

Getting Started with EMDR

Guidelines for clinicians in selecting clients for initial application of EMDR reprocessing during and immediately following basic training in EMDR

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Abstract

This article addresses questions raised by clinicians in training or recently trained in EMDR regarding case finding and selection criteria for their initial applications of EMDR. Guidelines are offered for number of sessions of practice during training, for identifying and deferring more complex cases until more experience is gained, and for recognizing clients where reprocessing of disturbing memories should be postponed in favor of client stabilization. Three classes of clients and targets, with descriptive case examples, are proposed for initial application of EMDR during the training process. Clinicians are encouraged to thoroughly read Shapiro's (2001) required text and other recently published books and journal articles and to actively participate in consultation with an EMDRIA Approved Consultant.

Getting started

... if we wait for the moment when everything, absolutely everything is ready, we shall never begin.

—Ivan Turgenev

These guidelines for getting started with using EMDR in clinical practice are offered in response to questions raised by clinicians currently in training or recently trained in EMDR. Because of the wide variation in clinical background, theoretical orientation, length of experience, learning style and clinical setting of those who attend EMDR training, different aspects of these guidelines may be useful for different clinicians.

The standard EMDR protocol focuses on the resolution of specific, stressful life events. These disturbing memories may involve traumatic experiences – that meet DSM-IV-TR Criterion A for Posttraumatic Stress Disorder – or they may involve other kinds of adverse life experiences. EMDRIA basic training standards do not currently require a specific number of reprocessing sessions during the basic training process. However, clinicians in EMDRIA approved basic trainings are required to participate in at least 10 hours of consultation based on *actual clinical practice*. A reasonable guideline is to use EMDR during the course of basic training in EMDR in 15–25 reprocessing sessions focused on cases with

milder clinical presentations. As clinicians gain experience and confidence with the standard EMDR procedural steps and an understanding of the range of client responses to EMDR reprocessing, they can extend the range of cases in which they offer EMDR reprocessing.

There are numerous dilemmas and potential pitfalls for clinicians getting started with using EMDR. This article will not attempt to address all of these issues, but will focus on basic client selection issues that may help clinicians achieve better initial treatment outcomes and to prepare themselves to make each phase of their EMDR training a more useful learning experience.

Early phases of basic training in EMDR provide an initial platform for clinical application of EMDR. The aim in the initial sessions of offering EMDR reprocessing is for clinicians to provide effective EMDR sessions to clients while gaining more confidence with the procedural steps and learning to easily recognize typical treatment effects as well as indications of ineffective responses. Based on these experiences, you will be able to benefit from learning advanced treatment strategies for more challenging treatment situations, which are covered in the later phases of basic training in EMDR and which are described in standard reference texts.

Expect some incomplete treatment sessions when initially applying the standard EMDR reprocessing procedural steps

Feedback from thousands of EMDR trained clinicians indicates that even when the client selection guidelines presented in the early phases of basic training in EMDR are followed, partially trained clinicians will have incomplete treatments with a significant percentage of clients. These experiences are a normal part of the training and professional development process. Indeed incomplete sessions occur from time to time even when experienced clinicians offer EMDR. Clients still benefit from EMDR reprocessing when sessions are incomplete. As you progress further in basic training in EMDR, you will refine your understanding of EMDR principles and procedures. You will acquire more advanced EMDR skills useful for times when client responses indicate ineffective reprocessing. You will become more effective and achieve a higher percentage of completed sessions. You will find you can effectively apply EMDR in a range of diagnoses beyond PTSD.

Some clinicians may mistakenly believe that they should not start offering EMDR reprocessing in their clinical setting until after they have completed basic training in EMDR. They may fear they will appear “unprofessional” if clients realize they are not “fully trained.” However, most clients are eager to experience effective treatment results. With appropriate informed

consent to EMDR and to your training status, most will request the opportunity to experience this “new” approach that may offer them more profound results than supportive talk therapy alone (Edmond and Rubin, 2004).

Some clinicians work in clinical settings that tend to present only complex cases. These clinicians may believe these cases are all too difficult for their initial applications of EMDR reprocessing. However, with appropriate consultation during basic training, nearly every clinician can be assisted with case finding, case conceptualization, stabilization, preparation, and target sequencing. Most will find that with appropriate guidance they can obtain the needed experience with EMDR reprocessing and produce meaningful clinical benefits in well-selected cases. Regardless of one’s clinical setting, it is essential during consultation to request assistance on initial case finding and treatment planning, so that early clinical practice experiences can be productive professional development opportunities. Building on success is always good. Learning from early problems and technical mistakes during consultation will produce greater resilience and confidence when basic training is completed.

Learning to “stay out of the way”

Early phases of EMDR basic training teach clinicians to “stay out of the way” and to make the fewest possible interventions during and between sets of bilateral eye movements or alternate bilateral stimulation. Before being trained in EMDR, nearly all clinicians have been trained to rely on verbal interventions ranging from empathic responses to subtle reframing to Socratic dialogue as the core of their therapeutic intervention. Advanced phases of EMDR training cover more active strategies to address ineffective reprocessing. Clinicians may initially tend to view these advanced interventions through the lens of their prior training rather than through the lens of the Adaptive Information Processing model.

Many clinicians find it challenging to learn to “stay out of the way” and allow each client’s process to unfold in its own way. Continuing on to later phases of basic training without first having an initial range of experiences applying the fundamentals of EMDR can lead clinicians to habitually take too verbally active a role and thereby divert clients from optimal treatment results. Participating in clinical training exercises in later phases of EMDR basic training, without sufficient initial EMDR clinical experiences, can also leave clinicians confused by new material. In later clinical training exercises, these clinicians may still need to focus on mastering more basic EMDR skills in the clinical practice exercises where the aim is to apply more advanced strategies. This can be frustrating and potentially embarrassing when one’s colleagues have pressed ahead and have

practiced and internalized basic EMDR skills. Sticking to the phrases in the standard reprocessing script and “staying out the way,” generally leads to better results in the early phases of training.

Be alert to family of origin issues in selecting clients for initial EMDR application

When first selecting clients for EMDR reprocessing sessions there are general criteria to be considered in early case finding and selection. In a phrase: all roads lead to home. So regardless of the presenting issue, always consider early family history and client attachment classification.

Clients with family of origin problems that included physical or sexual abuse, verbal abuse, or neglect of basic physical or emotional needs of themselves, their siblings or one of their primary care givers should, if possible, be postponed until the clinician has had some initial experiences. Clients with these backgrounds will be more likely to need interweaves and other advanced treatment strategies covered later in basic EMDR training or advanced courses.

Clients with these backgrounds are more likely to have issues with impaired self-regulation and affect tolerance, histories of (or current) substance abuse, suicide attempts, self-injurious behavior, aggressive behavior, and structural dissociation (dissociative disorder not otherwise specified and dissociative identity disorder). Sufficient screening and history taking should be obtained to determine that these risk factors are not present before proceeding with trauma focused reprocessing.

Since clients with significant dysfunction in their family of origin may minimize their known histories of neglect or abuse due to shame over their past, direct, specific questioning about family circumstances and specific risk factors (such as use of physical punishment and childhood sexual experiences) may be necessary in some cases to identify clients with these types of issues in their history. In addition, since clients with complex PTSD generally avoid reminders of their traumatic memories and may have significant memory gaps, even direct questioning may not always reveal the extent of early trauma and neglect. Use of standardized history taking instruments may permit clients to provide more comprehensive information in a way that is less triggering than face-to-face clinical interviewing. Structured assessment for a dissociative disorder and/or screening with the DES-II and the DES-taxon is strongly advised for clients with these backgrounds. See Leeds (2009) Chapter 5 for how to obtain suggested instruments.

When you are unable to obtain an adequate history or detects significant inconsistencies or minimization, you are advised to select other clients for your initial experiences in gaining confidence with EMDR reprocessing. After you have more experience and confidence in typical reprocessing responses, you can consider a wider range of clients for EMDR reprocessing.

Prior training and experience extends the range of initial cases

Clinicians, who have more extensive education, training and experience working with cases of complex PTSD and clients with the risk factors listed above, may already have developed more advanced skills in differential diagnosis, in recognizing limited self-capacities and in helping clients build greater resilience and coping skills. Their caseloads may be already skewed toward the deeper end of the complex PTSD and structural dissociation spectrum and those with more severe Axis II issues. These clinicians may need to begin their initial EMDR reprocessing work with more challenging cases. It is helpful to have completed reading (and re-reading) the basic required reading and to ask the basic training instructor for recommended advanced readings relevant to their clinical population.

Three classes of clients and targets for initial EMDR application

I would advise clinicians to focus on three general classes of clients and targets for their initial 15–25 EMDR reprocessing sessions. These clients are most likely to respond positively to the protocols taught earlier in basic EMDR training and are least likely to require use of the advanced EMDR skills covered later in the basic EMDR training. I will describe these three classes of client, give a case example for each and then offer some general readiness criteria for trauma focused reprocessing.

1. Clients without significant psychopathology whose history reflects a generally sound childhood can benefit with enhanced self-esteem, self-confidence and greater freedom to pursue their goals by working on mildly disturbing memories.
2. Clients with specific phobias –especially those of a traumatic origin – who do not suffer from another significant disorder (such as generalized anxiety disorder, social phobia, agoraphobia or another more serious disorder) and whose history shows a generally sound childhood can benefit from the phobia protocol (Leeds, 2009; Shapiro, 2001). On the other hand, see Young (1994) for descriptions of two cases successfully treated for phobias in patients with multiple personality disorder (treated by a highly experienced clinician) now described in the DSM-IV-TR as dissociative identity disorder.

3. Clients with single episode PTSD whose history shows a generally sound childhood and a good premorbid history are good candidates for initial experiences applying EMDR.

Case Examples of clients and targets for initial EMDR application

These case examples illustrate typical EMDR treatment effects with three types of uncomplicated clinical presentations. Keep in mind that in any given case, what appears to be uncomplicated can change as new memories or aspects of the case are revealed during reprocessing. These case examples are composites and are intended to illustrate treatment possibilities.

1. A client without significant psychopathology: Fred was a 28 year old shift supervisor at a production facility who had been promoted four months earlier after six years of experience as an assembly worker. The company employee assistance program coordinator referred him for time limited treatment with a preliminary diagnosis of an adjustment disorder with anxious mood. According to the EAP coordinator, after the initial excitement and enthusiasm about his promotion passed Fred started to experience irritability at work and home and had developed a mild sleep disorder. His on the job irritability with those he supervised had led to a discussion with his manager followed by two meetings with the EAP coordinator who made the referral for treatment. The goal of treatment was to help Fred adjust to his new responsibilities.

The EAP coordinator had already helped enroll Fred in a set of supervisor training programs that were scheduled to begin in two weeks, so his need for skills enhancement would be addressed in those training sessions. The EAP coordinator had suggested that the clinician might use EMDR to help Fred with adjusting to his new work responsibilities and had given Fred a copy of the EMDRIA brochure on EMDR.

The clinician, who received the referral to see Fred, had recently started, but not yet completed basic training in EMDR. The clinician determined during history taking that Fred was the second of four children from an intact, inner city family. Two of his siblings were employed and the third was a full time homemaker. Fred had a stable work history since completing high school. He had no history of substance abuse or previous psychotherapy. His DES score was 8. Other than the specific symptoms reported with his work adjustment problems, there were no signs of other psychopathology. His hobbies included playing golf with his fiancée and fishing.

In the first session, after discussing his problems adjusting to his new position, the clinician helped Fred identify the job related situations that most stimulated his increased anxiety. These included: leading production team meetings, giving corrective feedback, and making written comments in personnel files. Fred reported a consistent limiting belief was triggered in each of these situations, which Fred identified as: "It's not safe to make a mistake." He said he would rather believe "It's safe to make mistakes," and "I can handle my responsibilities well." While focusing on a recent anxiety triggering moment at a production team meeting, his pretreatment VoC on this preferred belief was between 2 and 3. His predominant feeling was anxiety with a sense of dread. Fred added that he couldn't understand why he felt that way. His SUD level on this memory was between a 6 and 7 and he felt the distress in his chest.

The clinician then taught Fred the calm place exercise and asked him to practice it the following week and to use it whenever these feelings were triggered. He gave Fred a description of the EMDR process which they planned to use in their second session and taught him the metaphor of being on the train and of being able to just notice the scenery passing by.

At the second session the clinician reviewed with Fred what they had discussed at the first meeting and asked him to consider when he might have ever felt this way before with the same body sensation and the same negative thought "It's not safe to make a mistake." Fred then described a troubling incident from when he was 10 years old. His older brother was away at a sports camp and his mother asked Fred to baby-sit his younger brother and sister one afternoon for a few hours while she went to the doctor. He had never before baby-sat for his siblings and he was very proud to be given that responsibility. It later turned out his mom had a serious case of pneumonia, which was successfully treated with antibiotics and did not require hospitalization. While she was away at the doctor's office, Fred fixed his brother and sister lunch, played games with them and gave them a bath.

His mother came home tired, feverish and worried whether the medication would be sufficient or if she would require hospitalization, something the family could not afford. She uncharacteristically yelled at Fred for leaving bath water in the tub and on the floor in the bathroom and for leaving a sharp knife on the kitchen counter where his younger brother might have been able to grab it. She described in particularly vivid terms what might have happened to his younger brother if he had gotten hold of the knife.

Fred's pride at his first opportunity to take care of his brother and sister was punctured by her harsh words and he felt a great deal shame and

disappointment in himself. For days afterward, as he helped his mother around the house while she rested in bed, he kept brooding about the frightening images of his brother getting hold of knife and hurting himself or his baby sister.

The negative and positive cognitions for this memory were the same as for the current stimuli of the production team meeting. The VoC was 2 and the SUD was 7. The clinician then proceeded to apply EMDR reprocessing to baby-sitting memory with the standard procedural steps. First the clinician targeted the baby sitting memory, reprocessing it till the SUD was reduced to 0, the preferred cognition was installed to a 7 and a body scan revealed no residual physical distress. Then they reprocessed the production team meeting to a 0 SUD, 7 VoC and clear body scan. Upon checking the other current stimuli, only one had any residual distress. This was also targeted and reprocessed. The second session was closed with a debriefing and a request to log any significant memories, thoughts or dreams.

In the third session, Fred reported no new disturbing memories or dreams. He reported he had slept soundly all week and had been much more self confident and relaxed at the production team meeting. He also said his fiancée told him he seemed happier and more at ease all week. His first supervision training session that week had been an enjoyable experience and he felt a sense of pride and increased confidence about his new responsibilities.

In exploring upcoming future situations, Fred said that he was slightly anxious about his responsibility to do a series of performance reviews for his production workers in a few weeks, something he had never done before. He added that he would soon be taking a training program that should help him with the instruction he would need to be successful. The targets from the previous session were checked and both his memory and all current stimuli remained at a 0 SUD with a 7 VoC on the PC. The clinician then used the positive template to strengthen Fred's confidence in his ability to learn and apply the skills he needed to be successful in conducting the performance reviews. The third session was concluded successfully. The clinicians told Fred that he was welcome to call for a follow-up appointment should he experience any other difficulties. They made plans to check in briefly by phone in two weeks to see how Fred was doing. At follow up Fred reported he was doing great and felt no need for further sessions. The next week the EAP coordinator called the clinician to thank him for helping Fred with his adjustment to his new responsibilities and to discuss another possible referral.

2. A client with a specific phobia: Stewart was an auto mechanic who was married with two children. His wife had won a family vacation through a sales promotion at her job and the family had an opportunity to take a vacation overseas, something they could never otherwise have afforded. The trip however would require Stewart to get a vaccination and he was so terrified of getting a shot that he had been refusing to go to the doctor. Rather than fight about this with his wife any more, he agreed to see the clinician they had gone to two years before for some marriage counseling.

The clinician had not known of Stewart's needle phobia during the few sessions of marriage counseling which had focused on issues regarding their son's school problems. The clinician had recently completed part of the basic training in EMDR and thought that it might be the best way to help Stewart over this problem. The clinician already knew most of Stewart's family history, but now learned that his injection phobia had begun when he underwent a series of injections at age 8 to treat a severe allergy. This allergy had caused several emergency room visits when Stewart had suddenly become so asthmatic he couldn't breathe. Somehow as a young boy he had concluded that the cause of his allergic reactions was the shots themselves even though as an adult he knew better. Even the thought of getting a shot made Stewart the adult fearful and he would begin coughing and wheezing.

The clinician asked Stewart to bring to the next session the inhaler, which he only used on rare occasions when he had mild asthmatic reactions. The clinician gave Stewart basic information about EMDR and the metaphor of being on the train. The clinician taught Stewart the calm place and installed it with eye movements. Stewart responded positively to the installation of the calm place and said he was looking forward to the next session. At the second session they targeted the memory of the injections Stewart had received as a boy. The picture was the image of the doctor holding the needle getting ready to put it into his arm. The NC was: "I'm going to die." The PC was: "I'm safe and the injection keeps me healthy." The VoC was 2. His emotion was strong fear. The SUD was 8. Stewart felt intense anxiety in his chest and throat and had some difficulty breathing.

As they began the bilateral eye movements, the sensations in Stewart's chest became more intense at first and then after the 3rd set of eye movements, Stewart said it was suddenly as if he was looking at the picture through the wrong end of telescope. It suddenly looked far away and not important any more. He started to laugh and then briefly cried, saying, "It's over. It's in the past. I'm not afraid any more." The SUD was found to be 0 and the clinician then completed the installation and the body scan. With half of the session time remaining, the clinician then decided to go ahead to do the rest of the phobia protocol including

contracting for Stewart to get the injection in two weeks. They then did a future template in which Stewart imagined going to the doctor's office and getting the shot. Stewart said he felt no distress at all when he imagined this, in fact he imagined talking with the doctor the whole time about how pleased he was with his wife for being so successful at work and winning the vacation for the family.

Steward called the clinician three weeks later to say that the injection had gone just fine although his arm was a bit sore a day or two later, but that it was a small price to pay for getting to go with his children on such a special trip.

3. A client with single episode PTSD: Kathy had always been a cheerful, upbeat person who looked on the bright side of things until she witnessed a hold up led by two armed men in a convenience store where she had been shopping six months ago. Over the next few weeks after this incident Kathy developed sleeping problems and had gradually become more fearful and moody. While visiting the doctor's office for her daughter's checkup and immunization she mentioned her problems to her family doctor. The doctor referred her for specific treatment to a clinician who had recently completed half of the EMDR basic training.

At intake, the clinician administered the DES, the SCL-90R, the IES and a standard history taking form, the Psychotherapy Assessment Checklist. (See Leeds, 2009 for how to obtain these instruments.) Kathy's DES score was 22. Her IES was in the clinical range at 24. Her SCL-90R Global Severity Index was 67 with elevations on a number of subscales including anxiety and depression. Her history showed no previous psychopathology and good adjustments to previous life challenges including the death of her grandmother when she was 14 and the miscarriage of her first pregnancy.

The clinician learned that in addition to having developed disturbed sleep and nightmares, Kathy had gradually become generally fearful about going out driving or shopping, worrying that she would again encounter men with guns committing a crime. She lived in a low crime neighborhood and was safe in her home. She knew her fears were irrational, but she had not been able to shake them.

The clinician taught Kathy a structured relaxation exercise in the first session and also normalized her symptoms by giving her some basic information about acute and posttraumatic stress responses and the changes traumatic experiences produce in the nervous system.

At the second visit, the clinician learned that the relaxation exercise had helped a bit at home, but that it didn't help at all when Kathy went out. The clinician normalized this response and gave Kathy information about overall treatment strategies including imaginal exposure, narrative and cognitive methods and EMDR and the potential risks and benefits of each one. Kathy said that since EMDR didn't require homework or describing the details and would work better than talk therapy, she wanted to give that a try first. After explaining a little bit more about the EMDR procedures, the clinician taught Kathy the calm place exercise, adding eye movements to enhance the experience and then asking Kathy to imagine using the calm place exercise at home and in the car. Kathy said she found the calm place exercise much more helpful than the progressive relaxation exercise of the first session and that she would use it during the week.

At the third visit, Kathy reported she'd used the calm place exercise several times during the week and found it helpful. In fact, she slept all night the night after the second session, but had returned to troubled, light sleep and disturbing dreams the rest of the week. Kathy wanted to talk about some parts of the holdup that she hadn't talked about at the first visit and then near the end of the third session said that the following week she wanted to do some reprocessing on the holdup memory. Near the end of that session, the clinician helped Kathy identify the picture, NC, PC, VoC, specific emotion, SUD and body location for the holdup memory. The NC was, "I'm not safe." The PC was, "It's over. I'm safe now." The VoC was 2, the SUD 9, the emotion fear in the belly. They then brought the session to a close with the calm place exercise and a reminder to keep a log.

In the fourth session, Kathy worked on the holdup memory with EMDR. The SUD and VoC were at the same level at the start of the session as the previous week. After 40 minutes of EMDR, the SUD was down to 2 and the VoC was up to 5. The clinician used the calm place exercise to help Kathy put away the residual distress and reminded her about keeping a log that week.

At the start the fifth session, Kathy reported having slept through the night every night but the night before the fifth session when she had a strange dream in which she had yelled at the holdup men, something that in fact she had not done during the original event because it would have been far too dangerous. The clinician suggested that they resume the reprocessing at that point focusing on the dream. They began focusing on the dream image and later returned to focus on the memory of the holdup, which was then rapidly treated to resolution with a 0 SUDS, 7 VoC, and a clear body scan.

The following session Kathy reported good sleep and a return to better spirits than she had felt in many months. She gone shopping on her own for the first time in many weeks and had experienced no fear in the car or in the stores. The clinician asked Kathy to imagine returning to the store in which the holdup had taken place and found there was a SUD of 5. Then they did a future template for visiting that store again, which processed uneventfully to resolution. Kathy asked to skip the next week and to return in two weeks for a follow up visit.

At the follow up visit two weeks later, Kathy reported she felt fine and was amazed at how long she had let the holdup bother her. She thanked the clinician for the treatment and said she didn't think she needed any more sessions. A phone call from the clinician six weeks later found Kathy her former cheerful self, making plans for the summer vacation.

Recognizing lack of client readiness for trauma focused reprocessing

While these case examples show clients with uncomplicated histories and comprehensive, rapid treatment effects, many clients will present with more complex histories or will need more sessions to build trust and develop resources and coping skills before being ready to reprocess their disturbing memories. When selecting clients for EMDR reprocessing sessions, there are general criteria for recognizing potential lack of client readiness. When these factors are present, it may be necessary to postpone reprocessing until after an initial focus on stabilization and the clinician has gained more skill and confidence in EMDR.

Indications of more complex issues requiring more complete EMDR training and a possible need to postpone trauma reprocessing

The following criteria should be considered as potential evidence that the client is not ready for trauma focused reprocessing regardless of a clinician's EMDR training level. Alternate treatment approaches focused on client stabilization may need to be employed with these clients.

- The client reports or is observed in the office being flooded with feelings of anxiety, fear or distress and is not able to identify the eliciting stimuli.
- Standard self-care and affect modulation methods, such as structured relaxation and guided imagery methods (such as calm place), do not alleviate client distress in the office or are not useful to the client between treatment session. This inability to modulate

affect leaves the client vulnerable to emotional flooding during and between treatment sessions.

- The client is alexithymia (cannot name and describe feelings).
- The client shows persistent depressed mood (dysthymia), low self-esteem and cognitive distortions, but may not complain of depression because the client considers these symptoms normal.
- The client has many incomplete projects and avoids dealing with significant areas of concern. The clinician may suspect the client has more areas of dissatisfaction than have been reported.
- The client has episodes when they cannot speak or can barely articulate their thoughts. The client appears confused or overwhelmed by emotional states at these times.
- The client cannot give coherent narrative accounts of events of the week (even with clinician prompting) such as stressful interactions with family members or co-workers. Instead the client gives fragmentary accounts of these situations and then lapses into vague self-critical comments.
- The client shows poor impulse control (over money; anger; substance use; sexuality); is accident prone; tends to be manipulated by others; functions significantly below their intellectual or work potential; avoids interpersonal conflict; is unable to achieve or maintain emotional intimacy; shows alternating approach-avoidance behavior with personal goals or relationships.

Summary

In conclusion, those beginning and with recent EMDR training are encouraged to select clients that will permit them to achieve positive treatment outcomes and to prepare themselves to make the next phase of their EMDR training a useful learning experience. As clinicians gain more experience they can apply EMDR to a wider range of clinical presentations. Reading Shapiro's (2001) required text and other recently published books and journal articles together with consultation with an EMDRIA Approved Consultant are also essential in helping clinicians gain a deeper understanding of how and when to apply EMDR and to develop the skills needed to do so effectively and with confidence.

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