Demanualizing EMDR thanks to standard variations

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Demanualizing EMDR

Thanks to standard variations

- Specialised and scripted protocols for special situations, disorders, and populations
  - Types
  - The original protocols
  - Discussion of their rationale and usefulness
  - Discussion of potential pitfalls
- Standard variations

Specialised and scripted protocols

Supporting the increasing application and recognition of EMDR

- Each year, a considerable number of publications support the application and effectiveness of EMDR therapy in the treatment of an ever-growing number of disorders, considering the specific features of diverse situations and populations
- Many authors announce the creation of a NEW protocol
- Each new protocol introduces specific “tweaks” to the standard protocol and procedures

Specialised and scripted protocols

Types of protocols

- Stabilisation and emotional regulation
- Recent events/early intervention
- Developmental (early/preverbal memories, children, adolescents, intellectual disabilities)
- Somatic (illness, pain)
- Diagnosis (phobia, addiction, OCD, depression)
- Population (first responders, military, minors)
- Complexity (complex trauma/DESNOS and dissociative disorders, comorbidity)
- Positive psychology
- Integrated (head compressions, exposure, ego state)

EMDR Basic Principles, Protocols, and Procedures

Describes a number of protocols and procedures for special situations

- Protocols for:
  - Single event
  - Current anxiety and behaviour
  - Recent traumatic events
  - Phobias
  - Excessive grief
  - Illness and somatic disorders

EMDR Basic Principles, Protocols, and Procedures

Describes a number of protocols and procedures for special situations

- Types of changes:
  - Extra preparation & continuous Phase 2 work
  - Target selection/sequencing
  - Past events (ancillary, 1st, worst, recent), present stimuli (intrusions, nightmares, triggers, physical manifestations), fears of the future and positive template
  - Fragments of unconsolidated memory
  - Update target sequencing plan during treatment
  - Video technique
  - Integrative approach

EMDR Basic Principles, Protocols, and Procedures

Describes a number of protocols and procedures for special situations

- EMDR therapy and the AIP model challenge conventional diagnostic wisdom
- Case conceptualisation is not based on current symptoms or diagnosis, but rather on the underlying unprocessed experiences in the form of dysfunctionally stored memory networks

EMDR Basic Principles, Protocols, and Procedures
Describes a number of protocols and procedures for special situations

- Was Francine telling us that the standard protocol cannot/shouldn't always be applied?
  - "The standard EMDR procedure is applied to various clinical problems by means of a number of specific protocols [...] Any of these protocols and procedures may be applicable to an individual client (e.g., a trauma survivor may need treatment that combines the protocols for specific traumas, phobias, and illness, a treatment that is positioned appropriately within the standard three-stage protocol." (Shapiro, 2001, p. 221)

EMDR Basic Principles, Protocols, and Procedures

Describes a number of protocols and procedures for special situations

- Specific protocols are a means of applying the standard 11-step EMDR procedure within the standard three-stage protocol

Specialised and scripted protocols

- As a professional community, we're claiming that EMDR therapy enables the treatment of any current symptomatology that can be traced back to dysfunctionally stored memory networks
- And yet we feel the need to create specific protocols for specific diagnoses, situations, and populations, which seems to go against the founding principles of the AIP model

Specialised and scripted protocols

- In basic training, we are taught to adhere strictly to the standard protocol and procedures (and this is important for learning and for research purposes)
- And yet new protocols come about because a therapist has “strayed” from the standard script
- Once it’s been published, we are taught to follow this new script as scrupulously as possible

Specialised and scripted protocols

- Which parts of EMDR are essential?
- The only individual component of standard procedures that has been specifically and repeatedly assessed by research is the dual attention stimulus (eye movements, tapping, or sounds)
- We have little or no research pertaining to the specific contribution of EMDR's other components

Specialised and scripted protocols

- Ideas for research
  - Comparisons of with vs. without PC, with or without VOC
  - "Focus on the image of … the negative words … and the *feelings in your body*" vs. "and the *emotions and where you feel them in your body*"
  - With or without Phase 5 Installation, Phase 6 Body Scan or Phase 8 Reevaluation
  - Self-referenced cognitions vs. state-of-the world cognitions ("humans are evil", "life is meaningless", "happiness comes at a price", "no one can be trusted", "women are stupid")

Specialised and scripted protocols

- Ideas for research
  - “Stay with that” vs. “go with that”
  - Different speeds of tapping
  - Using a single or two simultaneous forms of dual attention stimulation
  - 2 versions of the VOC: “from 1 completely false to 7 completely true” vs. “from 1 ‘I’m weak’ to 7 ‘I’m strong” (R Adler-Tapia & C Settle)
  - In Phase 4, frequently asking “and where do you feel that in your body” vs. never asking

Specialised and scripted protocols

- What we do have is a large and diverse number of beliefs (EMDR legends) that may one day be disproved by research
  - Tapping should be done as quickly as possible (“saccadic” instead of “poursuit”?)
  - Processing is smoother when the VOC in Phase 3 is >1 (“I can learn to defend myself”, “I’m strong enough”)
  - Cognitions need to be exact opposites (“I can’t learn to defend myself”, “I’m not strong enough”)
  - Therapeutic relationship is irrelevant, you could change therapists every 2 minutes without affecting the outcome
  - A visual image is the most powerful (“picture yourself on the phone” vs. “hear your mother’s tone of voice and her words”)

Specialised and scripted protocols

- Frequent questions (list-serves, consultees)
  - “This is the first time I have a client with this disorder. Can EMDR be used? Is there a protocol for this?”
- Following a scripted protocol should not substitute for obtaining proper knowledge, training, and consultation
- Most professional guidelines indicate that therapists should work within their limits of competence, knowledge, and experience

Specialised and scripted protocols

- Each new protocol introduces a form of creativity and may help us further understand how EMDR works
- Complexity (confusion?) is added when different authors each publish their own protocol for the same population/disorder/situation
  - Addiction
  - Phobias
  - OCD
  - Panic attacks
  - Recent events

Demanualizing EMDR thanks to standard variations

We already have strategies for

- Blocked processing
- Containment
- Increasing or decreasing the speed of processing

Existing strategies

- Altering type, speed, direction of DAS
- Focusing on body sensation (unspoken words, using movement, pressing location…)
- Scanning (scan incident for sthg more upsetting now – visual/sounds/dialogue)
- Alterations (change image, visualise the perpetrator not his actions, change time/distance, add positive statement; redirect to image/NC, check PC)
- Floatback or affect bridge to feeder memory
- Interweaves

Existing strategies

- Strategies that elicit phenomena that arise spontaneously during processing for many clients

Examples of changes to Phase 1
Target selection and representation

- Drawing the target (E Carvalho)
  - Draw a picture of a negative belief or self-perception
- Triggers or memories of urge to use (AJ Popky)
- Triggers or memories of urge to avoid, maladaptive positive affect, defenses (J Knipe)
- Addiction memory (M Hase)
  - Another type of dysfunctionally stored memories (cravings, drug consumption, relapse)

Examples of changes to Phase 1
Target selection and representation

- Positive affect tolerance and integration (A Leeds)
  - Feeling-state as a discrete behavioural state of shared positive emotion
- Feeling-state addiction protocol (R Miller)
  - Feeling-state as a fixed linkage between an event and a feeling

Standard variations

Target selection and representation

- A target may be any manifestation or representation of maladaptive or dysfunctionally stored information
  - Etiological, auxiliary, antecedent, aggravating, or contributive events
  - Identified through a common negative cognition, a pattern, 1st-worst-recent reasoning (timeline), and other hypotheses

Standard variations

Target selection and representation

- Any manifestation or representation of maladaptive/dysfunctionally stored information, incl. explicit and implicit memories
  - Episodic/ autobiographical memories
    - RE: traumatic memories—traditionally, what we call traumatic memories are often actually the autobiographical memories associated with the traumatic memory, which is implicit, state-specific & “felt as now/past is present”)
  - Implicit memories (traumatic & procedural): flashbacks, triggered states, urges, feeling-states, habitual responses, felt senses

Standard variations

Target selection and representation

- Any manifestation or representation of maladaptive/dysfunctionally stored information
  - Sensory representation (visual, auditory, olfactory, gustatory, sensorimotor, pictorial, or symbolic)
  - Single (consolidated) or multiple (target fragments)

Examples of changes to Phase 1

Treatment planning and target sequencing

- Chronological (timeline)
  - Past–present–future or 1st–worst–recent
  - Childhood before early childhood
  - Recent past before earlier memories
- Reverse chronological (A Hofmann, AJ Popky)
  - Future fears or goals–present triggers–past
  - Flashforward (R Logie & A de Jongh)
- Google-search/scanning (E Shapiro & B Laub)

Standard variations

Treatment planning and target sequencing

- The consensus seems to be to follow chronological order… unless you shouldn't!
- Many types of rationale: clinical judgment
- My suggestion: work organically
  - Select a theme or pattern
  - Select a target that will enable the client to make progress without upsetting their daily functioning or inner system too much
  - Select targets that clients can remember/elicit and hold in their awareness

Standard variations

Treatment planning and target sequencing

- Organicity (G Bateson, R Kurtz, P Ogden)
  - Describes a living system's inner wisdom and its inherent capacity to grow and to change while maintaining integrity in the face of challenge
  - Living systems may be helped but not repaired; only the individual can heal
  - Symptoms, limiting beliefs, behavioural tendencies arise organically in an attempt to adapt to the individual's environment, to protect the person's integrity or safety

Standard variations

Principles of organicity

- Encourage self-awareness in the present moment
- Foster collaboration and decision-making by offering a menu of choices
- Pace the process to attune with the client's present state
- Slow down time rather than trying to “make it happen”

Standard variations

Organic target sequencing

- An organic target sequencing plan focuses on underlying themes, core beliefs, patterns, without attempting to obtain a comprehensive list of explicit memories
- The aim is to target that which is accessible and tolerable
- Help client to study emotions, sensations, beliefs, thoughts, impulses to move, and images associated with an identified theme or pattern, and to be able to identify and elicit this state

Standard variations

Organic target sequencing

- At the beginning of a session, elicit the state associated with the targeted theme and see where it leads: whatever comes up is your target
  - “Remember that familiar feeling you get when your partner criticizes you for something, and your shoulders come forward, your facial muscles tighten, and you chest collapses slightly, and you get this sense of never getting anything right, never being good enough?”

Examples of changes to Phase 3
Reduced assessments

- Blind-to-therapist (D Blore et al.)
  - No cognitions in Phase 3; keyword – not image
  - Reassertion of control among “executive decision makers”
  - Shame/embarrassment
  - Minimising risk of vicarious traumatisation
  - Cultural issues: avoiding distress being witnessed by a fellow countryman (translator)
  - Prevention of information “leakage”
  - Client with severe stammer

Examples of changes to Phase 3
Reduced assessments

- OCD: Adapted phobia protocol (J Marr)
  - No cognitions in Phase 3
  - Rationale: all triggers, fears, and memories are treated as one complex multiple event, with each aspect representing a part of the whole; that whole target is desensitised before moving to cognitive installation
  - The cognitive work is left to the end because of the potential for the obsessive thoughts to disrupt the emotional and somatic processing

Examples of changes to Phase 3
Reduced assessments

- Pain protocols (M Grant ; C de Roos & S Veenstra)
  - Target is described in terms of size, shape, colour, temperature, texture…

Examples of changes to Phase 3
Reduced assessments

- Reduced protocol for children and adolescents (J Morris-Smith & M Silvestre)
  - The number of assessment components that are used depends on the child's age and developmental level
- Early trauma protocol (K O'Shea & S Paulsen)
  - Preconscious memories: no assessment (components are held implicitly)

Examples of changes to Phase 3
Reduced assessments

- Emergencies & recent events
  - ERP (G Quinn): NC, PC, emotion, and SUD are implicit
  - R-TEP (E Shapiro & B Laub): as much as possible
  - EMDR-PRECI (I Jarero & L Artigas): no PC for fragments
- Group protocols
  - EMDR-IGTP (I Jarero & L Artigas): (NC/emotion), SUD
  - G-TEP (E Shapiro): (PC from menu), SUD
- EMDR-On-the-Spot method for dementia (T Amano & M Toichi): assessment is implicit

Examples of changes to Phase 3
Alternatives to the SUD

- SUP: subjective level of pain (C de Roos & S Veenstra)
- LOU: level of urge to use (AJ Popky)
- LOUA: level of urge to avoid (J Knipe)
- LOPA: level of positive affect (J Knipe)

Standard variations
SUD redefined

- Level or intensity
- Of maladaptive affect, feeling, or sensation

Assessment

Components found in almost all protocols

- Sensory or pictorial image; realistic, imaginary, or symbolic representation of the target
- Level of disturbance (or other maladaptive affect, feeling, or sensation)
- Physical sensations

Standard variations

A good assessment depends on an essential part of Phase 2 work!

- The ease of Phase 3 depends on the quality of Phase 2 preparation
- The clients learns to identify the pattern of emotions, sensations, impulses to fight/flee/freeze/collapse, thoughts, beliefs, and images that are associated with a core theme, pattern, or negative belief
- The client often becomes skilled at putting words to that familiar state, which facilitates finding cognitions

Standard variations

Components of Phase 3 assessment

- For clients who tend to overthink, it might be preferable not to ask for cognitions in Phase 3
- However, these cognitions are also held implicitly in the body-and-mind-state
- The client's posture, muscular tension, prosody, breathing, expression are all telling the story of "I'm bad", "I'm not safe", "I'm helpless", "I must be perfect"
- Increasing somatic awareness gives access to the implicit or "bodily held"

Standard variations

Components of Phase 3 assessment

- Representation or image
- Negative cognition if possible (may be implicit)
- Positive cognition if possible
- VOC (if needed to verify cognitions)
- Emotion (may be implicit)
- Level of maladaptive affect, feeling, or sensation
- Body sensations

Standard variations

Components of Phase 3 assessment

- Representation or image
- And as many dimensions as possible that convey, express, or elicit the associated maladaptive/dysfunctionally stored information
- = As many dimensions as possible that are related to the state-specific processing of that memory network

Examples of changes to Phase 4

- Ideas such as focused (telescopic) processing and G-Search (E Shapiro & B Laub) or rerunning the video (J Marr)
  - Some clients spontaneously show EMD or EMDr type processing, not making any or many associative links

Standard variations

Back to target

- The meaning of going back to target will depend on the nature of the target (specific event, implicit or procedural memory, period of time)
- Additionally, in the absence of spontaneous opening of associative channels or generalisation, going back to target may require some modifications

Standard variations

Back to target

- Zoom in or out (in space or time)
  - Watch the video
  - What happened next?
  - Scan that period of time in your life
  - Can you think of another time?
  - Go back to just before it started
  - Watch it from above, like from a plane on a slow descent, looking down at the landscape… what stands out now?
  - Imagine flipping through the pages of a book… what's on the 1st page you stop to look at?

Standard variations

Back to target

- Explore other sensory or somatic modalities
  - E.g., a victim of sexual assault may only access visual and possibly tactile/somatic associations. Ask for any smells or sounds.
- The options facilitate the processing of multiple targets within one (target fragments) and the generalisation of effects

Standard variations

Techniques for maintaining dual attention in phase 4

- Adding to techniques such as the Back-of-the-head-scale and CIPOS (J Knipe) or the picture-in-the-picture (J Twombly), in cases of over-accessing or overwhelm,
- “Drop the content”: inviting the client to focus exclusively on the sensation as a mere sensation (dropping the thoughts and emotions) (P Ogden)

Examples of changes to Phase 5

The positive cognition

- Most authors who omit the PC or both cognitions in Phase 3 will elicit and install a PC in Phase 5
- For recent or unconsolidated events, a global or general PC is often installed once the fragments have been processed & integrated
- Some protocols (e.g., pain) recommend using a PC as a resource, coping, or antidote statement

Standard variations

Conclusion

- Options enabling the therapist to consider the client's system's inherent AIP organisation
  - When selecting targets (a precise moment, a period of time, or a fragmented whole)
  - When determining the targeting sequence
  - When selecting the components of assessment & the type of maladaptive affect, feeling, or sensation
  - When addressing over- and under-accessing or lack of generalisation
  - When considering the purpose of the positive cognition

Standard variations
Summary

- Target selection and treatment planning

  A target may be any manifestation of maladaptive or dysfunctionally stored information

  - Events
  - Explicit and implicit memories: episodic/ autobiographical, traumatic, procedural
  - Sensory, pictorial, or symbolic representation
  - Single (consolidated) or multiple (target fragments)

- Chronological or organic target sequencing

Standard variations

Summary

- Preparation
  - Teach client to identify the pattern of emotions, sensations, impulses to move, thoughts, beliefs, and images that are associated with a core theme, pattern, or negative belief
  - Increase somatic awareness to gain access to the implicit or “bodily held”

Standard variations
Summary

- Assessment
  - Sensory, pictorial, or symbolic representation
  - Negative cognition if possible (may be implicit)
  - Positive cognition if possible
  - VOC (if needed to verify cognitions)
  - Emotion (may be implicit)
  - Level/intensity: maladaptive affect, feeling, sensation
  - Body sensations
- As much as possible to access the targeted memory network's state-specific processing

Standard variations

Summary

- Back to target
  - Zoom in or out (in space or time)
  - Explore other sensory or somatic modalities
- Techniques for maintaining dual attention
- Installation: global, resource, antidote, or coping positive cognition

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