OK. But I kind of freak out whenever someone tries to pass me on the right. Also when I see a station wagon my heart starts pounding and I feel like something terrible is going to happen. It never does, but it really is upsetting and I never know when that's going to happen."

### **DESIRED BEHAVIOR**

**THERAPIST:** "How would you like to be functioning? What would be different if our work together turns out as you'd like it to?"

**CLIENT:** "I'd be able to drive like I used to, without overreacting when someone passes me on the right or if I see a station wagon. I'd be able to talk to my wife about

*what happened so she would understand why I've been affected so much by it. The bad dreams would stop. I'd be able to sleep through the night. Uh, I'd stop being so irritable with my kids and I would be able to remember things at work like I used to without having to write everything down."*

#### **CHECK FOR SECONDARY GAINS WITH SYMPTOMS**

**THERAPIST:** *"When you think about things turning out like that, is there anything you'd get to do or have to do, you don't have to do now? Or is there anything you'd have to give up?"*

#### **READINESS FOR CHANGE**

**CLIENT:** *"I'd give up the nightmares, the sleep problems and the extra note taking. I'd be able to talk to my wife and I'd feel like she understands finally. It's been like a wall between us and it would be a relief to have that gone and to feel close to her again."*

#### **CHECK FOR FORENSIC ISSUES**

**THERAPIST:** *"Has there been a trial about the accidental death of the passenger?"*

**CLIENT:** *"Yes, that got wrapped up a few weeks ago. I gave a deposition, but the District Attorney accepted a plea bargain. So it turned out I didn't have to testify. The driver of the sports car had a big insurance policy and they settled with the family too."*

# **CASE CONCEPTUALIZATION WITH CHILDREN**

**Robbie Adler-Tapia, Ph.D. & Carolyn Settle, MSW**

**CLIENT HISTORY:** Ask the child for targets as well as the parents, case manager, or other care givers. Often the child's targets will be different than the parent's targets. Parents can help fill in the gaps between what the child reports and what is happening in the child's life but the parent may not have insight into what the child is actually experiencing as problematic. Children are often more symptom focused than adults and often process in imagery or fantasy. For example, instead of focusing on the experience of being molested, the child may present with concerns about not being able to sleep in their own bed because the child thinks there are monsters in their room. Also, ask parents about the child's developmental history and any medical procedures. It is important to remember that what is traumatic for a child might not be assessed as traumatic for a child. By having the child identify the symptoms the child experiences as troublesome, the therapist is more likely to successfully engage the child in therapy versus using the parent's concerns as the focus of treatment. When even young children are respected and their concerns are addressed, they buy in to treatment and then may be more willing to proceed with addressing more difficult issues in therapy.

**TREATMENT PLANNING:** Treatment planning should be focused on addressing the symptoms (emotional and behavioral) that brought the child to treatment. This is often initially identified by the parent, but it is important to ask the child about symptoms or ask the child what would make them feel better. It is easy to ask the child, "What bothers you the most?" Or, "Tell me something that really bothers you?" The child's responses should guide the treatment plan and this needs to be explained to the parent.

**PREPARATION:** The therapist may have to teach mindfulness and emotional literacy. With EMDR, the therapist must assess where the child is functioning in all areas of development including cognitive and emotional in order to gage the treatment to the child's developmental level. For example, if the child can label a feeling that can actually be a cognition based on the developmental level of the child. This is especially true for children under 12 years who are just learning to talk about emotions. Also, it is important to assess what resources the child has both internally and externally and what skills and resources the child may need in order to continue with the Assessment Phase. Even if the child's environment is not stable, the therapist can use pieces of the EMDR protocol such as developing resources for the child to cope until the child can proceed with further stages of the EMDR protocol. Also, it may be helpful to teach the child to identify a Safe/Calm place that is imaginary as another self-soothing resource. Some children struggle with the Safe/Calm Place especially if when installing the Safe/Calm Place the therapist uses more than 2-4 saccades of BLS. Some children cannot tolerate any BLS without accessing disturbing materials; therefore, the therapist can consider this diagnostic. Developing strong resources and teaching emotional languaging for children is especially important and allows the therapist and child to proceed with the next stages of the EMDR protocol.

**ASSESSMENT:** (Image, NC, PC, VOC, Emotion, SUD, Body Sensation) The therapist can identify all the pieces of the protocol using some play therapy, art therapy, or other creative techniques (As can be seen in the video that will be shown). Therapists need to understand where the child is developmentally and be attuned to the child in order to elicit each specific piece of the protocol. Remember, it is the fundamental essence of that specific piece of the protocol that the therapist is trying to elicit.

**Targets/Channels of Association:** With children the channels of association are often much shorter thus allowing for rapid reprocessing of memories. The child should be asked to identify the target based on the child's symptoms. Children can be asked to draw pictures or create a picture in the sand tray of something that bothers them the most. Some children can be engaged in a Float back by asking them, how did you learn that or when did that start? Other children may not be able to identify a previous incident or an associated incident, but associative channels will open up during desensitization.

**Image:** A child can draw a picture of what happened or create it in the sand tray, or use the toys in the office to demonstrate what happened.

**NC/PC:** When you ask for the NC/PC the therapist can ask the child “When you think about that thing, what’s the bad thought?” Or you can use a play therapy technique for the child to draw a picture of the bad thought. Use all types of expressive skills the child has in order to tap the pieces of the memory network.

**VOC:** The therapist can place the bad thought and the good thought seven steps apart and ask the child where the child is between the bad thought and the good thought. This can be drawn on paper or on a white board. The idea is that the therapist is not just using words to elicit the VOC, but demonstrating something more tangible in order to assist the child in understanding the measurement of the VOC.

**Emotions:** Children need to be taught about emotions and offered some ideas of possible emotions, if the child does not offer an emotion independently. The therapist needs to remember what piece of the protocol the therapist is attempting to elicit and how that child might communicate a thought or a feeling. The younger the child the more likely the more abbreviated the emotional vocabulary. Using pictures of faces to demonstrate emotions or even practicing emotions with the therapist can be a rapport building and psycho educational process. It can be fun to practice faces that demonstrate emotions by having the child and therapist look in a mirror. There are many ways to teach children about their emotions and have children identify their emotions in the EMDR protocol.

**SUD:** Assessing the SUD is as simple as demonstrating the possible measure of disturbance with the width of the therapist’s hands. (Demonstrate by moving hands apart to show “This big. This big. This big.”)

**Body Sensations:** The therapist may have to demonstrate that someone can have “butterflies in their tummy” or a headache or someplace in their body that they are feeling bothered or uncomfortable. Children often express emotional distress somatically and the child may process somatically during desensitization as well. As you will see in the video, assessing body sensations with children is helpful as a more active process.

**DESENSITIZATION:** The therapist may have to switch modalities of BLS more frequently and allow the child to move around. Children can very active during desensitization while other children may come into the session alert and aware and report feeling sleepy during desensitization. The therapist might have the child sit on a yoga ball or allow the child to march around the room in order add movement in order to keep the child engaged in desensitization. This greatly improves the child’s ability to focus and stay engaged.

Types of BLS include visual, tactile, and auditory types of stimulation.

**EMs:** Children’s eyes can cross the midline as young as five years and for some children even younger. Besides following the therapist’s fingers, the therapist may use various tools for the child to track such as placing a puppet on the therapist’s hand to have the child follow visually or by using a “magic wand.”

The therapist may want to consider allowing the child to pick a toy or other object that the child has identified as a resource for the child to track for BLS.

**Tactile:** Children can use various devices or have the therapist tap on the child’s hands, knees, or other body part that is comfortable for the child. Children can march or play the drums and any other type of activity that creates bilateral stimulation. The butterfly hug is a tactile type of BLS that is often used in the group protocol of EMDR with children in crisis situations, which is different than the individual protocol.

**Auditory:** Children can use various devices that create alternating auditory stimulation or the therapist can use speakers on either side of the sand tray or play area for alternation auditory stimulation.

**INSTALLATION:** This usually happens very quickly with children and the therapist needs to coach the child to hold the original target and PC together while installing the good thought. The therapist may be surprised the many times children are just done and are ready to play.

**BODY SCAN:** The therapist just needs to coach the child on how to scan their body and refer to all the work used during the Preparation Phase to remind the child about body sensations. By giving the child a tool to use to “scan” their body like an x-ray, the child most likely will have greater understanding of the body scan procedure. It is important to explore somatic issues with children because children often demonstrate disturbance by expressing body complaints.

**CLOSURE:** Give the child and parent resources for processing between sessions and remind the child to use Safe Place and relaxation skills for any disturbing information that might arise. Parents are more likely to report some type of observed disturbance with the child like increased behavioral issues or sleep issues. It is very important to help the child and the parents to anticipate that issues between sessions are predictable and manageable. Children are very good at creating containers especially in an art therapy type of treatment process. Children are reminded to place what bothers them into the container when at home or school and to tell the therapist at the next session in order that the container can be emptied each week in therapy.

**REEVALUATION:** This is very important for children because this is the way that we really know that children have reprocessed the target. Children do not typically demonstrate a great deal affect during the desensitization phase; therefore, symptom reduction and behavioral improvement are good measures for assessing progress in treatment with child clients. Ask both parents and children in the presence of each other about any symptom changes or new symptoms, because often times the parents and children have different perspectives and are surprised at each other’s responses. Children will report their internal reprocessing of the symptoms and parents are often more focused on external evidence of changes in the child. Checking with the child will give the therapist a more accurate sense of reprocessing of the target and any residual information that needs to be focused on for continued processing.

## **SUMMARY ON EMDR WITH CHILDREN**

This is intended as a brief overview of working with children and further specialty training in using EMDR with children is strongly encouraged. You can do all the phases of EMDR and all pieces of the protocol. The therapist may omit parts because the therapist is not trained, but recent research studies have demonstrated that children as young as three-years of age can do the full protocol, if the therapist knows how to elicit the child’s responses. The therapist doesn’t have to understand what the child is processing. Some therapists think it needs to be real and that the therapist needs to understand. The beauty of the EMDR protocol is that treatment outcome is not based on therapist insight. Only the child needs to understand and sometimes children process a target without the therapist understanding. The evidence is the change in symptom manifestation and behavioral improvement. EMDR is very successful with even the youngest of children.

Further information and references to new text and treatment manual on EMDR with kids:  
<http://www.emdrkids.com/index.html>

## **EMDR CHILD ASSESSMENT FORMS**

Robbie Adler-Tapia, PhD and Carolyn Settle, MSW, LCSW

| Assessment Tool/Forms   | English | Spanish |
|---|---------|---------|
| Assent Form for Children  | x       | x       |
| BASC (Cecil Reynolds & Randy Kamphaus, 1992 BASC II just released last year)<br>Behavioral Assessment System for Children (Preschool and Children's version<br>for both parent and teacher)   |         |         |
| 2.5 – 5 years   | x       | x       |
| 6 – 11 years  | x       | x       |
| CDC (Children's Dissociative Checklist - Version 3 (Frank Putnam)<br><a href="http://www.energyhealing.net/pdf_files/cdc.pdf">http://www.energyhealing.net/pdf_files/cdc.pdf</a>  |         |         |
|   | x       | x       |
| EMDR Brochure (EMDRIA Children's SIG)   |         |         |
|   | x       | x       |
| CITES R – (Children's Impact of Traumatic Events Scale)<br>(Vicky Veitch Wolfe, Carol Gentil, Teresa Michienzi & Louise Sas, 1991)<br><a href="http://vinst.umdj.edu/VAID/TestReport.asp?Code=CITESR">http://vinst.umdj.edu/VAID/TestReport.asp?Code=CITESR</a> |         |         |
|   | x       | x       |
| Informed Consent (Parent)   |         |         |
|   | x       | x       |
| Sensory Integration Scales  |         |         |
| Infant/Toddler  | x       | x       |
| Preschooler   | x       | x       |
| School Age  | x       | x       |
| Treatment Plan Form   |         |         |
|   | x       | x       |
| TSSC (John Briere, 1996)<br>Trauma Symptom Checklist for Children<br>(Ages 8-18)  |         |         |
|   | x       | ?       |
| TSSC (Adler-Tapia, R) Ages 0-6  |         |         |
|   | x       |         |

PTSD and Dissociative Measures:

**[http://www.podcastforteachers.org/childrenfirstwebsite/cfresources/ptsd\\_dissociative\\_measures\\_201.pdf](http://www.podcastforteachers.org/childrenfirstwebsite/cfresources/ptsd_dissociative_measures_201.pdf)**

VINJ's Assessment Instruments: Searchable Inventory of Instruments Assessing Violent Behavior and Related Constructs in Children and Adolescents

<http://vinst.umdj.edu/VAID/getTest.asp>

Child and Adolescent Trauma Measures:

[http://www.podcastforteachers.org/childrenfirstwebsite/cfresources/catm\\_introduction.pdf](http://www.podcastforteachers.org/childrenfirstwebsite/cfresources/catm_introduction.pdf)

# **ANNOTATED BIBLIOGRAPHY OF RESEARCH ON EMDR IN INDIVIDUAL AND GROUP PSYCHOTHERAPY WITH CHILDREN**

**Robbie Adler-Tapia, Ph.D.**

## **RESEARCH ON EMDR IN INDIVIDUAL PSYCHOTHERAPY WITH CHILDREN**

**Adler-Tapia, R.L. & Settle, C.S. (In press).** EMDR in the treatment of childhood depression: Findings from a pilot study.

These researchers conducted a fidelity study on the ability of therapists to demonstrate adherence to the EMDR protocol with children two to ten years who were identified as victims of crime including child abuse or witnesses to homicide. The researchers used a manualized research protocol and on-going consultation with the research therapists who were all fully trained in EMDR and had advanced training on using EMDR with young children to treat children. Even though this study was a fidelity study focused on documenting therapists' ability to adhere to the EMDR protocol with young children, pre/post-test measures were implemented. Twelve children ages 3 to 9 years were referred for EMDR psychotherapy in this pilot study and were assessed pre-treatment with the Children's Impact of Events Scale, PTSS and the BASC (Behavioral Assessment System for Children) during intake. The children then participated in EMDR treatment with the full eight stages focused on reprocessing one identified target while containing other potential targets. The children were assessed post-treatment with repeated measures. Of the 7 children who completed the treatment protocol, all 7 children initially were assessed as displaying significant depressive symptoms prior to treatment and then demonstrated a significant reduction in depressive symptoms following treatment as assessed with the BASC. As noted on the BASC scale, all seven children were assessed by parents and teachers as displaying symptoms in the "At risk" or "Clinically Significant" range pre-treatment, with all 7 children assessed as being in the "Normal range" following 12 sessions of treatment with the EMDR protocol.

**Ahmad, A., Larsson, B., & Sundelin-Wahlsten, V. (2007).** EMDR treatment for children with PTSD: Results of a randomized controlled trial. *Nordic Journal of Psychiatry*, 61(5), 349–354.

*Ahmad, et. al., (2007)* conducted a randomized control study comparing the treatment efficacy of EMDR versus wait list control for two groups of children diagnosed with PTSD. Children were randomly assigned to either treatment with EMDR or to a wait list control (WLC). From a pool of 170 children referred to the study, 59 children were diagnosed with PTSD with 33 children enrolled in the study. Children were assigned to either EMDR treatment (17 children) or WLC (16 children.) The authors noted that the children in the EMDR treatment group received EMDR with modifications of the EMDR protocol. The authors noted that these modifications were documented in another article by the authors submitted for publication at the time of the publication of this study. In this study, therapists provided eight weekly outpatient sessions for a maximum of 45 minutes per child. The authors concluded that, the children who received EMDR treatment showed significant improvement specifically in the re-experiencing symptoms associated with PTSD

**Chemtob, C., Nakashima, J., & Carlson, J. (2002).** Brief treatment for elementary school children with disaster-related posttraumatic stress disorder: A field study. *Journal of Clinical Psychology*, 58(1), 99–112.

*Chemtob, et al. (2002)* used a used an ABA randomized lagged groups design to evaluation the use of three sessions of EMDR to treat forty children who were assessed as meeting the criteria for PTSD three years following a natural disaster. This study conducted assessments for trauma related symptoms with children who continued to display symptoms of PTSD following Hurricane Iniki in Hawaii. Designed to assess the efficacy of clinical treatment for children following a disaster, this was a controlled study aimed at evaluating the use of a brief treatment for post-disaster PTSD in children. This study was not designed to evaluate the efficacy of EMDR, but instead focused on the need for post-disaster treatment for children. The authors explained their rationale for choosing EMDR as the treatment method for this study and concluded that EMDR was manualized allowing for treatment fidelity and evidence of the potential for rapid treatment effects because previous studies on adults indicated the treatment efficacy with single traumatic events. Though not specifically focused on assessing the efficacy of EMDR as a treatment methodology, this study reported improvement in symptom presentation following three sessions of EMDR for children with disaster related PTSD.

**Cocco, N., & Sharpe, L. (1993).** An auditory variant of eye movement desensitization in a case of childhood post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 24(4)*, 373–377.

*Cocco and Sharpe (1993)* recorded a case study on the use of EMDR to treat PTSD in a four year-old boy. The authors reported that they used the “EMD procedure” to treat the child’s symptoms and the authors found a reduction in symptoms after three weeks. In this study, the authors documented a single case study in which the therapist used pieces of the EMDR protocol to treat a four year old. This study was one of the first studies to document the application of the EMDR protocol to a very young child.

**de Roos, C., Greenwald, R., de Jongh, A., and Noorthorn, E.O. (2004, November).**

EMDR (Eye Movement Desensitization and Reprocessing) versus CBT (Cognitive Behavioral Therapy) for disaster-exposed children: A controlled study. Poster session presented at the annual meeting of the International Society for Traumatic Stress Studies, New Orleans.

In this study, the researchers conducted a comparative study of EMDR versus CBT with fifty-two children 4-18 years following a fireworks factory explosion in Enschede, the Netherlands on May 13, 2000. The children were referred to the Mental Health Disaster After Care Center Mediant in Enschede and randomly assigned to either EMDR or CBT with 28 children referred to each treatment condition. Upon follow up, the researchers reported that 20 children in the CBT condition and 18 in the EMDR condition completed treatment. The researchers concluding that statistically, both treatment protocols were effective with EMDR statistically demonstrating a larger mean change per session requiring fewer sessions of treatment. The authors of this study noted that all therapists were fully trained in both EMDR and CBT and a manualized treatment protocol was used and evaluated by independent raters. The researchers also reported that the children in the EMDR group received a mean number of 3.2 sessions while the CBT group received a mean number of 4.0 sessions. Upon follow up, treatment results were maintained.

**Greenwald, R. (1994).** Applying eye movement desensitization and reprocessing (EMDR) to the treatment of traumatized children: Five case studies. *Anxiety Disorders Practice Journal, 1(2)*, 83–97.

**Greenwald (1994).** Documented five case studies of EMDR with children. The author provided two sessions of psychotherapy to five children referred to the writer following Hurricane Andrew

that hit Florida in 1992. The author reportedly administered a Structured Interview to the mother one to two weeks following the hurricane and just prior to treatment. In addition, the Problem Rating Scale (PRS) was administered to the mothers to assess the child's disturbance on each symptom as an estimate one week before the hurricane, the second week after the hurricane, and the week after treatment was completed, and measured Subjective Units of Disturbance (SUD) were administered during treatment. The author also wrote that follow-up telephone interviews were conducted one week and four weeks after the final treatment session noting that the children displayed improvement following treatment.

**Jaberghaderi, N., Greenwald, R., Rubin, A., Dolatabadim, S., & Zand, S. O. (2002).** A comparison of CBT and EMDR for sexually abused Iranian girls. *Clinical Psychology and Psychotherapy, 11*, 358-368.

*Jaberghaderi, et al. (2002)* compared EMDR with Cognitive Behavioral Therapy (CBT) in treating Iranian girls who had been sexually abused. The researchers randomly assigned fourteen girls ages twelve to thirteen years to CBT or EMDR treatment and then compared treatment outcomes between the two groups. The researchers conducted pre and post test measures including the CROPS, PROPS, Rutter Teacher Scale, and SUD that were administered pre-treatment and two weeks post-treatment. The researchers concluded that "Both treatments showed large effect sizes on the post-traumatic symptoms outcomes and a medium effect size on the behaviorally outcome, all statistically significant. A non-significant trend on self-reported post-traumatic stress symptoms favored EMDR over CBT."

**Muris, P., Merckelbach, H., Holdrinet, I., & Sijsenaar, M. (1998).** Treating phobic children: Effects of EMDR versus exposure. *Journal of Consulting and Clinical Psychology, 66*, 193–198.

**Muris, P., Merckelbach, H., van Haften, H., & Mayer, B. (1997).** Eye movement desensitization and reprocessing versus exposure in vivo: A single-session crossover study of spider-phobic children. *British Journal of Psychiatry, 171*, 82–86.

*Muris, et al. (1997 & 1998)* compared the use of EMDR versus exposure therapy in the treatment of children with spider phobias. The researchers concluded that there was not significant improvement from the use of EMDR. This study was the first to compare the use of exposure therapy and EMDR to the treatment of spider phobia in children. The researchers randomly assigned 26 children identified as "spider phobic" to three treatment conditions. The first phase of treatment consisted of either one, 1.5 hour session of EMDR (that reportedly followed the protocol recommended by Shapiro), computerized in vivo, or in vivo exposure therapy and then the children's symptoms were evaluated. A second phase of treatment included having all the children participate in a 2.5 hours group session of exposure in vivo. The researchers then administered a second series of assessments to all participants and concluded that exposure in vivo remains the treatment of choice for childhood spider phobia (pp. 193). This study is methodologically limited by the number of subjects in each treatment condition; the use of one, 1.5 hour session of EMDR for the treatment of 9 children, the multiple conditions including individual and group treatment.

**Oras, R., Cancela De Ezpeleta, S., & Ahmad, A. (2004).** Treatment of traumatized refugee children with eye movement desensitization and reprocessing in a psychodynamic context. *Nordic Journal of Psychiatry, 58*, 199–203.

*Oras, et al, (2004)* used EMDR to treat 13 children ages eight to sixteen years of age who were residing in a refugee camp in Sweden with their families between 1996 and 1999. All of the children had been exposed to terrorism and were placed in the refugee camp waiting to find out

the status of their applications to be granted asylum in Sweden. The children were referred to The Department of Child and Adolescent Psychiatry at Uppsala University Hospital in Sweden. The authors reported that EMDR was combined with talk therapy, play therapy and other treatment modalities depending on the needs of the child. Treatment sessions ranged from five to twenty-five sessions with EMDR focused therapy varying from one to five sessions per child client. The authors summarized the EMDR eight phase protocol in the article; however, a manualized treatment protocol and fidelity were not assessed. The authors initially assessed the children's symptoms with the PTSS-C, GAF and then re-assessed following treatment completion. The authors found a significant improvement in functioning and PTSD symptoms, especially in re-experiencing. On the PTSS-C and the GAF scales that were administered pre/post treatment, the therapists concluded that the children's PTS symptoms improved or abated, but that the children who presented with no symptoms following treatment were children whose families had been granted asylum and were living in permanent housing. The researchers concluded that the children demonstrated the most significant progress in symptoms associated with re-experiencing, but less on avoidance. This study is the first outcome study of individual treatment of EMDR with children to document the use of EMDR for children living in extreme uncertainty and difficult conditions in a refugee camp. Even though the authors included an overview of the EMDR eight phase treatment protocol in their article, the authors did not use a manualized treatment protocol nor was fidelity assessed. The authors reported that they integrated talk therapy, play therapy, and psychodynamic treatment into the treatment of the children. In this study, the treating psychologist did not administer the pre/post measurements in order to allow for improved validity from independent raters.

**Puffer, M., Greenwald, R., & Elrod, D. (1997).** A single session EMDR study with twenty traumatized children and adolescents. *International Electronic Journal of Innovations in the Study of the Traumatization Process and Methods for Reducing or Eliminating Related Human Suffering*, 3(2), Article 6. Retrieved February 28, 2008 from <http://www.fsu.edu/~trauma/v3i2art6.html>

*Puffer et al. (1997)* used a lag time design to assess the efficacy of one session of EMDR for children identified as having "a single traumatic memory." In this study, twenty two children ages eight to seventeen years were "evenly split into treatment and delayed-treatment groups on a convenience basis (they could choose to start before or after school vacation.)" The children were all administered the Children's Manifest Anxiety Scale (CMAS), Impact of Events Scale (IES), Subjective Units of Distress Scale (SUD), and, Validity of Cognition Scale (VOC) prior to starting treatment, which consisted of a single 90 minute session of EMDR provided by a doctoral student who had completed "the first half of the training available through the EMDR Institute." (pp. 4). The researchers concluded that "...the measures which focused directed on the traumatic memory (IES, SUD, VOC) all showed a stronger response to the EMDR treatment than did the CMAS, a more global measure of anxiety. (pp. 5). In this study again, since no manualized treatment protocol was used, it is difficult to determine what treatment the children received. This further compounds the study in that the doctoral student providing the therapy had not completed basic training in EMDR and that it would be difficult to imagine how a therapist could complete eight phases of treatment adhering to the EMDR protocol in ninety minutes.

**Rubin, A., Bischofshausen, S., Conroy-Moore, K., Dennis, B., Hastie, M., Melnick, L., et al. (2001).** The effectiveness of EMDR in a child guidance center. *Research on Social Work Practice*, 11(4), 435–457.

*Rubin et al. (2001)* randomly assigned 39 children ages 6-15 years in sibling sets to either the treatment or control group in an effort to compare treatment outcomes for children treated at a child guidance center. Forty-one percent of the children in this study had a parent with a diagnosable mental illness. The researchers gave one of the child's parents the Child Behavioral

Checklist to complete. At pre-test 33 of the 39 participants in the study had clinically elevated scores on the CBCL. In this study, the control group of children consisted of 16 children who received the center's standard of care treatment with the treatment group of 23 children receiving the same treatment as the control group along with the addition of three sessions of EMDR. The children in the study reportedly received a combination of individual play therapy, group therapy, and family therapy with the median number of sessions 21 for the experimental group and 22 for the control group with the range of therapy sessions not noted in the researcher study. The researchers concluded that no statistically significant findings were noted on post-test scores with either the treatment or control groups in this research study. The researchers concluded that more research needs to be conducted, but that no statistically significant findings were noted on post-test scores with either the treatment or control groups in this research study. The researchers noted that the children presented with mixed mental health diagnoses, 33% were taking psychotropic medications, and 41% had a parent diagnosed with a mental health disorder. Since the children demonstrated a range of clinical diagnoses and 41% of the children lived with a parent with a diagnosed mental health disorder, it is difficult to determine what variables may have impacted treatment outcomes.

**Scheck, M., Schaeffer, J.A., & Gillette, C. (1998).** Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. *Journal of Traumatic Stress, 11*, 25-44.

To study the efficacy of *Eye Movement Desensitization and Reprocessing (EMDR)* with traumatized young women, 60 women between the ages of 16 and 25 were randomly assigned to two sessions of either EMDR or an active listening (AL) control. Factorial ANOVA (analysis of variance) interaction effects and simple main effects for outcome measures (*Beck Depression Inventory, State-Trait Anxiety Inventory, Penn Inventory for Posttraumatic Stress Disorder, Impact of Event Scale, Tennessee Self-Concept Scale*) indicated significant improvement for both groups and significantly greater pre-post change for *EMDR*-treated participants. Pre-post effect sizes for the *EMDR* group averaged 1.56 compared to 0.65 for the AL group. Despite treatment brevity, the post treatment outcome variable means of *EMDR*-treated participants compared favorably with non-patient or successfully treated norm groups on all measures.

**Soberman, G., Greenwald, R., & Rule, D. (2002).** A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problems. *Journal of Aggression, Maltreatment and Trauma, 6*(1), 217-236.

*Soberman et al. (2002)* conducted a study where the researchers added three sessions of EMDR to the treatment protocol to 29 boys ages ten-to-sixteen years of age diagnosed with conduct disorder who were being treated at a mental health program that included both inpatient and outpatient treatment services. The boys were randomly assigned to either standard care or standard care "plus 3 trauma focused EMDR sessions." Soberman, et al. (2002) used EMDR to treat the suspected trauma underlying the overt presentation of conduct problems. This study found a significant reduction in "memory-related distress, as well as trends towards reduction of post-traumatic symptoms." The study also found that the boys who received the EMDR sessions also "showed large and significant reduction of problem behaviors by 2-month follow-up." (pp. 217). This is the first study to use EMDR to treat children diagnosed with conduct problems and conceptualize the children as having underlying trauma driving the overt behavioral symptoms.

**Tufnell, G. (2005).** Eye movement desensitization and reprocessing in the treatment of pre-adolescent children with post-traumatic symptoms. *Clinical Child Psychology and Psychiatry, 10*(4), 587-600.

Tufnell (2005) used EMDR to treat 4 children ages 4 years, 5 years, 10 years, and 11 years of age who were referred for psychotherapy after experiencing motor vehicle accidents and demonstrating post-traumatic stress symptoms. No standardized measures were used to assess the children's symptoms or functioning. All symptoms were based on parent report and therapist assessment. The author noted that treatment consisted of narrative EMDR sessions for the younger children and 3 sessions of EMDR for the two older children with a maximum 7 sessions for the children. In this article, the Tufnell concluded that treatment was rapid and efficacious. This study is the first published study documenting the use of EMDR for young children who had experienced motor vehicle accidents through the therapist's narrative of the treatment.

**Wanders, F., Serra, M., & de Jongh, A. (In press).** EMDR versus CBT for children with self-esteem and behavioral problems: A randomized controlled trial.

*Wanders et al.* (In press) conducted a comparative study of EMDR versus CBT with 26 children with behavioral problems were randomly assigned either four sessions of EMDR or CBT prior to standard of care in inpatient or outpatient clinics. On post-treatment assessment and six month follow-up, EMDR and CBT were found to have significant positive effects on behavioral and self-esteem problems with EMDR treatment more rapid and without homework as needed with CBT.

### **RESEARCH ON THE EMDR GROUP/BUTTERFLY HUG PROTOCOL WITH CHILDREN**

Adúriz, M., Bluthgen, C., Gorrini, Z., Maquieira, S., Nofal, S., & Knopfler, C. (in press). *Journal of Psychotraumatology for Iberoamérica*. The flooding in Santa Fé, Argentina.

Fernandez, I., Gallinari, E., & Lorenzetti, A. (2004). A school-based eye movement desensitization and reprocessing intervention for children who witnessed the Pirelli Building airplane crash in Milan, Italy. *Journal of Brief Therapy*, 2(2), 129–135.

**Fernandez, et al. (2004)** illustrated the use of EMDR with 236 school children between the ages of six and eleven years who had witnessed an airplane crash. This study included the largest population of children in a study of the EMDR group protocol. "The 'butterfly hug' is an "intervention that uses dual attention stimulation along with various aspects of the standard EMDR protocol" Jarero, et al (1999). Based on teacher reports thirty days after the treatment, the researchers concluded that all but two children had returned to pre-disaster functioning.

**Jarero, et al. (2006)** conducted a study on the EMDR Group Protocol with children in Piedras Negras, Mexico where a flood killed residents and destroyed many homes. The research team treated forty-four children ages 8-15 years with twenty-two boys and twenty-two girls participating in the study. The researchers used the EMDR Group Protocol created by the authors (Jarero, et. al, 1999) to treat the children. The researchers in this study conducted pretest and post-test assessments using the Children's Reaction to Traumatic Events Scale (CRTES) by Jones (2002) and found a significant drop in CRTES scores at a four week follow up with the group.

**Korkmazlar-Oral, U., & Pamuk, S. (2002).** Group EMDR with child survivors of the earthquake in Turkey. In J. Morris-Smith, Ed., EMDR: Clinical applications for children. *Association for child psychology and psychiatry: Occasional Papers Series*, 19, 47-50. William Yule, Ed. ACPD Occasional Paper Series Editor.

**Korkmazlar-Oral and Pamuk (2002)** treated two groups of children after an earthquake in Turkey with the EMDR group protocol. In this study, sixteen children ages ten and eleven were provided EMDR as a group activity. In order to be included in the study, the child had to have lost an immediate family member and had their home demolished, but the child could “no opportunity to share his/her experiences with anyone.” The entire treatment was reportedly provided in 3.5 hours. As the authors note, this article was written to document a humanitarian project to treat traumatized children and was not designed as a research study; therefore, it was only possible to report anecdotal data. This study was a field study where research methodology was secondary to treating the children who had experienced a disaster situation.

**Wilson, Tinker, Hofmann, Becker, & Marshall (2000, November)** presented a paper entitled *A field study of EMDR with Kosovar-Albanian refugee children using a group treatment protocol* at the annual meeting of the International Society for the Study of Traumatic Stress, San Antonio, Texas. The researchers conducted a field study of children in a refugee camp for ethnic Albanians from Kosovo in Hemar, Germany. Dr. Tinker reported that he and Dr. Wilson treated two groups of children with the Butterfly Hug Group Protocol. The younger group included seventeen children ages 6-10 years and an older group of nine children ages 11-13.

In this study, the children’s symptoms were measured pre and post treatment with the Saigh Children’s PTSD Inventory measure, and the Children’s Brief Psychiatric Rating Scale. In this field study, the children had experienced high levels of distress and trauma in their lives albeit not necessarily the same traumatic event. Valid pre and post treatment measures were used for both groups of children; however, the older group had already participated in treatment for six months prior to participating in the group protocol. The researchers were responding to the needs of the children and conducted the study secondary to meeting the mental health needs of the children.

**Zaghrou-Hodali, et al. (2008)** conducted a field study of children who had experienced a shooting in Bethlehem. Researchers noted that in addition to treating the children’s reactions to traumatic events in their homes and communities, the EMDR Group Protocol treatment contributed to the children demonstrating increased resiliency when the children encountered new traumatic events. Zaghrou-Hodali, et al. (2008), reported that seven children, ages 8-12 years were referred by their parents for psychological help following a shooting in which four of the children were injured and another child who was playing with the group was more seriously injured and received individual EMDR later when he was well enough to participate. The seven children were treated by two, fully trained EMDR therapists who had also been trained in the group protocol and had extensive clinical experience. The treatment included four sessions and a follow up session completed “between four and five months after the fourth consultation. (pp. 13). Zaghrou-Hodali, et al., reported using the Butterfly Hug protocol as described by Wilson et. al. (2000) that includes the eight phases of the EMDR protocol.

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## **EMDR WITH A TRAUMATIZED CHILD**

### **Case Example**

Roberto is 9 years old. His mother is 6 months pregnant. She has a long-term boyfriend now. Roberto does not know his father.

On the way home from a visit with friends late at night, a pedestrian stepped in front of the family vehicle. Mother's boyfriend was driving. One pedestrian suffered minor injuries and was transported to the hospital, but the other pedestrian was struck and instantly killed. Roberto did not leave the vehicle, but did get a glimpse of the body. His immediate concern was the well being of his pregnant mother.

In the first few weeks following the accident his mother noticed few signs of trauma, although Roberto did begin sleeping with his mother. However, his teacher (a long-term substitute for a well-liked teacher on maternity leave) began calling his mother about increasing behavioral problems. When he was suspended for two days for insubordinate behavior his mother called to arrange an appointment for Roberto.

There is no pre-accident history of mental illness, behavioral problems, or counseling. The family denies previous trauma.

Family history is significant for maternal phobia about driving. Mother reports that she has been in multiple car accidents and has always feared driving. Because this is a significant source of stress for her and her boyfriend, she had planned to take a test for a driver's permit. She was scheduled to take it two days after the accident occurred. She cancelled the test and has not rescheduled it.

The mental status exam revealed a friendly engaging child who is fully oriented, intelligent and well spoken. There is no evidence of thought disturbance or lethality risk. Although well within normal limits during the evaluation, he agrees that he becomes quickly irritable and has in recent weeks acted out physically—tearing up his room at night, throwing and breaking objects—all out of character for him. At school he has been cocky and disrespectful with the teacher. He also has periods of being quite clingy with his mother. He checks the locks of the doors and windows at home repeatedly and insists that everyone in the car is wearing a seatbelt. He has heightened startle response. While driving in the car recently, they were almost hit by another car, and Roberto had a flashback of the accident. He has had a significant decrease in sleep and reports initial and middle insomnia. He is getting about 5-6 hours of interrupted sleep each night. He reports fear of the dark and fear of being alone in his room. He sleeps with the ceiling and closet lights on and the door open. He fears that something will come through his window and that there is something in his closet. He reports frequent nightmares of the accident in which the pedestrian victim gets up from the ground and comes after him. He repeatedly states, *"It is so stupid. I'm stupid to be scared. I know it isn't real."* When asked how long he has had these fears he firmly states, *"Since January 5<sup>th</sup>, the date of the accident."* He reports that before that he wasn't afraid of anything.

When asked about school, he reports that he "hates" his substitute teacher and that the teacher does not like him. His regular teacher, whom he adores, went on maternity leave in January and won't be back until the end of May. He has had perfect attendance each year of school until this suspension. He reports that "nothing" is going well at school right now.

The clinician gained informed consent for EMDR from parents and client. Roberto was not fond of Eye Movements, but he really liked alternating hand squeezes, so he chooses this for processing.

The session proceeded as follows (with dots indicating hand squeezes):

### **PREPARATION/Modified Safe Place**

**Clinician:** *"Is there anything you can think of that has gone well since January 5P<sup>th</sup>?"*

**Roberto:** *"No"*

**Clinician:** *"What has gone a little bit well?"*

**Roberto:** *"Joe is driving really careful."*

**Clinician:** *"Think about that"...*

**Roberto:** *"Everyone is wearing their seatbelt...They aren't fussing as much anymore"...*

**Clinician:** *"What are they doing instead?"*

**Roberto:** *"Talking, not fussing."*

**Clinician:** *"Think about that"...*

**Roberto:** *"I got a new bed."*

**Clinician:** *"How do you like it?"...*

**Roberto:** *"I can see everywhere in my room from it."*

**Clinician:** *"Think about that"...*

**Roberto:** *"I can see the closet and the window and the door....It's good, I won't be scared in it."*

**Clinician:** *"Think about that"...*

**Roberto:** *"It's my new super bed."...*

**Clinician:** *"And how about at school, what's going well there?"*

**Roberto:** *"Nothing, my teacher hates me."*

**Clinician:** *"What's something that's a little okay at school, what classes do you like?"*

**Roberto:** *"Recess, playing tetherball."*

**Clinician:** *"Think about that"...*

**Roberto:** *"And art...music...gym...math."*

**Clinician:** *"Who at school cares about you?"*

**Roberto:** *"No one...Miss Jones."*

**Clinician:** *"Think about Miss Jones caring for you. Who else at school cares for you?"*

**Roberto:** *"Mrs. Jordan... Mr. Braddock... Mrs. Snyder...Miss King...Miss Eichstat."*

**Clinician:** *"Think about all of those people caring about you...where can you feel them caring about you?"...*

**Roberto:** *"In my heart."*

**Clinician:** *"Notice that"...*

He then tells the clinician he is most concerned about the dreams, making it clear that he is ready to work on them.

**Clinician:** *"Do you want to do squeezes to see if we can get those thoughts unstuck?"*

**Roberto:** *"Yes."*

We discuss the event. What is more disturbing to Roberto than the actual event is the recurring dream and we decide to target that.

### **REPROCESSING**

**PRESENTING ISSUE:** Car accident in which the client was a passenger and a pedestrian was killed.

**PICTURE (worst part of the dream):** *"The man is lying on the ground and he gets up and comes towards me"*

**NEGATIVE COGNITION:** *"I am stupid to be so scared."*

**POSITIVE COGNITION:** *"I am calm and safe and brave."*

These are not perfect cognitions, however the clinician accepts them. The "resonance" is appropriate.

**VOC:** 3

**EMOTIONS:** *"Scared."*

**SUD LEVEL:** *"All the way to the ceiling-9."*

**BODY SENSATION:** *"In my head and chest."*

Roberto is asked to hold the picture of the man coming towards him, the feeling of being scared, and the thought, "I am stupid to be so scared." No need to ask him to hold body sensations, they are already present. He is asked to watch it as though it were a video on TV..... [Dots indicate sets of hand squeezes.]

**Roberto:** *"The man is coming towards me"...*

**Clinician:** *"Think about that"...*

**Roberto:** *"My mom told me he's a Christian"...*

**Clinician:** *"What does that mean?"...*

**Roberto:** *"He's a good man...He doesn't want to hurt me...I will just go up to him and shake his hand...It's gone...I'm not scared anymore...It's gone"...*

When asked to picture the accident and the man coming towards him and to give a SUD level, Roberto kneels on the floor, puts his hand on the carpet and says, *"It's all the way to the ground. I'm not scared."*

We further install this feeling of safety and then his new super bed. He imagines turning off the lights and getting into bed this evening and being able to see everywhere in the room. He says, *"I will be fine. I'm not afraid."*

Roberto is pleased with the results of the session and was eager to tell his mother and her boyfriend what happened. He is pleased listening to my report of the session.

At a follow up session 2 ½ weeks later, Roberto is doing very well. He is sleeping soundly at night and has had no nightmares. He is sleeping with the ceiling light off, but keeps the closet light on. He says his mom keeps her closet light on too. He has stopped checking locks repeatedly, and no longer procrastinates about going to bed. There have been no calls or letters from the school. When mother stops in to see the teacher, she reluctantly admits that Roberto has not been a problem lately. Roberto reports that he decided that although he liked it when the kids had laughed at the jokes and behaviors that got him in trouble that the kids and teachers were "making a fool out of (him)." Asked how he is handling getting along with a teacher that apparently still doesn't like him he says, *"I just ignore her. I do what she says, like stand by her desk, but I don't get an attitude. I just keep pretending that it is almost the end of May (when his teacher will return)."* Asked overall, how the last 2 ½ weeks have been he says, *"It seems like a dream...it has been so nice."*

## IMPACT OF EVENT SCALE-REVISED

**Instructions:** Below is a list of difficulties people sometimes have after stressful life events. Please read each item and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to \_\_\_\_\_, how much were you distressed or bothered by these difficulties?

|   | Not<br>at all | Little<br>bit | Moder-<br>ately | Quite<br>a bit | Extr-<br>emely |
|---|---------------|---------------|-----------------|----------------|----------------|
| 1-Any reminder brought back feelings about it.  | 0             | 1             | 2               | 3              | 4              |
| 2-I had trouble staying asleep.   | 0             | 1             | 2               | 3              | 4              |
| 3-Other things kept making me think about it.   | 0             | 1             | 2               | 3              | 4              |
| 4-I felt irritable and angry.   | 0             | 1             | 2               | 3              | 4              |
| 5-I avoided letting myself get upset when I thought about it or was reminded of it.           | 0             | 1             | 2               | 3              | 4              |
| 6-I thought about it when I didn't mean to.   | 0             | 1             | 2               | 3              | 4              |
| 7-I felt as if it hadn't happened or wasn't real.   | 0             | 1             | 2               | 3              | 4              |
| 8-I stayed away from reminders about it.  | 0             | 1             | 2               | 3              | 4              |
| 9-Pictures about it popped into my mind.  | 0             | 1             | 2               | 3              | 4              |
| 10-I was jumpy and easily startled.   | 0             | 1             | 2               | 3              | 4              |
| 11-I tried not to think about it.   | 0             | 1             | 2               | 3              | 4              |
| 12-I was aware that I still had a lot of feelings about it, but I didn't deal with them.      | 0             | 1             | 2               | 3              | 4              |
| 13-My feelings about it were kind of numb.  | 0             | 1             | 2               | 3              | 4              |
| 14-I found myself acting or feeling like I was back at that time.                             | 0             | 1             | 2               | 3              | 4              |
| 15-I had trouble falling asleep.  | 0             | 1             | 2               | 3              | 4              |
| 16-I had waves of strong feelings about it.   | 0             | 1             | 2               | 3              | 4              |
| 17-I tried to remove it from my memory.   | 0             | 1             | 2               | 3              | 4              |
| 18-I had trouble concentrating.   | 0             | 1             | 2               | 3              | 4              |
| 19-Reminders of it caused me to have physical reactions, such as sweating, trouble breathing. | 0             | 1             | 2               | 3              | 4              |
| 20-I had dreams about it.   | 0             | 1             | 2               | 3              | 4              |
| 21-I felt watchful and on-guard.  | 0             | 1             | 2               | 3              | 4              |
| 22-I tried not to talk about it.  | 0             | 1             | 2               | 3              | 4              |

Impact of Event Scale - Revised

Scoring Information

Avoidance Subscale = mean of items 5, 7, 8, 11, 12, 13, 17, 22

Intrusion Subscale = mean of items 1, 2, 3, 6, 9, 16, 20

Hyperarousal Subscale = mean of items 4, 10, 14, 15, 18, 19, 21

**Assessing Psychological Trauma and PTSD  
A Handbook for Practitioners**

Chapter 15: The Impact of Event Scale-Revised

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# **CLINICAL SIGNS OF DISSOCIATIVE DISORDERS**

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## **History of years of psychotherapy with little progress**

(Kluft, 1985; Putnam et al., 1986).

- a. Client has varying diagnoses over the years.
- b. Client may have a history of multiple psychiatric hospitalizations with different diagnoses.

## **Symptoms of depersonalization and/or derealization (Putnam et al., 1986).**

For example, the client:

- a. Doesn't feel like her/himself (e.g. bigger or smaller).
- b. Reports that her/his surroundings do not look the same.
- c. Looks in the mirror and sees something other than typical reflection.
- d. Experiences "floating" alongside or above the body.
- e. Reports that daily environment seems dream-like or as if (s)he is walking in a fog.

## **Memory lapses (Putnam et al., 1986)**

For example, the client:

- a. Does not recall how she/he got to the shopping mall.
- b. Finds unfamiliar items at home, and does not recall buying them or how they were acquired.
- c. (S)he cannot offer a coherent narrative history. However, this also may occur because of substance abuse, illness, depression, and dementia. Note that a highly organized DID patient may confabulate and fill in the amnesic "gaps".

## **Flashbacks and intrusive thoughts**

- a. The client has flashbacks and intrusive thoughts for childhood events or recent traumata.
- b. DID can be conceptualized as resulting from chronic, serial PTSD (Spiegel, 1993).

## **Schneiderian symptoms (Kluft, 1987; Ross et al., 1990)**

Of the 11 first-rank Schneiderian symptoms, the client may endorse several of them.

For example, the most frequently reported include:

- a. Hearing "audible thoughts" or "voices arguing". However DID clients usually say that they hear voices in the head, not externally (as in schizophrenia)?
- b. Experiencing "made" feelings, i.e., feelings that come out of the "blue" without having a logical way of explaining them.
- c. Having "made" thoughts and behaviors or other of the first-rank symptoms may be reported.

DID patients report more frequent first-rank symptoms than patients having schizophrenia (Ross et al., 1990)?

The DID patient will show a full range of affect whereas the schizophrenic patient usually will demonstrate blunted affect.

## **Somatic symptoms (Putnam, 1989, pp. 65-67)**

The client may:

- a. Report chronic headaches that are intractable to over-the-counter analgesics.
- b. Have physical complaints and pain that physicians cannot account for and which may be "somatic memories".

## **Sleep disturbance (Loewenstein, 1991)**

The client may report frequent nightmares or night terrors. Note that sleepwalking is usually associated with a dissociative disorder.

## **Depression**

One of the primary complaints of the DID patient is an affective disorder. Frequently, there is a history of suicide attempts or suicidal ideation. (Putnam et al., 1986).

All clients should complete the Dissociative Experiences Scale (DES; Carlson & Putnam, 1992). On the DES, a cut-off score of 20 is recommended (Ross, 1995). For clients scoring greater than that and/or responding positively to these clinical signs outlined above, the clinician should suspect the presence of an underlying dissociative disorder. Administration of the Dissociative Disorders Interview Schedule-DSM-IV Version (DDIS; Ross, 1997, pp. 383-402) or the Structure Clinical Interview for DSM-IV- Dissociation Revised (SCID-D Revised; see Steinberg, 1995) can provide a thorough assessment and help to confirm the actual diagnosis.

## **Screening for Dissociative Disorders**

### **Dissociative Experiences Scale II (Carlson & Putnam, 1993).**

For screening adult clients for dissociative disorders, the most widely researched and clinically used instrument. This is a 28 item self-administered questionnaire that will take your client about 10 minutes to complete and about 10 minutes for the therapist to score. The DES II is to be used with adults older than 18 years of age. It is translated and norms are developed for 16 languages.

### DES-T

The Dissociative Experiences Scale is based on the conceptualization of dissociation as a continuum ranging from normal dissociative experiences, such as "highway hypnosis," daydreaming, or absorption in a book that one is reading, to pathological dissociation that may involve depersonalization/derealization experiences or amnesia for dissociated experiences. More recently, it is demonstrated that there is a discreet variable or taxon of "pathological dissociation" which is distinct from normal or nonpathological dissociation (Waller et al., 1996; Waller & Ross, 1997).

On the DES, the former is illustrated by items such as "Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them." The latter, pathological dissociation, is illustrated by such items as "Some people have the experience of feeling that other people, objects and the world around them are not real" and "Some people have the experience of finding new things among their belongings that they do not remember buying." This class or taxon of pathological dissociation can be assessed by a subset of eight items on the DES and was named the DES-T (Waller et al., 1996). These items are numbers **3, 5, 7, 8, 12, 13, 22 and 27** on the DES. Because scoring of the DES-T is somewhat complicated, a Microsoft Excel 97 spreadsheet was created by Darryl Perry and is in the public domain. It is available and can be downloaded from the website of the International Society for the Study of Dissociation (<http://www.isst-d.org>). The Excel spreadsheet will assist in calculating the probability that any given individual or client is a member of the dissociative taxon, i.e. – dissociates pathologically..

While the DES-T can indicate the probability that a particular individual exhibits pathological dissociative symptoms, it provides neither a thorough assessment nor a conclusive diagnosis of the client's dissociative disorder. It will be necessary to evaluate the client more thoroughly to obtain a definitive diagnosis. Either of three resources are available. These include the Dissociative Disorders Interview Schedule or the Structured Clinical Interview for DSM-IV Dissociation or the Multi-dimensional Inventory of Dissociation (see below).

### Other Available Screening Instruments Include:

#### **Somatoform Dissociation Questionnaire**-developed by Ellert Nijenhuis

The SDQ is available in a 20-item or a five-item format. Both can be obtained on the developer's website.

**Multi-scale Dissociation Inventory (MDI)** developed by John Briere. This is available from Psychological Assessment Resources, Sarasota, FL ([www.par.com](http://www.par.com)).

#### **For the screening of adolescents and children several resources are available:**

**The Adolescent Dissociative Experiences Scale (A-DES)** is a screening instrument only and is available for children ages 11-18 years old. The A-DES is a 30-item self-report that takes the client about 15 minutes to complete. Item content inquires about a range of dissociative symptoms including absorption and imaginal involvement, dissociative amnesia, depersonalization and derealization, and lastly, passive influence (Armstrong et al., 1997).

**The Child Dissociative Checklist (CDC)** is available for screening dissociative symptoms in children ages five to 11 years old. The CDC is a 20-item measure that is completed by a parent or other adult that has significant contact with the child and it takes approximately 15 minutes to complete. Validity and reliability are good (Putnam & Peterson, 1994).

### Follow-Up Evaluation:

**The Dissociative Disorders Interview Schedule-DSM-IV Version (DDIS-DSM-IV) by Colin Ross.** The DDIS is a 132-item structured clinical interview that takes approximately 90 minutes to administer. The items and the manual for scoring are available in his text on Dissociative Identity Disorder (Ross, 1997). Also, the information is available on Dr. Ross' website: (<http://www.rossinst.com>).

**The Structured Clinical Interview for DSM-IV-Dissociative Disorders Revised (SCIS-D Revised) by Marlene Steinberg (1999).** This is also a structured clinical interview and may take approximately two hours to administer. There is data indicating that screening patients with the DES (cut off score=20) and then administering the SCID-D Revised to all patients scoring higher than the cut off score will provide high levels of specificity and sensitivity. This will minimize the potential for "false negative" as well as "false positive" diagnoses (Steinberg, 1999). An adolescent version of the SCID-D is available.

**Multi-Dimensional Inventory of Dissociation (MID) by Paul Dell.** This self-administered personality inventory that can assist the therapist in making a specific diagnosis of a dissociative disorder or its absence. It is available on the website for the International Society for the Study of Trauma and Dissociation ([www.isst-d.org](http://www.isst-d.org)) where you can download at no cost the personality inventory and the administrative manual for its scoring.

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# **MANUAL FOR THE DISSOCIATIVE EXPERIENCE SCALE**

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## **ABSTRACT**

The authors review a wide range of studies that relate to the norms, reliability, and validity of the Dissociative Experiences Scale (DES). Appropriate clinical and research use of the scale are discussed together with factor analytic studies and fruitful statistical analysis methods. Current research with the DES is described and promising new research questions are highlighted. Suggestions are made for translating and using the DES in other cultures. A second version of the DES, which is easier to score, is included as an appendix.

Copies of this manual may be purchased for \$12 from the Sidran Foundation as well as updated information and DES translations (several languages available).

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### **INTRODUCTION**

Carlson & Putnam

Our understanding of the role of dissociative symptoms in psychological disorders has changed significantly over the last decade. Previously, dissociative disorders were thought to be rare and the role of dissociation in other mental disorders was not given much consideration. But recent studies have found incidence rates for multiple personality disorder (the most severe of the dissociative disorders) that range from 2.4 to 11.3 percent of inpatient psychiatric samples (Bliss & Jeppsen, 1985; Graves, 1989; Ross, 1991; Ross, Anderson, Fleisher, & Norton, 1991). Furthermore, high rates of dissociative symptoms have been found in samples of subjects with posttraumatic stress disorder (Branscomb, 1991; Bremner, Southwick, Brett, Fontana, Rosenheck, & Charney, 1992; Carlson & Rosser-Hogan, 1991; Kulka, Schlenger, & Fairbank, 1988; Waid, 1988) and in subjects with histories of childhood abuse (Anderson, Yassenik, & Ross, in press; Chu & Dill, 1990; Coons, Bowman, Pellow, & Schneider, 1989; Coons, Cole, Pellow, & Milstein, 1990; Goodwin, Cheeves, & Connell, 1990; Herman, Perry, & van der Kolk, 1989; Ross, Anderson, Heber, & Norton, 1990a; Sanders & Giolas, 1991; Sanders, McRoberts, & Tollefson, 1989; van der Kolk, Perry, & Herman, 1991). These and other findings reviewed below indicate that dissociation may be an important process for a large number of psychiatric patients.

The Dissociative Experiences Scale was developed to serve as a clinical tool to help identify patients with dissociative psychopathology and as a research tool to provide a means of quantifying dissociative experiences. Though its development and initial validation have been described elsewhere (Bernstein & Putnam, 1986), considerable new research has provided extensive norms for the scale and new information on the scale's reliability and validity. We present here information that should be pertinent to a wide variety of contexts in which the scale is used.

### **DESCRIPTION AND APPROPRIATE USE OF THE SCALE**

The Dissociative Experiences Scale (DES) is a brief, self-report measure of the frequency of dissociative experiences. The scale was conceptualized as a trait measure (as opposed to a state measure) and it inquires about the frequency of dissociative experience in the daily lives of subjects. The scale was developed to provide a reliable, valid, and convenient way to quantify dissociative experiences. It was designed to be useful in determining the contribution of dissociation to various psychiatric disorders and as a screening instrument for dissociative disorders (or disorders with a significant dissociative component such as posttraumatic stress disorder). A response scale that allowed subjects to quantify their experiences for each item was used so that scores could reflect a wider range of dissociative symptomatology than possible using a dichotomous (yes/no) format.

Though the scale has been used to measure dissociation in non-clinical (normal) populations, this was not its intended purpose and users should be aware of this. Since non-clinical subjects typically score in a fairly narrow range at the low end of the scale on the DES, small differences among these subjects may not be meaningful.

Similarly, since the DES was developed for use with adults (persons 18 or older): the language used and the experiences described are appropriate for adults, but may not be appropriate for younger persons. Though the scale had been used in research on persons between 12 and 17 from both the general population and from a psychiatric sample (Ross, Ryan, Anderson, Ross, &

Hardy, 1989; Sanders et al., 1989), the validity of scores for persons under 18 has not been investigated. The scores may have a different meaning for younger persons because they may interpret the questions differently. We are now in the process of developing a DES suitable for use with adolescents.

Finally, the DES was not intended as a diagnostic instrument. High DES scores should not be construed as an indicator of a dissociative disorder diagnosis. The section on the use of cutoff scores provides information about the use of the DES in detecting patients with dissociative disorders. Researchers or clinicians who want a diagnostic instrument should consider using a diagnostic interview for dissociative disorders (see Clinical Use section).

### **DEVELOPMENT OF THE SCALE**

The items for the DES were developed from interviews with persons with DSM-III diagnoses for dissociative disorders and in consultation with experts in the diagnosis and treatment of dissociative disorders. Items were developed that included experiences of disturbance in memory, identity, awareness, and cognition. These included experiences usually labeled amnesia, depersonalization, derealization, absorption, imaginative involvement. Experiences of the dissociation of moods or impulses were excluded from the scale so that the items would not overlap with alterations in mood and impulses associated with affective disorders. In other words, it was thought desirable to avoid having a dissociation scale on which some subjects might have high scores resulting only from frequent experiences of alterations in mood or impulses. Items were worded to be comprehensible to the widest possible range of individuals and to avoid implications of any social undesirability of the experiences.

A discussion of the response scale used on the original version of the scale is provided in Bernstein & Putnam (1986). [A second version of the scale was recently developed to provide a scale which is easier to score, but still provides some precision in quantification (see section on DES II below).

Pilot testing of the scale was completed on two preliminary forms of the scale using normal and schizophrenic subjects. These samples were chosen so that we could insure that questions were understood by a wide range of subjects, including those with severe psychiatric disorders. Comments were also solicited from clinicians treating patients with dissociative disorders.

### **ADMINISTRATION AND SCORING OF THE SCALE**

The scale is a self-report measure, so it is self-administered. Through directions on the cover sheet of the scale, subjects are instructed to only consider those experiences not occurring under the influence of drugs or alcohol when marking answers. In cases when the subject is illiterate or has difficulty reading, the instructions and questions can be read aloud and repeated and the subject can be assisted in marking the appropriate question. If a subject does not understand the response scale line, he or she can be told that the 0% end means "This never happens to you" and the 100% end means that "This is always happening to you."

### **USE OF CUTOFF SCORES WITH THE DES**

The use of a cutoff score to identify those who might have a dissociative disorder or a disorder with a considerable dissociative component is discussed in detail in Carlson et al. (Carlson et al., 1993). As described above, using a total score of 30 or above to identify those who may be severely dissociative will result (on the average) in the correct identification of 74% of those who are MPD and correct identification of 80% of those who are not MPD (Carlson et al., in press). In this analysis, 61% of those who scored 30 or above who were not MPD had posttraumatic stress disorder or a dissociative disorder other than MPD. This means that a very high proportion of

those who score 30 or over will probably have a disorder other than MPD that has a considerable dissociative component. A receiver operating characteristics analysis described in Carlson et al. (1993) indicated that 30 was the optimal cutoff score in terms of maximizing the accuracy of predictions.

By applying Bayes's theorem (Meehl & Rosen, 1955) to the cutoff analysis, we can see what effect the low base rates for MPD have on the accuracy of predictions made from DES scores. The application of Bayes's theorem to the general psychiatric population shows that the probability of a person with MPD scoring under 30 is quite low: if the analysis is representative, only 1% of those scoring under 30 will be MPD. But it is quite probable that those scoring 30 or over are not actually MPD. This is because the frequency of MPD is quite low, even in a psychiatric population (see introduction for estimates of prevalence). In fact, projections from one analysis indicate that only 17% of those in a given sample who score 30 or over on the DES will actually be MPD psychiatric (Carlson et al., 1993). The other 83% of the "high scorers" will be people who do not have MPD, though many of these will have PTSD or a dissociative disorder other than MPD. Clinical users of the DES need to keep these findings in mind and remember that the DES is not a definitive tool for diagnosing patients with MPD, but is a screening tool to identify those who may have high levels of dissociation. Reliable and valid structured clinical interviews for dissociative disorders are available to aid clinicians in making diagnoses (see Clinical Use section below).

### **CLINICAL USE OF THE DES**

Many clinicians have used the DES as a screening device to identify high dissociators, but are unsure how to proceed when someone obtains a high score on the scale. Most times that a client scores over 20 or 30 on the DES, the clinician will want to know more about the dissociative experiences that contributed to the high score. One approach at further investigation would be to use the completed scale to interview the client. For each item worth a score of 20 or more, the clinician could ask the client for an example of the dissociative experience. (E.g. Can you give me an example of the time when you found something among your possessions that you didn't remember buying?") With this method, it is possible to find out if a client has understood a question differently than it was intended. For example, a client might answer the above question with "Sometimes my wife buys me new shirts and I find them in my closet." Clearly, this experience is not an example of dissociation and the high score is misleading.

Another approach would be to use one of two available structured clinical interviews for dissociative disorders. The Dissociative Disorders Interview Schedule developed by Ross (Ross et al., 1989) and the Structured Clinical Interview for DSM-III-R Dissociative Disorders (Steinberg et al., 1990) developed by Steinberg can both be used to make or rule out a dissociative disorder diagnosis.

## DES

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### Directions

This questionnaire consists of twenty-eight questions about experiences that you may have in your daily life. We are interested in how often you have these experiences. It is important, however, that your answers show how often these experiences happen to you when you are not under the influence of alcohol or drugs.

To answer the questions, please determine to what degree the experience described in the question applies to you and circle the number to show what percentage of the time you have the experience.

### Example:

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%  
(never) (always)

Date \_\_\_\_\_ Age \_\_\_\_\_ Sex M\_\_ F\_\_

1. Some people have the experience of driving a car and suddenly realizing that they don't remember what has happened during all or part of the trip. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

2. Some people find that sometimes they are listening to someone talk and they suddenly realize that they did not hear part or all of what was said. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

3. Some people have the experience of finding themselves in a place and having no idea how they got there. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

4. Some people have the experience of finding themselves dressed in clothes that they don't remember putting on. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

5. Some people have the experience of finding new things among their belongings that they do not remember buying. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

6. Some people sometimes find that they are approached by people that they do not know who call them by another name or insist that they have met them before. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**7.** Some people sometimes have the experience of feeling as though they are standing next to themselves or watching themselves do something and they actually see themselves as if they were looking at another person. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**8.** Some people are told that they sometimes do not recognize friends or family members. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**9.** Some people find that they have no memory for some important events in their lives (for example, a wedding or graduation). Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**10.** Some people have the experience of being accused of lying when they do not think that they have lied. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**11.** Some people have the experience of looking in the mirror and not recognizing themselves. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**12.** Some people have the experience of feeling that other people, objects, and the world around them are not real. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**13.** Some people have the experience of feeling that their body does not seem to belong to them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**14.** Some people have the experience of sometimes remembering a past event so vividly that they feel as if they are reliving the event. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**15.** Some people have the experience not being sure whether things that they remember happening really did happen or whether they just dreamed them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**16.** Some people have the experience being in a familiar place but finding it strange and unfamiliar. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**17.** Some people find that when they are watching television or a movie they become so absorbed in the story that they are unaware of other events happening around them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**18.** Some people find that they become so involved in a fantasy or daydream that it feels as though it were really happening to them. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**19.** Some people find that they are sometimes able to ignore pain. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**20.** Some people find that they sometimes sit staring off into space, thinking of nothing, and are not aware of the passage of time. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**21.** Some people sometimes find that when they are alone they talk out loud to themselves. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**22.** Some people find that in one situation they may act so differently compared with another situation that they feel almost as if they were two different people. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**23.** Some people sometimes find that in certain situations they are able to do things with amazing ease and spontaneity that would usually be difficult for them (for example, sports, work, social situations, etc.). Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**24.** Some people sometimes find that they cannot remember whether they have done something or have just thought about doing it (for example, not knowing whether they have just mailed a letter or have just thought about mailing it). Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**25.** Some people find evidence that they have done things that they do not remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**26.** Some people sometimes find writings, drawings, or notes among their belongings that they must have done but cannot remember doing. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**27.** Some people sometimes find that they hear voices inside their head that tell them to do things or comment on things that they are doing. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

**28.** Some people sometimes feel as if they are looking at the world through a fog so that people and objects appear far away or unclear. Circle a number to show what percentage of the time this happens to you.

0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

# **A GENERAL GUIDE TO THE USE OF EMDR IN THE DISSOCIATIVE DISORDERS**

## **EMDR Dissociative Disorders Taskforce**

### **Purpose**

This paper will offer general guidelines in the application of EMDR with the dissociative disorders, with paramount concern for client safety. The intended audience is the established clinician who is new to the diagnosis and treatment of dissociative disorders. The paper is not intended to define standards of care or specific training requirements or certification guidelines. Further, it is not intended to supersede expert clinical judgment or training in dissociative disorders or hypnosis.

### **Assumptions**

The following are some assumptions underlying this paper:

1. EMDR with dissociative disorders is best imbedded within a total treatment approach and does not stand alone as a treatment.
2. There is a high prevalence of undiagnosed dissociative disorders in clinical populations.
3. There is a high cost to patient, therapist, and the therapeutic alliance of failing to adequately consider the possibility of dissociative disorders before first using
4. EMDR in a patient's treatment.

As our understanding continues to develop, these guidelines may need revision. The following is a guide for therapists in evaluating patients in the use of EMDR and determining whether and at what point EMDR may be safely introduced into the patient's treatment.

### **Screening**

1. The therapist should screen every patient for the presence of an underlying dissociative disorder regardless of the presenting complaint. Screening approaches include the DES (Bernstein & Putnam, 1986) or a Mental Status Examination for Dissociative Disorders (Loewenstein, 1991). The therapist has not conducted sufficient screening if that screening is limited to in-session monitoring for evidence of "switching".
2. After screening, if the index of suspicion for a dissociative disorder is low, the therapist may proceed with the Shapiro EMDR protocol including preparatory steps, as appropriate for the presenting problems.

### **Clarifying the Diagnosis**

3. After screening, if the index of suspicion for a dissociative disorder is high, the therapist should conduct further diagnostic clarification (e.g., the DDIS (Ross, 1989) or the lengthier SCID-D (Steinberg, Rounsaville, & Cicchetti, 1991), or should obtain appropriate consultation.
4. If the assessment reveals that a dissociative disorder is present, the decision to proceed with EMDR is best guided by considering both therapist and patient factors, as follows:

### **Assessing Therapist Factors**

1. It should be determined whether the therapist is sufficiently trained in the dissociative disorders, as evidenced by
  - A) having taken formal courses in the area
  - B) having been supervised in the psychotherapy of dissociative patients.

2. It should be determined whether the therapist is sufficiently skilled in the treatment of dissociative disorders as evidenced by such abilities as:
  - A) troubleshooting with hostile alters, child alters, and perpetrator alters
  - B) anticipating and accommodating transferences
  - C) recognizing and working with hypnotic and dissociative phenomena, managing
  - D) crises and determining the need for medical and/or inpatient backup.
3. The therapist should have considerable experience using EMDR on patients without dissociative disorders before attempting it on highly dissociative patients. The therapist needs skill in the “cognitive interweave” interventions and other active interventions described in the Part 2 of the training.
4. Unless the above skills are present, the therapist should either refer the patient, or seek additional training in the fields of dissociative disorders and hypnosis before using EMDR on the dissociative patient (see Appendix A).
5. If the requisite skills and training are present, the therapist may implement EMDR within the context of a thorough treatment plan, only if positive patient factors below are present.

### **Assessing Patient Factors**

Patient factors are important in planning the treatment of dissociative patients, with or without EMDR. Because of the rapidly destabilizing potential of EMDR, however, the patient factors directly affect the risks associated with the procedure.

Assess patient suitability for EMDR treatment by ascertaining if the patient has:

- A) good affect tolerance
- B) a stable life environment
- C) willingness to undergo temporary discomfort for long term relief
- D) good ego strength
- E) adequate social support and other resources
- F) history of treatment compliance

The following assessment is a necessary element of assessment of any dissociative patient for any treatment. With EMDR, however, the costs associated with failing to determine whether the patient exhibits “red flags”, which would tend to argue against the use of EMDR. Those red flags include:

- A) on-going self-mutilation
- B) active suicidal or homicidal intent
- C) uncontrolled flashbacks
- D) rapid switching
- E) extreme age
- F) physical frailty
- G) terminal illness
- H) need for concurrent adjustment of medication
- I) ongoing abusive relationships
- J) alter personalities that are strongly opposed to abreaction
- K) extreme character pathology, especially severe narcissistic, sociopathic, borderline disorders
- L) serious dual diagnoses such as schizophrenia or active substance abuse.

**Note:** The presence of “red flags” may not constitute absolute contraindications. However, the risks and complexities that accrues if the therapist proceeds with EMDR in the presence of these red flags are considerable. The potential benefits must outweigh these risks, and safety precautions must be in place. Only therapists who are highly experienced with

managing those complications are prepared to proceed with EMDR for patients evidencing these red flags.

### **Embedding EMDR in the Treatment Plan**

6. If the therapist and patient factors described above are appropriate, EMDR may be one component in a progressive course of treatment. The total treatment plan is best guided by the accumulated knowledge of the field of dissociation, and may include hypnosis, EMDR, behavior therapy, cognitive therapy, and other methods.

### **Preparing for EMDR**

7. The therapist should prepare the patient for EMDR with the intention of minimizing the likelihood and impact of any problems occurring in the middle of EMDR sessions. At the same time, the therapist needs to “expect the unexpected”, to use Kluff’s phrase. At a minimum, the patient should carefully explain the procedure with the intent of achieving sufficient “informed consent” of the entire system, recognizing that this is not a fully attainable goal. To the degree that the system consents, the EMDR is likely to proceed smoothly. Suggestions for the entire system to observe even if parts are reluctant can prevent surprised alters from aborting the EMDR.
8. The therapist’s preparation of the patient for EMDR may be affected by such factors as:
  - A) system complexity
  - B) informed consent of the relevant portions of the system
  - C) cooperation between the parts
  - D) permeability of dissociative barriers
  - E) overall system motivation for change

A straightforward, cooperative and co-conscious system is easier to prepare for EMDR than one that is hostile, complex, and impermeable. Preparation for EMDR may proceed in tandem with other therapeutic activities including establishing rapport, teaching of affect containment skills, and other educational components.

### **Early Treatment Phases**

Early in the treatment of a dissociative disorder, therapists should refrain from the use of EMDR. Exceptions may exist under extraordinary circumstances to be defined in consultation.

Caution: The use of eye movement too early in treatment risks premature penetration of dissociative barriers. This could produce such results as flooding of the system, uncontrolled destabilization and increased suicidal or homicidal risk. For crisis intervention the therapist should only attempt eye movement if the risks of failing to intervene are as high without as with the intervention.

### **Middle Treatment Phases**

Throughout the integration phase of treatment, the therapist may find various uses for EMDR, including for example:

- A) EMDR’s prototypic application, the neutralization of trauma through abreaction
- B) facilitation of internal dialogue using Ego State Therapy (Watkins, 1992) during EMDR
- C) restructuring of cognitive distortions used as EMDR targets
- D) building of alternative coping behaviors using EMDR installations
- E) ego strengthening through installations Fusion

### **Final Treatment Phases**

In the post-integration and termination stages of treatment, EMDR may have continued application, including for:

- A) additional coping skills development
- B) generalization or learning into new situations
- C) facilitating the patient in making meaning of their life's trauma, pain and healing
- D) resolving remaining obstacles to achievement of life goals.

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### **APPENDIX A-ADDITIONAL TRAINING**

For clinicians who seek additional training in the diagnosis and treatment of dissociative disorders, there are a number of avenues, including the following examples. Note that this list is not intended to be exhaustive nor exclusive.

#### **SOCIETY MEMBERSHIPS**

International Society for the Study of Dissociation (ISSD)

Phone (847) 480-0899

American Society of Clinical Hypnosis (ASCH)

Phone (708) 297-3317

#### **JOURNALS**

ISSD

60 Revere Drive, Suite 500

Northbrook, IL 60062

American Journal of Clinical Hypnosis

Business Manager

2200 East Devon Avenue, Suite 271

Des Plaines, IL 60018

#### **CONFERENCE AND WORKSHOPS**

International Society for the Study of Dissociation

American Society of Clinical Hypnosis

American Psychiatric Association

Privately offered workshops

#### **CONSULTATION**

Some individuals may find private consultation with a recognized expert in the field of dissociative disorders to be beneficial.

### **APPENDIX B- SUGGESTED READING**

The following are a few of the sources available for self study in dissociation:

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## **ADDITIONAL STRESS MANAGEMENT STRATEGIES**

(For incomplete sessions or additional stabilization)

### **A. LIGHT STREAM TECHNIQUE**

- Ask client to concentrate on upsetting body sensations.
- Identify the following by asking, *"If it had a \_\_\_\_\_, what would it be?"*
  - a. shape      d. temperature
  - b. size        e. texture
  - c. color       f. sound (high pitched or low)

Ask, *"What is your favorite color you associate with healing?"*

- Say, *"Imagine that this favorite colored light is coming in through the top of your head and directing itself at the shape in your body. Let's pretend that the source of this light is the cosmos so the more you use, the more you have available. The light directs itself at the shape and resonates, vibrates in and around it. And as it does, what happens to the shape, size or color?"*
- If client gives feedback that it is changing in any way, continue repeating a version of the underlined portion and ask for feedback until the shape is completely gone. This usually correlates with the disappearance of the upsetting feeling. After it feels better, bring the light into every portion of the person's body, and give her a positive statement for peace and calm until the next session. Ask client to become externally aware at count of five.

### **B. SPIRAL TECHNIQUE**

- Client is asked to bring up a disturbing memory and to concentrate on the body sensations that accompany the disturbance. Client is told this is an imaginal exercise and there are no right or wrong responses.

*"When you bring up the memory, how does it feel from 0-10?"*

*"Where do you feel it in your body?"*

- Clinician then asks client to concentrate on body sensations.

*"Concentrate on the feeling in your body. Pretend the feelings are energy. If the sensation was going in a spiral, what direction would it be moving in, clockwise or counterclockwise?"*

- Whatever the client answers, respond, “Good,” and instruct him/her to move the spiral in the opposite direction.

*“Now with your mind, let’s change direction and move the spiral (state clockwise or counterclockwise to indicate the opposite direction). “Just notice what happens as it moves in the opposite direction.”*

Ask, “What happens?”

- If the technique works the client will report that moving in the opposite direction will cause the feelings to dissipate and the SUD to drop. Teach it to the client for self-use. If the client says the spiral doesn’t change, doesn’t move, nothing happens, then choose another technique.

### **C. BREATHING SHIFT**

- Ask the client to bring up a good, happy or positive memory. Try to use whatever affect is most useful. Ask him to notice where his breath is starting and to put his hand over that location in his body. Let him breathe a moment or two and instruct him to notice how it feels. Now ask him to bring up a memory with a low level of disturbance and notice how his breath changes. Ask him to put his hand over that location in his body. Now ask him to change his hand to the previous location and deliberately change his breathing pattern accordingly. This should cause the disturbance to dissipate. Teach it to the client for self-use.

### **D. DIAPHRAGMATIC BREATHING**

- Ask the client to take a deep breath and fill lungs completely so they get the most out of breathing. You may suggest that they scoot forward in their chair and place one hand over their abdomen and the other hand over their chest (Demo for client).
- *“Start by exhaling and then breathe in all the way with your abdomen for a count of two and then breathe in all the way with your chest for a count of two. Hold that for a count of seven and then breathe out all the way with your abdomen for a count of four and breathe out with your chest for a count of four.”*
- Demo for the client and/or do it together. Repeat the sequence four times.

## EMDR EVALUATED CLINICAL APPLICATIONS

EMDR is now widely recognized as a first line treatment of trauma (e.g., American Psychiatric Association, 2004; Bisson & Andrew, 2007; Bleich et al., 2002; CREST, 2003; DVA/DoD, 2004; Foa et al., 2009; INSERM, 2004; NICE, 2005)

EMDR clinical applications are based upon the adaptive information processing model (AIP; see Shapiro, 2001, 2002, 2006, 2007) which posits that the direct reprocessing of the stored memories of etiological events and other experiential contributors can have a positive effect in the treatment of most clinical complaints. This prediction has received support in a case studies and open trials with a variety of diagnoses. Expanding the standard protocols (Shapiro, 1995, 2001), additional applications have been developed in clinical practice by experts and consultants in a number of specialty areas. To-date, while numerous controlled studies have supported EMDR's effectiveness in the treatment of trauma and PTSD across the lifespan, other clinical applications are generally evaluated in case studies or open trials and are in need of further investigation.

As with all treatments for most of these disorders, little controlled research has been conducted, a state of affairs evident in an evaluation report by a task force set in motion by the Clinical Division of the American Psychological Association (Chambless, Baker, Baucom, Beutler, Calhoun, Crits-Christoph, et al., 1998). This report revealed that only about a dozen complaints, such as specific phobias and headaches had empirically well-supported treatments. Many of the treatments listed as empirically validated had not been evaluated for the degree to which they provided substantial long-term clinical effects. For the latest listing see: <http://therapyadvisor.com>

While EMDR protocols for PTSD have been widely investigated by controlled research, it is hoped that additional promising applications will be thoroughly investigated. Suggested parameters have been thoroughly delineated (Shapiro, 2001, 2002). To aid researchers in identifying protocols available for study, and to assist clinicians in obtaining supervision for proposed applications, published materials and conference presentations are listed below. Many presentations have been taped and are available from the conference coordinators. Presenters may also be accessed directly through the EMDR International Association <http://www.emdria.org>

Another excellent resource is The Francine Shapiro Library (FSL) developed by Barbara Hensley Ed.D. and hosted by Northern Kentucky University. It is the premier repository for scholarly articles and other important writings related to the Adaptive Information Processing (AIP) model and EMDR. The intent of the FSL is twofold: (1) to electronically house documents related to EMDR or AIP and (2) to maintain a comprehensive, accurate, and up-to-date list of citations related to AIP and EMDR. [http://library.nku.edu/emdr/emdr\\_data.php](http://library.nku.edu/emdr/emdr_data.php)

Since the initial efficacy study (Shapiro, 1989a), positive therapeutic results with EMDR have been reported with a wide range of populations including the following:

1. **Combat veterans from the Iraq Wars, the Afganistan War, the Vietnam War, the Korean War, and World War II who were formerly treatment resistant and who no longer experience flashbacks, nightmares, and other PTSD sequelae** (Blore, 1997a; Carlson, Chemtob, Rusnak, & Hedlund, 1996; Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998; Daniels, Lipke, Richardson, & Silver, 1992; Lipke, 2000; Lipke & Botkin, 1992; Russell, 2006, 2008; Russell, Silver, Rogers, & Darnell, 2007; Silver & Rogers, 2001; Silver, Rogers, & Russell,

2008; Thomas & Gafner, 1993; Wesson & Gould, 2009; White, 1998; Young, 1995; Zimmermann, Güse, Barre, Biesold, 2005).

2. **Persons with phobias, panic disorder and generalized anxiety disorder who revealed a rapid reduction of fear and symptoms** (De Jongh & ten Broeke, 1998; De Jongh, ten Broeke & Renssen, 1999; De Jongh, van den Oord, & ten Broeke, 2002; Doctor, 1994; de Roos, & de Jongh, 2008; Feske & Goldstein, 1997; Fernandez & Feretta, 2007; Goldstein, 1992; Gauvreau, & Bouchard, 2008; Gattinara, 2009; Goldstein & Feske, 1994; Gros & Antony, 2006; Howard & Cox (2006); Kleinknecht, 1993; Nadler, 1996; Newgent, Paladino, Reynolds, 2006; O'Brien, 1993; Protinsky, Sparks, & Flemke, 2001a; Schurmans, 2007). Some controlled studies of spider phobics have revealed comparatively little benefit from EMDR, (e.g., Muris & Merckelbach, 1997; Muris, Merckelbach, Holdrinet, & Sijsenaar, 1998; Muris, Merckelbach, van Haaften & Nayer, 1997) but evaluations have been confounded by lack of fidelity to the published protocols (see De Jongh et al., 1999; Shapiro, 1999 and Appendix D). One evaluation of panic disorder with agoraphobia (Goldstein, de Beurs, Chambless, & Wilson, 2000) also reported limited results (for comprehensive discussion per Shapiro, 2001, 2002; see also Appendix D).
3. **Crime victims, police officers, fire fighters, and field workers who are no longer disturbed by the aftereffects of violent assaults and/or the stressful nature of their work** (Baker & McBride, 1991; Dyregrov, 1993; Jensma, 1999; Kitchiner, 2004; Kitchiner & Aylard, 2002; Kleinknecht & Morgan, 1992; Lansing, Amen, Hanks, Rudy, 2005; McNally & Solomon, 1999; Page & Crino, 1993; Rost, Hofmann & Wheeler, 2009; Shapiro & Solomon, 1995; Solomon, 1995, 1998; Solomon, & Dyregrov, 2000; Wilson, Becker, Tinker, & Logan, 2001).
4. **People relieved of excessive grief due to the loss of a loved one or to line-of-duty deaths, such as engineers no longer devastated with guilt because their train unavoidably killed pedestrians** (Gattinara, 2009; Lazrove et al., 1998; Puk, 1991a; Shapiro & Solomon, 1995; Solomon, 1994, 1995, 1998; Solomon & Kaufman, 2002; Solomon & Rando, 2007; Solomon & Shapiro, 1997; Sprang, 2001).
5. **Children and adolescents healed of the symptoms, including depression, caused by disturbing life experiences** (Ahmad et al., 2007; Bae, Kim, & Park, 2008; Bronner et al., 2009; Chemtob, Nakashima, Hamada & Carlson, 2002; Cocco & Sharpe, 1993; Datta & Wallace, 1994, 1996; Fernandez, 2007; Fernandez, Gallinari, & Lorenzetti, 2004; Greenwald, 1994, 1998, 1999, 2000, 2002; Hensel, 2006, 2009; Jaberghaderi, Greenwald, Rubin, Dolatabadim, & Zand, 2004; Johnson, 1998; Jarero, Artigas, & Hartung, 2006; Korkmazler-Oral & Pamuk, 2002; Kraft, Schepker, Goldbeck, & Fegert, 2006; Lovett, 1999; Maxfield, 2007; Oras et al., 2004; Pellicer, 1993; Puffer, Greenwald & Elrod, 1998; Rodenburg et al., in press; Russell & O'Connor, 2002; Scheck, Schaeffer, & Gillette, 1998; Shapiro, 1991; Soberman, Greenwald, & Rule, 2002; Stewart & Bramson, 2000; Streeck-Fischer, 2005; Taylor, 2002; Tinker & Wilson, 1999; Tufnell, 2005; Wanders, Serra, & de Jongh, 2008; Zaghrout-Hodali, Alissa, & Dodgson, 2008).
6. **Sexual assault victims who are now able to lead normal lives and have intimate relationships** (Edmond, Rubin, & Wambach, 1999; Hyer, 1995; Kowal, 2005; Parnell, 1994, 1999; Puk, 1991a; Rothbaum, 1997; Rothbaum, Astin, Marsteller, 2005; Scheck, Schaeffer, & Gillette, 1998; Shapiro, 1989b, 1991, 1994; Wolpe & Abrams, 1991).
7. **Victims of natural and manmade disasters able to resume normal lives** (Chemtob et al, 2002; Colelli, & Patterson, 2008; Fernandez, 2008; Fernandez, et al, 2004; Gelbach, 2008; Grainger, Levin, Allen-Byrd, Doctor, & Lee, 1997; Jarero, Artigas, Mauer, Lopez Cano, & Alcala, 1999; Jayatunge, 2008; Knipe, Hartung, Konuk, Colelli, Keller, & Rogers, 2003; Konuk, Knipe, Eke, Yuksek, Yurtsever, & Ostep, 2006; Shapiro & Laub, 2008; Shusta-Hochberg, 2003; Silver, Rogers, Knipe & Colelli, 2005).
8. **Accident, surgery, and burn victims who were once emotionally or physically debilitated and who are now able to resume productive lives** (Blore, 1997b; Broad & Wheeler, 2006; Hassard, 1993; McCann, 1992; Puk, 1992; Softic, 2009; Solomon & Kaufman, 1994).

9. **Victims of family, marital and sexual dysfunction who are now able to maintain healthy relationships** (Bardin, 2004; Capps, 2006; Errebo & Sommers-Flanagan, 2007; Keenan & Farrell, 2000; Gattinara, 2009; Kaslow, Nurse, & Thompson, 2002; Knudsen, 2007; Koedam, 2007; Levin, 1993; Madrid, Skolek & Shapiro, 2006; Moses, 2007; Phillips et al. 2009; Protinsky, Sparks, & Flemke, 2001b; Shapiro, Kaslow, & Maxfield, 2007; Snyder, 1996; Stowasser, 2007; Talan, 2007; Wernik, 1993; Wesselmann & Potter, 2009).
10. **Clients at all stages of chemical dependency, sexual deviation/addiction, and pathological gamblers, who now show stable recovery and a decreased tendency to relapse** (Amundsen & Kårstad, 2006; Besson, Eap, Rougemont-Buecking, Simon, Nikolov, Bonsack, 2006; Cox & Howard, 2007; Hase, Schallmayer, & Sack, 2008; Henry, 1996; Marich, 2009; Popky, 2005; Ricci, 2006; Ricci et al., 2006; Shapiro & Forrest, 1997; Shapiro, Vogelmann-Sine, & Sine, 1994; Vogelmann-Sine, Sine, Smyth, & Popky, 1998; Zweben & Yeary, 2006).
11. **People with dissociative disorders who progress at a rate more rapid than that achieved by traditional treatment** (Cohen, 2009; Fine, 1994; Fine & Berkowitz, 2001; Lazrove, 1994; Lazrove & Fine 1996; Marquis & Puk, 1994; Paulsen, 1995; Rouanzoin, 1994; Twombly, 2000, 2005; Young, 1994).
12. **People with performance anxiety or deficits in school, business, performing arts, and sport who have benefited from EMDR as a tool to help enhance performance** (Barker, & Barker, 2007; Crabbe, 1996; Foster & Lendl, 1995, 1996; Graham, 2004; Maxfield & Melnyk, 2000).
13. **People with somatic problems/somatoform disorders, including migraines, chronic pain, phantom limb pain, chronic eczema, gastrointestinal problems, CFS, psychogenic seizures, eating disorders, and negative body image, who have attained a relief of suffering** (Bloomgarden, & Calogero, 2008; Brown, McGoldrick, & Buchanan, 1997; Chemali & Meadows, 2004; Dziegielewski & Wolfe, 2000; Friedberg, 2004; Gattinara, 2009; Grant, 1999; Grant & Threlfo, 2002; Gupta & Gupta, 2002; Kelley, & Selim, 2007; Kneff & Krebs, 2004; Kowal, 2005; Marcus, 2008; Mazzola et al., 2009; McGoldrick, Begum, & Brown, 2008; Ray & Zbik, 2001; Royle, 2008; Russell, 2008a, b; Schneider et al., 2007, 2008; Tinker & Wilson, 2006; Van Loey & Van Son, 2003; Wilensky, 2006; Wilson et al., 2000).
14. **Adults and adolescents successfully treated for diagnosed depression** (Bae, Kim & Park, 2008; Broad & Wheeler, 2006; Gomez, 2008; Hogan, 2001; Manfield, 1998b; Protinsky, Sparks, & Flemke, 2001a; Tanaka, & Inoue, 1999; Uribe, & Ramirez, 2006).
15. **Clients with acute trauma and wide variety of PTSD and trauma-based personality issues who experience substantial benefit from EMDR** (Allen & Lewis, 1996; Bisson, Ehlers, Matthews, Pilling, Richards, Turner, 2007; Brown & Shapiro, 2006; Carbone, 2008; Cohn, 1993; Fensterheim, 1996; Forbes, Creamer, & Rycroft, 1994; Gelinias, 2003; Hogberg, Pagani, Sundin, Soares, Aberg-Wistedt, Tarnell, et al, 2007; Kutz, Resnik, & Dekel, 2008; Ironson, et al., 2002; Kim & Choi, 2004; Kitchiner, 1999, 2000; Korn & Leeds, 2002; Lee, et al., 2002; Manfield, 1998a; Manfield & Shapiro, 2003; Marcus, Marquis, & Saki, 1997; Marquis, 1991; Maxwell, 2003; McCullough, 2002; McLaughlin et al, 2008; Parnell, 1996; 1997; Pollock, 2000; Power et al., 2002; Protinsky, Sparks, & Flemke, 2001a; Puk, 1991b; Raboni, Tufik, & Suchecki, 2006; Renfrey & Spates, 1994; Rittenhouse, 2000; Sandstrom et al., 2008; Schneider, Nabavi, Heuft, 2005; Seidler & Wagner, 2006; Shapiro & Forrest, 1997; Shapiro & Laub, 2008; Spates & Burnette, 1995; Spector & Huthwaite, 1993; Sprang, 2001; van der Kolk, Spinazzola, Blaustein, Hopper, Hopper, Korn, Simpson, 2007; Vaughan, et al., 1994; Vaughan, Wiese, Gold, & Tarrier, 1994; Wilson, Becker, & Tinker, 1995, 1997; Wolpe & Abrams, 1991; Zabukovec, Lazrove & Shapiro, 2000).

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# **EMDR: TRAUMA RESEARCH FINDINGS AND FURTHER READING**

## **International Treatment Guidelines**

- **American Psychiatric Association (2004).** *Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder.* Arlington, VA: American Psychiatric Association Practice Guidelines.

*EMDR is recommended as an effective treatment for trauma.*

- **Bleich, A., Kotler, M., Kutz, I., & Shalev, A. (2002).** A position paper of the (Israeli) National Council for Mental Health: *Guidelines for the assessment and professional intervention with terror victims in the hospital and in the community.* Jerusalem, Israel.

*EMDR is one of three methods recommended for treatment of terror victims.*

- **California Evidence-Based Clearinghouse for Child Welfare (2010).** Trauma Treatment for Children. <http://www.cebc4cw.org>.

*EMDR and Trauma-focused CBT are considered "Well-Supported by Research Evidence."*

- **Chambless, D.L. et al. (1998).** Update of empirically validated therapies, II. *The Clinical Psychologist*, 51, 3-16.

*According to a taskforce of the Clinical Division of the American Psychological Association, the only methods empirically supported ("probably efficacious") for the treatment of any post-traumatic stress disorder population were EMDR, exposure therapy, and stress inoculation therapy. Note that this evaluation does not cover the last decade of research.*

- **CREST (2003).** *The management of post traumatic stress disorder in adults.* A publication of the Clinical Resource Efficiency Support Team of the Northern Ireland Department of Health, Social Services and Public Safety, Belfast.

*EMDR and CBT were stated to be the treatments of choice.*

- **Department of Veterans Affairs & Department of Defense (2004).** *VA/DoD Clinical Practice Guideline for the Management of Post-Traumatic Stress.* Washington, DC: Veterans Health Administration, Department of Veterans Affairs and Health Affairs, Department of Defense. Office of Quality and Performance publication 10Q-CPG/PTSD-04.

*EMDR was placed in the "A" category as "strongly recommended" for the treatment of trauma.*

- **Dutch National Steering Committee Guidelines Mental Health Care (2003).** Multidisciplinary Guideline Anxiety Disorders. Quality Institute Health Care CBO/Trimbos Institute. Utrecht, Netherlands.

*EMDR and CBT both designated as treatments of choice for PTSD*

- **Foa, E.B., Keane, T.M., Friedman, M.J., & Cohen, J.A. (2009).** *Effective treatments for PTSD: Practice Guidelines of the International Society for Traumatic Stress Studies* New York: Guilford Press.

*EMDR was listed as an effective and empirically supported treatment for PTSD, and was given an AHCPR "A" rating for adult PTSD. This guideline specifically rejected the findings of the previous Institute of Medicine report, which stated that more research was needed to judge EMDR effective for adult PTSD. With regard to the application of EMDR to children, an AHCPR rating of Level B was assigned. Since the time of this publication, two additional randomized*

studies on EMDR have been completed (see below).

- **INSERM (2004).** *Psychotherapy: An evaluation of three approaches.* French National Institute of Health and Medical Research, Paris, France.

*EMDR and CBT were stated to be the treatments of choice for trauma victims.*

- **National Institute for Clinical Excellence (2005).** *Post traumatic stress disorder (PTSD): The management of adults and children in primary and secondary care.* London: NICE Guidelines.

*Trauma-focused CBT and EMDR were stated to be empirically supported treatments for choice for adult PTSD.*

- **National Collaborating Centre for Mental Health (2005).** *Post traumatic stress disorder (PTSD): The management of adults and children in primary and secondary care.* London: National Institute for Clinical Excellence.

*Trauma-focused CBT and EMDR were stated to be empirically supported treatments for choice for adult PTSD.*

- **Therapy Advisor (2004-7):** <http://www.therapyadvisor.com>

*An NIMH sponsored website listing empirically supported methods for a variety of disorders. EMDR is one of three treatments listed for PTSD.*

- **United Kingdom Department of Health (2001).** Treatment choice in psychological therapies and counseling evidence based clinical practice guideline. London, England.

*Best evidence of efficacy was reported for EMDR, exposure, and stress inoculation*

### **Meta-analyses**

EMDR has been compared to numerous exposure therapy protocols, with and without CT techniques. It should be noted that exposure therapy uses one to two hours of daily homework and EMDR uses none. The most recent meta-analyses are listed here.

- **Bisson, J., & Andrew, M. (2007).** Psychological treatment of post-traumatic stress disorder (PTSD). *Cochrane Database of Systematic Reviews* 2007, Issue 3. Art. No.: CD003388. DOI: 10.1002/14651858.CD003388.pub3.

*“Trauma focused cognitive behavioral therapy and eye movement desensitization and reprocessing have the best evidence for efficacy at present and should be made available to PTSD sufferers.”*

- **Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005).** A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, 162, 214-227.

*EMDR is equivalent to exposure and other cognitive behavioral treatments and all “are highly efficacious in reducing PTSD symptoms.”*

- **Davidson, P.R., & Parker, K.C.H. (2001).** Eye movement desensitization and reprocessing (EMDR): A meta-analysis. *Journal of Consulting and Clinical Psychology*, 69, 305-316.

*EMDR is equivalent to exposure and other cognitive behavioral treatments.*

- **Maxfield, L., & Hyer, L.A. (2002).** The relationship between efficacy and methodology in studies investigating EMDR treatment of PTSD. *Journal of Clinical Psychology*, 58, 23-41.

***A comprehensive meta-analysis reported the more rigorous the study, the larger the effect.***

- **Rodenburg, R., Benjamin, A., de Roos, C, Meijer, A.M., & Stams, G.J. (in press).** Efficacy of EMDR in children: A meta – analysis. *Clinical Psychology Review*.

*“Results indicate efficacy of EMDR when effect sizes are based on comparisons between EMDR and non-established trauma treatment or no-treatment control groups, and incremental efficacy when effect sizes are based on comparisons between EMDR and established (CBT) trauma treatment.”*

- **Seidler, G.H., & Wagner, F.E. (2006).** Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study. *Psychological Medicine*, 36, 1515-1522.

*“Results suggest that in the treatment of PTSD, both therapy methods tend to be equally efficacious.”*

### **Randomized Clinical Trials**

- **Carlson, J., Chemtob, C.M., Rusnak, K., Hedlund, N.L, & Muraoka, M.Y. (1998).** Eye movement desensitization and reprocessing (EMDR): Treatment for combat-related post-traumatic stress disorder. *Journal of Traumatic Stress*, 11, 3-24.

Twelve sessions of EMDR eliminated post-traumatic stress disorder in 77.7% of the multiply traumatized combat veterans studied. There was 100% retention in the EMDR condition. Effects were maintained at follow-up. This is the only randomized study to provide a full course of treatment with combat veterans. Other studies (e.g., Boudewyns/Deville/Jensen/Pitman et al. /Macklin et al.) evaluated treatment of only one or two memories, which, according to the International Society for Traumatic Stress Studies Practice Guidelines (2000), is inappropriate for multiple-trauma survivors. The VA/DoD Practice Guideline (2004) also indicates these studies (often with only two sessions) offered insufficient treatment doses for veterans.

- **Abbasnejad, M., Mahani, K. N., & Zamyad, A. (2007).** Efficacy of "eye movement desensitization and reprocessing" in reducing anxiety and unpleasant feelings due to earthquake experience. *Psychological Research*, 9 (3-4), 104-117.

*“EMDR is effective in reducing earthquake anxiety and negative emotions (e.g. PTSD, grief, fear, intrusive thoughts, depression, etc) resulting from earthquake experience. Furthermore, results show that, improvement due to EMDR was maintained at a one month follow up.”*

- **Ahmad A, Larsson B, & Sundelin-Wahlsten V. (2007).** EMDR treatment for children with PTSD: Results of a randomized controlled trial. *Nord J Psychiatry*, 61, 349-54.

Thirty-three 6-16-year-old children with a DSM-IV diagnosis of PTSD were randomly assigned to eight weekly EMDR sessions or the WLC group. EMDR was found to be an effective treatment in children with PTSD from various sources and who were suffering from a variety of co-morbid conditions.

- **Arabia, E., Manca, M.L. & Solomon, R.M. (2011).** EMDR for survivors of life-threatening cardiac events: Results of a pilot study. *Journal of EMDR Practice and Research*, 5, 2-13.

*“Forty-two patients undergoing cardiac rehabilitation . . . were randomized to a 4-week treatment of EMDR or imaginal exposure (IE). . . . EMDR was effective in reducing PTSD, depressive, and anxiety symptoms and performed significantly better than IE for all variables. . . . Because the standardized IE procedures used were those employed in-session during [prolonged exposure] the results are also instructive regarding the relative efficacy of both treatments without the addition of homework.”*

- **Chemtob, C.M., Nakashima, J., & Carlson, J.G. (2002).** Brief-treatment for elementary school children with disaster-related PTSD: A field study. *Journal of Clinical Psychology, 58*, 99-112.

*EMDR was found to be an effective treatment for children with disaster-related PTSD who had not responded to another intervention.*
- **Cvetek, R. (2008).** EMDR treatment of distressful experiences that fail to meet the criteria for PTSD. *Journal of EMDR Practice and Research, 2*, 2-14.

*EMDR treatment of disturbing life events (small “t” trauma) was compared to active listening, and wait list. EMDR produced significantly lower scores on the Impact of Event Scale (mean reduced from “moderate” to “subclinical”) and a significantly smaller increase on the STAI after memory recall.*
- **de Roos, C. (2011).** A randomised comparison of cognitive behavioural therapy (CBT) and eye movement desensitisation and reprocessing (EMDR) in disaster exposed children. *European Journal of Psychotraumatology, 2*: 5694 - DOI: 10.3402/ejpt.v2i0.5694

*“Children (n=52, aged 4-18) were randomly allocated to either CBT (n=26) or EMDR (n=26) in a disaster mental health after-care setting after an explosion of a fireworks factory. . . Both treatment approaches produced significant reductions on all measures and results were maintained at follow-up. Treatment gains of EMDR were reached in fewer sessions.”*
- **Edmond, T., Rubin, A., & Wambach, K. (1999).** The effectiveness of EMDR with adult female survivors of childhood sexual abuse. *Social Work Research, 23*, 103-116.

*EMDR treatment resulted in lower scores (fewer clinical symptoms) on all four of the outcome measures at the three-month follow-up, compared to those in the routine treatment condition. The EMDR group also improved on all standardized measures at 18 months follows up (Edmond & Rubin, 2004, Journal of Child Sexual Abuse).*
- **Edmond, T., Sloan, L., & McCarty, D. (2004).** Sexual abuse survivors’ perceptions of the effectiveness of EMDR and eclectic therapy: A mixed-methods study. *Research on Social Work Practice, 14*, 259-272.

*Combination of qualitative and quantitative analyses of treatment outcomes with important implications for future rigorous research. Survivors’ narratives indicate that EMDR produces greater trauma resolution, while within eclectic therapy; survivors more highly value their relationship with their therapist, through whom they learn effective coping strategies.*
- **Hogberg, G. et al., (2007).** On treatment with eye movement desensitization and reprocessing of chronic post-traumatic stress disorder in public transportation workers: A randomized controlled study. *Nordic Journal of Psychiatry, 61*, 54-61.

*Employees who had experienced “person-under-train accident or had been assaulted at work were recruited.” Six sessions of EMDR resulted in remission of PTSD in 67% compared to 11% in the wait list control. Significant effects were documented in Global Assessment of Function (GAF) and Hamilton Depression (HAM-D) score. **Follow-up: Högberg, G. et al. (2008).** Treatment of post-traumatic stress disorder with eye movement desensitization and reprocessing: Outcome is stable in 35-month follow-up. *Psychiatry Research, 159*, 101-108.*
- **Ironson, G.I., Freund, B., Strauss, J.L., & Williams, J. (2002).** Comparison of two treatments for traumatic stress: A community-based study of EMDR and prolonged exposure. *Journal of Clinical Psychology, 58*, 113-128.

*Both EMDR and prolonged exposure produced a significant reduction in PTSD and depression symptoms. This is the only research comparing EMDR and exposure therapy that equalized homework. The study found that 70% of EMDR participants achieved a good outcome in three active treatment sessions, compared to 29% of persons in the prolonged exposure condition. EMDR also had fewer dropouts.*

- **Jaberghaderi, N., Greenwald, R., Rubin, A., Dolatabadim S., & Zand, S.O. (2004).** A comparison of CBT and EMDR for sexually abused Iranian girls. *Clinical Psychology and Psychotherapy*, 11, 358-368.

*Both EMDR and CBT produced significant reduction in PTSD and behavior problems. EMDR was significantly more efficient, using approximately half the number of sessions to achieve results.*

- **Kemp M., Drummond P., & McDermott B. (2010).** A wait-list controlled pilot study of eye movement desensitization and reprocessing (EMDR) for children with post-traumatic stress disorder (PTSD) symptoms from motor vehicle accidents. *Clinical Child Psychology and Psychiatry*, 15, 5-25.

*“An effect for EMDR was identified on primary outcome and process measures including the Child Post-Traumatic Stress – Reaction Index, clinician rated diagnostic criteria for PTSD, Subjective Units of Disturbance and Validity of Cognition scales. All participants initially met two or more PTSD criteria. After EMDR treatment, this decreased to 25% in the EMDR group but remained at 100% in the wait-list group.”*

- **Lee, C., Gavriel, H., Drummond, P., Richards, J. & Greenwald, R. (2002).** Treatment of post-traumatic stress disorder: A comparison of stress inoculation training with prolonged exposure and eye movement desensitization and reprocessing. *Journal of Clinical Psychology*, 58, 1071-1089.

*Both EMDR and stress inoculation therapy plus prolonged exposure (SITPE) produced significant improvement, with EMDR achieving greater improvement on PTSD intrusive symptoms. Participants in the EMDR condition showed greater gains at three-month follow-up. EMDR required three hours of homework compared to 28 hours for SITPE.*

- **Marcus, S., Marquis, P. & Sakai, C. (1997).** Controlled study of treatment of PTSD using EMDR in an HMO setting. *Psychotherapy*, 34, 307-315.

*Funded by Kaiser Permanent. Results show that 100% of single-trauma and 77% of multiple-trauma survivors were no longer diagnosed with post-traumatic stress disorder after six 50-minute sessions.*

- **Marcus, S., Marquis, P. & Sakai, C. (2004).** Three- and 6-month follow-up of EMDR treatment of PTSD in an HMO setting. *International Journal of Stress Management*, 11, 195-208.

*Funded by Kaiser Permanent, follow-up evaluation indicates that a relatively small number of EMDR sessions result in substantial benefits that are maintained over time.*

- **Power, K.G., McGoldrick, T., Brown, K., et al. (2002).** A controlled comparison of eye movement desensitization and reprocessing versus exposure plus cognitive restructuring, versus waiting list in the treatment of post-traumatic stress disorder. *Journal of Clinical Psychology and Psychotherapy*, 9, 299-318.

*Both EMDR and exposure therapy plus cognitive restructuring (with daily homework) produced significant improvement. EMDR was more beneficial for depression, and social functioning, and required fewer treatment sessions. Subsequent reevaluation of the data indicated that “For pre- to post-treatment IES mean change score, EMDR patients also appeared to have had better treatment outcome than E+CR patients” and EMDR therapy was a predictor of positive outcome:*

Karatzias, A., Power, K. McGoldrick, T., Brown, K., Buchanan, R., Sharp, D. & Swanson, V. (2006). Predicting treatment outcome on three measures for post-traumatic stress disorder. *Eur Arch Psychiatry Clin Neuroscience*, 20, 1-7.

- **Rothbaum, B. (1997).** A controlled study of eye movement desensitization and reprocessing in the treatment of post-traumatic stress disorder sexual assault victims. *Bulletin of the Menninger Clinic*, 61, 317-334.

*Three 90-minute sessions of EMDR eliminated post-traumatic stress disorder in 90% of rape victims.*

- **Rothbaum, B.O., Astin, M.C., & Marsteller, F. (2005).** Prolonged exposure versus eye movement desensitization (EMDR) for PTSD rape victims. *Journal of Traumatic Stress*, 18, 607-616.

*In this NIMH funded study both treatments were effective: "An interesting potential clinical implication is that EMDR seemed to do equally well in the main despite less exposure and no homework. It will be important for future research to explore these issues."*

- **Scheck, M., Schaeffer, J.A., & Gillette, C. (1998).** Brief psychological intervention with traumatized young women: The efficacy of eye movement desensitization and reprocessing. *Journal of Traumatic Stress*, 11, 25-44.

*Two sessions of EMDR reduced psychological distress in traumatized adolescents/ young women and brought scores within one standard deviation of the norm.*

- **Shapiro, F. (1989).** Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, 2, 199–223.

*Seminal study appeared the same year as first controlled studies of CBT treatments. Three-month follow-up indicated substantial effects on distress and behavioural reports. Marred by lack of standardized measures and the originator serving as sole therapist.*

- **Soberman, G. B., Greenwald, R., & Rule, D. L. (2002).** A controlled study of eye movement desensitization and reprocessing (EMDR) for boys with conduct problems. *Journal of Aggression, Maltreatment, and Trauma*, 6, 217-236.

*The addition of three sessions of EMDR resulted in large and significant reductions of memory-related distress, and problem behaviors by 2-month follow-up.*

- **Taylor, S. et al. (2003).** Comparative efficacy, speed, and adverse effects of three PTSD treatments: Exposure therapy, EMDR, and relaxation training. *Journal of Consulting and Clinical Psychology*, 71, 330-338.

*The only randomized study to show exposure statistically superior to EMDR on two subscales (out of 10). This study used therapist assisted "in vivo" exposure, where the therapist takes the person to previously avoided areas, in addition to imaginal exposure and one hour of daily homework (@ 50 hours). The EMDR group used only standard sessions and no homework.*

- **Van der Kolk, B., Spinazzola, J. Blaustein, M., Hopper, J. Hopper, E., Korn, D., & Simpson, W. (2007).** A randomized clinical trial of EMDR, fluoxetine and pill placebo in the treatment of PTSD: Treatment effects and long-term maintenance. *Journal of Clinical Psychiatry*, 68, 37-46.

*EMDR was superior to both control conditions in the amelioration of both PTSD symptoms and depression. Upon termination of therapy, the EMDR group continued to improve while the Fluoxetine participants again became symptomatic.*

- **Vaughan, K., Armstrong, M.F., Gold, R., O'Connor, N., Jenneke, W., & Tarrier, N. (1994).** A trial of eye movement desensitization compared to image habituation training and applied muscle

relaxation in post-traumatic stress disorder. *Journal of Behavior Therapy & Experimental Psychiatry*, 25, 283-291.

*All treatments led to significant decreases in PTSD symptoms for subjects in the treatment groups as compared to those on a waiting list, with a greater reduction in the EMDR group, particularly with respect to intrusive symptoms. In the 2-3 weeks of the study, 40-60 additional minutes of daily homework were part of the treatment in the other two conditions.*

- **Wanders, F., Serra, M., & de Jongh, A. (2008).** EMDR Versus CBT for Children With Self-Esteem and Behavioral Problems: A Randomized Controlled Trial. *Journal of EMDR Practice and Research*, 2, 180-189.

*Twenty-six children (average age 10.4 years) with behavioral problems were randomly assigned to receive either 4 sessions of EMDR or CBT. Both were found to have significant positive effects on behavioral and self-esteem problems, with the EMDR group showing significantly larger changes in target behaviors.*

- **Wilson, S., Becker, L.A., & Tinker, R.H. (1995).** Eye movement desensitization and reprocessing (EMDR): Treatment for psychologically traumatized individuals. *Journal of Consulting and Clinical Psychology*, 63, 928-937.

*Three sessions of EMDR produced clinically significant change in traumatized civilians on multiple measures.*

- **Wilson, S., Becker, L.A., & Tinker, R.H. (1997).** Fifteen-month follow-up of eye movement desensitization and reprocessing (EMDR) treatment of post-traumatic stress disorder and psychological trauma. *Journal of Consulting and Clinical Psychology*, 65, 1047-1056. Follow-up at 15 months showed maintenance of positive treatment effects with 84% remission of PTSD diagnosis.

### **Non-Randomized Studies**

- **Aduriz, M.E., Bluthgen, C. & Knopfler, C. (2009).** Helping child flood victims using group EMDR intervention in Argentina: Treatment outcome and gender differences. *International Journal of Stress Management*, 16, 138-153.

*A comprehensive group intervention with 124 children, who experienced disaster related trauma during a massive flood utilizing a one session group protocol. Significant differences were obtained and maintained at 3-month follow up.*

- **Devilley, G.J., & Spence, S.H. (1999).** The relative efficacy and treatment distress of EMDR and a cognitive behavioral trauma treatment protocol in the amelioration of post-traumatic stress disorder. *Journal of Anxiety Disorders*, 13, 131-157.

*This study found CBT superior to EMDR. The research is marred by higher expectations in the CBT condition: Treatment was delivered in both conditions by the developer of the CBT protocol.*

- **Fernandez, I. (2007).** EMDR as treatment of post-traumatic reactions: A field study on child victims of an earthquake. *Educational and Child Psychology. Special Issue: Therapy*, 24, 65-72.

*This field study explores the effectiveness of EMDR and the level of post-traumatic reactions in a post-emergency context on 22 children victims of an earthquake. The results show that EMDR contributed to the reduction or remission of PTSD symptoms and facilitated the processing of the traumatic experience*

- **Fernandez, I., Gallinari, E., & Lorenzetti, A. (2004).** A school- based EMDR intervention for children who witnessed the Pirelli building airplane crash in Milan, Italy. *Journal of Brief Therapy*, 2, 129-136.

A group intervention of EMDR was provided to 236 schoolchildren exhibiting PTSD symptoms 30 days post-incident. At four-month follow up, teachers reported that all but two children evinced a return to normal functioning after treatment.

- **Grainger, R.D., Levin, C., Allen-Byrd, L., Doctor, R.M. & Lee, H. (1997).** An empirical evaluation of eye movement desensitization and reprocessing (EMDR) with survivors of a natural catastrophe. *Journal of Traumatic Stress*, 10, 665-671.

*A study of Hurricane Andrew survivors found significant differences on the Impact of Event Scale and subjective distress in a comparison of EMDR and non-treatment condition.*

- **Hensel, T. (2009).** EMDR with children and adolescents after single-incident trauma an intervention study. *Journal of EMDR Practice and Research*, 3, 2-9.

*36 children and adolescents ranging in age from 1 year 9 months to 18 years 1 month were assessed at intake, post-waitlist/pretreatment, and at follow up. EMDR treatment resulted in significant improvement, demonstrating that children younger than 4 years of age showed the same benefit as the school-age children.*

- **Jarero, I., & Artigas, L. (2010).** The EMDR integrative group treatment protocol: Application with adults during ongoing geopolitical crisis. *Journal of EMDR Practice and Research*, 4, 148-155.

*"In this study, the EMDR-IGTP was applied during three consecutive days to a group of 20 adults during ongoing geopolitical crisis in a Central American country in 2009. . . Changes on the IES were maintained at 14 weeks follow-up even though participants were still exposed to ongoing crisis."*

- **Jarero, I., Artigas, L., & Hartung, J. (2006).** EMDR integrative group treatment protocol: A post-disaster trauma intervention for children and adults. *Traumatology*, 12, 121-129.

*A study of 200 children treated with a group protocol after a flood in Mexico indicates that one session of treatment reduced trauma symptoms from the severe range to low (subclinical) levels of distress. Data from successful treatment at other disaster sites are also reported.*

- **Jarero, I., Artigas, L., Lopez-Lena, M. (2008).** The EMDR integrative group treatment protocol: Application with child victims of mass disaster. *Journal of EMDR Practice and Research*, 2, 97-105.

*"In this study the EMDR-IGTP was used with 16 bereaved children after a human provoked disaster in the Mexican State of Coahuila in 2006. Results showed a significant decrease in scores on the Child's Reaction to Traumatic Events Scale that was maintained at 3-month follow-up."*

- **Konuk, E., Knipe, J., Eke, I., Yuksek, H., Yurtsever, A., & Ostep, S. (2006).** The effects of EMDR therapy on post-traumatic stress disorder in survivors of the 1999 Marmara, Turkey, earthquake. *International Journal of Stress Management*, 13, 291-308.

*Data reported on a representative sample of 1500 earthquake victims indicated that five sessions of EMDR successfully eliminated PTSD in 92.7% of those treated, with a reduction of symptoms in the remaining participants.*

- **Puffer, M.; Greenwald, R. & Elrod, D. (1997).** A single session EMDR study with twenty traumatized children and adolescents. *Traumatology-e*, 3(2), Article 6.

*In this delayed treatment comparison, over half of the participants moved from clinical to normal levels on the Impact of Events Scale, and all but 3 showed at least partial symptom relief on several measures at 1-3 m following a single EMDR session.*

- **Ribchester, T., Yule, W., & Duncan, A. (2010).** EMDR for childhood PTSD after road traffic accidents: Attentional, memory, and attributional processes. *Journal of EMDR Practice and Research*, 4(4), 138-147.

*“EMDR was used with 11 children who developed posttraumatic stress disorder (PTSD) after road traffic accidents. All improved such that none met criteria for PTSD on standardized assessments after an average of only 2.4 sessions. . . Treatment was associated with a significant trauma-specific reduction in attentional bias on the modified Stroop task, with results apparent both immediately after therapy and at follow-up.”*

- **Silver, S.M., Brooks, A., & Obenchain, J. (1995).** Eye movement desensitization and reprocessing treatment of Vietnam war veterans with PTSD: Comparative effects with biofeedback and relaxation training. *Journal of Traumatic Stress*, 8, 337-342.

One of only two EMDR research studies that evaluated a clinically relevant course of EMDR treatment with combat veterans (e.g., more than one or two memories; see Carlson et al., above). The analysis of an inpatient veterans' PTSD program (n=100) found EMDR to be superior to biofeedback and relaxation training on seven of eight measures.

- **Silver, S.M., Rogers, S., Knipe, J., & Colelli, G. (2005).** EMDR therapy following the 9/11 terrorist attacks: A community-based intervention project in New York City. *International Journal of Stress Management*, 12, 29-42.

*Clients made highly significant positive gains on a range of outcome variables, including validated psychometrics and self-report scales. Analyses of the data indicate that EMDR is a useful treatment intervention both in the immediate aftermath of disaster as well as later.*

- **Solomon, R.M. & Kaufman, T.E. (2002).** A peer support workshop for the treatment of traumatic stress of railroad personnel: Contributions of eye movement desensitization and reprocessing (EMDR). *Journal of Brief Therapy*, 2, 27-33.

*60 railroad employees who had experienced fatal grade crossing accidents were evaluated for workshop outcomes, and for the additive effects of EMDR treatment. Although the workshop was successful, in this setting, the addition of a short session of EMDR (5-40 minutes) led to significantly lower, sub clinical, scores which further decreased at follow up.*

- **Sprang, G. (2001).** The use of eye movement desensitization and reprocessing (EMDR) in the treatment of traumatic stress and complicated mourning: Psychological and behavioral outcomes. *Research on Social Work Practice*, 11, 300-320.

*In a multi-site study, EMDR significantly reduced symptoms more often than the CBT treatment on behavioral measures, and on four of five psychosocial measures. EMDR was more efficient, inducing change at an earlier stage and requiring fewer sessions. Positive recall of the deceased was significantly greater post treatment in the EMDR condition.*

- **Wadaa, N. N., Zaharim, N. M., & Alqashan, H. F. (2010).** The use of EMDR in treatment of traumatized Iraqi children. *Digest of Middle East Studies*, 19, 26-36.

*“Our findings are consistent with the conclusion . . . that EMDR is effective for civilian PTSD, and it applies its treatment in a user-friendly manner . . . The results of the study demonstrated the effectiveness of EMDR in the treatment of PTSD in the experimental group compared to the control group.”*

- **Zaghrou-Hodali, M., Alissa, F. & Dodgson, P.W. (2008).** Building resilience and dismantling

fear: EMDR group protocol with children in an area of ongoing trauma. *Journal of EMDR Practice and Research*, 2, 106-113.

*Results indicate that the EMDR approach can be effective in a group setting, and in an acute situation, both in reducing symptoms of posttraumatic and peritraumatic stress and in “inoculation” or building resilience in a setting of ongoing conflict and trauma.*

### **Adaptive Information Processing, and EMDR Procedures**

The Adaptive Information Processing model (Shapiro, 2001, 2002, 2007) is used to explain EMDR's clinical effects and guide clinical practice. This model is not linked to any specific neurobiological mechanism since the field of neurobiology is as yet unable to determine this in any form of psychotherapy (nor of most medications). This section includes literature to provide an overview of the model and procedures, as well as selected research and case reports that demonstrate the predictive value of the model in the treatment of life experiences that appear to underlie a variety of clinical complaints.

- **Arseneault, L., Cannon, M, Fisher, H.L. Polanczyk, G. Moffitt, T.E. & Caspi, A. (2011).** Childhood trauma and children's emerging psychotic symptoms: A genetically sensitive longitudinal cohort study. *Am J Psychiatry*, 168, 65–72.  
*“Trauma characterized by intention to harm is associated with children's reports of psychotic symptoms. Clinicians working with children who report early symptoms of psychosis should inquire about traumatic events such as maltreatment and bullying.”*
- **Bae, H., Kim, D. & Park, Y.C. (2008).** Eye movement desensitization and reprocessing for adolescent depression. *Psychiatry Investigation*, 5, 60-65.  
*Processing of etiological disturbing memories, triggers and templates resulted in complete remission of Major Depressive Disorder in two teenagers. Treatment duration was 3-7 sessions and effects were maintained at follow-up.*
- **Brown, S. & Shapiro, F. (2006).** EMDR in the treatment of borderline personality disorder. *Clinical Case Studies*, 5, 403-420.  
*20 EMDR sessions that focused on reprocessing the memories seemingly at the foundation of the pathology, along with triggers and future templates resulted in a complete remission of BPD, including symptoms of affect dysregulation, as measured on the Inventory of Altered Self Capacities.*
- **Brown, K. W., McGoldrick, T., & Buchanan, R. (1997).** Body dysmorphic disorder: Seven cases treated with eye movement desensitization and reprocessing. *Behavioural and Cognitive Psychotherapy*, 25, 203–207.  
*Seven consecutive cases were treated with up to three sessions of EMDR. Complete remission of BDD symptoms were reported in five cases with effects maintained at one- year follow-up.*
- **de Roos, C., Veenstra, A.C, et al. (2010).** Treatment of chronic phantom limb pain (PLP) using a trauma-focused psychological approach. *Pain Research and Management*, 15, 65-71.  
*10 consecutive cases of phantom limb pain were treated with EMDR resulting in the reduction or elimination of pain in all but two cases. Results were maintained at 2.8-year follow-up.*
- **Fernandez, I., & Faretta, E. (2007).** EMDR in the treatment of panic disorder with agoraphobia. *Clinical Case Studies*, 6, 44-63.

*As predicted by AIP, the processing of etiological events, triggers and memory templates was sufficient to alleviate the diagnosis without the use of therapist-assisted in vivo exposure.*

- **Gauvreau, P. & Bouchard, S. (2008)** Preliminary evidence for the efficacy of EMDR in treating generalized anxiety disorder. *Journal of EMDR Practice and Research*, 2, 26-40.

*Four subjects were evaluated using a single case design with multiple baselines Results indicate that subsequent to targeting the experiential contributors, at post treatment and at 2 months follow-up, all four participants no longer presented with GAD diagnosis.*

- **Madrid, A., Skolek, S., & Shapiro, F. (2006)** Repairing failures in bonding through EMDR. *Clinical Case Studies*. 5, 271-286.

*EMDR processing of experiential contributors to bonding disruption, in addition to current triggers, and a memory template of an alternative/problem free pregnancy and birth resulted in the repair of maternal bonding, analogous to the positive findings with the repair of disrupted attachment.*

- **McGoldrick, T., Begum, M. & Brown, K.W. (2008)**. EMDR and olfactory reference syndrome: A case series. *Journal of EMDR Practice and Research* 2, 63-68.

*EMDR treatment of four consecutive cases of ORS whose pathological symptoms had endured for 8–48 years resulted in a complete resolution of symptoms in all four cases, which was maintained at follow-up.*

- **Mol, S. S. L., Arntz, A., Metsemakers, J. F. M., Dinant, G., Vilters-Van Montfort, P. A. P., & Knottnerus, A. (2005)**. Symptoms of post-traumatic stress disorder after non-traumatic events: Evidence from an open population study. *British Journal of Psychiatry*, 186, 494–499.

*Supports a basic tenet of the Adaptive Information Processing model that “Life events can generate at least as many PTSD symptoms as traumatic events.” In a survey of 832 people, “For events from the past 30 years the PTSD scores were higher after life events than after traumatic event.”*

- **Obradovic, J., Bush, N.R., Stamperdahl, J., Adler, N.E. & Boyce, W.T. (2010)**. Biological sensitivity to context: The interactive effects of stress reactivity and family adversity on socioemotional behavior and school readiness. *Child Development*, 1, 270–289.

*“A substantive body of work has established that environmental adversity can have a deleterious effect on children’s functioning” “Exposure to adverse, stressful events . . .has been linked to socioemotional behavior problems and cognitive deficits.”*

- **Perkins, B.R. & Rouanzoin, C.C. (2002)**. A critical evaluation of current views regarding eye movement desensitization and reprocessing (EMDR): Clarifying points of confusion. *Journal of Clinical Psychology*, 58, 77-97.

*Reviews common errors and misperceptions of the procedures, research, and theory.*

- **Raboni, M.R., Tufik, S., and Suchecki, D. (2006)**. Treatment of PTSD by eye movement desensitization and reprocessing improves sleep quality, quality of life and perception of stress. *Annals of the New York Academy of Science*, 1071, 508-513.

*Specifically citing the hypothesis that EMDR induces processing effects similar to REM sleep (see also Stickgold, 2002, 2008), polysomnograms indicated a change in sleep patterns post treatment, and improvement on all measures including anxiety, depression, and quality of life after a mean of five sessions.*

- **Ray, A. L. & Zbik, A. (2001).** Cognitive behavioral therapies and beyond. In C. D. Tollison, J. R. Satterhwaite, & J. W. Tollison (Eds.) *Practical Pain Management* (3rd ed.; pp. 189-208). Philadelphia: Lippincott.

*The authors note that the application of EMDR guided by the Adaptive Information Processing model appears to afford benefits to chronic pain patients not found in other treatments.*

- **Ricci, R. J., Clayton, C. A., & Shapiro, F. (2006).** Some effects of EMDR treatment with previously abused child molesters: Theoretical reviews and preliminary findings. *Journal of Forensic Psychiatry and Psychology*, 17, 538-562.

*As predicted by the Adaptive Information Processing model the EMDR treatment of the molesters' own childhood victimization resulted in a decrease in deviant arousal as measured by the plethysmograph, a decrease in sexual thoughts, and increased victim empathy. Effects maintained at one year follow up.*

- **Russell, M. (2008).** Treating traumatic amputation-related phantom limb pain: case study utilizing eye movement desensitization and reprocessing (EMDR) within the armed services. *Clinical Case Studies*, 7, 136-153.

*"Since September 2006, over 725 service-members from the global war on terrorism have survived combat-related traumatic amputations that often result in phantom limb pain (PLP) syndrome. . . . Four sessions of Eye Movement Desensitization and Reprocessing (EMDR) led to elimination of PLP, and a significant reduction in PTSD, depression, and phantom limb tingling sensations."*

- **Schneider, J., Hofmann, A., Rost, C., & Shapiro, F. (2008).** EMDR in the treatment of chronic phantom limb pain. *Pain Medicine*, 9, 76-82. doi:10.1111/j.1526-4637.2007.00299.

*As predicted by the Adaptive Information Processing model the EMDR treatment of the event involving the limb loss, and the stored memories of the pain sensations, resulted a decrease or elimination of the phantom limb pain which maintained at 1 year follow up.*

- **Schneider, J., Hofmann, A., Rost, C., & Shapiro, F. (2007).** EMDR and phantom limb pain: Case study, theoretical implications, and treatment guidelines. *Journal of EMDR Science and Practice*, 1, 31-45.

*Detailed presentation of case treated by EMDR that resulted in complete elimination of PTSD, depression and phantom limb pain with effects maintained at 18-month follow-up.*

- **Shapiro, F. (2001).** *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2<sup>nd</sup> ed.). New York: Guilford Press.

*EMDR is an eight-phase psychotherapy with standardized procedures and protocols that are all believed to contribute to therapeutic effect. This text provides description and clinical transcripts and an elucidation of the guiding Adaptive Information Processing model.*

- **Shapiro, F. (2002).** (Ed.). *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism*. Washington, DC: American Psychological Association Books.

*EMDR is an integrative approach distinct from other forms of psychotherapy. Experts of the major psychotherapy orientations identify and highlight various procedural elements.*

- **Shapiro, F. (2007).** EMDR, adaptive information processing, and case conceptualization. *Journal of EMDR Practice and Research*, 1, 68-87.

*Overview of EMDR treatment based upon an Adaptive Information Processing case conceptualization. Early life experiences are viewed as the basis of pathology and used as targets for processing. The three-pronged protocol includes processing of the past events that have set the foundation for the pathology, the current triggers, and templates for appropriate future functioning to address skill and developmental deficits.*

- **Shapiro, F. (2006).** EMDR and new notes on adaptive information processing: Case formulation principles, scripts and worksheets. Camden, CT: EMDR Humanitarian Assistance Programs (<http://www.emdrhap.org>).

*Overview of Adaptive Information Processing model, including how the principles are reflected in the procedures, phases and clinical applications of EMDR. Comprehensive worksheets for client assessment, case formulation, and treatment as well as scripts for various procedures.*

- **Shapiro, F., Kaslow, F., & Maxfield, L. (Eds.) (2007).** *Handbook of EMDR and Family Therapy Processes.* New York: Wiley.

*Using an Adaptive Information Processing conceptualization a wide range of family problems and impasses can be addressed through the integration of EMDR and family therapy techniques. Family therapy models are also useful for identifying the targets in need of processing for those engaged in individual therapy.*

- **Solomon, R. & Shapiro, F. (2008).** EMDR and the adaptive information processing model: Potential mechanisms of change. *Journal of EMDR Practice and Research*, 2, 315-325.

*This article provides a brief overview of some of the major precepts of the Adaptive Information Processing model, a comparison and contrast to extinction-based information processing models and treatment and a discussion of a variety of mechanisms of action.*

- **Teicher, M.H. . Samson, J.A., Sheu, Y-S, Polcari, A. & McGreenery, C.E. (2010).** Hurtful words: Association of exposure to peer verbal abuse with elevated psychiatric symptom scores and corpus callosum abnormalities. *Am J Psychiatry*, 167, 1464 - 1471.

*"These findings parallel results of previous reports of psychopathology associated with childhood exposure to parental verbal abuse and support the hypothesis that exposure to peer verbal abuse is an aversive stimulus associated with greater symptom ratings and meaningful alterations in brain structure."*

- **Uribe, M. E. R., & Ramirez, E. O. L. (2006).** The effect of EMDR therapy on the negative information processing on patients who suffer depression. *Revista Electrónica de Motivación y Emoción (REME)*, 9, 23-24.

*The study evaluated the impact of EMDR treatment on bias mechanisms in depressed subjects in regard to negative emotional valence evaluation. "The results indicated that it generated important cognitive emotional changes in such mechanisms." Priming tests indicated changes in the negative valence evaluation of emotional information indicative of recovery with decreased reaction times in the neutral and positive stimuli processing."*

- **Wesselmann, D. & Potter, A. E. (2009).** Change in adult attachment status following treatment with EMDR: Three case studies. *Journal of EMDR Practice and Research*, 3, 178-191.

*Subsequent to EMDR treatment "all three patients made positive changes in attachment status as measured by the [Adult Attachment Inventory], and all three reported positive changes in emotions and relationships."*

- **Wilensky, M. (2006).** Eye movement desensitization and reprocessing (EMDR) as a treatment for phantom limb pain. *Journal of Brief Therapy*, 5, 31-44.

*“Five consecutive cases of phantom limb pain were treated with EMDR. Four of the five clients completed the prescribed treatment and reported that pain was completely eliminated, or reduced to a negligible level. . . The standard EMDR treatment protocol was used to target the accident that caused the amputation and other related events.”*

### **Mechanism of Action**

EMDR contains many procedures and elements that contribute to treatment effects. While the methodology used in EMDR has been extensively validated (see above), questions still remain regarding mechanism of action. However, since EMDR achieves clinical effects without the need for homework, or the prolonged focus used in exposure therapies, attention has been paid to the possible neurobiological processes that might be evoked. Although the eye movements (and other dual attention stimulation) comprise one only one procedural element, this element has come under greatest scrutiny. Randomized controlled studies evaluating mechanism of action of the eye movement component follow this section.

- **Elofsson, U.O.E., von Scheele, B., Theorell, T., & Sondergaard, H.P. (2008).** Physiological correlates of eye movement desensitization and reprocessing. *Journal of Anxiety Disorders*, 22, 622-634.

*Changes in heart rate, skin conductance and LF/HF-ratio, finger temperature, breathing frequency, carbon dioxide and oxygen levels were documented during the eye movement condition. It was concluded the “eye movements during EMDR activate cholinergic and inhibit sympathetic systems. The reactivity has similarities with the pattern during REM sleep.”*

- **Hornsveld, H. K., Landwehr, F., Stein, W., Stomp, M., Smeets, S., & van den Hout, M. A. (2010).** Emotionality of loss-related memories is reduced after recall plus eye movements but not after recall plus music or recall only. *Journal of EMDR Practice and Research*, 4, 106-112.

*“Recall-plus-music was added to investigate whether reductions in emotionality are associated with relaxation. . . Participants reported a greater decline in emotionality and concentration after eye movements in comparison to recall-only and recall-with-music. It is concluded that eye movements are effective when negative memories pertain to loss and grief.”*

- **Kapoula Z, Yang Q, Bonnet A, Bourtoire P, Sandretto J (2010).** EMDR Effects on Pursuit Eye Movements. *PLoS ONE* 5(5): e10762. doi:10.1371/journal.pone.0010762

*EMDR treatment of autobiographic worries causing moderate distress resulted in an “increase in the smoothness of pursuit [which] presumably reflects an improvement in the use of visual attention needed to follow the target accurately. Perhaps EMDR reduces distress thereby activating a cholinergic effect known to improve ocular pursuit.”*

- **Lee, C.W., Taylor, G., & Drummond, P.D. (2006)** The active ingredient in EMDR: Is it traditional exposure or dual focus of attention? *Clinical Psychology and Psychotherapy*, 13, 97-107.

*This study tested whether the content of participants’ responses during EMDR is similar to that thought to be effective for traditional exposure treatments (reliving), or is more consistent with distancing which would be expected given Shapiro’s proposal of dual focus of attention. Greatest improvement on a measure of PTSD symptoms occurred when the participant processed the trauma in a more detached manner, which indicates the underlying mechanisms of EMDR and exposure therapy are different.*

- **Lilley, S.A., Andrade, J., Graham Turpin, G., Sabin-Farrell, R. & Emily A. Holmes, E.A. (2009).** Visuospatial working memory interference with recollections of trauma. *British Journal of Clinical Psychology*, 48, 309–321.

*Tested patients awaiting PTSD treatment and demonstrated that the eye movement condition*

had a significant effect on vividness of trauma memory and emotionality compared to counting and exposure only. In addition, “the counting task had no effect on vividness compared to exposure only, suggesting that the eye-movement task had a specific effect rather than serving as a general distractor” (p. 317)

- **MacCulloch, M. J., & Feldman, P. (1996).** Eye movement desensitization treatment utilizes the positive visceral element of the investigatory reflex to inhibit the memories of post-traumatic stress disorder: A theoretical analysis. *British Journal of Psychiatry*, 169, 571–579.

*One of a variety of articles positing an orienting response as a contributing element (see Shapiro, 2001 for comprehensive examination of theories and suggested research parameters). This theory has received controlled research support (Barrowcliff et al., 2003, 2004).*

- **Propper, R., Pierce, J.P., Geisler, M.W., Christman, S.D., & Bellorado, N. (2007).** Effect of bilateral eye movements on frontal interhemispheric gamma EEG coherence: Implications for EMDR therapy. *Journal of Nervous and Mental Disease*, 195, 785-788.

*“Specifically, the EM manipulation used in the present study, reported previously to facilitate episodic memory, resulted in decreased interhemispheric EEG coherence in anterior prefrontal cortex. Because the gamma band includes the 40 Hz wave that may indicate the active binding of information during the consolidation of long-term memory storage (e.g., Cahn and Polich, 2006), it is particularly notable that the changes in coherence we found are in this band. With regard to PTSD symptoms, it may be that by changing interhemispheric coherence in frontal areas, the EMs used in EMDR foster consolidation of traumatic memories, thereby decreasing the memory intrusions found in this disorder.”*

- **Rogers, S., & Silver, S. M. (2002).** Is EMDR an exposure therapy? A review of trauma protocols. *Journal of Clinical Psychology*, 58, 43-59.

*Theoretical, clinical, and procedural differences referencing two decades of CBT and EMDR research.*

- **Rogers, S., Silver, S., Goss, J., Obenchain, J., Willis, A., & Whitney, R. (1999).** A single session, controlled group study of flooding and eye movement desensitization and reprocessing in treating posttraumatic stress disorder among Vietnam War veterans: Preliminary data. *Journal of Anxiety Disorders*, 13, 119–130.

*This study was designed as primarily a process report to compare EMDR and exposure therapy. A different recovery pattern was observed with the EMDR group demonstrating a more rapid decline in self-reported distress.*

- **Sack, M., Hofmann, A., Wizelman, L., & Lempa, W. (2008).** Psycho physiological changes during EMDR and treatment outcome. *Journal of EMDR Practice and Research*, 2, 239-246

*During-session changes in autonomic tone were investigated in 10 patients suffering from single-trauma PTSD. Results indicate that information processing during EMDR is followed by during-session decrease in psycho physiological activity, reduced subjective disturbance and reduced stress reactivity to traumatic memory.*

- **Sack, M., Lempa, W., Steinmetz, A., Lamprecht, & Hofmann, A. (2008).** Alterations in autonomic tone during trauma exposure using eye movement desensitization and reprocessing (EMDR) - results of a preliminary investigation. *Journal of Anxiety Disorders*, 22, 1264-1271.

*The psycho-physiological correlates of EMDR were investigated during treatment sessions of trauma patients. The initiation of the eye movements sets resulted in immediate changes that indicated a pronounced de-arousal.*

- **Servan-Schreiber, D., Schooler, J., Dew, M.A., Carter, C., & Bartone, P. (2006).** EMDR for PTSD: A pilot blinded, randomized study of stimulation type. *Psychotherapy and Psychosomatics*, 75, 290-297.

*Twenty-one patients with single-event PTSD (average IES: 49.5) received three consecutive sessions of EMDR with three different types of auditory and kinesthetic stimulation. All were clinically useful. However, alternating stimulation appeared to confer an additional benefit to the EMDR procedure.*

- **Stickgold, R. (2002).** EMDR: A putative neurobiological mechanism of action. *Journal of Clinical Psychology*, 58, 61-75.
- **Stickgold, R. (2008).** Sleep-dependent memory processing and EMDR action. *Journal of EMDR Practice and Research*, 2, 289-299.

*Comprehensive explanations of mechanisms and the potential links to the processes that occur in REM sleep. Controlled studies have evaluated these theories (see next section; Christman et al., 2003; Kuiken et al. 2001-2002).*

- **Suzuki, A., et al. (2004).** Memory reconsolidation and extinction have distinct temporal and biochemical signatures. *Journal of Neuroscience*, 24, 4787– 4795.

*The article explores the differences between memory reconsolidation and extinction. This new area of investigation is worthy of additional attention. Reconsolidation may prove to be the underlying mechanism of EMDR, as opposed to extinction caused by prolonged exposure therapies. “Memory reconsolidation after retrieval may be used to update or integrate new information into long-term memories . . . Brief exposure . . . seems to trigger a second wave of memory consolidation (reconsolidation), whereas prolonged exposure . . . leads to the formation of a new memory that competes with the original memory (extinction).”*

- **Wilson, D., Silver, S. M., Covi, W., & Foster, S. (1996).** Eye movement desensitization and reprocessing: Effectiveness and autonomic correlates. *Journal of Behaviour Therapy and Experimental Psychiatry*, 27, 219–229.

*Study involving biofeedback equipment has supported the hypothesis that the parasympathetic system is activated by finding that eye movements appeared to cause a compelled relaxation response. More rigorous research with trauma populations is needed.*

### **Randomized Studies of Hypotheses Regarding Eye Movements**

A number of International Practice Guideline committees have reported that the clinical component analyses reviewed by Davidson & Parker (2001) are not well designed (International Society for Traumatic Stress Studies/ISTSS (2000); DoD/DVA). Davidson & Parker note that there is a trend toward significance for eye movements when the studies conducted with clinical populations are examined separately. Unfortunately even these studies are methodologically flawed. As noted in the ISTSS guidelines (Chemtob et al., 2000), since these clinical populations received insufficient treatment doses to obtain substantial main effects, they are inappropriate for component analyses. However, as noted in the DoD/DVA (2004) guidelines, numerous memory researchers have evaluated the eye movements used in EMDR. These studies have found a direct effect on emotional arousal, imagery vividness, attention flexibility, and memory association. In addition, a new study has examined the hypothesis that the eye movements cause a “distancing effect” (Lee & Drummond, 2008) and is listed below.

- **Andrade, J., Kavanagh, D., & Baddeley, A. (1997).** Eye-movements and visual imagery: A working memory approach to the treatment of post-traumatic stress disorder. *British Journal of Clinical Psychology*, 36, 209-223.

*Tested the working memory theory. Eye movements were superior to control conditions in reducing image vividness and emotionality.*

- **Barrowcliff, A.L., Gray, N.S., Freeman, T.C.A., & MacCulloch, M.J. (2004).** Eye-movements reduce the vividness, emotional valence and electro dermal arousal associated with negative autobiographical memories. *Journal of Forensic Psychiatry and Psychology*, 15, 325-345.

*Tested the reassurance reflex model. Eye movements were superior to control conditions in reducing image vividness and emotionality.*

- **Barrowcliff, A.L., Gray, N.S., MacCulloch, S., Freeman, T. C.A., & MacCulloch, M.J. (2003).** Horizontal rhythmical eye-movements consistently diminish the arousal provoked by auditory stimuli. *British Journal of Clinical Psychology*, 42, 289-302.

*Tested the reassurance reflex model. Eye movements were superior to control conditions in reducing arousal provoked by auditory stimuli.*

- **Christman, S. D., Garvey, K. J., Propper, R. E., & Phaneuf, K. A. (2003).** Bilateral eye movements enhance the retrieval of episodic memories. *Neuropsychology*, 17, 221-229.

*Tested cortical activation theories. Results provide indirect support for the orienting response/REM theories suggested by Stickgold (2002, 2008). Saccadic eye movements, but not tracking eye movements were superior to control conditions in episodic retrieval.*

- **Christman, S. D., Propper, R. E., & Brown, T. J. (2006).** Increased interhemispheric interaction is associated with earlier offset of childhood amnesia. *Neuropsychology*, 20, 336.

*"The results of the current Experiment 2 suggest that the eye movements employed in EMDR may induce a neurobiological change in interhemispheric interaction and an attendant psychological change in episodic retrieval."*

- **Engelhard, I.M., van den Hout, M.A., Janssen, W.C., & van der Beek, J. (2010).** Eye movements reduce vividness and emotionality of "flashforwards." *Behaviour Research and Therapy*, 48, 442-447.

*"This study examined whether eye movements reduce vividness and emotionality of visual distressing images about feared future events. . . Relative to the no-dual task condition, eye movements while thinking of future-oriented images resulted in decreased ratings of image vividness and emotional intensity."*

- **Engelhard, I.M., van Uijen, S.L. & van den Hout, M.A. (2010).** The impact of taxing working memory on negative and positive memories. *European Journal of Psychotraumatology*, 1: 5623 - DOI: 10.3402/ejpt.v1i0.5623

*Additional investigation of eye movements compared to Tetris from a working memory perspective.*

- **Engelhard, I.M., et al. (2011).** Reducing vividness and emotional intensity of recurrent "flashforwards" by taxing working memory: An analogue study. *Journal of Anxiety Disorders* 25, 599-603.

*"Results showed that vividness of intrusive images was lower after recall with eye movement, relative to recall only, and there was a similar trend for emotionality."*

- **Gunter, R.W. & Bodner, G.E. (2008).** How eye movements affect unpleasant memories: Support for a working-memory account. *Behaviour Research and Therapy* 46, 913- 931.

*Three studies were done with cumulatively support a working-memory account of the eye movement benefits in which the central executive is taxed when a person performs a distracter*

*task while attempting to hold a memory in mind.*

- **Kavanagh, D. J., Freese, S., Andrade, J., & May, J. (2001).** Effects of visuospatial tasks on desensitization to emotive memories. *British Journal of Clinical Psychology*, 40, 267-280.

*Tested the working memory theory. Eye movements were superior to control conditions in reducing within-session image vividness and emotionality. There was no difference one-week post.*

- **Kuiken, D., Bears, M., Miall, D., & Smith, L. (2001-2002).** Eye movement desensitization reprocessing facilitates attentional orienting. *Imagination, Cognition and Personality*, 21, (1), 3-20.

*Tested the orienting response theory related to REM-type mechanisms. Indicated that the eye movement condition was correlated with increased attentional flexibility. Eye movements were superior to control conditions.*

- **Kuiken, D., Chudleigh, M. & Racher, D. (2010).** Bilateral eye movements, attentional flexibility and metaphor comprehension: The substrate of REM dreaming? *Dreaming*, 20, 227–247.

*This study adds additional support to the orienting response theory related to REM-type mechanisms. Evaluations of participants experiencing significant loss or trauma demonstrate differential effects in a comparison of eye movement and non-eye movement conditions.*

- **Lee, C.W., & Drummond, P.D. (2008).** Effects of eye movement versus therapist instructions on the processing of distressing memories. *Journal of Anxiety Disorders*, 22, 801-808.

*“There was no significant effect of therapist’s instruction on the outcome measures. There was a significant reduction in distress for eye movement at post-treatment and at follow-up. The results were consistent with other evidence that the mechanism of change in EMDR is not the same as traditional exposure.”*

- **Maxfield, L., Melnyk, W.T. & Hayman, C.A. G. (2008).** A working memory explanation for the effects of eye movements in EMDR. *Journal of EMDR Practice and Research*, 2, 247-261.

*In two experiments participants focused on negative memories while engaging in three dual-attention eye movement tasks of increasing complexity. Results support a working memory explanation for the effects of eye movement dual-attention tasks on autobiographical memory.*

- **Parker, A., Buckley, S. & Dagnall, N. (2009).** Reduced misinformation effects following saccadic bilateral eye movements. *Brain and Cognition*, 69, 89-97.

*Bilateral saccadic eye movements were compared to vertical and no eye movements. “It was found that bilateral eye movements increased true memory for the event, increased recollection, and decreased the magnitude of the misinformation effect.” This study supports hypotheses regarding effects of interhemispheric activation and episodic memory.*

- **Parker, A. & Dagnall, N. (2007).** Effects of bilateral eye movements on gist based false recognition in the DRM paradigm. *Brain and Cognition*, 63, 221-225.

*Bilateral saccadic eye movements were compared to vertical and no eye movements. Those in the bilateral eye movement condition “were more likely to recognise previously presented words and less likely to falsely recognize critical non-studies associates.”*

- **Parker, A., Relph, S. & Dagnall, N. (2008).** Effects of bilateral eye movement on retrieval of item, associative and contextual information. *Neuropsychology*, 22, 136-145.

*The effects of saccadic bilateral eye movement were compared to vertical eye movements and no eye movements on the retrieval of item, associative and contextual information. Saccadic eye movements were superior on all parameters in all conditions.*

- **Schubert, S.J., Lee, C.W. & Drummond, P.D. (2011).** The efficacy and psychophysiological correlates of dual-attention tasks in eye movement desensitization and reprocessing (EMDR). *Journal of Anxiety Disorders*, 25, 1-11.

*“EMDR-with eye movements led to greater reduction in distress than EMDR-without eye movements. Heart rate decreased significantly when eye movements began; skin conductance decreased during eye movement sets; heart rate variability and respiration rate increased significantly as eye movements continued; and orienting responses were more frequent in the eye movement than no-eye movement condition at the start of exposure.”*

- **Sharpley, C. F. Montgomery, I. M., & Scalzo, L. A. (1996).** Comparative efficacy of EMDR and alternative procedures in reducing the vividness of mental images. *Scandinavian Journal of Behaviour Therapy*, 25, 37-42.

*Eye movements were superior to control conditions in reducing image vividness.*

- **Van den Hout, M., Muris, P., Salemink, E., & Kindt, M. (2001).** Autobiographical memories become less vivid and emotional after eye movements. *British Journal of Clinical Psychology*, 40, 121-130.

*Tested their theory that eye movements change the somatic perceptions accompanying retrieval, leading to decreased affect, and therefore decreasing vividness. Eye movements were superior to control conditions in reducing image vividness. Unlike control conditions, eye movements also decreased emotionality.*

### **Additional Psychophysiological & Neurobiological Evaluations of EMDR Treatment**

All psycho physiological studies have indicated significant de-arousal. All neurobiological studies have indicated significant effects, including changes in cortical, and limbic activation patterns, and increase in hippocampal volume.

**Bossini L. Fagiolini, A. & Castrogiovanni, P. (2007).** Neuroanatomical changes after EMDR in Posttraumatic Stress Disorder. *Journal of Neuropsychiatry and Clinical Neuroscience*, 19, 457-458.

**Harper, M. L., Rasolkhani-Kalhorn, T., & Drozd, J. F. (2009).** On the neural basis of EMDR therapy: Insights from qeeg studies. *Traumatology*, 15, 81-95.

**Kowal, J. A. (2005).** QEEG analysis of treating PTSD and bulimia nervosa using EMDR. *Journal of Neurotherapy*, 9(Part 4), 114-115.

**Lamprecht, F., Kohnke, C., Lempa, W., Sack, M., Matzke, M., & Munte, T. (2004).** Event-related potentials and EMDR treatment of post-traumatic stress disorder. *Neuroscience Research*, 49, 267-272.

**Lansing, K., Amen, D.G., Hanks, C. & Rudy, L. (2005).** High resolution brain SPECT imaging and EMDR in police officers with PTSD. *Journal of Neuropsychiatry and Clinical Neurosciences*, 17, 526-532.

**Levin, P., Lazrove, S., & van der Kolk, B. A. (1999).** What psychological testing and neuroimaging tell us about the treatment of posttraumatic stress disorder (PTSD) by eye movement desensitization and reprocessing (EMDR)? *Journal of Anxiety Disorders*, 13, 159-172.

**Nardo D et al. (2009, in press).** Gray matter density in limbic and paralimbic cortices is associated with trauma load and EMDR outcome in PTSD patients. *Journal of Psychiatric Research*. doi:10.1016/j.jpsychires.2009.10.014

**Oh, D.-H., & Choi, J. (2004).** Changes in the regional cerebral perfusion after Eye Movement Desensitization and Reprocessing: A SPECT study of two cases. *Journal of EMDR Practice and Research, 1*, 24-30.

**Ohta ni, T., Matsuo, K., Kasai, K., Kato, T., & Kato, N. (2009).** Hemodynamic responses of eye movement desensitization and reprocessing in posttraumatic stress disorder. *Neuroscience Research, 65*, 375–383.

**Pagani, M. et al. (2007).** Effects of EMDR psychotherapy on 99mTc-HMPAO distribution in occupation-related post-traumatic stress disorder. *Nuclear Medicine Communications, 28*, 757–765.

**Propper, R., Pierce, J.P., Geisler, M.W., Christman, S.D., & Bellorado, N. (2007).** Effect of bilateral eye movements on frontal interhemispheric gamma EEG coherence: Implications for EMDR therapy. *Journal of Nervous and Mental Disease, 195*, 785-788.

**Richardson, R., Williams, S.R., Hepenstall, S., Sgregory, L., McKie, & Corrigan, F. (2009).** A single-case fMRI study EMDR treatment of a patient with posttraumatic stress disorder. *Journal of EMDR Practice and Research, 3*, 10-23.

**Sack, M., Lempa, W., & Lemprecht, W. (2007).** Assessment of psycho physiological stress reactions during a traumatic reminder in patients treated with EMDR. *Journal of EMDR Practice and Research, 1*, 15-23.

**Sack, M., Nickel, L., Lempa, W., & Lamprecht, F. (2003)** Psychophysiological regulation in patients suffering from PTSD: Changes after EMDR treatment. *Journal of Psychotraumatology and Psychological Medicine, 1*, 47 -57. (German)

**van der Kolk, B., Burbridge, J., & Suzuki, J. (1997).** The psychobiology of traumatic memory: Clinical implications of neuroimaging studies. *Annals of the New York Academy of Sciences, 821*, 99-113.

### **Combat Veteran Treatment**

As noted in the American Psychiatric Association Practice Guidelines (2004, p.18), in EMDR “traumatic material need not be verbalized; instead, patients are directed to think about their traumatic experiences without having to discuss them.” Given the reluctance of many combat veterans to divulge the details of their experience, this factor is relevant to willingness to initiate treatment, retention and therapeutic gains. It may be one of the factors responsible for the lower remission and higher dropout rate noted in this population when CBT techniques are used.

As described previously, Carlson et al. (1998) reported that after twelve treatment sessions, 77.7% of the combat veterans no longer met criteria for PTSD. There were no dropouts and effects were maintained at 3- and 9-month follow-up. In addition, the Silver et al., (1995) analysis of an inpatient veterans’ PTSD program (n = 100) found EMDR to be superior to biofeedback and relaxation training on seven of eight measures. All other randomized studies of veterans have used insufficient treatment doses to assess PTSD outcomes (e.g., two sessions; see ISTSS, 2000; DVA/DoD, 2005). Sufficient treatment time must be used for multiply traumatized veterans (e.g., see below: Russell et al., 2007). However, in a process analysis, Rogers et al. (1999) compared one session of EMDR and exposure therapy with inpatient veterans, and a different recovery pattern was observed. The EMDR group demonstrated a more rapid decline in self-reported distress (e.g., SUD levels decreased with EMDR and increased with exposure).

As stated in the American Psychiatric Practice Guidelines (2004, p. 36), if viewed as an exposure therapy, “EMDR employs techniques that may give the patient more control over the exposure experience (since EMDR is less reliant on a verbal account) and provides techniques to regulate anxiety in the apprehensive circumstance of exposure treatment. Consequently, it may prove advantageous for patients who cannot tolerate prolonged exposure as well as for patients who have

difficulty verbalizing their traumatic experiences. Comparisons of EMDR with other treatments in larger samples are needed to clarify such differences.”

Such research is highly recommended. In addition, since EMDR utilizes no homework to achieve its effects it may be particularly suited for front line alleviation of symptoms (see Russell, 2006; Wesson & Gould, 2009). Further, the prevalent somatic and chronic pain problems experienced by combat veterans indicate the need for additional research based upon the reports of Russell (2008), Schneider et al., (2007, 2008) and Wilensky (2007), which demonstrate EMDR’s capacity to successfully treat phantom limb pain (see also Ray & Zbik, 2001). The ability of EMDR to simultaneously address PTSD, depression, and pain can have distinct benefits for DVA/DoD treatment.

*The following contain clinically relevant information for the treatment of veterans, including therapy parameters.*

**Carlson, J., Chemtob, C.M., Rusnak, K., Hedlund, N.L., & Muraoka, M.Y. (1998).** Eye movement desensitization and reprocessing (EMDR): Treatment for combat-related post-traumatic stress disorder. *Journal of Traumatic Stress, 11*, 3-24.

**Cook, J.M., Biyanova, T., & Coyne, J.C. (2009).** Comparative case study of diffusion of eye movement desensitization and reprocessing in two clinical settings: Empirically supported treatment status is not enough. *Professional Psychology: Research and Practice, 40*, 518–524.

**Errebo, N. & Sommers-Flanagan, R. (2007).** EMDR and emotionally focused couple therapy for war veteran couples. In F. Shapiro, F. Kaslow, & L. Maxfield (Eds.) *Handbook of EMDR and family therapy processes*. New York: Wiley

**Lipke, H. (2000).** *EMDR and psychotherapy integration*. Boca Raton, FL: CRC Press.

**Russell, M. (2006).** Treating combat-related stress disorders: A multiple case study utilizing eye movement desensitization and reprocessing (EMDR) with battlefield casualties from the Iraqi war. *Military Psychology, 18*, 1-18.

**Russell, M. (2008).** Treating traumatic amputation-related phantom limb pain: A case study utilizing eye movement desensitization and reprocessing (EMDR) within the armed services. *Clinical Case Studies, 7*, 136-153.

**Russell, M.C. (2008).** War-related medically unexplained symptoms, prevalence, and treatment: utilizing EMDR within the armed services. *Journal of EMDR Practice and Research, 2*, 212-226.

**Russell, M.C. (2008).** Scientific resistance to research, training and utilization of eye movement desensitization and reprocessing (EMDR) therapy in treating post-war disorders *Social Science & Medicine, 67*, 1737–1746.

**Russell, M.C., & Silver, S.M. (2007).** Training needs for the treatment of combat-related posttraumatic stress disorder. *Traumatology, 13*, 4-10.

**Russell, M.C., Silver, S.M., Rogers, S., & Darnell, J. (2007).** Responding to an identified need: A joint Department of Defense-Department of Veterans Affairs training program in eye movement desensitization and reprocessing (EMDR) for clinicians providing trauma services. *International Journal of Stress Management, 14*, 61-71.

**Silver, S.M. & Rogers, S. (2002).** *Light in the heart of darkness: EMDR and the treatment of war and terrorism survivors*. New York: Norton.

**Silver, S.M., Rogers, S., & Russell, M.C. (2008).** Eye movement desensitization and reprocessing (EMDR) in the treatment of war veterans. *Journal of Clinical Psychology: In Session, 64*, 947—957.

**Wesson, M. & Gould, M. (2009).** Intervening early with EMDR on military operations: A case study.  
*Journal of EMDR Practice and Research*, 3, 91-97.

## **RESEARCH ON THE ROLE OF EYE MOVEMENTS** **(Excerpts from Shapiro, 2002)**

In 1989, Francine Shapiro<sup>TP12-14</sup>PT noticed that the upsetting emotions accompanying disturbing thoughts disappeared as her eyes moved rapidly back and forth on their own. She began experimenting with this and found that when others moved their eyes, their upsetting emotions also improved. She conducted a case study and a controlled study, which supported her theory that eye movements (EMs) helped to lower the distress of traumatic memories. The idea that eye movements could alter thinking patterns had been documented previously. A series of experiments revealed that spontaneous EMs was associated with unpleasant emotions and cognitive changes.

Since that time, there has been a great deal of research investigating the eye movements alone. Before detailing that information, please remember that EMDR is a psychotherapy with many active ingredients. The eye movements are only one element. According to the International Society for Traumatic Stress Studies (ISTSS) guidelines, the component research has been flawed and more needs to be done. However, EMDR is not unique, in that no form of therapy has been definitively evaluated in terms of the specific qualities that are most helpful. While component analyses are useful to help refine procedures, and furthering our understanding of the neurobiological aspects of change, they cannot guide clinical practice unless they are conducted according to rigorous scientific and clinical standards. In the meanwhile, in order to provide the best help for clients, all empirically supported forms of therapy should be done with all their components intact, as that is the way they have been evaluated as effective in outcome studies.

As with any complex form of therapy, it is important for research studies analyzing the various EMDR components to use large numbers of participants with appropriate problems. Also, the researchers providing the treatment should follow all steps in the EMDR protocol and offer the participants an appropriate length of treatment only then, will it be possible to evaluate effects of specific EMDR elements. The same mistakes have been made in evaluating many previous psychotherapy components. For instance, the evaluation of a therapy known as systematic desensitization has been similarly flawed. €

In the case of EMDR, three different types of studies have looked at this issue. It can be very confusing when the results are inappropriately combined. For instance, In the Davidson and Parker meta-analysis,<sup>TP20</sup>PT all published EMDR studies from 1988 to 2000 were examined in order to determine whether eye movements were actually necessary. EMDR-with-EMs did not appear to be more helpful than EMDR-without-EMs, when all types of studies were considered. However, when the results of the clinical dismantling studies are examined, EMDR-with-EMs is significantly superior to EMDR-without-EMs.

There have been 20 published studies that investigated the role of EMs in EMDR. Studies have typically compared EMDR-with-EMs to a control condition in which the EM component was modified (e.g., EMDR-with-eyes-focused-and-unmoving). There have been four different types of studies: (1) case studies, (2) dismantling studies using clinical participants, (3) dismantling studies using nonclinical analogue participants, and (4) component action studies in which eye movements are examined in isolation.

**Case studies.** Four case studies evaluated the effects of adding EMs to the treatment process, and three found EMs to enhance treatment. Montgomery and Ayllon found eye movements to be necessary for EMDR treatment effects in five of six civilian PTSD patients.

They wrote that the addition of the eye movement component “resulted in the significant decreases in self-reports of distress previously addressed. These findings are reflected by decreases in psycho-physiological arousal” (p. 228). Lohr, Tolin, and Kleinknecht reported, “the addition of the eye movement component appeared to have a distinct effect in reducing the level of [SUD] ratings” (p. 149).

In another study Lohr, Tolin and Kleinknecht treated two claustrophobic subjects and found distress decreased substantially only after EMs were added to the rest of the EMDR procedure. The fourth study TP<sup>24</sup>PT did not use standard EMDR protocol for phobias, nor the standard procedures for accessing the image, formulating the negative belief, or eliciting new links to helpful information in the memory system. In addition, the client was instructed to relax between sets of EMs until the SUD rating was reduced to previous levels, a procedure not used in EMDR. The procedures used in this study did not eliminate the phobia and no effect was found for the EM condition.

Clinical dismantling studies with diagnosed participants. There have been four controlled dismantling studies with PTSD participants and two studies where participants were diagnosed with other anxiety disorders. These studies have tended to show that EMDR-with-EMs is slightly better than EMDR-with-modification. However, the difference was not large enough to be considered significant. In general, the results are unclear. For example, Devilly, Spence, and Rapee reported rates of reliable change of 67% for the EM condition, compared to 42% of the non-EM condition. Renfrey and Spates reported a decrease in PTSD diagnosis of 85% for the EM group and 57% for the non-EM group.

Unfortunately, these studies are limited by severe problems. For example, there were only seven or eight persons per condition in the Renfrey and Spates PTSD study when larger numbers (e.g., 30-40 in each condition) are needed to obtain meaningful results. The participants in the other three PTSD studies were combat veterans, who received only two sessions and/or treatment for only one traumatic memory. Such an inadequate course of treatment seemed to have only a moderate effect and would have needed more participants in order to detect any possible differences between groups. There has yet to be a well-designed dismantling study with a large enough sample to assess treatment effects.

Clinical dismantling studies with analogue participants. The controlled studies that used analogue participants with non-clinical anxiety found no effect for EMs. There are many problems with these analogue studies, which typically used normal college student participants. One problem is that the outcomes were evaluated on the basis of symptom elimination, without using the standard EMDR procedures and protocols. These were omitted or shortened, causing the meaning of the outcomes to be unclear. Most problematic, is that all of the EMDR procedures are expected to have some positive results. Predictably, the analogue participants responded equally well to truncate EMDR-without-EMs, because the procedures contain a number of clinically helpful elements. In other words, the sub-clinical distress of the analogue participants was relieved with minimal treatment, making it difficult to detect differences between conditions.

In short, when eliminating only one component from a complex clinical method, diagnosed populations capable of change in the amount of treatment time given, such as single trauma PTSD, should be used. Using a sufficient number of appropriate subjects, who have a high enough level of distress (not susceptible to placebo), would allow the elimination of only one component to have a detectable effect. As with any other form of psychotherapy, eliminating only part of EMDR procedures does not eliminate all the clinical benefit.

**Component action studies.** Component action studies are different from other types of component analyses, because they test EMs in isolation. These studies typically provide brief sets of EMs to examine their effects on memory, emotions, thoughts/beliefs, or physiology. The purpose is to investigate the effects of moving the eyes (without the rest of the EMDR procedures) by comparing EMs to control conditions such as thinking about the image or tapping. For example, a participant might be asked to picture a memory image, then to move his or her eyes for a brief period, and then to rate the vividness of the image. This permits a pure test of the specific effects of EMs and non-EMs by removing the other elements of EMDR that are thought to be helpful. The studies have generally used non-clinical participants, each of whom receives all of the various conditions (e.g., EMs and taps). This makes it easier to detect differences in response to the conditions. Also, since it is the same person experiencing the conditions, differences may be linked to the condition, rather than to individual differences (e.g., different people may respond differently to the same condition).

Component action studies have generally been conducted by neuropsychologists and memory researchers investigating a specific hypothesis. As such, they help further our understanding of mechanisms by carefully choosing control conditions and linking findings to other areas of interest. These studies are listed below, and the theories each have investigated are briefly reviewed in the next section. [See an updated list of studies in the previous section]

- Andrade, J., Kavanagh, D., & Baddeley, A. (1997). Eye-movement and visual imagery: a working memory approach to the treatment of post-traumatic stress disorder. *British Journal of Clinical Psychology, 36*, 209-223.
- Barrowcliff, A. L., Gray, N. S., Freeman, T. C. A., & MacCulloch, M. J. (2004). Eye-movements reduce the vividness, emotional valence and electro dermal arousal associated with negative autobiographical memories. *Journal of Forensic Psychiatry and Psychology.*
- Barrowcliff, A. L., Gray, N. S., MacCulloch, S. Freeman, T. C. A., & MacCulloch, M. J. (2003). Horizontal rhythmical eye-movements consistently diminish the arousal provoked by auditory stimuli. *British Journal of Clinical Psychology, 42*, 289-302.
- Christman, S. D., Garvey, K. J., Propper, R. E. & Phaneuf, K. A. (2003). Bilateral eye movements enhance the retrieval of episodic memories. *Neuropsychology, 17*, 221-229.
- Kavanagh, D. J., Freese, S., Andrade, J., & May, J. (2001). Effects of visuospatial tasks on desensitization to emotive memories. *British Journal of Clinical Psychology, 40*, 267-280.
- Kuiken, D., Bears, M., Miall, D., & Smith, L. (2001-2002). Eye movement desensitization reprocessing facilitates attentional orienting. *Imagination, Cognition and Personality, 21(1)*, 3-30.
- Sharpley, C. F., Montgomery, I. M., & Scalzo, L. A. (1996). Comparative efficacy of EMDR and alternative procedures in reducing the vividness of mental images. *Scandinavian Journal of Behaviour Therapy, 25*, 37-42.
- van den Hout, M., Muris, P., Salemink, E., & Kindt, M. (2001). Autobiographical memories become less vivid and emotional after eye movements. *British Journal of Clinical Psychology, 40*, 121-130.

## **HOW ARE THE EYE MOVEMENTS HELPFUL IN EMDR?**

A common suggestion is that EMs, or other dual attention stimulation, elicit an orienting response. The orienting response is a natural response of interest and attention that occurs when attention is drawn to something new. There are three different models to explain the role of the orienting response in EMDR: cognitive/information processing,<sup>30,31</sup> neurobiological,<sup>32,33,34</sup> and behavioral.<sup>35,36</sup> To some extent, these models view the same phenomenon from different perspectives.

Barrowcliff and colleagues<sup>37</sup> suggest that the orienting in EMDR is actually an “investigatory reflex,” that results in a basic relaxation response that happens after realizing that there is no threat. By pairing this relaxation state with the previously upsetting memory, the client now has a new way of experiencing the memory and may notice a decrease in distress. This process is known as reciprocal inhibition.

Others suggest that the orienting response may disrupt the traumatic memory network, interrupting previous links to negative emotions, and allowing for the integration of new information. A study by Kuiken, Bears, Miall & Smith,<sup>38</sup> which tested the orienting response theory found that the eye movements were related to increased attentional flexibility. It is also possible that the orienting response stimulates neurobiological mechanisms, which activate episodic memories and integrate them into cortical semantic memory.<sup>34</sup> This theory has recently received experimental support.<sup>39</sup> Further research is needed to test these hypotheses.

There are several research studies<sup>30,40,41</sup> indicating that EMs and other stimuli affect perceptions of the targeted memory, decreasing image vividness and the related emotions. Two possible mechanisms have been proposed to explain how this effect may contribute to EMDR treatment. Kavanaugh and colleagues<sup>40</sup> suggest that EMs disrupt working memory, decreasing vividness, and that this results in decreased emotionality. Van den Hout and colleagues<sup>41</sup> hypothesize that EMs change the body sensations accompanying the retrieved memory, leading to decreased affect, and therefore decreasing vividness.

Detailed descriptions of hypotheses and suggested research investigations may be found in:

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures* (2P<sup>nd</sup> ed.). New York: Guilford.

However, it is important to remember that EMDR is a multifaceted treatment with many active ingredients, beyond the bilateral stimulation. See the above text and the following for comprehensive discussions:

Shapiro, F. (2002). (Ed.). *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism*. Washington, DC: American Psychological Association Books.

### **References**

<sup>12</sup>Shapiro, F. (1995). *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*. New York: Guilford.

<sup>13</sup>Shapiro, F. (1989). Eye movement desensitization: A new treatment for post-traumatic stress disorder. *Journal of Behavior Therapy and Experimental Psychiatry*, 20, 211-217.

<sup>14</sup>Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, 2, 199-223.

- <sup>15</sup> Antrobus, J. S. (1973). Eye movements and non-visual cognitive tasks. In V. Zikmund (Ed.), *The oculomotor system and brain functions* (pp. 354-368). London: Butterworths.
- <sup>16</sup> Antrobus, J. S., Antrobus, J. S., & Singer, J. (1964). Eye movements, accompanying daydreams, visual imagery, and thought suppression. *Journal of Abnormal and Social Psychology*, *69*, 244-252.
- <sup>17</sup> Chemtob, C. M., Tolin, D. F., van der Kolk, B. A., & Pitman, R. K. (2000). Eye movement desensitization and reprocessing in E. A. Foa, T. M. Keane & M. J. Friedman (Eds.), *Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies*. New York: Guilford.
- <sup>18</sup> Kazdin, A. E. (1994). Methodology, design, and evaluation in psychotherapy research. In A. E. Bergin & S. L. Garfield (Eds.), *Handbook of psychotherapy and behavior change* (4<sup>th</sup> ed., pp. 19-71). New York: Wiley.
- Kazdin, A. E. (1998). *Research design in clinical psychology* (3<sup>rd</sup> ed.). Needham Heights, MA: Allyn & Bacon.
- Kazdin, A. E. & Bass, D. (1989). Power to detect differences between alternative treatments in comparative psychotherapy outcome research. *Journal of Consulting and Clinical Psychology*, *57*, 138-147.
- <sup>19</sup> Wolpe, J. (1990). *The practice of behavior therapy* (4<sup>th</sup> ed.). New York: Pergamon Press.
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## **CLINICAL RESEARCH PROTOCOLS**

Shapiro, F. (1999). Eye movement desensitization and reprocessing (EMDR) and the anxiety disorders: Clinical and research implications of an integrated psychotherapy treatment. *UJournal of Anxiety Disorders*, 13, No. 1-2, 35-67. (Excerpt)

The generic therapeutic protocol underlying comprehensive EMDR treatment includes a “three-pronged” protocol subsequent to appropriate therapeutic stabilization and client preparation. Specifically, the client is engaged in: (a) processing of experiences contributing to the dysfunction, (b) processing triggers that elicit present disturbance, and (c) incorporating imaginal templates of positive/useful skills and behaviors for future adaptive actions. For each of the various clinical complaints (phobias, PTSD, etc.), variations of procedure and the use of specific targets for processing are suggested to the therapist. For instance, for single-event traumata, it is suggested that the therapist target the memory or image of the actual event, along with any flashback scene, dream image, or specific stimuli that are accessible by the client. It is recommended to clinicians that to address their clients’ avoidance behaviors they should have them imagine engaging in previously avoided situations during EMDR processing while simultaneously utilizing a variety of new behaviors while feeling comfortable and in control (Shapiro, 1995).

The successful treatment of PTSD of multiple-trauma victims, such as combat veterans and repeated molestation victims, usually requires longer treatment time than is the case for single-trauma clients, since many of various traumata must be targeted separately (Carlson et al., 1998, Lipke, 1999; Marcus et al., 1997; Shapiro, 1995; Shapiro & Forrest, 1997). An examination of the studies in which EMDR was used with multiply traumatized combat veterans indicates that, like any other method, it is important that EMDR adhere to the clinically relevant standards for this population. Not surprisingly, those studies characterized by an insufficient number of sessions (e.g., 1-2) for treating multiply traumatized combat veterans and/or those that address only one or two traumatic memories out of many (i.e., Boudewyns & Hyer, 1996; Boudewyns et al., 1993; Devilly, Spence, & Rapee, 1998; Jensen, 1994; Pitman et al., 1996) obtained negligible or modest effects. In contrast, the one published study with consistent procedural fidelity (Carlson et al., 1998) and an appropriate number of sessions (12) for this clinical population (see Shapiro, 1995, 1996a, 1998) found EMDR treatment to be very effective. Specifically, Carlson et al., (1998) found that 75% of their EMDR subjects were no longer diagnosed with PTSD at a 9-month follow-up session. This effect greatly exceeds that found for any other method tested in controlled studies of combat veterans (e.g., Boudewyns & Hyer, 1990; Cooper & Clum, 1989; Keane, Fairbank, Cadell, & Zimering, 1989) and directly contradicts the belief that chronic PTSD is not amenable to treatment (Shalev, Bonne, & Eth, 1996).

The eight-phase EMDR treatment tailors its protocols to meet the needs of the specific client. For example, a standardized protocol was developed in 1990 specifically for the treatment of phobias (Shapiro, 1990). However, while clinical observations have supported the use of this phobia protocol (e.g., Fensterheim, 1996; Lipke, 1994; Marquis, 1991), experimental results have been more equivocal. One of the reasons for this contradictory outcome may be that the phobia protocol that has been used in research is not the one used in clinical practice (Shapiro, 1995). Furthermore, those procedural elements of the clinical protocol that have been used have often been misapplied. Thus, the protocols have been truncated in order to conduct component analyses (e.g., Lohr, Tolin, & Kleinknecht, 1995, 1996; Sanderson & Carpenter, 1992), procedural elements, such as free association, have been eliminated (e.g., Acierno, Tremont, Last, & Montgomery, 1994; Bates, McGlynn, Montgomery, & Mattke, 1996; Sanderson & Carpenter, 1992), and (even when otherwise specified by the researchers) procedures have been carried out improperly and protocol targets eliminated (e.g., Bates et al., 1996; Kleinknecht, 1993; Muris & Merckelbach, Holdrinet, & Sijnsenaar, 1998). Table 1, which lists all of the phobia studies of which the author is aware, illustrates the common deficits in procedural and protocol adherence. Indicated in the first column of this table is a fidelity rating of EMDR procedure utilization (as described in Shapiro, 1995). Two doctoral level clinical psychologists served as blind evaluators. Their expertise in EMDR had previously been assessed and verified, and they received copies of only the procedure sections of the English language studies (translations to blindly assess fidelity were not available for those published in the Netherlands) and were asked to rate the fidelity of treatment on a 0-10 scale. Each evaluator had accumulated approximately 25 years of general clinical experience and 7 years of EMDR experience (including 5 years as an EMDR instructor). For each of the EMDR utilizations they designated a fidelity number based upon the degree to which its components and procedures (see discussion below) were appropriately used. The remaining columns of Table 1 indicate the phobia protocol steps that were employed in each study and their results. Those studies that used 5 or more of the 11 standardized phobia protocol steps resulted in a complete elimination of the presenting complaint, those that used less than five produced only partial

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remissions, and those that used none of the steps achieved no effect at all. A short discussion will attempt to illustrate the various problems of procedural implementation identified in these articles.

While the consequences that failing to adhere to the defined steps of the phobia protocols have on treatment success are obvious from Table 1, it is not always easy for readers unfamiliar with the EMDR process to determine from reading the research paper if a given study has or has not complied with them, or whether the procedural elements were faithfully executed. However, review of a recent set of studies (Muris & Merckelbach, 1995, 1997; Muris et al., 1997, 1998) should clarify this matter. In these studies, the issue of whether or not procedural fidelity had been achieved was a source of debate because some positive effects were actually achieved.<sup>P<sup>2P</sup></sup> Specifically, self reports of fear were reduced according to the SUD Scale and were validated on other standardized measures as well. Furthermore, a variable increase of steps was achieved on a Behavior Avoidance Test. Nevertheless, a careful examination of these studies reveals them to be substandard in a variety of ways. The first of these flaws is the failure to use appropriate positive cognitions. For example, the statement, "I am someone who is able to control a spider" should not have been used because it is not ecologically valid. That is, in real life an individual cannot typically control a spider's actions. Other deficiencies include (a) using an inaccurate order and incomplete delineation of assessment components; (b) describing, rather than specifying the location of, the delineated physical sensation (see previous discussion and Shapiro, 1995); (c) giving instruction to "relax" between sets (except in the latest study, Muris et al., 1998); (d) failing to introduce procedural variations, including the cognitive interweave, to reduce the SUD level or increase the validity of the positive cognition (e.g., note that the reported mean SUD level is well above the 1-2 needed for the *Installation* phase; Shapiro, 1995); (e) introducing the positive cognition prematurely; and (f) failing to incorporate the *Preparation*, *Body Scan*, *Closure*, or *Reevaluation* phases into the procedure. In addition to these procedural problems, only 3 (or less) of the 11 phobia protocol steps were used (see Table 1).<sup>P<sup>2P</sup></sup> Similar claims based upon SUD reduction have been made by researchers of other studies with even less adherence to procedural and protocol fidelity (e.g., Bates et al., 1996; Sanderson, & Carpenter, 1992).

## **EMDR TREATMENT OF PHOBIAS-RESEARCH OVERVIEW**

Excerpted from: Shapiro, F. (1999) Eye movement desensitization and reprocessing (EMDR): Clinical and research implications of an integrated psychotherapy treatment. *Journal of Anxiety Disorders*, 13, 35-67.

**U**Table 1

Procedural and Protocol Fidelity to Standard Eye Movement Desensitization and Reprocessing (EMDR)  
Treatment of Phobias

| Investigator                                  | F | 1 | 2 | 3 | 4 | 5              | 6 | 7 | 8              | 9 | 10 | 11 | 12 | Results                                   |
|---|---|---|---|---|---|----------------|---|---|----------------|---|----|----|----|---|
| Acierno et. al., 1994                         | 2 |   |   |   |   |                |   |   |                |   |    |    | x  | None                                      |
| Bates et al., 1996                            | 2 |   |   |   |   |                |   |   |                |   |    |    | x  |   |
| De Jongh & Ten Broeke, 1993                   |   |   | x | x | x | x              | x | x | x              | x |    |    |    | Largely Eliminated                        |
| De Jongh & Ten Broeke 1994                    |   |   | x | x | x | x              | x | x | x              | x | x  |    |    | Elimination                               |
| De Jongh & Ten Broeke 1996                    |   |   | x | x | x | x              | x | x | x              | x | x  |    |    | Elimination                               |
| De Johgh & Ten Broeke 1998                    | 8 |   | x | x | x | x              | x | x | x              | x | x  |    |    | Elimination                               |
| Kleinknecht, 1993                             | 3 |   |   |   |   |                | x | x | x              | x | x  | x  |    | Elimination                               |
| Lohr, Tolin & Kleinknecht, 1995P <sup>a</sup> |   |   |   |   |   |                |   |   |                |   |    |    |    |   |
| S-1   | 3 |   |   | x |   | x              |   |   |                |   |    |    |    | Initial Remission with behavioral relapse |
| S-2   |   |   |   |   | x | x              |   |   |                |   |    |    |    |   |
| Lohr et al., 1996                             |   |   |   |   |   |                |   |   |                |   |    |    |    |   |
| S-1   | 5 |   |   | x | x |                |   |   |                |   |    |    |    | Partial Elimination                       |
| S-2   |   |   |   | x |   | x              |   |   |                |   |    |    |    |   |
| Muris & de Johgh, 1996                        |   |   |   |   | x | x              |   |   | x              |   |    |    |    | Standardized fear Reduction/+ BAT         |
| Muris & Merckelbach, 1995                     | 6 |   |   |   | x | x              |   |   | x              |   |    |    |    | Standardized fear Reduction/+BAT          |
| Muris & Merckelbach, 1997                     | 4 |   |   |   | x | x <sup>a</sup> |   |   | x <sup>a</sup> |   |    |    |    | Self-report fear reduction/minor +BAT     |
| Muris et al., 1997                            | 5 |   |   |   | x | x <sup>b</sup> |   |   | x <sup>b</sup> |   |    |    |    | Standardized fear Reduction/minor +BAT    |
| Muris et al., 1998                            | 4 |   |   |   | x | x              |   |   | x              |   |    |    |    | Self-report fear +BAT                     |
| Sanderson & Carpenter, 1992                   | 0 |   |   |   |   |                |   |   |                |   |    |    | x  | None                                      |
| Ten Broeke & De Jongh, 1993                   |   |   |   |   | x | x              | x | x | x              |   |    |    |    | Elimination                               |

F=Procedural fidelity blindly assessed on scale of 0 to 10 (not available for articles written in Dutch).

1-11= (components of standard EMDR/phobia protocol): 1=therapist provided specific EMDR education and instruction in self-control techniques; 2=therapist extracted and processed the ancillary events that contribute to phobia; 3= therapist extracted and processed the first time fear was experienced; 4=therapist extracted and processed the patient's most disturbing experience; 5=therapist extracted and processed the most recent time fear was experienced; 6=therapist extracted and processed any associated present stimuli; 7=therapist directed client to process physical sensations or other manifestations of fear, including hyperventilation; 8=therapist helped client to incorporate a detailed template for fear-free future action; 9=therapist and client arranged contract for *in vivo* action; 10=client runs mental videotape for full sequence of *in vivo* action and reprocesses disturbance; 11=clinician uses journal report to complete processing of targets revealed between sessions. 12=outside standard protocol-only undifferentiated "fearful image" targeted.

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Results=elimination of phobic behavior reported *in vivo* (and in session measures); fear reduction demonstrated in session on standardized measures; fear reduction demonstrated in session through self-report; fear reduction demonstrated through BAT (Behavioral Avoidance Test); + = increase in number of steps achieved.

<sup>PaP</sup>N = 2. Each subject (S-1, S-2) received only two (different) protocol steps.

<sup>PbP</sup> Designated targets were not treated in all subjects in the experiment during the single 1-1.5 hour treatment session.

The researchers' finding that *in vivo* exposure is superior to some of the imaginal aspects of the EMDR protocol is unsurprising given the treatment restraints and undoubted superiority of live exposure and modeling for this population (De Jongh, Ten Broeke, & Renssen, 1999 [this issue]). However, in order to provide a more objective comparison, care should be taken in future tests of EMDR to incorporate the steps specifically designed to eliminate anticipatory anxiety and avoidance behavior (Steps 8-11; Shapiro, 1995). It is recommended that the anticipatory anxiety and avoidance behavior measured in the Behavioral Avoidance Test be addressed by means of the template for future action and the frame-by-frame "videotape," which are incorporated into the EMDR protocols but were not utilized by these researchers (De Jongh et al., 1999 [this issue]). Further, as with all clinical research, it is strongly suggested that fidelity checks by qualified evaluators be incorporated to endure an adequate test of the method under evaluation (Beutler, Machado, & Neufeldt, 1994; Elkin, 1994).

### **Discussion and Recommendations for Future Research**

#### **Phobias**

As seen in Table 1, a review of the research on phobias indicates only sporadic adherence to the standardized EMDR protocols that have been constructed for this population on the basis of much clinical observation. As previously noted, however, certain patterns of memory storage and association have been described and standardized in order to guide clinical practice (Shapiro, 1995). For instance, it has often been found that addressing a specific memory of the phobic response can stimulate memories of earlier events that may have laid the groundwork for the pathology (Shapiro, 1995; Goldstein & Feske, 1994; Lohr, Tolin, & Kleinknecht, 1995). The lack of suitable processing of these ancillary events can contribute to relapse, just as can the lack of preparation for future confrontations (Lohr, Tolin, & Kleinknecht, 1995). In other instances, however, the processing of stimuli (e.g., Kleinknecht, 1993) or pivotal events can lead to the spontaneous remission of pathology (e.g., Lohr et al., 1996). It is recognized that some phobias can be eliminated by merely targeting and processing a pivotal memory of the trauma or fear, and/or of an imagined encounter, while others involve a protocol step in which anticipatory anxiety is attended to directly (Shapiro, 1995). The examination of differential client need and responses will be an important area of interest for future research (Beutler, 1991).

Based upon the observed differences among clients and phobic conditions, the EMDR phobia protocols (Shapiro, 1990, 1995) have been written to address all of the generally observed elements contributing to the phobic response and, when necessary, to lead the client through imaginal encounters with the feared event, along with planned *in vivo* exposure to identify any additional triggers that may exist. The application of the entire protocol is taught to the clinician and has revealed positive effects in reported research (De Jongh & Ten Broeke, 1994, 1996, 1998; De Jongh, Ten Broeke, & Van der Meer, 1995, in press; Ten Broeke & De Jongh, 1993). Therefore, regardless of the utility of any of its individual parts (e.g. Kleinknecht, 1993) or the partial elimination of phobic responses evidenced in a one-session only EMDR application (e.g., Muris & Merkelbach, 1995, 1997; Muris et al., 1997, 1998), it is important to test the entire protocol in future controlled research (Beutler, 1991). Only after the complete protocol has been adequately tested should component analyses be initiated (Kaxdin, 1992). Further, as indicated by a review of the phobia research (see above and De Jongh et al., 1999 [this issue]), there is a strong need for treatment supervision and adequate fidelity checks by recognized clinical experts, as there is for any methodology that is the subject of experimental test (Beutler et al., 1994; Elkin, 1994). Otherwise, there is no guarantee that the method being utilized is actually the method recognized by the originator and advocated for clinical practice, regardless of the subjective fidelity evaluation of the researcher (e.g., Bates et al., 1996; Muris & Merkelbach, 1995, 1997; Muris et al., 1998; Sanderson & Carpenter, 1992; see Lipke, 1991).

#### **Diverse Clinical Complaints**

Additional research should address the various protocols that have been constructed for the treatment of other presenting complaints (e.g., somatic disorders, obsessive compulsive disorder, panic disorder, addictions, etc.). While reports have supported the efficacy of EMDR for the treatment of panic disorder (Feske & Goldstein, 1997; Goldstein & Feske, 1994; Nadler, 1996; Shapiro & Forrest, 1997) and obsessive-compulsive disorder

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(Whisman, 1996), EMDR is utilized within a cognitive behavioral framework. However, the addition of EMDR appears to result in successful treatment without the need for therapist-assisted *in vivo* exposure. Research is currently underway by the originator of this model to evaluate the clinical reports. In the studies of panic disorder (Feske & Goldstein, 1997; Goldstein & Feske, 1994), the clinically suggested EMDR protocol was stripped of its integrative aspects (e.g., the coping skills/self-control techniques taught in the *Preparation* phase) in order to test only the EMDR-specific elements of the approach (A. Goldstein, personal communication). It will be important, therefore, to test the entire integrative EMDR protocol in future research.

With respect to other presenting complaints, the suggested generic protocol underlying EMDR treatment entails: (a) reprocessing earlier experiences that contribute to the pathology, (b) reprocessing the triggers that elicit present disturbance, and (c) incorporating positive templates for appropriate future action. The contribution of earlier experiences to numerous clinical complaints appears to be supported in a recent study of the effects of EMDR on the remission of dysmorphic body disorder after one to three sessions. This outcome revealed a potential link of body dysmorphic disorder to an etiology similar to those identified for the anxiety disorders (Brown, McGoldrick, & Buchanan, 1997). It should be observed that when EMDR is advocated for the treatment of complex pathologies, such as substance abuse (Shapiro, Vogelmann-Sine Sine, 1994) or dissociative disorders (Lazrove & Fine, 1996; Paulsen, 1995), it is only in combination with traditional methods followed by specialists in the field. It is also important to note that at this time no methods have been designated as “well-established empirically validated treatments” for these pathologies (Chambless et al., 1998).

### Component Analyses

As previously noted, a sufficient number of controlled EMDR outcome studies for the treatment of PTSD have been done by now to turn to an examination of the various components of the procedure as used with this population and, by so doing, determine their relative importance (Kazdin, 1992). Presumably, all clinicians would wish to use the most efficient and streamlined therapeutic procedures. However, any effective method consists of a number of components that presumably interact with each other in ways that are initially unclear. Weighing these various components in order to distinguish those that are significant from those that are not can only be done by means of controlled studies in which the overall treatment effects used in the comparisons are maximized (Kazdin & Bass, 1989). For example, analogue (subclinical) subjects, usually obtained from student populations, who are suffering from a disturbing memory may receive benefits even if only some aspects of a particular therapeutic procedure are used, while this will almost certainly not be the case for subjects diagnosed with PTSD, since this population is considered to be especially resistant to treatment, as well as to the effects of placebo (e.g., Solomon et al., 1992). On the other hand, the large and consistent changes on standard psychometrics that are required to make sensitive discriminations among individual components of a complex method will not be revealed without a sufficiently large number of subjects, sufficient treatment time, and adequate attention to trauma specifications, secondary gains, etc.

As noted previously, in the only component analysis study of diagnosed PTSD subjects (Montgomery & Ayllon, 1994) evaluating the original “EMD” protocol (Shapiro, 1989a), it was necessary to add the eye movements to the presumed components of exposure and cognitive restructuring to produce a positive treatment effect. However, it can be expected that the present procedures of EMDR because of their inclusion of many clinical refinements not found in the relatively simplistic EMD technique, will have a robust therapeutic effect even in the absence of the eye movement (or alternative stimulation) component. Therefore, it should be underscored that care must be taken to ensure that component analyses of therapeutic procedures as complex as EMDR are not only scientifically rigorous but clinically valid. It may be proposed, therefore, that for the most accurate assessment of the specific effects of each of the various components of a therapeutic procedure for treating PTSD, noncompensated, singly traumatized, diagnosed PTSD subjects should be used and evaluated by investigators who have demonstrated their ability to adhere to treatment fidelity. Furthermore, it is important that the full procedure be appropriately utilized and the components chosen for analysis be separate and distinct from those of the comparison condition and, of course, should make theoretical sense (Beutler, 1991; Norcross & Rossi, 1994; Shapiro, 1995).

Unfortunately, while a number of studies have undertaken component analyses of EMDR, few have met the preceding criteria. Some component studies have used multiply traumatized combat veterans as subjects and provided insufficient treatment time (e.g. Boudewyns, Stwertka, Hyer, Albrecht, & Sperr, 1993; Devilly et al., 1998) and/or treated only one or two memories (e.g., Boudewyns & Hyer, 1996; Pitman et al., 1996). Neither of these conditions can adequately reflect potential positive changes in the global psychometrics used to test the treatment effects with combat veterans (Fairbank & Keane, 1982). Since the realities of research frequently restrict the number of treatment sessions that may be used, the complexity of the multiple traumata and

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probably secondary gain issues are likely to attenuate the size of the obtained treatment effects, rendering this population inappropriate for making the fine discriminations necessary for useful component analysis.

When attempting to measure the relative importance of the various components of any therapeutic procedure, it is imperative that a sufficient number of research subjects be used to provide the statistical power to detect relatively small treatment effects (Cohen, 1988; Kaxdin & Bass, 1989; Rossi, 1990). Although single-trauma victims represent a more suitable population for component analyses than multiple-trauma victims, an inadequate number of subjects has often been used (e.g., 7-9 per condition) to allow for an unambiguous measure of the expected small differences among conditions using standardized measures (e.g., Renfrey & Spates, 1994<sup>P3P</sup>). Unfortunately, while a component analysis by D. Wilson et al. (1996) identified a "signature physiological basis for the effect of this component, this study failed to meet many of the standards of good outcome research (e.g., lack of standardized diagnostic measures) and, therefore, requires replication under more rigorous conditions (see Shapiro, 1996a).

<sup>P3P</sup> Thus, despite the fact that out of the participants initially diagnosed with PTSD only 13.5% in the combined eye movement conditions still met criteria at the posttest, while 50% in the eye fixation condition maintained this diagnosis, and the investigators termed the eye movement conditions "more efficient" (p.238) the small sample sizes prevented the apparently large differences from being statistically significant. However, marginally significant ( $p < .06$ ; C.R. Spates, personal communication) effects for rapidity of effect were obtained.

Additional attempted component analyses that failed to find differences between conditions (e.g., Dunn, Schwartz, Hatfield, & Wiegele, 1996; Sanderson & Carpenter, 1992) used subclinical populations, truncated or omitted the standard EMDR protocols from their procedures (Fensterheim, 1996b; Shapiro, 1995, 1998), and did not meet many of the criteria for good outcome research (Feske, 1998; Shapiro, 1995, 1998). While other controlled component analyses have obtained positive effects for the eye movement condition at posttest (e.g., Andrade et al., 1997; Feske & Goldstein, 1997; Gosselin & Matthews, 1995; D. Wilson et al., 1996; see also Lipke, 1999) and single-subject designs have found positive and "distinct" effects of eye movements (e.g., Lohr, Tolin, & Kleinknecht, 1995, 1996; Montgomery & Ayllon, 1994), many of these studies are also plagued by a number of methodological problems (Shapiro, 1995, 1996). Adding to the confusion is the fact that some component analyses (e.g. Bauman & Melnyk, 1994; Pitman et al., 1996) have used as their placebo conditions alternative stimuli that have actually been used by successful practitioners of EMDR for many years as effective substitutes for the eye movements (Shapiro, 1991b, 1994, 1995). Therefore, a failure to find a difference between eye movements and these control stimuli, while interesting, does not imply that the eye movement or other forms of stimulation or alternate attention are irrelevant to the procedure. Thus, the unfortunate but inescapable conclusion from an examination of all of the EMDR component analyses implemented so far is that no unambiguous determination of the weighting of its individual components is yet possible (Feske, 1998). However, as we have seen, it should be noted that the significance of any given component may be differentially weighted depending upon the target population. In regards to the application to PTSD, eliminating all the non-patient analogue and multiply traumatized combat veteran studies that used fewer than three sessions and/or provided treatment that was inappropriately restricted to one or two memories out of many, only three studies remain with diagnosed PTSD, all of which have generally supported the specificity of eye movements. These studies are (a) Montgomery and Ayllon (1994) and D. Wilson et al., (1996), who clearly documented the positive additive effects of the eye movement and (b) Renfrey and Spates (1994), who used only six/seven subjects per cell at posttest and obtained marginally significant ( $p < .06$ ; C.R. Spates, personal communication) effects for rapidity of therapeutic change compared to eye fixation and concluded that the eye movement conditions were "more efficient" (p.238). Clearly more clinically and scientifically valid research must be done.

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You are invited to join the EMDR Institute Discussion List, the electronic forum created to further the understanding and development of the clinical applications of EMDR and to encourage discussion of EMDR theory and research.

This list is open policies.

Please note: It is necessary to have an email account to participate.

### **Contributions to the discussion include:**

- Queries and commentaries about EMDR clinical protocols, treatment and theoretical issues
- Information about published books and articles on EMDR and related topics
- Descriptions or questions about interesting or challenging cases
- Innovations in clinical practice supported by outcome data
- Questions and commentaries on EMDR-related research
- Proposals (including 'trial balloon' ideas) for research
- Issues on standards of clinical practice and research on EMDR
- Discussion of or suggestions for EMDR humanitarian projects
- Opportunities for professional presentations on EMDR to clinicians and researchers who have taken the EMDR Institute Weekend 1 or Weekend 2 of the basic training and agree to abide by forum

### **How to Subscribe to the EMDR Institute Discussion List**

Go [http://lists.emdr.com/mailman/listinfo/emdr\\_lists.emdr.com](http://lists.emdr.com/mailman/listinfo/emdr_lists.emdr.com)

Put in your email address and your first and last name and then submit.

### **Leaders (list owners) for the EMDR Institute Discussion List**

#### **1. Address questions** about topics or list guidelines to:

roykiessling@me.com Roy Kiessling, LISW, EMDR Institute Trainer  
(513) 324-3637 List Moderator

#### **2. For subscriptions and email problems contact:**

inst@emdr.com Technical Liaison  
(831) 761-1040



EMDR Institute PO Box 750 Watsonville CA 95077  
 Tel: 831-761-1040 Fax: 831-761-1204 [www.emdr.com](http://www.emdr.com)

## BOOK & VIDEO PURCHASE FORM

- |  |                                 |
|--|---------------------------------|
| • <b><i>Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols &amp; Procedures</i></b> F Shapiro  | <b>\$62</b> Required Reading    |
| • <b><i>EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress and Trauma</i></b> F Shapiro & M Forrest<br>Recommended for clients and clinician<br>Call 800-810-4145x503 to order quantities | <b>\$18</b> Required Reading    |
| • <b><i>Handbook of EMDR &amp; Family Therapy Processes</i></b><br>Edited by F Shapiro, F Kaslow & L Maxfield  | <b>\$55</b> Required Reading    |
| • <b><i>EMDR as an Integrative Psychotherapy Approach</i></b><br>Edited by F Shapiro   | <b>\$50</b> Recommended Reading |
| • <b><i>EMDR: Working with Grief</i></b> F Shapiro   | <b>\$80</b> Recommended DVD     |

### TRAUMA AND GENERAL APPLICATION

- |   |             |
|---|-------------|
| • <b><i>EMDR and Psychotherapy Integration</i></b> H Lipke  | <b>\$29</b> |
| • <b><i>Light in the Heart of Darkness: EMDR &amp; the Treatment of War and Terrorism Survivors</i></b> S Silver & S Rogers | <b>\$32</b> |
| • <b><i>EMDR in Treatment of Adults Abused as Children</i></b><br>L Parnell   | <b>\$30</b> |
| • <b><i>EMDR: A Closer Look-Video</i></b>   | <b>\$95</b> |
| • <b><i>EMDR for Trauma-APA Psychotherapy Video Series II</i></b>   | <b>\$99</b> |
| • <b><i>EMDR and the Relational Imperative: The Therapeutic Relationship in EMDR Treatment</i></b> M Dworkin                | <b>\$45</b> |
| • <b><i>EMDR Solutions: Pathways to Healing</i></b> R Shapiro   | <b>\$37</b> |
| • <b><i>Healing the Heart of Trauma and Dissociation</i></b><br>C Forgash & M Copeley                                       | <b>\$55</b> |
| • <b><i>Looking Through the Eyes of Trauma and Dissociation</i></b><br>S Paulsen, PhD                                       | <b>\$35</b> |
| • <b><i>EMDR Scripted Protocols: Basic Populations</i></b> M Luber  | <b>\$65</b> |
| • <b><i>EMDR Scripted Protocols: Special Populations</i></b> M Luber  | <b>\$85</b> |
| • <b><i>An EMDR Primer: From Practicum to Practice</i></b> BHensley   | <b>\$50</b> |

### CHILDREN

- |  |             |
|--|-------------|
| • <b><i>EMDR and the Art of Psychotherapy with Children Book and Treatment Manual</i></b> R Tapia & C Settle | <b>\$72</b> |
| • <b><i>Through The Eyes of a Child</i></b> R Tinker & S Wilson  | <b>\$37</b> |
| • <b><i>Small Wonders: Healing Childhood Trauma with EMDR</i></b><br>JLovett                                 | <b>\$18</b> |

### SELF-HELP CD

- |   |             |
|---|-------------|
| • <b><i>Letting Go of Stress</i></b> E Miller | <b>\$16</b> |
| • <b><i>Loving Kindness</i></b> S & O Levine  | <b>\$13</b> |
| • <b><i>Forgiveness</i></b> S & O Levine      | <b>\$13</b> |
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## **EMDR HUMANITARIAN ASSISTANCE PROGRAMS**

2911 Dixwell Ave #201, Hamden, CT 06518

Phone: 203-288-4456 Email: [Temdrhap@emdrhap.org](mailto:Temdrhap@emdrhap.org) Website: [www.emdrhap.org](http://www.emdrhap.org)

Dear Colleague:

EMDR-HAP is a non-profit organization that may be viewed as the mental health equivalent of Doctors without Borders. We are an international volunteer network of therapists who have seen such dramatic and rapid improvements in our own clients using EMDR that we are providing an opportunity for deep healing to people suffering from trauma worldwide. EMDR is a powerful agent of change, and HAP seeks to engender profound change in our local communities and the larger world community by providing access to EMDR training where it might otherwise be inaccessible.

Funded by private donations, HAP therapist/educators have traveled to war-torn regions, disaster sites, and developing nations, providing training to local mental health professionals. We have provided training for therapists in such places as Bosnia and Croatia, Northern Ireland, Kenya, The Ukraine, Columbia, El Salvador, the Middle East, Indonesia and Bangladesh.

Volunteers have also extended EMDR education and support to therapists in underserved US communities and pioneered ways of applying insights from EMDR to expand public understanding of traumatic stress and extend effective care to trauma victims. Efforts within the United States include training therapists in inner cities, treating survivors and witnesses of urban violence, treating former sex workers suffering from the trauma of histories of sexual abuse, and exploring how EMDR can break the cycle of violence by working within the prison system.

HAP volunteers also provide training to local clinicians treating survivors of natural and manmade disasters. We were active in Oklahoma City after the bombing, in the wake of the crash of TWA Flight 800, in the response to floods in Grand Forks, North Dakota, and the Columbine School shootings. After 9-11, we set up *The Disaster Mental Health Recovery Network*, a referral program of over 400 therapists providing a pro-bono EMDR intervention to those directly impacted by the terrorist attacks. Over 900 referrals have been made in the New York City Area alone.

Dedicated to aiding trauma victims to heal their pain and reclaim their lives, our clinicians provide trauma education and EMDR training that is sensitive to the cultural norms of local trauma survivors and their indigenous therapists. We also support research to discover and advance the most effective use of EMDR for humanitarian purposes. All volunteers are trained in EMDR methodologies and all are licensed in the mental health field. HAP coordinates efforts and shares resources with local mental health organizations to provide training materials and travel costs for volunteers.

You can help us continue our work by giving as generously as you can to HAP. Some donors give the equivalent of what they charge their clients for an EMDR session. Whatever you give, your tax-deductible donation makes a profound difference for victims of trauma worldwide.

With deep gratitude,

Robert A. Gelbach, Ph.D.

**HAP is a 501(c)(3) organization under federal law.**

***To make a tax-deductible contribution, send a check to:  
EMDR-HAP, 2911 Dixwell Ave #201, Hamden, CT 06518***

Yes, I will donate the following amount to support HAP:  
\$500 \_\_\_ \$300 \_\_\_ \$200 \_\_\_ \$125 \_\_\_ \$75 \_\_\_ other \_\_\_

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## **EMDR HAP STORE**

**You can find helpful information on EMDR at the EMDR-HAP Store**

*A Sampling of Available Resources for New EMDR Practitioners:*

Laminated pictorial VOC and SUD Scale for Children  
EMDR Progress Notes  
Pain Control with EMDR Treatment Manual  
Chemical Dependency Treatment Manual  
Therapeutic Interweave in EMDR Manual  
EMDR Introductory Video  
Light Stream Relaxation Audiotape  
Empirically Evaluating EMDR with Single-Case Design  
Treatment of Combat Related PTSD  
EMDR Questionnaires  
Handbook For EMDR Clients  
Plus Conference Tapes from the formative 1991-1995 EMDR Institute Conferences

Available at most EMDR Institute Trainings, or  
Order Online at [www.emdrhap.org/store.htm](http://www.emdrhap.org/store.htm)  
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Order by Phone: 1-800-531-3640

EMDR Humanitarian Assistance Programs, Inc.  
PO Box 6505, Hamden, CT 06517

Proceeds of the HAP Store support the EMDR Humanitarian Assistance Programs, Inc.

Support your growth in using EMDR, with helpful resources from the HAP Store.

Support the growth of EMDR as a resource for healing from trauma, through the work of HAP volunteers worldwide.

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**EMDR INTERNATIONAL ASSOCIATION (EMDRIA)**

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**NEUROTEK**

## EMDR NO FEE NETWORKING GROUPS

The following list is provided to give EMDR Institute trained clinicians an opportunity to network with other EMDR trained clinicians in their area to share experiences and information pertaining to EMDR. These are no fee discussion meetings. If you would like to join a group, please contact the group coordinator in your area.

**PLEASE NOTE:** The EMDR Institute does not warrant or otherwise assume responsibility for content of meetings nor competency of the contact person.

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|                     | Houston         | Alan Schneider   | 713-839-9186 | Contact Pam Kaye   |
| <b>Virginia</b>     | Hurst           | William Gumm     | 817-589-1419 |  |
|                     | Charlottesville | Denise Horton    | 434-296-2930 | <a href="mailto:torreon28@earthlink.net">torreon28@earthlink.net</a>                 |
|                     | Norfolk         | David Paige      | 757-497-3670 |  |
|                     | Norfolk         | Faye Joseph      | 757-622-7017 |  |
| <b>Vermont</b>      | Richmond        | Marilyn Spiro    | 804-282-6165 | <a href="mailto:mSpiro@verizon.net">mSpiro@verizon.net</a>                           |
|                     | Woodstock       | Madeleine Tobias | 802-457-6162 | <a href="mailto:madytoo@hotmail.com">madytoo@hotmail.com</a>                         |
| <b>Washington</b>   | Colville        | Christine Wilson | 509-690-0715 | <a href="mailto:christineallenewilson@gmail.com">christineallenewilson@gmail.com</a> |
| <b>Wisconsin</b>    | Brookfield      | Wendy Freitag    | 414-777-1757 | <a href="mailto:wjfreitag@aol.com">wjfreitag@aol.com</a>                             |
|                     | Eau Claire      | Robin Swain      | 715-832-4060 | <a href="mailto:rswain@softhome.net">rswain@softhome.net</a>                         |
| <b>Wyoming</b>      | Madison         | Arden Mahlberg   | 608-255-9330 | <a href="mailto:afmahlberg@aol.com">afmahlberg@aol.com</a>                           |
|                     | Cheyenne        | Jan Schaad       | 307-630-4688 | <a href="mailto:jaqschaad@hotmail.com">jaqschaad@hotmail.com</a>                     |

#### INTERNATIONAL-NON-US COUNTRIES

|                     |                  |                               |                |  |
|---------------------|------------------|-------------------------------|----------------|--|
| <b>Australia</b>    | Sydney           | Mark Grant                    | 011-29437 9219 | <a href="mailto:markgrant@ozemail.com.au">markgrant@ozemail.com.au</a>       |
| <b>Canada</b>       | Vancouver        | Lee Nicolas                   | 604-844-3873   | <a href="mailto:lnichola@eciad.bc.ca">lnichola@eciad.bc.ca</a>               |
|                     | Victoria         | Allison Reeves                | 250-595-5441   | <a href="mailto:mareeves@shaw.ca">mareeves@shaw.ca</a>                       |
| <b>France</b>       | Toulouse         | Tony Brazil                   | 05 62 16 37 58 | <a href="mailto:tonybrazil@club-internet.fr">tonybrazil@club-internet.fr</a> |
| <b>Germany</b>      | Kassel           | Christa Diegelmann            | 49-561-35006   | <a href="mailto:idinstitut@aol.com">idinstitut@aol.com</a>                   |
| <b>Hong Kong</b>    | Shamshuipo, Kln. | Kitty Wu                      | 852 3408 7439  | <a href="mailto:wukyky@ha.org.hk">wukyky@ha.org.hk</a>                       |
| <b>Israel</b>       | Raanana          | Udi Oren                      | 09-7454291     | <a href="mailto:udioren@emdr.co.il">udioren@emdr.co.il</a>                   |
|                     | Tivon, Haifa     | Elan Shapiro                  |                | <a href="mailto:elanshapiro@gmail.com">elanshapiro@gmail.com</a>             |
| <b>Scotland</b>     | Tivon, Haifa     | Yair Emanuel & Esti Bar-Sadeh |                | 972- 4-983-2760  |
| <b>South Africa</b> | Stirling         | Philip Dutton                 | 01786 447654   |  |
|                     | Durban           | Reyhana Seedat                | 031-201-0307   | <a href="mailto:rravat@iafrica.com">rravat@iafrica.com</a>                   |
| <b>Spain</b>        | Barcelona        | Maria A Plaxats               | 34-93-2653374  | <a href="mailto:plaxats-emdr@arrakis.es">plaxats-emdr@arrakis.es</a>         |

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## **FACILITATOR CONSULTATION LISTING**

The following listing is intended to provide geographical and professional information about the EMDR facilitators who supervise the practica at the Weekend 1 and 2 trainings and provide consultation for the required 10 hours to complete the Basic Training. The list is organized to indicate the individual clinicians by state, city, availability for consultation, areas of clinical specialty, and telephone numbers.

Clinicians included in this listing have completed the Facilitator Training, a training which provides a more extensive involvement in the understanding and use of the EMDR method, under the guidance and direct supervision of the EMDR Institute, Inc. The minimum eligibility standards required of facilitators are: currently licensed or certified to provide clinical treatment and current status as an EMDRIA approved consultant. (See [www.emdria.org](http://www.emdria.org) for consultant requirements.)

To maintain facilitator status, facilitators are required to review the Basic Training each year. Above all, all persons listed are committed to the adherence of the highest standard of ethics and clinical competence as a representative of the EMDR Institute facilitator team. The foregoing standards were developed by the Facilitator Selection Committee.

### **CONSULTATION**

As a service to EMDR practitioners (but **NOT** as an endorsement of the consultations or providers), the EMDR Institute, Inc., has prepared the enclosed listing to indicate the availability for consultation, type of consultation offered, and clinical specialties for each facilitator.

**PLEASE NOTE:** All fees, consultation offerings, available times and locations are determined by the individual facilitator. Please contact the facilitator of your choice directly for information about his/her consultation program.

### **CATEGORIES OF CONSULTATION AND SUGGESTED FEES**

|   |   |
|---|---|
| 1-Individual  | Maximum fee-\$120/hour  |
| 2-Small group (maximum 10 people)                   | Fee-Dependent upon number of participants and length of session |
| 3-Individual telephone (first 10 minutes-no charge) | Maximum fee-\$120/hour  |

The EMDR Institute, Inc. acknowledges that the persons included on the Consultation and Facilitator List are members of the facilitator team and EMDRIA Approved Consultants in good standing. The EMDR Institute, Inc. does not warrant or otherwise assume responsibility for the private consultation services provided by a facilitator nor his/her competency to provide such consultation.

**The EMDR Institute, Inc  
January 2012**

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**ALL CLINICIANS ON FACILITATOR LISTING SPECIALIZE IN TREATING TRAUMA & PTSD**

|                                   | <b><u>PHONE #</u></b> | <b><u>EMAIL</u></b>  | <b><u>SPECIALTY</u></b>   |
|-----------------------------------|-----------------------|--|---|
| <b><u>ALASKA</u></b>              |                       |  |   |
| Michele Halloran, LPC             | 907-729-1393          | <a href="mailto:mickimav@yahoo.com">mickimav@yahoo.com</a>                 | DID, Family Systems<br>Addictions, Couples                      |
| Linda O Webber, PhD               | 907-646-7600x2        | <a href="mailto:iica@alaska.net">iica@alaska.net</a>                       |   |
| <b><u>ARIZONA</u></b>             |                       |  |   |
| <b><u>Phoenix</u></b>             |                       |  |   |
| Ana Gomez, LPC                    | 602-803-4601          | <a href="mailto:anag@anagomeztherapy.com">anag@anagomeztherapy.com</a>     | Children, Trauma, Abuse   |
| Shelley Uram, MD                  | 602-279-9252          |  | Children, & Adolescents   |
| <b><u>Prescott</u></b>            |                       |  |   |
| Laurie Tetreault, CMFT            | 928-771-9422          | <a href="mailto:ltetro@g.com">ltetro@g.com</a>                             | Victimization, Anxiety Disorders                                |
| <b><u>Scottsdale</u></b>          |                       |  |   |
| Beverlee L Chasse, LPC            | 480-427-3550          | <a href="mailto:bjchasse@cox.net">bjchasse@cox.net</a>                     | Compulsive Behaviors,<br>Addictions, Anxiety                    |
| Soozi Bolte, LPC, LISAC           | 480-236-6682          | <a href="mailto:soozi@cox.net">soozi@cox.net</a>                           | Couples, Addictions   |
| Carolyn Settle, LCSW              | 480-551-1181          | <a href="mailto:settle.carolyn@gmail.com">settle.carolyn@gmail.com</a>     | Anxiety, Depression, Children                                   |
| <b><u>Tempe</u></b>               |                       |  |   |
| RobbieTapia, PhD                  | 480-753-1655          | <a href="mailto:dradler-tapia@cox.net">dradler-tapia@cox.net</a>           | Children & Adolescents  |
|                                   |                       | <b>Fluent in Spanish</b>   |   |
| <b><u>NORTHERN CALIFORNIA</u></b> |                       |  |   |
| <b><u>Berkeley</u></b>            |                       |  |   |
| Karen Harber, PhD                 | 510-526-7080          | <a href="mailto:kharber1@aol.com">kharber1@aol.com</a>                     | Affective Disorder,<br>Relationships                            |
| Phyllis H. Klaus, LMFT            | 510-559-8000          | <a href="mailto:phyllisklaus@gmail.com">phyllisklaus@gmail.com</a>         | Incest Survivors, Somatic                                       |
| Sheila Krystal, PhD               | 510-540-0855          | <a href="mailto:fshekrystal@aol.com">fshekrystal@aol.com</a>               | Spiritual Emergency, Seizure<br>Disorders, Anxiety & Depression |
| Joan Lovett, MD                   | 510-524-0488          | <a href="mailto:joanlovettmd@gmail.com">joanlovettmd@gmail.com</a>         | Children, Medical Issues,<br>Peak Performance                   |
| Susan Tieger, LMFT                | 510-653-1793          | <a href="mailto:stieger@att.net">stieger@att.net</a>                       | Creativity, Couples,<br>Performance                             |
| <b><u>Corte Madera</u></b>        |                       |  |   |
| Lynne Dixon, MS, MFT              | 415-346-4876          | <a href="mailto:imdixon@mindspring.com">imdixon@mindspring.com</a>         | Illness, Grief, Loss, Anxiety                                   |
| <b><u>Davis</u></b>               |                       |  |   |
| Susan Curry, LMFT                 | 530-756-8649          | <a href="mailto:smcurry@sbcglobal.net">smcurry@sbcglobal.net</a>           | Panic, Depression, Phobias                                      |
| <b><u>Los Altos</u></b>           |                       |  |   |
| Steven Marcus, PhD                | 650-962-1987          | <a href="mailto:doctormarcus@sbcglobal.net">doctormarcus@sbcglobal.net</a> | Adults, Dysfunctional Families,<br>Phobias, Headaches           |
| <b><u>Mountain View</u></b>       |                       |  |   |
| Janice Done Lowe, LMFT            | 207-347-1077          | <a href="mailto:janice.lowe1@gmail.com">janice.lowe1@gmail.com</a>         | Complex PTSD, DID, Performance                                  |
| <b><u>Novato</u></b>              |                       |  |   |
| Lynne Dixon, MS, MFT              | 415-346-4876          | <a href="mailto:imdixon@mindspring.com">imdixon@mindspring.com</a>         | Illness, Grief, Loss, Anxiety                                   |
| <b><u>Oakland</u></b>             |                       |  |   |
| Ann Gildersleeve, PhD             | 510-339-2333          | <a href="mailto:lannes4@aol.com">lannes4@aol.com</a>                       | Trauma, Mood, Anxiety   |
| Karin Kleiner, MFT                | 510-339-6600          | <a href="mailto:kjkleiner@aol.com">kjkleiner@aol.com</a>                   | Anxiety, Phobias, Couples                                       |
| Suzanne Slyman, MFT               | 510-530-2671          | <a href="mailto:suzslyman@earthlink.net">suzslyman@earthlink.net</a>       | Spiritual Issues, Relationships                                 |
| Susan Tieger, MFT                 | 510-653-1793          | <a href="mailto:stieger@att.net">stieger@att.net</a>                       | Creativity, Performance, Couples                                |
| <b><u>Palo Alto</u></b>           |                       |  |   |
| Gerald Puk, PhD                   | 650-328-5821          | <a href="mailto:geraldpukphd@sbcglobal.net">geraldpukphd@sbcglobal.net</a> | DID, Peak Performance, Anxiety                                  |
| Phyllis H. Klaus, LMFT            | 510-559-8000          | <a href="mailto:phyllisklaus@gmail.com">phyllisklaus@gmail.com</a>         | Incest Survivors, Somatic                                       |
| <b><u>Pleasanton</u></b>          |                       |  |   |
| Michael McCratic, MFT             | 925-846-7768          | <a href="mailto:mmmft@aol.pacbell.net">mmmft@aol.pacbell.net</a>           | Couples, Anger, Anxiety, Phobia                                 |
| <b><u>San Francisco</u></b>       |                       |  |   |
| Linda Cohn, MFT                   | 415-693-0630          | <a href="mailto:lindacohn2@gmail.com">lindacohn2@gmail.com</a>             | Art Therapy, Adults, Children                                   |
| Lynne Dixon, MFT                  | 415-346-4876          | <a href="mailto:imdixon@mindspring.com">imdixon@mindspring.com</a>         | Illness, Grief, Loss, Anxiety                                   |
| Rachel Erwin, MFT                 | 510-387-9727          | <a href="mailto:rachel@rachelerwin.com">rachel@rachelerwin.com</a>         | Torture, Anxiety, Depression                                    |

|  |              |  |   |
|--|--------------|--|---|
| Cynthia Kong, LMFT                                 | 415-285-1987 | ckongmft@gmail.com   | Somatic, Diversity, Relationships                             |
| Priscilla Marquis, PhD                             | 415-254-3306 | priscilla.marquis@kp.org   | Adults, Anxiety, DID  |
| Gerald Puk, PhD                                    | 650-328-5821 | geraldpukphd@sbcglobal.net   | DID, Peak Performance, Anxiety                                |
| Cathy Wickham, MFT                                 | 415-821-7248 | cathywickham@comcast.net   | Grief, Abuse, Spirituality                                    |
| <b>San Jose</b>                                    |              |  |   |
| Jennifer Lendl, PhD                                | 408-244-6186 |  | ADD, Spirituality, Peak Performance                           |
| Rena Zahorsky, LMFT                                | 408-266-7826 | <a href="mailto:zahorskferry@earthlink.net">zahorskferry@earthlink.net</a>     | Childhood Abuse, Depression                                   |
| <b>San Mateo</b>                                   |              |  |   |
| Cynthia Kong, MFT                                  | 415-285-1987 | ckongmft@gmail.com   | Somatic, Diversity, Relationships                             |
| <b>Knowledge of French, Shanghainese, Mandarin</b> |              |  |   |
| <b>CENTRAL CALIFORNIA</b>                          |              |  |   |
| <b>Aptos</b>                                       |              |  |   |
| Donna Raposa, LMFT                                 | 831-685-3310 | <a href="mailto:dra8876890@aol.com">dra8876890@aol.com</a>                     | Children, Self-esteem   |
| <b>Atascadero</b>                                  |              |  |   |
| Julie Stowasser, LMFT                              | 805-466-4681 | <a href="mailto:julie@juliestowasser.com">julie@juliestowasser.com</a>         | Children, Domestic Violence                                   |
| <b>Fresno</b>                                      |              |  |   |
| Jean Ertl, LCSW                                    | 559-225-6100 | <a href="mailto:jeanniertl@juno.com">jeanniertl@juno.com</a>                   | Military, Crisis, Depression                                  |
| <b>San Luis Obispo</b>                             |              |  |   |
| Julie Stowasser, LMFT                              | 805-544-2273 | <a href="mailto:julie@juliestowasser.com">julie@juliestowasser.com</a>         | Children, Domestic Violence                                   |
| <b>Santa Barbara</b>                               |              |  |   |
| Craig Penner, MFT                                  | 805-966-7794 | <a href="mailto:craigpenner@aol.com">craigpenner@aol.com</a>                   | Relationships, Children, Depression                           |
| <b>Santa Marguerita</b>                            |              |  |   |
| Marilynn Rice, PhD                                 | 805-756-2644 | <a href="mailto:ricemf@aol.com">ricemf@aol.com</a>                             | DID, Family, Children   |
| <b>SOUTHERN CALIFORNIA</b>                         |              |  |   |
| <b>Arcadia</b>                                     |              |  |   |
| Laura Dickson, LCSW                                | 626-445-3862 | <a href="mailto:ldicksonlcsw@sbcglobal.net">ldicksonlcsw@sbcglobal.net</a>     | Attachment, Phobia, Abuse                                     |
| <b>Burbank</b>                                     |              |  |   |
| Leni Belcher-Belshay, MFT                          | 818-425-9482 | <a href="mailto:lbbelshay@yahoo.com">lbbelshay@yahoo.com</a>                   | Depression, Grief, Performance                                |
| <b>Corona</b>                                      |              |  |   |
| Linda Vanderlaan, PhD                              | 951-279-7099 | <a href="mailto:lindavanderlaan@att.net">lindavanderlaan@att.net</a>           | Dissociative Disorders  |
| <b>Del Mar</b>                                     |              |  |   |
| Susan Goodell, LMFT                                | 619-997-5333 | <a href="mailto:suegoodell@sbcglobal.net">suegoodell@sbcglobal.net</a>         | Anxiety, Depression, Grief, Stress Management, Women's Issues |
| <b>Encinitas</b>                                   |              |  |   |
| Nancy Williamson, MFT                              | 760-479-1749 | <a href="mailto:nancywilliamson@cox.net">nancywilliamson@cox.net</a>           | Relationships, Grief, Health                                  |
| <b>Encino</b>                                      |              |  |   |
| Ginger Gilson, MFT                                 | 818-342-6370 | <a href="mailto:gingerg91356@yahoo.com">gingerg91356@yahoo.com</a>             | Incest, Eating Disorders, CISD                                |
| <b>Fallbrook</b>                                   |              |  |   |
| Hal Linebarger, LMFT                               | 530-304-3418 | <a href="mailto:hal_linebarger@sbcglobal.net">hal_linebarger@sbcglobal.net</a> | Addictions, Depression, Anxiety, Performance                  |
| <b>Fullerton</b>                                   |              |  |   |
| Curtis Rouanzoin, PhD                              | 714-577-0400 | <a href="mailto:ccrouanzoin@yahoo.com">ccrouanzoin@yahoo.com</a>               | Dissociative Disorders  |
| Ken Vanderlip, PhD                                 | 714-385-1770 | <a href="mailto:ken@de-stressforsuccess.com">ken@de-stressforsuccess.com</a>   | Stress Management, Performance                                |
| Jocelyne Shiromoto, LCSW                           | 714-502-8566 | <a href="mailto:jshiromoto@gmail.com">jshiromoto@gmail.com</a>                 | Depression, Family, Anxiety                                   |
| <b>Fluent in French</b>                            |              |  |   |
| <b>Irvine</b>                                      |              |  |   |
| Jocelyne Shiromoto, LCSW                           | 714-502-8566 | <a href="mailto:jshiromoto@gmail.com">jshiromoto@gmail.com</a>                 | Depression, Anxiety, Family                                   |
| <b>Fluent in French</b>                            |              |  |   |
| <b>La Mesa</b>                                     |              |  |   |
| Susan Brown, LCSW                                  | 619-698-5435 | <a href="mailto:sbrownlcsw@gmail.com">sbrownlcsw@gmail.com</a>                 | Substance Abuse   |
| <b>Long Beach</b>                                  |              |  |   |
| Marie Pletka, MFT                                  | 562-920-7419 | <a href="mailto:vrbljudo@aol.com">vrbljudo@aol.com</a>                         | Critical Incident, Peak Performance, Anxiety                  |
| <b>Malibu</b>                                      |              |  |   |
| Ron Doctor, PhD                                    | 310-230-9804 | <a href="mailto:mysticron@gmail.com">mysticron@gmail.com</a>                   | Anxiety, Adjustment Disorders                                 |
| <b>Newport Beach</b>                               |              |  |   |

|                           |              |  |   |
|---------------------------|--------------|--|---|
| Lois Bregman, LCS         | 949-261-6330 | <a href="mailto:lbregman2@cox.net">lbregman2@cox.net</a>                     | Eating Disorders, Abuse   |
| Janeen Cunningham, MFT    | 949-722-7900 | <a href="mailto:seal1641@aol.com">seal1641@aol.com</a>                       | Depression, Panic, Divorce  |
| Elizabeth West, MFT       | 949-975-1864 | <a href="mailto:ewesttherapist@verizon.net">ewesttherapist@verizon.net</a>   | Abuse, Anxiety, Depression<br>Sex Addiction   |
| <b>Orange</b>             |              |  |   |
| Ken Vanderlip, PhD        | 714-385-1770 | <a href="mailto:ken@de-stressforsuccess.com">ken@de-stressforsuccess.com</a> | Stress, Peak Performance<br>ACA & Recovery  |
| Janice Done Lowe, LCPC    | 207-347-1077 | <a href="mailto:janice.lowe1@gmail.com">janice.lowe1@gmail.com</a>           | Dissociative Disorders, Performance   |
| <b>Palm Springs</b>       |              |  |   |
| Joan Cartwright, PhD      | 415-788-9122 | <a href="mailto:jcartw1064@aol.com">jcartw1064@aol.com</a>                   | Childhood Abuse, Panic  |
| <b>Placentia</b>          |              |  |   |
| Curtis Rouanzoin, PhD     | 714-577-0400 | <a href="mailto:ccrouanzoin@yahoo.com">ccrouanzoin@yahoo.com</a>             | Dissociative Disorders  |
| Jocelyne Shiromoto, LCSW  | 714-502-8566 | <a href="mailto:jshiromoto@gmail.com">jshiromoto@gmail.com</a>               | Depression, Anxiety, Family   |
| <b>Fluent in French</b>   |              |  |   |
| <b>San Diego</b>          |              |  |   |
| Nancy Williamson, MFT     | 760-479-1749 | <a href="mailto:nancywilliamson@cox.net">nancywilliamson@cox.net</a>         | Divorce, Grief, Health  |
| Susan Brown, LCSW         | 619-698-5435 | <a href="mailto:sbrownlcsw@gmail.com">sbrownlcsw@gmail.com</a>               | Substance Abuse   |
| Alicia Outcalt, LCSW      | 858-344-9440 | <a href="mailto:aaoutcalt@ucsd.edu">aaoutcalt@ucsd.edu</a>                   | Adults, LGBT, Cultural Issues   |
| <b>Tarzana</b>            |              |  |   |
| Ginger Gilson, MFT        | 818-342-6370 | <a href="mailto:gingerg91356@yahoo.com">gingerg91356@yahoo.com</a>           | Pain, Abuse, Anxiety  |
| <b>Valencia</b>           |              |  |   |
| Jan Click, LCSW           | 661-632-2551 | <a href="mailto:janclicklcsw@ca.rr.com">janclicklcsw@ca.rr.com</a>           | Military, Abuse, Grief,<br>Attachment   |
| <b>Van Nuys</b>           |              |  |   |
| AJ Popky, PhD             | 818-908-8940 | <a href="mailto:aj.popky@gmail.com">aj.popky@gmail.com</a>                   | Military, Addictions, Phobias   |
| <b>Woodland Hills</b>     |              |  |   |
| Don Dorsey, EdD           | 818-773-1842 | <a href="mailto:rusticdon@earthlink.net">rusticdon@earthlink.net</a>         | Abuse, Survivors, Intimacy<br>Problems  |
| <b><u>COLORADO</u></b>    |              |  |   |
| <b>Boulder</b>            |              |  |   |
| Keith Andresen, LPC       | 303-443-5682 | <a href="mailto:kandre1041@aol.com">kandre1041@aol.com</a>                   | Abuse, Medical Trauma, Anxiety  |
| <b>Colorado Springs</b>   |              |  |   |
| Michael Galvin, PhD       | 719-634-4444 | <a href="mailto:drgalvin@earthlink.net">drgalvin@earthlink.net</a>           | Dissociation, Phobias   |
| John Hartung, PsyD        | 719-475-8038 | <a href="mailto:jhartung@uccs.edu">jhartung@uccs.edu</a>                     | EMDR in Couples Therapy   |
| Lillian Sideris, LPC      | 719-596-1530 | <a href="mailto:lilsideris@mindspring.com">lilsideris@mindspring.com</a>     | Depression, Family, Children,<br>Self Esteem/Weight, Crisis<br>Abuse, Depression, Medical |
| Chandra Nagireddy, PhD    | 719-761-4444 | <a href="mailto:fchandra@drchandra.com">fchandra@drchandra.com</a>           |   |
| <b>Conifer</b>            |              |  |   |
| Jonathan Brooks, PhD      | 303-679-3113 | <a href="mailto:drjonathanbrooks@gmail.com">drjonathanbrooks@gmail.com</a>   | Anxiety, Survivor Issues  |
| <b>Denver</b>             |              |  |   |
| Jeffrey Haber, EdD        | 303-321-2277 | <a href="mailto:denverjeffrey@comcast.net">denverjeffrey@comcast.net</a>     | Anxiety, Depression   |
| Laura L. Knutson, LCSW    | 303-753-8850 | <a href="mailto:lauraknu@comcast.net">lauraknu@comcast.net</a>               | Peak Performance, Childhood,<br>Sexual Assault, Family of Origin                          |
| Jana Marzano, LPC         | 303-220-1151 | <a href="mailto:janamarzan@aol.com">janamarzan@aol.com</a>                   | Children, Adults, Depression,<br>Abuse, Addictions  |
| <b>Fort Collins</b>       |              |  |   |
| Janet Wright, LCSW        | 970-224-2207 | <a href="mailto:wright72782@gmail.com">wright72782@gmail.com</a>             | Depression, Anxiety, Grief,<br>Children   |
| <b>Longmont</b>           |              |  |   |
| Jim Knipe, PhD            | 719-238-3545 | <a href="mailto:jsknipe44@earthlink.net">jsknipe44@earthlink.net</a>         | Narcissistic Personality, DID   |
| <b>Pueblo</b>             |              |  |   |
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**Powell**

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| <b>Bend</b>              |              |  |  |
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| <b>Portland</b>          |              |  |  |
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| <b>PENNSYLVANIA</b>      |              |  |  |
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| <b>Kennett Square</b>    |              |  |  |
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| <b>Media</b>             |              |  |  |
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| <b>Philadelphia</b>      |              |  |  |
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| Marilyn Luber, PhD       | 215-545-8296 | <a href="mailto:marluber@aol.com">marluber@aol.com</a>                     | Stress Related Issues                          |
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| <b>Upper Black Eddy</b>  |              |  |  |
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| <b>RHODE ISLAND</b>      |              |  |  |
| <b>Cranston</b>          |              |  |  |
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| <b>Warwick</b>           |              |  |  |
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| <b>SOUTH CAROLINA</b>    |              |  |  |
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| <b>Taylors</b>           |              |  |  |
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| <b>TENNESSEE</b>         |              |  |  |
| <b>Clarksville</b>       |              |  |  |

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| Wally Juraschka, PhD<br><b>Fluent in German</b> | 901-647-7822 | <a href="mailto:wally2j@aol.com">wally2j@aol.com</a>                                 | Anxiety, Complex PTSD, Ego State Therapy                |
| <b>TEXAS</b>                                    |              |  |   |
| <b>Austin</b>                                   |              |  |   |
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| <b>Coppell/Dallas</b>                           |              |  |   |
| Jamie Zabukovec, PsyD                           | 214-857-0534 | <a href="mailto:Jamie.zabukovec@va.gov">Jamie.zabukovec@va.gov</a>                   | Sports Psychology, Chronic Pain, Military               |
| <b>Houston</b>                                  |              |  |   |
| David Ogren, PhD                                | 713-622-1278 | <a href="mailto:djogren@earthlink.net">djogren@earthlink.net</a>                     | Abuse, Gay-Lesbian Issues                               |
| <b>UTAH</b>                                     |              |  |   |
| <b>Pleasant Grove</b>                           |              |  |   |
| Leslie Brown, LPC                               | 801-785-1169 | <a href="mailto:leslielbrown53@msn.com">leslielbrown53@msn.com</a>                   | Children, Adults, Depression, Performance Enhancement   |
| <b>Salt Lake City</b>                           |              |  |   |
| Daniel Sternberg, PhD                           | 801-364-2779 | <a href="mailto:slosedona@aol.com">slosedona@aol.com</a>                             | Anxiety Disorders, Pain                                 |
| <b>VERMONT</b>                                  |              |  |   |
| <b>Burlington &amp; South Hero</b>              |              |  |   |
| Sandra Berna                                    | 802-488-6109 | <a href="mailto:sandraberma1114@gmail.com">sandraberma1114@gmail.com</a>             | Anxiety, Depression, Children,                          |
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| <b>VIRGINIA</b>                                 |              |  |   |
| <b>Alexandria</b>                               |              |  |   |
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| <b>Richmond</b>                                 |              |  |   |
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| <b>WASHINGTON</b>                               |              |  |   |
| <b>Bellevue</b>                                 |              |  |   |
| Debra Littrell, LMFT                            | 425-747-5774 | <a href="mailto:debra@transformativespirit.com">debra@transformativespirit.com</a>   | Body Centered, Somatic, Experiential, Critical Incident |
| <b>Bainbridge Island</b>                        |              |  |   |
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| <b>Colville</b>                                 |              |  |   |
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| <b>Gig Harbor</b>                               |              |  |   |
| Rosalie Thomas, PhD                             | 253-851-3808 | <a href="mailto:rthom@centurytel.net">rthom@centurytel.net</a>                       | Sex Therapy, Anxiety, Depression                        |
| <b>Kirkland</b>                                 |              |  |   |
| Jari Preston, CMFT                              | 206-527-8696 | <a href="mailto:jaripreston@msn.com">jaripreston@msn.com</a>                         | Depression, Family, Anxiety                             |
| <b>Lynnwood</b>                                 |              |  |   |
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| <b>Olympia</b>                                  |              |  |   |
| Katy Murray, LCSW                               | 360-438-0306 | <a href="mailto:katymurraymsw@comcast.net">katymurraymsw@comcast.net</a>             | Substance Abuse, Depression                             |
| <b>Spokane</b>                                  |              |  |   |
| Katie O'Shea, CMHC                              | 509-838-3932 | <a href="mailto:mkatieoshea@gmail.com">mkatieoshea@gmail.com</a>                     | Abuse & Neglect, Children                               |
| <b>WISCONSIN</b>                                |              |  |   |
| <b>Fitchberg</b>                                |              |  |   |
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| <b>Milwaukee</b>        |              |  |  |  |
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| <b>Superior</b>         |              |  |  |  |
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| <b>Wauwatosa</b>        |              |  |  |  |
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| <b>WYOMING</b>          |              |  |  |  |
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| <b>Cheyenne</b>         |              |  |  |  |
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### INTERNATIONAL EMDR FACILITATOR LIST BY COUNTRY

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| Irene Segat, PhD                   | 54 11 4775 7136     | <a href="mailto:isegat@cvtci.com.ar">isegat@cvtci.com.ar</a>                                   | Anxiety Disorders             |
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| Paz Gomez Slater, PhD              | 54 11 5622019043    |  |                               |
| Andrea Belen Snaith, PhD           | 54 11 4554-9667     |  |                               |
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|                                    |                     | <b>Fluent in French and English</b>  |                               |
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|                                    |                     | <b>Fluent in English</b>   |                               |
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|                                    |                     | <b>Fluent in Italian &amp; English</b>   | Pregnancy/Infertility         |
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| Silvio Zirlinger, MD               | 54 11 4855-8863     |  |                               |
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| <b><u>AUSTRALIA</u></b>            |                     |  |                               |
| <b><u>ACT</u></b>                  |                     |  |                               |
| <b>Hall</b>                        |                     |  |                               |
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| <b><u>NEW SOUTH WALES</u></b>      |                     |  |                               |
| <b>Bondi</b>                       |                     |  |                               |
| Zara Yellin, Clin Psych            | 61 29 369-5442      |  |                               |
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