An Introduction to EMDR and Related Approaches in Psychotherapy

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- Read the enclosed course.
- Complete the questions at the end of the course.
- Return your completed Answer Sheet to NetCE by mail or fax, or complete online at www.NetCE.com. Your postmark or facsimile date will be used as your completion date.
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Faculty

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Faculty Disclosure

Contributing faculty, Jamie Marich, PhD, LPCC-S, LICDC-CS, RMT, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner

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Division Planner Disclosure

The division planner has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for counselors, social workers, and therapists who are interested in incorporating EMDR-related approaches into their work with clients.

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Course Objective

The purpose of this course is to provide an overview of the EMDR approach to treatment of trauma-related psychopathology in order for clinicians to evaluate its appropriateness for their clients.

Learning Objectives

Upon completion of this course, you should be able to:

1. Define trauma and explain the manifestation of unhealed trauma on the human experience, as conceptualized by the eye movement desensitization and reprocessing (EMDR) approach to psychotherapy and its adaptive information processing (AIP) model.
2. Explain how EMDR was discovered and developed by Francine Shapiro, making connections to the overall healing role of bilateral stimulation in the human experience.
3. Outline components of the AIP model.
4. Describe, in a general sense, how EMDR works to help a person stabilize, reprocessing, and reintegrate after a traumatic experience(s).
5. Discuss the variations in how EMDR is used by clinicians in the modern era.
6. Distinguish what makes an intervention purely EMDR therapy versus an EMDR-related intervention.
7. Summarize the characteristics of candidates for EMDR therapy and related approaches.
8. Describe how to implement a basic "tapping in" strategy for client stabilization (an EMDR-informed intervention).
9. Discuss how to conduct a trauma history/assessment on a client using principles of the AIP model.
10. Decide whether or not further training in EMDR or an EMDR-related intervention is a good fit for one's own clinical repertoire.

EVIDENCE-BASED PRACTICE RECOMMENDATION

Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Eye movement desensitization and reprocessing (EMDR) is an approach to psychotherapy that continues to grow in popularity and utility with a variety of clinical populations. In this continuing education course, participants will receive an orientation to EMDR and how it is being used in a variety of clinical settings. Although not intended to be a full training course in EMDR, the course will provide a full explanation of how the therapy works and how the EMDR approach conceptualizes the impact of trauma on the human experience. As a result, some related techniques and clinical case conceptualization skills can be derived from the course, even if the reader is not fully trained in EMDR.

FOUNDATIONS: EMDR AND TRAUMA

In order to understand EMDR, it is first important to understand what trauma means and how unhealed trauma impacts human behavior. This section will briefly define and discuss what trauma means. From this general discussion, the section progresses to discuss the history of EMDR and explain how Dr. Francine Shapiro formally discovered and developed it. Although more detail about this process will inevitably be visited throughout the course, the basics are provided in this section. Then, the model that Dr. Shapiro developed based on her early work with EMDR, the adaptive information processing (AIP) model, will be examined. The AIP model provides a framework through which one can more precisely define trauma and the role unhealed trauma plays in shaping the human experience. It also provides a pathway for healing trauma using the mechanism of reprocessing. The AIP model may be valuable to clinical work whether or not EMDR therapy is used.

A BRIEF PRIMER ON TRAUMA

Trauma derives from the Greek word *traumatikos*, meaning wound. In a broad sense, trauma simply refers to human wounding, be it physical, emotional, verbal, sexual, spiritual, or in any other domain of human existence. When professionals discuss issues of trauma, it is rare to hear the same definition offered twice. The helping professions have done so much over the years to make the definition technical and clinical, yet many find it useful to keep the conceptualization of trauma as simple as possible: trauma refers to human wounding that has not yet been healed or otherwise addressed.

The American Psychological Association defines trauma as [1]:

> An emotional response to a terrible event, like an accident, rape, or natural disaster. Immediately after the event, shock and denial are typical. Longer term reactions include unpredictable emotions, flashbacks, strained relationships, and even physical symptoms like headaches or nausea. While these feelings are normal, some people have difficulty moving on with their lives.

This meaning, although useful as a technical operations definition, comes with limitations. First, for many survivors, trauma is not just a one-time event, it is a series of experiences, like growing up in poverty or as part of an oppressed group, with too many "events" to even name. Second, trauma manifests in different ways for different people contingent upon a variety of contextual factors. Thus, attempting to condense it into a single definition often seems forced and sterile. Bessel van der Kolk, MD, refrains from giving a standardized, set definition of trauma in his book *The Body Keeps the Score: Brain, Mind, and Body in the Healing of Trauma*. He does offer that [2]:

> Trauma, by definition, is unbearable and intolerable. Most rape victims, combat soldiers, and children who have been molested become so upset when they think about what they experienced that they try to push it out of their minds, trying to act as if nothing happened, and move on. It takes a tremendous amount of energy to keep functioning while carrying the memory of terror and the shame of utter weakness and vulnerability.

FRANCINE SHAPIRO AND THE DISCOVERY OF EMDR

There is a clear link between unhealed trauma and symptoms manifesting in the body. Dr. Shapiro began her work with mind-body medicine connections as far back as the late 1970s, as a result of her own experiences with cancer recovery. As Dr. Shapiro explains in her story of how her serendipitous discovery in a park one day led her to develop what would become EMDR, she was always experimenting on herself. In a 2011 documentary, Shapiro explained that as she was walking, she noticed that some distressing thoughts began to disappear, the types of thoughts that you would normally have to bring up and consciously engage. Shapiro, in the spirit of mindfulness, kept paying attention, and when a type of disturbing thought came up she noticed that her eyes started moving back and forth. After her series of spontaneous eye movements, she recalled the thought and noticed that it did not have the same charge as before. This ushered in a process of experimenting on herself, her colleagues, and willing volunteers; what emerged were the initial procedures of eye movement desensitization, or EMD [3; 4].

Shapiro's initial working hypothesis was that she stumbled into a simple desensitization technique, something that essentially tapped on into rapid eye movement (REM) sleep in an awakened state. The *Journal of Traumatic Stress Studies* published her first formal research, a randomized controlled study, in 1989 [5]. Shortly after that publication, she added the concept of reprocessing to create EMDR. As she continued to develop her work, she noticed that the procedures elicited free associations that allowed people to process memories or other remnants of painful experiences that were not processed at the time of the memory. Hence the use of the term reprocessing instead of just processing. In 1990, a visually impaired individual presented for treatment and thus could not easily track eye movements. At that point, many in the field had already begun referring to EMDR as the "finger-waving technique" (usually in a pejorative sense) to reference the procedure used to guide clients to move their eyes back and forth. Although the eye movements happened spontaneously in her initial walk of discovery, she induced them purposefully in others by moving her hand across a person's plane of vision. This blind individual could not easily track eye movements, so Shapiro and those close to her began experimenting with alternative forms of creating bilateral stimulation. A device was created to generate audio tones that alternated back and forth, and they also discovered that tapping alternately on the individual's legs could produce similar effects. Although eye movements remain the most researched mode for creating the bilateral stimulation, actual eye movements are not required to do EMDR. Indeed, many individuals who present for treatment prefer the audio tones or the various forms of tactile stimulation to fully engage in the process. This will be discussed in detail later in this course.

EMD, and later EMDR, was initially met with a great deal of skepticism by the psychotherapeutic professions in general. Shapiro hypothesizes that many academics criticized what she was doing because clinicians were so enthusiastic about it. As clinicians, and later those with academic credibility, began to discover how the approach seemed to offer an answer to healing traumas where traditional talk methods had been failing, EMDR began to attract more believers. Although skepticism about EMDR remains to this day, it is becoming increasingly more mainstream within the helping professions due to the growing body of research supporting its efficacy. In discussing

preferred treatments for post-traumatic stress disorder (PTSD) in the modern era, EMDR is typically listed alongside the more traditional approaches, such as cognitive-behavioral therapy (CBT) and prolonged exposure. In 2013, the World Health Organization (WHO) guidelines for trauma care identified trauma-focused CBT and EMDR therapy as the only psychotherapies recommended for children, adolescents, and adults with PTSD [6]. Before 2016, EMDR appeared on the National Registry of Evidence-Based Programs and Practices, a list published by the Substance Abuse and Mental Health Services Administration (SAMHSA) following rigorous research and review; SAMHSA is re-reviewing all modalities as of 2016 [7]. A plethora of clinical bodies worldwide, including the American Psychiatric Association, the American Psychological Association, and the International Society for Traumatic Stress Studies, have listed EMDR on their best practices or highly efficacious lists in the treatment of PTSD since the early 2000s [8].

EVIDENCE-BASED PRACTICE RECOMMENDATION

The National Collaborating Centre for Mental Health recommends that people with PTSD, including those with mild-to-moderate PTSD, be referred for a formal psychological intervention (trauma-focused CBT or EMDR).

(http://www.guideline.gov/content.aspx?id=34828. Last accessed May 16, 2016.)

Level of Evidence: Expert Opinion/Consensus Statement

interactive activity

Show Me the Research

Interested in reviewing the specific research that led to EMDR being widely accepted? The Francine Shapiro Library, available at http://emdria.omeka.net, catalogues everything that has ever been published on EMDR—positive, negative, or neutral. Scholarly, clinical, and popular articles/other resources are represented in this database.

In several publications and interviews, Dr. Shapiro has conveyed that EMDR is a bit of a clunky name, indicative of the therapy in its original form. In an interview with Dr. Shapiro, she revealed that today she would name it something like "reprocessing therapy" [3]. As will continue to be highlighted throughout this course, eye movements are not essential to EMDR therapy, but Shapiro explains that she chose to keep the name EMDR for historical reasons.

As of 2014, Dr. Shapiro is advocating those who practice, research, and write about EMDR to begin using the term EMDR therapy instead of just EMDR. For her, it is important to distinguish that the simple technique has evolved into a distinct approach to psychotherapy that deserves to be discussed in the same way as CBT and other approaches referred to as therapy. The WHO definition of EMDR in their practice guidelines clearly uses the language to describe EMDR as a distinct approach to psychotherapy [6]:

> [EMDR] therapy is based on the idea that negative thoughts, feelings, and behaviors are the result of unprocessed memories. The treatment involves standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions, and bodily sensations and (b) bilateral stimulation that is most commonly in the form of repeated eye movements. Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework.

FOUNDATIONS OF PSYCHODYNAMIC THERAPY, CBT, AND EMDR THERAPY		
Therapy	**Foundation of Pathology**	**Treatment**
Psychodynamic therapy	Intrapsychic conflicts	Transference/verbal "working through"
CBT	Dysfunctional beliefs and behaviors	Direct procedural manipulations of beliefs and behaviors
EMDR therapy	Unprocessed psychologically stored memories	Accessing and processing of memories, triggers, and future templates
Source: [13]		*Table 1*

ADAPTIVE INFORMATION PROCESSING: TRAUMA AND THE EMDR APPROACH

The existence of a model that distinguishes EMDR from other forms of psychotherapy is one of the reasons that EMDR merits distinction as a type of therapy. The model Shapiro developed was originally called the accelerated information processing model, now referred to as the adaptive information processing (AIP) model. In a 2014 communication to the members of the EMDR International Association (EMDRIA), Shapiro made the correlation that CBT, psychodynamic therapy, and EMDR therapy have unique foundations of pathology and approached to treatment (***Table 1***) [13].

The AIP is a model, not a theory, although upon reviewing earlier information processing models published in the 1950s and 1960s, one can see clear roots in behaviorist theory. Originally published in the second edition of Shapiro's textbook *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*, the AIP model has gone through various permutations in semantics and points of emphases. The basic hypotheses of the AIP model, as published by the EMDRIA, are [9; 10]:

- The neurobiologic information processing system is intrinsic, physical, and adaptive.
- This system is geared to integrate internal and external experiences.
- Memories are stored in associative memory networks and are the basis of perception, attitude, and behavior.
- Experiences are translated into physically stored memories.
- Stored memory experiences are contributors to pathology and to health.
- Trauma causes a disruption of normal adaptive information processing, which results in unprocessed information being dysfunctionally held in memory networks.
- Trauma can include Criterion A events, as defined in the fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), and/or the experience of neglect or abuse that undermines an individual's sense of self-worth, safety, ability to assume appropriate responsibility for self or other(s), or limits one's sense of control or choices.
- New experiences link into previously stored memories, which are the basis of interpretations, feelings, and behaviors.
- If experiences are accompanied by high levels of disturbance, they may be stored in the implicit/nondeclarative memory system. These memory networks contain the perspectives, affects, and sensations of the disturbing event and are stored in a way that does not allow them to connect with adaptive information networks.
- When similar experiences occur (internally or externally), they link into the unprocessed memory networks and the negative perspective, affect, and/or sensations arise.
- This expanding network reinforces the previous experiences.

- Adaptive (positive) information, resources, and memories are also stored in memory networks.
- Direct processing of the unprocessed information facilitates linkage to the adaptive memory networks and a transformation of all aspects of the memory.
- Nonadaptive perceptions, affects, and sensations are discarded.
- As processing occurs, there is a posited shift from implicit/nondeclarative memory to explicit/declarative memory and from episodic to semantic memory systems.
- Processing of the memory causes an adaptive shift in all components of the memory, including sense of time and age, symptoms, reactive behaviors, and sense of self.

The roots of Shapiro's training as a behavioral psychologist are evident in this model, which is now well-known to EMDR therapists. The Gagné model is the earliest in behavioral theory resembling the AIP model [35]. In her work, Shapiro specifically cites models by Peter Lang, Stanley Rachman, Gordon Bower, Edna Foa, and Michael Kozak as forerunners to the AIP.

The AIP model recognizes that humans learn things, either about themselves or their surrounding world, as a result of traumatic experience. When trauma remains unprocessed, so do these trauma-charged pieces of information, and there is an evitable effect on output (e.g., how we feel, how we think, how we act). For example, if the traumatic experience(s) leaves a cognitive imprint of "I'm not good enough," this is likely to manifest in other areas of human experience. Consider how the belief "I'm not good enough" might play out emotionally, somatically, or even spiritually. A solid course of reprocessing (such as with EMDR therapy) allows the maladaptively stored belief ("I'm not good enough") to shift to a more positive, natural opposite ("I am good enough"). It is not enough for the belief to be confronted. Many patients who have had therapy before know what their negative beliefs are and may even know what they should believe, but the shift has not internalized [11].

For people who continue to manifest distress at an emotional, somatic, and/or spiritual level, the processing work should incorporate these other channels. As explained in the AIP model, unprocessed components or manifestations of memory can be stored in a variety of states—visual, cognitive, sonic, emotional, somatic, existential, or a combination [12]. These states can transform during processing to an adaptive resolution. Information processing transmutes information though all accessed channels of memory. For Shapiro, the modality of choice is EMDR therapy, but there are many other ways to process "stuck" information. The key is determining where a person is still "stuck" and accessing that channel. For many clients, the cognitive work has been done, but the emotional, somatic, or existential work still needs to be completed [11].

There is a great deal in the AIP model that can be useful to a general understanding of trauma and how, when it remains unhealed, it inevitably impacts human behavior. There are many ways to engage in processing to an adaptive resolution. Examples include drumming, dancing, praying, meditating, writing, creating, sharing with others, and receiving bodywork. In Shapiro's view, because EMDR therapy calls upon so many components of the human experience (e.g., thinking, feeling, sensing, remembering, believing, seeing, hearing) in its standard protocol, it is the ideal way to process maladaptively stored traumatic memories to an adaptive resolution. The specifics of the protocol and how it calls upon these elements to set up EMDR work will be discussed in detail later in the course.

Perhaps the most significant concept that clinicians beyond EMDR have drawn from in Shapiro's AIP work is the taxonomy of large-T and small-t trauma. Shapiro developed EMDR and the AIP model in the era of the DSM-III and DSM-IV, in which the qualifying traumas for a diagnosis of PTSD generally needed to be threats to life or limb (or perceived to be), referred to as Criterion A traumas. Hence, large-T traumas, or events that most people would find upsetting (e.g., war, natural disaster), are essentially Criterion A traumas. Although many clinicians still consider the large-T/small-t taxonomy useful, Shapiro has moved away from this original distinction, now opting for the term "adverse life experiences" [13]. These adverse life experiences may or may not qualify for a DSM-5 diagnosis of PTSD. It is important to note that it was never intended for people to use the large-T/small-t system as a value judgment; small-t trauma can be just as valid and just as clinically significant as large-T trauma [12]. The hope is that using the term "adverse life experiences" will keep inadvertent value judgments from taking place.

The DSM-5 significantly expanded the definition of Criterion A trauma. In the DSM-IV-TR, Criterion A trauma required there to be some threat to physical integrity or life. In the DSM-5, witnessing a traumatic experience (real or threatened) happen to someone else also qualifies, as does violent or accidental death (real or threatened) to a family memory or close friend. Sexual assault and certain cases of vicarious traumatization connected to work experiences also now qualify as Criterion A [37]. Although the presence of a Criterion A trauma is a necessary qualification for a diagnosis of PTSD, not all persons who experience Criterion A trauma will develop PTSD.

Newer versions of the AIP model reflect this shift away from the "small-t trauma" language. This nomenclature is preferable, especially in cultures (e.g., military, public safety) in which a "traumatized" label may come with stigma. Additionally, even though Shapiro's initial conceptualization of large-T and small-t trauma was a significant advancement in how trauma is viewed, many perceived these distinctions as value judgments, with the implication that large-T traumas are automatically worse than small-t traumas. However, it is clear that small-t traumas can be just as damaging and just as clinically significant as the large-T traumas that would qualify for PTSD.

Shapiro's introduction of the small-t concept (now adverse life experiences not meeting the criteria for PTSD) was a revolutionary step forward in how trauma is conceptualized. It is now accepted that trauma does not have to qualify for PTSD or fit DSM Criterion A for it to be life-changing or even clinically significant. Shapiro defined these adverse life experiences as upsetting life events that may prove difficult to heal and integrate into one's larger experience [12]. This can include a variety of experiences, including racial or ethnic discrimination, verbal abuse, bullying, divorce, a medical crisis, spiritual abuse, mind control, emotional blackmail, or loss of a pet. While these traumas may not have the life-threatening connotation of Criterion A, they can be life-altering. If a person is not able to process or make sense of an experience due to a variety of reasons, these traumas can be just as damaging [11].

Many clients struggle with these types of adverse life experiences, believing that if they did not experience a major disaster, then their trauma is somehow less legitimate or significant. Professionals and family members may reinforce this devastating belief by comparing traumas and oppressions. There will always be critics who reject the "small-t trauma" concept, dismissing such events as not traumatic and as an essential part of the human experience. It is important to remember that experiencing a trauma is not pathologic, but when traumas are unresolved and unhealed, problems can ensue. People whose lives are affected by unprocessed adverse life experiences have every right to access treatment, regardless of whether the experiences are considered Criterion A, especially psychotherapy and other psychosocial interventions that can help them to heal [11].

Several mental health conditions may be explained or exacerbated by unresolved adverse life experiences that do not meet the criteria for PTSD diagnosis. The links between major depressive disorders, persistent depressive disorder, and various anxiety disorders and earlier, unprocessed life experiences are apparent. Even personality disorders, long regarded as difficult to treat, may be better conceptualized in light of the pervasive impact of unresolved trauma on childhood development. In the book *The Angry Heart: Overcoming Borderline and Addictive Disorders*, Joseph Santoro suggests that borderline personality disorder is a manifestation of complex PTSD [14]. Many of the Cluster B personality disorders develop in individuals who experienced profound trauma in childhood, usually a combination of Criterion A traumas and adverse life experiences not meeting this standard [11].

DEFINING EMDR

DEMYSTIFYING BILATERAL STIMULATION AS A HEALING MECHANISM

Before exploring how EMDR is believed to work, it is important to examine how bilateral stimulation, in general, can provide healing to the brain. There are countless examples of how bilateral stimulation is accessed in nature for healing or other positive mechanisms of action. Cultures around the globe have used bilateral processes, specifically drumming and dancing, for millennia. Bilateral stimulation refers to any alternating, back-and-forth movement. As discussed, Shapiro initially developed EMDR with bilateral eye movements following her serendipitous discovery, although she soon discovered that alternating taps on the legs, hands, or with the feet, or bilateral audio tones could produce a similar effect. Many believe that EMDR accesses a natural healing mechanism (i.e., bilateral stimulation) that exists within the brain. There is evidence in world literature, history, and anthropology indicating that others before Shapiro noticed the effects of bilateral stimulation, especially in cultures where dancing and drumming have been used for centuries as a way to release distress [15]. The books and poems of Native American author Sherman Alexie document how tribes have utilized dance, an activity of tactile bilateral stimulation, to cope with distress and heighten performance for centuries [16; 17]. Kyra Gaunt documented how generations of African American girls have used clapping games, double-dutch jump rope, and other bilateral rhythmic activities to transition into adulthood [18]. Massage therapists also use bilateral stimulation quite a bit. For instance, a massage therapist will often alternate pressure from shoulder to shoulder or from hip to hip.

Bilateral stimulation is everywhere. Walking is bilateral stimulation, as is running, swimming, and dancing. As Linda Curran observed in *Trauma Competency* [19]:

> Bilateral stimulation is not dangerous, nor is EMDR as a modality. If it were, wouldn't it follow that we should all abreact when walking, snapping our fingers, or playing Miss Mary Mac? However, when administered by clinicians without prerequisite knowledge to effectively address and treat trauma's sequelae, the EMDR protocol proves challenging, fear-inducing, and oftentimes, traumatizing for clinicians and re-traumatizing for clients.

Although clients may never have heard of EMDR, they may have adopted bilateral "techniques" to help alleviate stress, such as tossing an item from hand to hand or watching a swaying object. EMDR builds on these seemingly innate tendencies for therapeutic benefit.

EMDR AND THE BRAIN

A precise, scientifically infallible explanation of how exactly EMDR works to help people process trauma within the human brain is still lacking. However, such a delay in precise knowledge does not negate the validity of the evidence for EMDR's efficacy. For example, it took 40 years after the discovery of penicillin's antibacterial action before the medical community was able to exactly explain how it works at a biologic level [2]. It is possible to offer a general profile of what is believed to happen in the brain during EMDR therapy. First, it is important to offer a rudimentary explanation of how unhealed traumatic experiences are stored in the human brain. Then, the course will provide a discussion of what the extant literature and research reveal about how EMDR therapy and related information assists with processing these experiences.

For survivors of trauma, the twists and tangles in the neuronetworks of the brain exist within the lower levels: the limbic brain and the brain stem. In working with trauma, the most basic concept to grasp, based on MacLean's triune brain model, is that the human brain is composed of three separate brains, each with its own separate functions and senses of time (e.g., the R-complex brain or brainstem, the limbic brain, and the cerebral brain or neocortex) [20]. While this model's use in terms of neuroanatomic evolution is considered by some to be outdated or oversimplified, it is useful as a purely explanatory tool. It describes the brain structure in a manner that is easy to understand and use as a conceptualization for treatment planning [20]:

- The R-complex brain (reptilian brain): Includes the brainstem and cerebellum. It controls reflex behaviors, muscle control, balance, breathing, and heartbeat, and is very reactive to direct stimulation.
- The limbic brain: Contains the amygdala, hypothalamus, and hippocampus. It is the source of emotions and instincts within the brain, including attachment and survival. When this part of the brain is activated, emotion is activated. According to MacLean, everything in the limbic system is either agreeable (pleasure) or disagreeable (pain/distress), and survival is based on the avoidance of pain and the recurrence of pleasure.
- The neocortex (or cerebral cortex): Contains the frontal lobe and is unique to primates. The more evolved brain, it regulates executive functioning, which can include higher-order thinking skills, reason, speech, meaning, and sapience (e.g., wisdom, calling on experience).

Humans rely on all three brains to function. Thus, optimal processing of information would require all three brains to harmoniously operate to facilitate this essential processing. When the regulatory capacities of the limbic brain are impaired, it works longer and harder than it was ever intended to, causing the symptoms associated with traumatic stress.

interactive activity

In a CBS affiliate news story, psychiatrist Daniel Amen, MD, speaks with a survivor of complex trauma shortly after he completes a brain scan. Amen explains to this patient, an adult child of an alcoholic, a veteran of the first Gulf War, and a recent survivor of an accident, "Your brain is working too hard." This phrase simply and elegantly explains how the brain, especially the limbic brain, is affected by unresolved trauma. This clip, which also serves as a three-minute orientation to EMDR, may be viewed here: https://www.youtube.com/watch?v=zBtqWrs2-K0.

The goal of successful trauma processing is to move or to connect the charged material from the limbic brain into a part of the brain that is more efficient in its long-term storage capacities. Most persons working in the psychologic professions have cared for a person in crisis at one point or another, often encouraging the person to "leave the past in the past" and "focus on the now." These interventions

are often a default because so much of the training in the helping professions is cognitively focused, making it natural for those with traditional training to confront a person's negative thinking or attempt to persuade a person to see the positive spin in any negative situation. This approach is often unsuccessful, perhaps because it only engages the neocortex, not the entire brain. It is the limbic region of the brain, activated during the original trauma to help the person survive (through flight, fight, or freeze to submission), where the unprocessed material remains. Because the left frontal lobe is "turned off" (i.e., no blood flow) and the right frontal lobe is "abandoned" (i.e., awareness but lack of ability to process) during trauma, the individual is unable to link the limbic activation with frontal lobe functions during the experience. For a person in crisis or intense emotional distress, this process is playing out in real time and/or triggers from earlier, unprocessed experiences fuel the distress.

As noted, for optimal healing to occur, all three brains must work together; unprocessed trauma creates disconnection in the brain. Any movement-based or body-based intervention automatically works with the limbic and reptilian brains, and this activation can be valuable in accessing and processing traumatic life experiences.

The bilateral processes involved with EMDR, whether they are eye movements, audio tones, or tactile motions, stimulate all three brains. In 2014, Pagani, Hogberg, Fernandez, and Siracusano published a comprehensive summary on all of the imaging and other biologic monitoring studies conducted on EMDR therapy to date [21]. EMDR-related neurobiologic changes were monitored by electroencephalogram (EEG) during therapy sessions and showed a shift of the maximal activation from emotional limbic to cortical cognitive brain regions—the first documented finding of its kind. Neuroimaging investigations of the effects of psychotherapies treating PTSD, including EMDR therapy, have reported findings consistent with modifications in cerebral blood flow on single photon emission computed tomography, in neuronal volume and density (on magnetic resonance imaging), and in brain electric signal on EEG. This validates the belief that the mechanisms of EMDR therapy promote positive shifts in where traumatic memories are stored in the brain. Some hypothesize that long-term positron emission tomography scan studies will reveal how EMDR works to heal the traumatized brain [21].

HOW EMDR IS CONDUCTED

As discussed, Shapiro clearly views the present state of her discovery as a separate and distinct form of psychotherapy with a theoretical model as a guide and distinct phases. The EMDRIA maintains a standing definition of what constitutes EMDR that is very closely aligned with Shapiro's ideas. There are several different types of protocols required for therapy to be considered EMDR [12]. In the broadest sense, the protocol refers to Shapiro's eight-phase model of EMDR treatment: client history, preparation, assessment, desensitization, installation, body scan, closure, and re-evaluation.

Client History

In EMDR therapy, client history is similar to the intake/assessment procedure that is used in all forms of psychotherapy. In this phase, the clinician takes a basic client history, a relationship begins to be established, and the clinician ultimately determines if EMDR treatment is appropriate for the client. An AIP-informed approach should be used in the gathering of this history.

Preparation

The second phase, preparation, continues the development of the therapeutic alliance and integration of exercises designed for client stabilization. These can include, but are not limited to, guided visualizations like the "safe place" exercise. Generally, the more complex the client, the more preparation will be needed. The essential goal of this phase is to ready the client for deeper work on the traumatic memories/issues in phases three through six.

Assessment

The assessment phase involves determining the target(s) of EMDR processing. In EMDR training, clinicians learn a series of questions that compose a targeting sequence. (This is covered more fully later in this course.)

Desensitization

Desensitization consists of the application of bilateral stimulation sets after establishing the targeting sequence, designed to shift the traumatically stored material into more adaptive states. The time that one spends in desensitization (i.e., the number and length of bilateral stimulation sets) varies from client to client. Some clients can work through desensitization of a targeting sequence in one session, and others need several sessions. If desensitization is not completed within an allotted session, phase seven should be done before ending the appointment; the next session may be reopened with phase three.

Installation

Installation follows successful processing of the targeted memory or issue, working with the positive belief states or other positive shifts a person's desensitization has allowed. The same bilateral stimulation process is used to install, or promote integration of, these more positive states.

Body Scan

In the sixth phase, the client should check in with any shifts that have occurred in his or her body as a result of the desensitization and installation. If the body scan is relatively clear, one moves on to the next phase. If some distress or disturbance remains at a body level, more desensitization is necessary; the memory or issue likely did not process deeply enough. This should continue until the body scan is relatively clear. The body scan is a technique used in many mind-body practices (e.g., mindfulness meditation) and was adapted by Shapiro for use in the EMDR protocol.

Closure

Closure consists of the procedures that a client and clinician implement to bring a session to a place where the client feels calm enough, especially at the affective/somatic level, to leave a session. These procedures may include exercises and strategies developed in the preparation phase.

Re-Evaluation

The final phase, referred to as re-evaluation, involves continuing to monitor client progress after a successful processing through of a targeting sequence. Together, the client and clinician determine the other targets that may need to be addressed in order for the client to achieve his or her goals (in which case the EMDR therapy cycles back through phases three through seven). The re-evaluation process can also include the target of future templates or scenarios connected to the work done in previous phases. Re-evaluation, in theory, can continue indefinitely.

Putting the Protocol into Action

The parallels to the three-stage consensus model of trauma treatment (e.g., stabilization, processing, reintegration) are obvious. Pierre Janet originally published the three-stage model in 1889, and it has stood the test of time as a best practice framework in the treatment of trauma, regardless of the specific modality or approach [22]. Phases one and two of the EMDR model are analogous to stabilization, phases three through six equate with processing, and phases seven and eight correspond with reintegration.

Shapiro also describes EMDR as having a three-pronged protocol, meaning that EMDR therapy is designed to clear out past disturbances in order to improve present and future functioning [12]. This three-pronged protocol also makes good sense. The purpose of EMDR is to help a person live a more adaptive life, so clear connections to present and future functioning should be made when visiting the past [12].

SAMPLE 11-STEP PROTOCOL FOR EMDR	
Scripted Step	**Sample Response/Action from Client**
Identify the presenting issue or memory	Never feeling safe when I get in a car because of a bad accident that happened five years ago.
What picture represents the worst part of that incident?	Seeing the truck that hit me moving into my lane. (NOTE: If no picture is available, the "worst part" may be a sensation, sound, or other sensory imprint.)
What words go best with that picture to describe how you feel about yourself now?	I am in danger.
When you bring up that picture, what would you like to believe about yourself now?	I am safe in general.
When you think of that picture (the truck changing lanes), how true does "I am safe" feel to you now on a scale from 1 (completely false) to 7 (completely true)?	2
When you bring up that picture and the words "I am in danger," what emotions do you feel now?	Fear, terror
On a scale of 0 (no disturbance) to 10 (the most disturbance imaginable), how disturbing does the incident feel to you now?	8
Where do you feel it in your body?	The chest (racing heartbeat)
Desensitization	The client holds the picture of the truck changing lanes together with the racing heartbeat in his chest, and puts it together with the negative belief "I am in danger."
Apply stimulation for approximately 12 to 24 sets of bilateral stimulation, then ask, "What are you getting now?"	I am noticing how my heart is racing even faster.
After the client reports a new experience, have the client "go with that." That experience can be anything: a new memory, a new sensation, a new thought, a new twist on the memory, or nothing. The general principle is to "keep going" with whatever comes up until the SUDs=0, the VoC=7, and the body scan is clear.	
Source: Compiled by Author	*Table 2*

The third usage of protocol work relates to how a clinician sets up and executes an EMDR session. In essence, the script that trainees are given to complete phases three through six, which includes elements like measuring subjective units of distress (SUDs) and the validity of cognition (VoC) scale, would be a part of the protocol. The prescribed, sequenced steps for phases three through six, as originally produced by Shapiro, are also referred to as the 11-step procedure (***Table 2***) [12]. Prescribed usage of the SUDs and VoC scales is a major part of this protocol. The SUDs scale, originally developed by behaviorist Joseph Volpe, is the classic 0–10 scale of intensity. In EMDR, 0 means no distress, while 10 signals maximum possible distress. The VoC scale was developed as a way to measure the validity of certain cognitions, like "I am good enough." This is a 1–7 scale, in which 1 equals completely false, and 7 equals completely true. Although this was originally developed to avoid confusion, many clinicians and clients have found the 1–7 VoC scale to be one of the most confusing parts of the EMDR protocol. Alternatively, clients may opt to give percentages, for instance, "'I'm good enough' is 80% true in this moment."

All of these steps are the "ideal" of how a targeting sequence should work—the textbook set-up of an EMDR session following preparation that is designed to take a client deeper on his or her journey of resolving the traumatic memory. After mastering this basic targeting sequence, it can be applied to any situation, memory, issue, or cognition. Of course, there are considerations that should be taken into account based on individual clients. For example, when working with children, the language should be modified to be developmentally appropriate. Some clients may not feel it is possible to come down to a zero level with their SUDs rating simply because something happened. In her text, Shapiro validates this phenomenon as possible or ecological. Many people can leave the SUDs at a 1 or 2 and have a clear body scan, a completely true positive cognition, and corresponding behavior changes.

Several books have been published on how to use these standard EMDR protocols in special situations [23; 24; 25]. There are many spin-off protocols available, some of which were developed by Shapiro (e.g., the Recent Events Protocol) and many that other clinicians have developed. Most of these specialty protocols are simple variations on this basic targeting sequence. An exception to that would be Shapiro's own phobia protocol, where she advises that the following six states connected to the phobia should all be processed in separate target sequences: the first, the worst, the most recent, any ancillary events related to the phobia, any present stimuli, and any other physical sensations/signs of fear.

In evaluating the question of how EMDR works, it is a blend of model, methodology, and mechanism. There is a clear model associated with EMDR therapy (i.e., the AIP model), the methodology is the eight-phase protocol, and the mechanism is the impact of EMDR in the brain. There are clinicians who have taken deviations from the founder's word-for-word presentation, and for many, using these variations has been vital to using EMDR with clients.

THE FOUR FACES OF EMDR: VARIATIONS

It is Shapiro's stance that EMDR therapy should be executed exactly as she presents it in order for it to be done with optimal efficacy. Although this position has served EMDR well in terms of research validation, for many clinicians, the strict protocols do not allow for enough variation based on individual clients. The EMDRIA definition of EMDR allows for some flexibility and adaptability based on client development. For example, in working with children or clients of another culture, it may be imperative to change the language in the protocol. But the EMDRIA definition of EMDR uses Shapiro's eight phases and maintains that phases three through six should not be altered. (Phases one, two, seven, and eight can be more easily adapted.) Shapiro maintains that EMDR is an interaction between client, clinician, and method, although many critics believe that too much emphasis on method is at the expense of an organic client-clinician interaction [12].

When returning to a clinical setting, modification of certain aspects of the textbook protocol may be necessary in order to honor clients' organic leading of the experience and to honor one's inner-prompting to bring other parts of the therapeutic training experience. If variations in the strict protocol are supported by outcomes, there is no reason to adhere to pure EMDR methods.

One way to conceptualize variations in EMDR approaches is the Four Faces of EMDR model [26]. According to this model, EMDR takes four major shapes in modern-day clinical practices, and clinicians tend to resonate with the presentation that most speaks to their personality; no approach is "better" than another.

SAMPLE EMDR PROTOCOL WITH MODIFICATION	
Step	**Sample Response from Client**
Identify the target memory	Never feeling safe when I get in a car because of a bad accident that happened five years ago.
Identify an associated image (or worst part of the incident)	Seeing the truck that hit me moving into my lane. (NOTE: If no picture is available, the "worst part" may be a sensation, sound, or other sensory imprint.)
Identify emotions	Fear, terror
Describe body sensation or discomfort	Racing heartbeat
Identify negative cognition	I'm in danger.
When the client is visibly distressed, begin desensitization with bilateral stimulation.	
Source: Compiled by Author	*Table 3*

Face 1

Face 1 is protocol-oriented EMDR, or what Shapiro now refers to as EMDR therapy (with the new emphasis on therapy). To this point, this course has focused primarily on Face 1. Therapists who identify as Face 1 EMDR therapists generally learn best through having a scripted series of protocols to follow and feel most secure when clinically practicing within such paradigms.

Face 2

Face 2 EMDR is more flexible than a Face 1 approach. Face 2 EMDR uses Shapiro's original protocols and procedures, with modifications made by the clinician to better suit the clinician's personal style or to better accommodate the client's learning/processing style and other unique needs. Flexible EMDR therapy is still largely regarded as an approach to psychotherapy. However, many who practice flexible EMDR choose to incorporate other models of treatment conceptualization aside from Shapiro's AIP model [12]. People who practice flexible EMDR are more likely than Face 1 practitioners to use the general EMDR approach to psychotherapy alongside of another approach to psychotherapy (e.g., 12-step facilitation, ego-state therapy, Gestalt, CBT, mindfulness-informed interventions, expressive arts therapies, attachment theory).

Face 2 EMDR therapists, in addition to naturally making combinations with other theories and approaches to psychotherapy, are more likely to make modifications in the strict 11-step set up for phases three through six. These modifications can be made while still adhering to Shapiro's eight essential phases. For example, in her modified protocol, Parnell streamlined the set-up to be less clunky and significantly less numeric [15]. ***Table 3*** is a hypothetical example of how EMDR phase three assessment may be set up using Parnell's classic modification.

Clinically, Parnell, and many Face 2 and Face 3 EMDR therapists, have found a modified approach to work as well as the longer set-up because the essential ingredient of EMDR is being met: the traumatic neural network is being accessed and then stimulated. Clients' ratings, which often work well in research, do not often translate to clinical practice. In Parnell's work, SUDs ratings or the positive cognitions may be used when they organically arise during desensitization. For example, if the bulk of a session is spent processing and a therapist wants to check in about distress level, obtaining SUDs ratings at various intervals can be a good chance to determine how the client is moving with the memory/issue. However, when setting up the targeting sequence and the client is getting distressed, stopping to ask for ratings can disrupt the process.

Many EMDR experts, like Laurel Parnell, David Grand, Robin Shapiro, and Ricky Greenwald, have written about widening the scope of EMDR. Grand's work *Natural Flow EMDR* eventually channeled into him developing his own intervention, brainspotting, and Greenwald has long advocated for the use of EMDR within the classic three-stage consensus model of trauma-informed treatment [36].

Face 2 (and 3) EMDR therapists are more likely than Face 1 EMDR therapists to use other approaches to bilateral stimulation aside from eye movements. Although many Face 1 EMDR therapists will use the alternative forms of stimulation, many adhere to an "eye movements first" policy, because those are the most researched. Face 2 EMDR therapists often give clients the choice of what stimulation modality they prefer.

Face 3

Those who practice in Face 3 are considered even more off-book, especially with Shapiro's assertions that EMDR is a distinct approach to therapy, not a technique. For Face 3 therapists, EMDR is simply used as an adjunctive technique or procedure to another psychotherapeutic orientation. With this face, EMDR does not dominate or guide the treatment. Some Face 3 practitioners stay true to Shapiro's eight-phase main protocol, whereas others modify it to suit their main orientation. They use the desensitization procedure as a technique to work through blocks with various degrees of fidelity to the 11-step setup.

An example of a Face 3 EMDR clinician is Linda Curran. Curran has shared the following thoughts that encapsulate Face 3 EMDR [26]:

> I believe that EMDR is a modality that has proved efficacious in both internal resourcing and reprocessing traumatic material. There should be no need for me, or any other clinician, to renounce his/her chosen discipline to utilize EMDR as a modality…I completely identify with old-school trauma therapy, a.k.a. Gestalt therapy. Gestalt therapy is a humanistic, present-centered, relational psychotherapy with an emphasis on contact, body/somatic awareness, and the working through of unfinished business. As PTSD (both simple and complex) is the quintessential disorder of unfinished physiologic, emotional, and cognitive business, Gestalt therapy lends itself perfectly. In terms of EMDR, I do EMDR, but I am not an EMDR therapist.

Face 4

EMDR-informed interventions, Face 4, exist as separate and distinct modalities or approaches developed by clinicians who were originally trained in EMDR and have used EMDR-informed interventions or evolutions of original EMDR elements to create a new technique or approach to therapy. Perhaps the most popular new modality that has grown from experimentation within EMDR is brainspotting. In 2013, David Grand published his first book on the phenomenon, a technique derived from EMDR but with greater simplicity in implementation [36]. Other evolutions include the developmental needs meeting strategy (DNMS), developed by Shirley Jean Schmidt; induced after-death communication, by Alan Botkin; and progressive counting, developed by Ricky Greenwald [28; 29]. Of these modalities, progressive counting has some empirical evidence suggesting it is at least as effective as EMDR. As Greenwald promotes, it is easier to learn and to teach than standard EMDR [29]. Although delving into a full exploration of each therapy is beyond the scope of this course, research on these therapies may help therapists determine if they may be useful in their practice, especially if traditional EMDR does not totally resonate.

In 2008, Laurel Parnell published a book, *Tapping In*, that teaches the general public how to use bilateral tapping [34]. The Parnell book was somewhat controversial at the time it was published, but Shapiro has since published a book on self-help techniques derived from EMDR [27].

CANDIDATES FOR EMDR

A variety of clients can benefit from EMDR therapy or EMDR-related techniques, presuming that the clients are open to exploring the possibilities. EMDR has, to date, been officially validated for clients with PTSD. However, there are a plethora of case studies, field reports, and other research articles demonstrating the efficacy of EMDR for a variety of diagnoses. If one can appreciate the role of adverse life experiences in causing or exacerbating other diagnoses, using EMDR with other diagnoses is not a stretch. However, official empirical research is lagging, so clinical practice recommendations do not generally recommend it as an approach yet. Another issue is that PTSD and other trauma-related diagnoses exist comorbid with other major diagnoses, like substance use disorders and eating disorders. Although EMDR has not been officially validated as a treatment for addiction, many clinicians have incorporated EMDR into their work with addicts because of the high comorbidity between substance use disorders and trauma- and stressor-related disorders. As long as the client is sufficiently stabilized, using EMDR phase two approaches or stabilization approaches from other traditions, the trauma reprocessing phases of EMDR can be used with most willing clients.

In many cases, clients who have tried standard "talk therapy" approaches and have not met their goals are generally willing to attempt EMDR because it offers a different avenue. Each client can go through phases one and two, as long as the treating clinician is sensitive to the dynamics of trauma-sensitivity. For instance, in doing phase one work, the issue of taking a detailed trauma history should not be forced if clinical judgment suggests that relaying the entire history verbally would worsen the client's condition. Some general recommendations for determining whether a client is a candidate for EMDR include [26]:

- Can the client maintain dual awareness of past and present? In other words, if a safe place or other guided visualization exercise is done with the client or a target is set on a past memory, will the client know that he or she is still in the office and not really going there? Dual awareness is essential for the most effective, safest EMDR.
- If the client is taking psychotropic medications, especially for conditions like organic mood disorder (e.g., bipolar) or organic psychotic disorders (e.g., schizoaffective disorder), is he or she stable? The period when a client and his/her psychiatrist are experimenting to try to find the right combination and dosage is not the best time to do any kind of trauma-processing work. In the early days of EMDR, many did not venture into using it with clients who had severe mental illnesses other than PTSD. However, EMDR practitioners are continuing to find that if safety conditions are met and appropriate modifications are made to meet the client where he or she is at, EMDR is not necessarily off limits.
- Are the client's basic needs being met? If the client's basic needs (e.g., food, shelter, safety) are not being met, it is generally not a good time to do trauma-processing work. Consider working with a case manger or other community resources to ensure the client's basic needs are being met before starting processing; this is part of the preparation and stabilization process.

- For clients with eating disorders, simply eradicating the core trauma with EMDR or any other modality will not resolve the eating disorder. Rather, a sensible behavioral plan combined with stabilization work is needed as a base. Consider collaborating with other behavioral health and wellness professionals, if needed. Then, trauma processing can be titrated into the treatment to enhance the treatment gains and help with relapse prevention.
- For clients with addictions and other acting out behaviors, simply eradicating the core trauma with EMDR or any other modality will generally not resolve the behavioral manifestation. Collaborative strategies, at which Face 2 and Face 3 EMDR practitioners excel, are key. For instance, behavior modification plans and EMDR do not have to be mutually exclusive; they can work well in concert. As with eating disorders, titrate the trauma processing into the treatment to enhance the treatment gains and help with relapse prevention.

Shapiro has also recommended that clinicians should not do EMDR with a client they would not normally feel comfortable treating [4; 12]. For instance, if a clinician is very comfortable working with addiction, using EMDR therapy with addicted clients would likely be appropriate. However, if one does not usually work with young children or couples, EMDR should not be done with those types of clients because he or she may not competent in the modifications that may need to be made. In general, if a client who is often defined as a part of a "special population" (e.g., children, military, gender and sexual minorities) seeks out EMDR, the likelihood of their success is greater if they are working with a clinician who understands that population.

CASE STUDIES

Case 1: Client D

Client D approaches a counselor for services after reading about her work with trauma and addiction. He is 57 years of age and has nine years of sobriety from alcohol at the time he seeks help. A successful businessman during his drinking days, he changed professions in recovery and pursued an advanced degree to work as a treatment clinician. At the time he presents for counseling, he is working in a prominent leadership position in a treatment setting. Although Client D has been an active member of a 12-step fellowship for many years, he finds himself struggling with the rigidity on certain issues as interpreted by many groups. He is actively exploring ways to expand his recovery wellness. In the history taking, Client D reveals that his biological mother relinquished him at the time of his birth. After spending seven days in a home for unwed mothers, a couple unable to conceive adopted him. Five years later, they were able to naturally conceive Client D's younger sister, and then years later they adopted another son from an unwed mother. Client D describes that, overall, he was well cared for by his adopted parents and he describes his childhood as relatively carefree. However, there are still some issues from that period that continue to play out in his life.

When Client D presents for services, he is unsure if he can even name the relinquishment and experiences connected to being adopted as trauma. However, he has keen awareness that even though he is sober and successful in his work, he is struggling in many other life domains, namely connecting with others. He has also identified problems with compulsive overeating throughout the years, even following his sobriety from alcohol. In the initial history-taking session, the counselor explains to Client D that trauma does not have to meet PTSD criteria to name it as trauma, explaining the concept of adverse life experiences as they are described in the AIP model. She also uses the wound metaphor as a teaching device.

Client D is traveling a great distance to see the counselor for services. During the initial history-taking session, the counselor assesses him to be sufficiently stable and capable of handling an extended history. She asks him to write out as much of a narrative as he is comfortable writing about his history. Upon reading his presentation, the following statements are identified as trauma-fueled statements influencing his presenting maladaptive symptoms and become candidates for EMDR targeting sequences:

- "I have vague memories of feeling like I was under the microscope whenever I was with people."
- When his friends found out he was adopted (at around 6 years of age), they acted in total disbelief and shifted their attitude toward him: "I am guessing I may have felt at the time that something was wrong with [being adopted]."
- "I felt hugely ashamed and humiliated. I guess more important is that it added to my feelings that something was wrong with me. I no longer felt safe around other people or myself."
- "I seemed to become distant or withdrawn. I remember beginning to feel at all times like I didn't belong wherever I went."
- "Some of my fondest childhood memories come from spending time at the lake."
- "I got sober in August 2005, still wondering, as I had my whole life, who I was, where I had come from, and if I had blood family still living."
- At the prospect of meeting his biological half-sister, with whom he was just able to establish contact: "I fear that I'll disappoint her somehow."
- On his general reason for seeking services: "I still feel like a chronic malcontent who is often dissatisfied and rebellious."

In this initial session, the counselor begins gathering information about Client D's existing coping skills, most of which were gained from 12-step exposure. He mentions that he has begun exercising again, and she encourages him to continue. The two begin discussing a plan for how Client D could build more body-based coping skills (e.g., breathing) into his daily regimen. The counselor provides him with online resources that teach breathing and related skills, and he is willing to try these before the second session.

When Client D presents for his second session, he and the counselor review which breathing strategies worked best for him and discuss other visualizations that might work for distress tolerance. The counselor picks up on his statement in the history that some of his fondest childhood memories came from spending time at the lake, and they transition this into a safe place exercise with bilateral stimulation. Client D chooses to alter the place for the purpose of the exercise and use the serenity of a Caribbean beach and also chooses tactile bilateral stimulation (using a machine to create the tapping). They also "tap in" a positive experience the client had at a 12-step meeting the night before the session. Anything positive and adaptive can be frontloaded, pre-installed, or "tapped in" as an act of preparation.

Client D responds well to these preparation exercises, and by the third session he expresses readiness to commence processing. The counselor reads the negative self beliefs that were identified in his narrative and asks him to notice which one(s) seemed to most resonate in his body as distressing. For him, it is clearly the statement, "Something is wrong with me." The counselor sets up the targeting sequence using a combination of the traditional 11-step setup and the Parnell modified protocol. (Note: This counselor generally does not rely on numbers unless she feels it is useful for the process to ask.) Client D is able to give the following information at the start of the first reprocessing session:

- Negative cognition: Something is wrong with me.
- Positive/preferred cognition (client's goal): I can work through it.
- Floatback to earliest recollection of the negative cognition: The day when client's two friends made a big deal about him being adopted. The client was called a liar and accused of deceit.
- Worst part (not necessarily an image): Client D feels he was the last to know that adoption is something people do not want to talk about.
- Emotions: Anger (mostly at himself)
- Body: Hands go tense

Client D is instructed to hold all of these things together and to "just notice" his experience as the counselor turns on the machine to begin the bilateral stimulation. As a technical note, when bilateral stimulation is used to install positive material in phase two preparation, the speed is on the slower side. However, when a client is processing, the speed of the bilateral stimulation is generally faster, analogous to pressing down on the gas pedal to move the client through distress. The technical choices associated with speed are generally covered in standard EMDR trainings.

Within the first two to three sets of bilateral stimulation, Client D is able to very deeply connect with what is going on his body. For the client, a self-confessed intellectual who has the tendency to overanalyze, being able to just sit with body level experience and notice is huge. The bilateral stimulation is applied at one-minute intervals, and at the end of each set, the counselor checks in to see what Client D is noticing. Whatever he reports, the counselor advises him to "go with that" or "just notice that." The free association components of EMDR are a major part of the reprocessing experience, because clinicians do not ask the clients "What are you thinking?" or "What are you feeling?" The goal is not to analyze and interpret in a verbal sense. Rather, when something comes up, the client is encouraged to just notice, be curious, and explore, as the stimulation is applied. For Client D, many of his check-ins reveal experiences like, "There is a heaviness in my chest when I think about [the sound of his peers' laughter]." He just notices this feeling as the stimulation is applied, and after several sets, he begins spontaneously manifesting his own insights. Toward the end of the first reprocessing hour, he is able to make a connection with the positive cognition, "I'm okay. I'm content." At the end of the session, when the counselor checks in with him about the initial issue/belief, he reports a clear body scan. His initial goal statement/positive cognition of "I can work through it" is completely true, and he is able to name two other positive cognitions to claim as completely true: "I am a human being" and "I can trust myself." The session ends with installing both of these completely true positive cognitions together with the clear body scan.

In the second reprocessing session, Client D and the counselor check back in with the initial memory that was taken through the targeting sequence in the session prior to determine if anything else may have come up. Client D reports, "I now have the power to observe it—I was just a kid. I should forgive myself for putting myself through all of that." He says that in the session prior, he felt as though he was reliving it. This shift in perspective about the memory is a common experience after memories are processed with EMDR. In the spirit of the three-pronged protocol, the counselor and Client D commence the second reprocessing session by having him just notice how he presently views the memory. By going with the free association together with the application of bilateral stimulation, Client D spontaneously begins articulating new positive beliefs about himself that he is able to work with and come to as completely true statements: "I have the power," "I've got this," "I am safe," and "I don't have to protect myself anymore." Additionally, the two positive beliefs that he reported in the previous session held as completely true statements. In the final check-in during that second reprocessing session, the client reports a clear body scan and articulates

two new positive beliefs: "I am whole" and "I don't feel judged anymore." He states, "I'm anchored, attached to the present."

In the next session, after checking in with the positive beliefs to make sure that they hold as true statements, the counselor transitions into future template work. There is an option to take the other negative statements identified in the client's history and set those up as separate targeting sequences. However, when the counselor checks in with Client D about these statements, they no longer seem valid. In EMDR, it is common to have a generalization phenomenon, defined as the automatic resolution of other memories and issues of concern that occurs after reprocessing the memory that seems the most charged to the client. Thus, the two move into working on the future element of the three-pronged protocol after having successfully worked through the past and present.

For his future template, Client D states that he wants to work on issues of connectedness and problems connecting with others. Following some organic dialogue about the issue, he identifies the belief that he is somewhat confident that he can connect with others. The counselor asks him what is keeping him from complete confidence that he could connect, and he immediately identifies a message that he received in 12-step recovery: "Ego is bad." The counselor asks him to consider that notion and any body experiences as he holds it. After applying a few sets of bilateral stimulation, Client D recognizes that he is kinder and gentler—and that he could extend that to himself and others. He then makes a connection to a famous story in 12-step recovery about the "bright-light experience," and he relates feeling that he finally has something to give to others. Previously, his feeling like a fraud, both personally and professionally, stood in the way. In the next few sets of bilateral stimulation, he makes connections to his family and work life. He ends the session expressing: "I am more than a victim, a survivor, or a 'rescue.' I am whole." The client and counselor install this realization as a completely true positive belief.

The final two in-person sessions with Client D can be described as EMDR re-evaluation. The positive beliefs achieved in previous sessions hold as completely true statements with clear body scans. Natural conversation progresses into discussing what potential pitfalls that he might see in moving forward. Client D identifies, "I can find fault like there's a reward for it, at least that's been my pattern." He states that this tendency began around the time of the target memory, at 6 years of age. The counselor asks him to hold the present experience of that memory together with his insight about finding fault. After a couple sets of bilateral stimulation, he expresses: "That's my head talking, not my heart or my soul." In the next set: "That's a useless energy drain." The counselor decides, in testing the potency of the generalization effect, to inquire about one of the client's other negative beliefs identified at the time of history taking: "I am disconnected." She asks him how valid that belief seems in the moment, and he responds, "It was a delusion—I'm finding the connection within." The counselor instructs him to "go with that" for a few sets for bilateral stimulation, and he ultimately expresses, "I am home." When asked what, to him, the opposite of "I am disconnected" would be (i.e., his positive cognition), he states, "I have the capacity to be connected." He reports this is a completely true statement, and it is installed with bilateral stimulation and a clear body scan. Client D then holds this positive belief as he pictures future life scenarios, and no distress or concern registers.

Client D and the counselor follow up via phone call three weeks after the last session (as part of the re-evaluation process), and the client notes overall positive progress and maintenance of goals in the weeks since the final in-person session. He states he is no longer "obsessing" over how he feels and is "over" his fraud complex. He reports 20 pounds of weight loss in the weeks since his EMDR work and an increase in faith that everything in his life is going to be fine. A final phone call one month later confirms the maintenance of these gains.

Discussion

Client D's story is an example of EMDR therapy being used as a recovery enhancement measure. Although clinically not meeting the criteria for PTSD upon presentation, it is clear that trauma, especially attachment-related or developmental trauma, continued to cause symptoms of depression and overall disconnection with life, even after his substance use disorder was put into remission. Client D's journey may read like a textbook case of how EMDR can work very quickly, and in many ways, his case allows for that because he presented for treatment already reasonably stabilized; he had a job, nine years of sobriety, strong family support, and a willingness to work on himself. In essence, he was the model client for an EMDR clinician. The reality can be somewhat different, often treating clients who have not worked on themselves to the level Client D had. Additionally, clients generally described as survivors of complex trauma can also pose a challenge in conducting strict EMDR. Deborah Korn observed, "While EMDR and other trauma treatments have been proven efficacious in the treatment of simpler cases of PTSD, the effectiveness of treatments for more complex cases has been less widely studied" [30].

The more complicated the client, the more contingencies should be planned for in the delivery of EMDR. Many Face 2 EMDR practitioners believe that enhanced flexibility allows counselors to be better able to work with these subjectively more complicated clients. In addition, more complicated clients generally require a longer period in phase two preparation, especially if they are coming to treatment with little to no skills for regulating distress.

Case 2: Client J

Client J, a lower-income white woman who is 39 years of age, has been in and out of community mental health facilities for the better part of her adult life. She suffers from both bipolar disorder and PTSD, resulting from a series of abuses at the hands of her alcoholic parents and sexual assaults in late adolescence. Although Client J has never been diagnosed with a substance use disorder, she reports periods of substance abuse throughout her adult life to cope with stress, usually when she is not compliant with her medications for the bipolar disorder. She struggles significantly with medication compliance. Although her bipolar symptoms are regulated when she is medicated, she often complains about the side effects and the cost of the medications.

Her counselor does not initially consider EMDR, because Client J seems so unstable. The client is adamant that if she is just prescribed the right medication, all of her problems will go away. During the first two months of treatment, the counselor carefully meets her where she is and does not use overt confrontation, even about behaviors that are clearly detrimental to her mental health progress (e.g., choosing certain friends, attempting to reason with her equally troubled ex-husband). As a result, a solid alliance forms. Through some trial and error, Client J's psychiatrist is able to find a medication that works well in keeping the bipolar symptoms reasonably stabilized, and the level of the client's day-to-day lability significantly decreases.

During the first few months, the counselor works with Client J on coping skills, including guided imagery and deep breathing. She responds well to these two exercises, so the counselor suggests that they try adding some tactile bilateral stimulation, explaining that the tapping may help further enhance her relaxation. The two work on a lightstream guided imagery technique, together with some tactile stimulation, and Client J reports that she feels more relaxed than ever before. During the next session, the counselor teaches Client J a guided imagery safe place exercise using bilateral stimulation, and she reports that she likes this exercise as well. For the next one to two months, they focus on these trauma-informed coping exercises. Because Client J does not have much good going on in her life, aside from receiving subsidized housing and having a solid relationship with her case manager, building resources becomes incredibly important.

After observing how well Client J responds to the preparation exercises, the counselor explains that stimulation could be used in a different way to help process some of her traumatic memories, and the client is willing to try this approach. The first several sessions of trauma processing with EMDR are all over the place, and the counselor uses a significant amount of interweave, or open-ended questions/statements typically used to assist complex clients work through blocks within the EMDR processing. However, after these first several sessions, Client J is able to quickly process a series of traumatic memories that are both recent (e.g., an accident) and deep-seated (e.g., past abuse). EMDR is used off and on over a nine-month period. (Breaks in formal EMDR bilateral reprocessing occur because, during some sessions, Client J states a need to just talk, which could be viewed as part of re-evaluation.) Significant improvements in Client J's overall self-image and decision-making begin. In the counselor's last contact with Client J by phone, she reports that she is remaining on her bipolar medications and realizes that she will probably need to do so for the rest of her life. However, her mood swings are no longer as violent and her life-style choices have improved because much of the underlying traumatic material has been processed.

Discussion

If the counselor had rushed into reprocessing past traumas with EMDR, more harm would have resulted. It was important to introduce coping skills/preparation slowly and carefully, then add the bilateral stimulation, and then proceed with trauma processing. If one prepares for the journey, the journey will be smoother—a major lesson in helping people processing their traumatic memories with EMDR.

STABILIZATION, ASSESSMENT, AND SELF-HELP USING EMDR

STABILIZATION, PREPARATION, AND THE "TAPPING IN" APPROACH

Phase two EMDR preparation corresponds with the general stage of stabilization in the three-stage framework for trauma processing originally published by Janet [31]. The three-stage consensus framework is often considered a best practice for trauma-informed care, and regardless of which therapeutic modality one practices or primarily uses in clinical practice, it is vital to stabilize or prepare clients at the affective level before taking them deeper into their processing work. Even therapists who do not practice EMDR can learn the basic bilateral "tapping" approach for affect regulation or for installing any other positive resource or coping method with which a client resonates. These skills should be practiced on oneself before attempting to teach them to a client.

Monkey Tap/Butterfly Hug

In nature, primates cross their arms over their chest and tap their shoulders in an alternating pattern to self-soothe. This natural phenomenon of bilateral stimulation may be duplicated to practice self-soothing. EMDR therapists refer to this exercise as Butterfly Hug or Monkey Tap. It is taught with the following steps:

- Cross your arms over your chest.
- Begin tapping your hands against your body in a slow, deliberate, alternating fashion. Use the same slow pace as the walking meditation; tapping quickly can induce anxiety.
- Tap for about one minute and then return your hands to your lap or the table and just breathe for a few moments. Repeat as many sets as needed for relaxation.

- Be mindful that the appropriate speed of tapping varies from person to person. If the tapping ever seems to induce anxiety, it generally means that you are tapping too fast. What is slow to one person might be fast to someone else. So, honor individual variation.
- You do not have to cross the arms over your chest to benefit from tapping; some people find this intrusive. Alternately, you can tap your feet from side-to-side or tap your hands against the arms of a chair or on the tops of your knees.

When a person finds a speed and style of tapping that works the best for him or her, this general tapping principle can be used to "tap in" or "install" positive associations. This can be a positive memory, a positive belief statement, elements of a guided visualization exercise, or the presence of a sacred person or guide. Another sensory stimulus that is positive to the client, such as a pleasurable scent, a song with a positive connotation, or a tactile sensation (e.g., a hot bath, a warm blanket), may be introduced.

CONDUCTING A TRAUMA HISTORY/ASSESSMENT INFORMED BY THE AIP MODEL

Many people learn EMDR but do not use the therapy to its fullest capacity, either because of their own lack of confidence or need to practice more or because the clientele they serve is not ready for much work past phase two preparation. However, even if counselors/therapists do not use full-scale EMDR for trauma reprocessing, having EMDR training inevitably influences the way that they ask questions. Refer back to the tenets of the AIP model presented in an earlier section of this course and consider how this model could improve one's approach to history taking and assessment.

Asking a person to identify the beliefs about self that have been acquired throughout life is a powerful gateway through which to assess for trauma, or in AIP terms, to ascertain negative cognitions and their origins. Having a patient rehash the whole trauma narrative is generally counterproductive and can potentially cause more harm than good. Instead, ask the client to identify two or three significantly negative, driving beliefs about the self that seem to be causing problems. Tracing the origins of these beliefs will likely provide most, if not all, of the information needed to begin working with the client in a trauma-sensitive manner in whatever modality is selected.

Some individuals come into professional services with a clear sense of their blocking negative beliefs; "I'm not good enough," "I'm to blame," or "The world is out to get me" are very common. People may have a sense of some but may not recognize others.

As an assessment strategy, begin by having a client identify core driving beliefs. A general list of negative schema or self-defeating beliefs may be used as a guide. After identifying the core negative beliefs, consider asking any one of the following questions (based on clinical judgment) to trace the origin of that belief:

- When was the first time you ever remember getting that message about yourself?
- When was the worst time you ever remember getting that message about yourself?
- When was the most recent time that you received that message about yourself?
- What role did your loss play in giving you this message?
- Does this message predate the loss in any way?

Using a negative cognitions list and asking these questions will often provide the necessary information about any traumas, whether or not they are PTSD level, and the contexts surrounding them. Clients' answers may be used to initiate a dialogue, if appropriate. Deciding when to use this strategy is up to clinical discretion. If a client is sufficiently stable and a strong rapport has been built in an initial session, the exercise may be done at that time. Other times, it may be best to wait until the second to fourth session to ensure the client has obtained at least some basic affect regulation skills and will be able to handle the intensity that doing such an exercise might elicit.

Using such an assessment strategy will help identify the key themes and, in discovering the themes, more fully appreciate the context. This type of strategy may simply be a guide for communication with the client. The information obtained here can be used to devise the best possible treatment plan, help select strategies and approaches, and when the time comes for deeper work, help identify the key issues for processing.

Part of a trauma-informed assessment is learning about the client's sense of future orientation. A potentially damaging assumption professionals make is that every client wants a better future. In some cases, the client may not be coming into treatment for himself or herself; a friend, a family member, the legal system, or an employer may want the client to seek help. External motivation does not necessarily mean that treatment will not work, but it is a variable that should be taken into consideration in treatment planning. Perhaps most significantly, trauma can leave a person with a disintegrated sense of a future. If a person is operating with negative beliefs of hopelessness (e.g., "I will never amount to anything"), these cognitions will likely need to be addressed before that client can consider future goals. Minimal or no future orientation does not mean that treatment will be ineffective, but it must be addressed as part of the treatment before a person can conceptualize future planning.

FURTHER TRAINING AND COLLABORATION

IS EMDR TRAINING RIGHT FOR MY CLINICAL PRACTICE?

Shapiro's initial intention was for people to read an article about the EMD/EMDR protocol and implement it into their existing therapy, and anyone can pick up a book and learn the process, like many early leaders did. Indeed, many people continue to learn EMDR this way. However, supervised practice and/or engaging in EMDR therapy (as a client) is generally necessary to crystallize the learning. Advanced training is also a great safeguard if one's competency is ever called into question (e.g., in a liability issue or board complaint).

There are official basic training programs endorsed by EMDRIA and those that are not. For a list of complete EMDRIA-approved training providers, visit http://www.emdria.org. The official guidelines for an EMDRIA-approved basic training are a minimum six full days of training (usually split into two parts or over the course of a semester), plus 10 hours of consultation following the training. The price can range from $1,200 to $5,000. Some organizations, like the EMDR Humanitarian Assistance Programs, offer lower cost, full-scale trainings, although employment with a publicly funded agency is generally necessary in order to access the trainings. More information about these trainings and eligibility is available at http://www.emdrhap.org.

Completing a basic training does not confer the title of Certified EMDR Therapist in the eyes of EMDRIA; only the descriptor of "trained in EMDR" may be used. Clinicians can practice with partial training (i.e., completed the first part of a full training program), although the full basic training is recommended. In order to obtain EMDR's official credential, an additional 12 hours of continuing education training, 20 hours of additional consultation with an EMDRIA-approved consultant, and documentation of practicing EMDR with a certain amount of clients are required. To be clear,

EMDRIA certification is not mandatory to be able to practice EMDR. Some insurance companies may require official certification to list a provider on their panels as specializing in EMDR, but this is the only possible financial benefit (other than the marketing of using the credential).

In response to the intensity of EMDRIA-approved channels and the financial impediments that keep many people from seeking trainings, many individuals and organizations began offering modified trainings. Some even ventured into offering certifications alternate to the EMDRIA certification. Most of these programs teach the basic fundamentals of the EMDR protocol but cannot lead to EMDRIA-approved certification. These non-EMDRIA-sanctioned trainings have been the source of much controversy, but ultimately, EMDR is not a trademarked therapy and alternate training options are allowed, though without a road to official certification.

It is imperative, particularly if investing in the full training, to have clients with which to practice the therapy, or the skills gained in training may be lost. It is also important to be sure that one's employer allows EMDR therapy and that the clients in one's practice are candidates for the full process. Working in a community agency with complicated clients does not rule out being able to master and use EMDR, yet this is generally best done if ongoing consultation and support are available.

COLLABORATING WITH EMDR PROVIDERS

When clients are referred to an EMDR provider, the first step will be classic phase one history-taking: an evaluation about the presenting problem, assessment of how unresolved trauma/adverse life experiences may be complicating that problem, and determination of the client's appropriateness for EMDR. A significant proportion of referred clients will not be candidates for EMDR, typically because of overmedication with central nervous system depressants (particularly benzodiazepines, generally a strong inhibitor of trauma processing work) and/or poor motivations for wanting to do the EMDR work.

Preliminary evidence suggests that an EMDR clinician can successfully do EMDR with another therapist's client or as part of a treatment team that includes several clinicians [32; 33]. A strong rapport with a primary therapist may translate to greater trust in the EMDR clinician. It is good practice, when working together, to obtain a release of information so collaborative contact can occur. In cases of long-term therapy, some time may be spent in the EMDR history-taking session exploring the primary therapeutic relationship. Positive statements about collaboration can create an effective bridge of trust and rapport from the original therapist to the EMDR practitioner.

CONCLUSION

EMDR is a modern psychotherapy that draws on many time-honored approaches to healing. The way that founder Francine Shapiro integrated many of these methods into a singular approach to psychotherapy has been a significant innovation in the helping professions. There is a great deal of interest in EMDR, yet much misunderstanding about the therapy still abounds. This course has been designed to allow professionals to have a general knowledge of EMDR and to make decisions about what role the therapy can play in their clients' lives. Some people who take this course may go on to get trained, and others may be open to using collaborative referrals with EMDR providers in their clinical work.

GLOSSARY

Adaptive information processing (AIP) model: A model constructed by EMDR founder Francine Shapiro to provide a framework for explaining how unhealed trauma affects human behavior and how reprocessing can assist in moving unprocessed material to more adaptive states. Strong roots in behaviorist theory and older models of this nature.

Assessment: Phase three in Shapiro's eight-phase EMDR protocol. Involves determining where to target the EMDR processing and setting up that target. In EMDR training, clinicians learn a series of questions that compose a targeting sequence.

Bilateral stimulation: Any back-and-forth movement across the center plane of the body. In EMDR, common uses of bilateral stimulation include alternating horizontal or diagonal eye movements, audio tones, or tapping.

Body scan: Phase six in Shapiro's original eight-phase protocol. Consists of checking in with any shifts that have occurred in the client's body as a result of the desensitization and installation. If the body scan is relatively clear, one moves on to phase seven. If some distress or disturbance remains at a body level, more desensitization is applied, suggesting that the memory or issue did not process deeply enough. Continue until body scan is relatively clear.

Brainspotting: An approach to processing traumatic memories developed through experimenting with standard EMDR, credited to David Grand.

Client history: Phase one in Shapiro's eight-phase EMDR protocol. Similar to the intake/assessment procedure that is used in all forms of psychotherapy. In this phase, the clinician takes a basic client history, a relationship begins to be established, and the clinician ultimately determines if EMDR treatment is appropriate for the client.

Closure: Phase seven in Shapiro's eight-phase EMDR protocol. These are the procedures that a client and clinician implement to bring a session to a place where the client feels calm enough, especially at the affective/somatic level, to leave a session.

Desensitization: Phase four in Shapiro's eight-phase EMDR protocol. The application of bilateral stimulation sets after setting up the targeting sequence, designed to shift the traumatically stored material into more adaptive states. The time that one spends in desensitization (i.e., the number and length of bilateral stimulation sets) varies from client to client.

Developmental needs meeting strategy (DNMS): An approach to reprocessing traumatic memories and psychotherapy developed by Shirley Jean Schmidt, who originally began her work within EMDR.

Eye movement desensitization (EMD): The forerunner to what is now referred to as EMDR.

Eye movement desensitization and reprocessing (EMDR): Defined by creator Francine Shapiro as a distinct approach to psychotherapy. The therapy offers unprocessed, physiologically stored memories as the etiology of problems in functioning, and the treatment involves accessing and processing of memories, triggers, and future templates. The treatment involves standardized procedures that include focusing simultaneously on spontaneous associations of traumatic images, thoughts, emotions, and bodily sensations and bilateral stimulation, most commonly in the form of repeated eye movements. Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen adaptive beliefs related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve detailed descriptions of the event, direct challenging of beliefs, extended exposure, or homework.

EMDR International Association (EMDRIA): An organization that exists separately from Shapiro's EMDR Institute. Formed in 1995, EMDRIA works closely with Shapiro and is the official overseer of standards and training in EMDR therapy.

Generalization: A phenomenon that occurs when reprocessing the memory that seems the most charged to the client results in the other memories and issues of concern automatically resolving themselves due to their intricate connection to that charged memory.

Induced after-death communication: An approach to psychotherapy developed by Alan Botkin, originally an EMDR therapist. A system in which clients report being able to conduct unfinished conversations/business with their deceased love ones. Many see this as a "mystical" offshoot of traditional EMDR.

Installation: Phase five in Shapiro's eight-phase EMDR protocol. Following successful processing of the targeted memory or issue, working with the positive belief states or other positive shifts that to which a person's desensitization has allowed. The same bilateral stimulation process is used to install, or promote integration of, these more positive states.

Preparation: Phase two in Shapiro's eight-phase EMDR protocol. Continued development of the therapeutic alliance and integration of exercises designed for client stabilization. These can include, but are not limited too, guided visualizations. Generally, the more complex the client, the more preparation will be needed. The essential goal of this phase is to ready the client for deeper work on the traumatic memories/issues.

Progressive counting: An approach to psychotherapy/reprocessing traumatic memories within a phase-model of trauma treatment.

Re-evaluation: Phase eight in Shapiro's eight-phase EMDR protocol. Continuing to monitor client progress after a successful processing through of a targeting sequence. This can also include target future templates or scenarios connected to the work done in previous phases. Re-evaluation, in theory, can continue indefinitely.

Three-pronged protocol: A concept positing that EMDR therapy is designed to clear out past disturbance so as to improve present and future functioning.

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National Collaborating Centre for Mental Health. *Common Mental Health Disorders: Identification and Pathways to Care*. London: National Institute for Health and Clinical Excellence; 2011. Summary retrieved from National Guideline Clearinghouse at http://www.guideline.gov/content.aspx?id=34828. Last accessed May 16, 2016.