

EMDR PRACTICE GUIDELINES EMDR WITH ADULTS

Eye Movement Desensitization and Reprocessing [EMDR] (Shapiro, 1989) is a treatment technique during which accelerated processing of traumatic memory is facilitated through the shifting of attention between the left and right hemispheres of the brain. The methods utilized to facilitate the rapid switching of attention include the use of tapping, eye movement or sound.

Precursors to the acquisition of traumatic memory frequently include the victim's thought and belief that death is imminent or an actual near-death experience. The constellation of neurobiological changes experienced during the psychological and physical arousal associated with extreme or prolonged fear is believed to be stored in discrete "packages" in the brain of the victim. The process of EMDR appears to facilitate the retrieval of the traumatic memory as well as all the associated thoughts, emotions and sensations. Processing the memory allows consolidation of the various associations and facilitates normal memory storage. Participants in the process of EMDR report that the memory is still present, but does not carry the previously associated states of arousal and distress.

Papers published more recently discuss the application of EMDR for disorders not necessarily related to a traumatic event. EMDR has been used in the treatment of anxiety disorders, phobias, substance abuse, pain control and body dysmorphic disorder, to name a few.

Guidelines

- Elicit a history of the trauma and the behaviors believed to be associated.
- Select targets for intervention.
- Carefully explain the technique of EMDR and the benefits as well as the risks of using the technique. Document the discussion explicitly in the treatment record.
- Establish a safe relationship with the client. Safety, boundaries and coping skills are especially critical when utilizing EMDR.
- Encourage the client to voice and discuss questions and concerns.
- Assist the client in establishing a "safe" place. The use of EMDR in the establishment of a safe place is a useful technique.

Safety factors and contraindications

- "Clients should be able to feel comfortable with the possibility of experiencing a high level of vulnerability, a lack of control, and any physical sensations from the event that may be inherent in the target memory (Shapiro, 1990, p. 90).

- The client should be able to utilize coping strategies such as relaxation and stress management.
- The ability to cope with the arousal accompanying the retrieval and processing of traumatic memory and the between-session surfacing of associated memories is essential. The client and clinician must develop a safety plan and the clinician should feel confident that the client would be able to remember and follow the plan.
- Ideally the client possesses a network of support from family and/or friends. If such a network does not exist the clinician must determine if the client is able to proceed without support other than that of the clinician.
- Memory reprocessing is rigorous; therefore good health is an important consideration.

A large body of controlled research has been conducted on the efficacy of EMDR. For the most part, there are few contraindications. However, if the health of the client is poor; if the traumatic memory involves an actual near-death experience (as opposed to the belief that death was imminent); if the client has a physical impairment or an active drug/alcohol problem, consideration should be given to conducting the EMDR in an inpatient setting. If there is any risk of the client becoming a danger to self or others, the EMDR should be conducted in an inpatient setting.

- According to Shapiro, there is a risk of seizure with the use of this technique. The client should be informed of this risk prior to treatment if the candidate has a history of a seizure disorder.
- “A physician consultation should always be sought if the clinician suspects that a physical condition, including neurological impairment, might present a problem” (Shapiro, 1995, p.p. 94-95).
- If a client complains of eye pain, the session should be terminated immediately. Consultation with an eye specialist who has been educated regarding the type of eye movements required should be completed before any further treatment. Clients who wear contact lenses should remove their lenses before treatment.
- Clients with a history of substance abuse should have a strong support system such as a 12-step program before engaging in EMDR treatment. Special care should be taken to inform the client of the risks of resuming or increasing the abuse of substances as a response to the stressful material surfaced in treatment. Documentation of informed consent should be noted in the treatment record.
- Informed consent is critical before a client who is involved in court case engages in EMDR. Clinicians must explain and explicitly document that the client was informed that after EMDR his or her memory of the event may be less clear; that the extreme emotion accompanying the event may have abated; and that case law has not established the acceptance of EMDR by the judicial system. Although EMDR is not hypnosis, it may be viewed as such by judges (Shapiro, 1995).

The assessment of secondary gain and the impact of the loss of symptoms around which a victim’s life has been organized are vital. The individual must understand and be

prepared for potentially great changes in functioning with the resolution of the trauma. Peer groups, with which the client has identified and derived support, may no longer be beneficial. These issues must be explored thoroughly and appropriate action plans developed before engaging in EMDR treatment.

Training/supervision requirements

- Minimal training required for using this technique is successful completion of Level I training achieved by attendance at a seminar certified by the EMDR Institute.
- Supervision of clinicians utilizing EMDR must be provided by a clinician with Level II training as well as post Level II experience.
- Therapists considering use of this technique with clients who have a diagnosis of Dissociative Disorder should have significant experience in treating clients with this diagnosis, in addition to having at least a Level I training from trainers recognized by the EMDR Institute as well as specialized training in the use of EMDR with dissociative disorders. Ideally, the clinician should have Level II training before utilizing EMDR with dissociative clients.

Exclusions for the use of EMDR

- Clients who are actively psychotic (i.e., experiencing hallucination, delusions, etc.).
- Clients with uncontrolled seizure disorder.
- Clients experiencing a current traumatic situation should not be treated with EMDR for previous traumas until the present trauma is resolved.

EMDR Bibliography

Lovett, J. (1999). *Small wonders: Healing childhood trauma with EMDR*. New York: The Free Press.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures*. New York: The Guilford Press.

Shapiro, F. & Forrest, M.S. (1996). *EMDR: The Breakthrough therapy for overcoming anxiety, stress, and trauma*. New York: HarperCollins.

Wilson, S.A., Becker, L.A., & Tinker, R. H. (1995). Eye movement desensitization and reprocessing (EMDR) treatment for psychologically traumatized individuals. *Journal of Consulting and Clinical Psychology*, 63(6), 928-937.

Wilson, S.A., & Tinker, R. H., (1999). *Through the eyes of a child: EMDR with children*. New York: W. W. Norton.

Internet Resources:

<http://www.emdr.com>

<http://www.emdrportal.com>