EMDRIA Definition of EMDR

Date of adoption 5/26/03, 10/18/03; Revised 10/25/09, 06/23/11, 12/07/11, 2/25/12

1.0A. Purpose of Definition – This definition serves as the foundation for policy development and implementation of EMDRIA's programs in the service of its mission. This definition is intended to support consistency in EMDR training, standards, credentialing, continuing education, and clinical application, while fostering the further evolution of EMDR through a judicious balance of innovation and research. This definition also provides a clear and common frame of reference for EMDR clinicians, consumers, researchers, the media and the general public.

1.0B. Definition - EMDR is an evidence-based psychotherapy for Posttraumatic Stress Disorder (PTSD). In addition, successful outcomes are well-documented in the literature for EMDR treatment of other psychiatric disorders, mental health problems, and somatic symptoms. The model on which EMDR is based, Adaptive Information Processing (AIP), posits that much of psychopathology is due to the maladaptive encoding of and/or incomplete processing of traumatic or disturbing adverse life experiences. This impairs the client's ability to integrate these experiences in an adaptive manner. The eight-phase, three-pronged process of EMDR facilitates the resumption of normal information processing and integration. This treatment approach, which targets past experience, current triggers, and future potential challenges, results in the alleviation of presenting symptoms, a decrease or elimination of distress from the disturbing memory, improved view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers.

BI. Foundational Sources and Principles for Evolution - Shapiro's (2001) Adaptive Information Processing model, guides clinical practice, explains EMDR's effects, and provides a common platform for theoretical discussion. The AIP model provides the framework through which the eight phases and three prongs (past, present, and future) of EMDR are understood and implemented. The evolution and elucidation of both mechanisms and models are ongoing through research and theory development.

BII. Aim of EMDR - In the broadest sense, EMDR is an integrative psychotherapy approach intended to treat psychological disorders, to alleviate human suffering and to assist individuals to fulfill their potential for development, while minimizing risks of harm in its application. For the client, EMDR treatment aims to achieve comprehensive treatment safely, effectively and efficiently, while maintaining client stability.

BIII. Framework - Through EMDR, resolution of traumatic and disturbing adverse life experiences is accomplished with a unique standardized set of procedures and clinical protocols which incorporates dual focus of attention and alternating bilateral visual, auditory and/or tactile stimulation. This process activates the components of the memory of disturbing life events and facilitates the resumption of adaptive information processing and integration. The following are some of the AIP tenets which guide the application of EMDR, i.e., planning treatment and achieving outcomes:

BIIIa. Adverse life experiences can generate effects similar to those of traumatic events recognized by the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2000) for the diagnosis of Posttraumatic Stress Disorder (PTSD) and trigger or exacerbate a wide range of mental, emotional, somatic, and behavioral disorders. Under optimal conditions, new experiences tend to be assimilated by an information processing system that facilitates their linkage with already existing memory networks associated with similarly categorized experiences. The linkage of these memory networks tends to create a knowledge base regarding such phenomena as perceptions, attitudes, emotions, sensations and action tendencies.

BIIIb. Traumatic events and/or disturbing adverse life experiences can be encoded maladaptively in memory resulting in inadequate or impaired linkage with memory networks containing more adaptive information. Pathology is thought to result when adaptive information processing is impaired by these experiences which are inadequately processed. Information is maladaptively encoded and linked dysfunctionally within emotional, cognitive, somatosensory, and temporal systems. Memories thereby become susceptible to dysfunctional recall with respect to time, place, and context and may be experienced in fragmented form. Accordingly, new information, positive experiences and affects are unable to functionally connect with the disturbing memory. This impairment in linkage and the resultant inadequate integration contribute to a continuation of symptoms.

BIV. EMDR Psychotherapy Guidelines: EMDR procedures facilitate the effective reprocessing of traumatic events or adverse life experiences and associated beliefs, to an adaptive resolution. Specific procedural steps are used to access and reprocess information which incorporates alternating bilateral visual, auditory, or tactile stimulation. These well-defined treatment procedures and protocols facilitate information reprocessing. EMDR utilizes an 8-phase, 3-pronged, approach to treatment that optimizes sufficient client stabilization before, during, and after the reprocessing of distressing and traumatic memories and associated stimuli. The intent of the EMDR approach to psychotherapy is to facilitate the client's innate ability to heal. Therefore, during memory reprocessing, therapist intervention is kept to the minimum necessary for the continuity of information reprocessing.

BIVa. Based on available relevant research, treatment fidelity to the 8 phases (Shapiro, 2001) produces the best results. However, in certain situations and for some populations, the following procedures may be implemented in more than one way as long as the broad goals of each phase are achieved.

BIVai. In the **Client History Phase (Phase 1),** the clinician begins the process of treatment planning using the concept of incomplete processing and integration of memories of adverse life experiences. The clinician identifies as complete a clinical picture as is prudent before offering EMDR reprocessing. The clinician determines the suitability of EMDR therapy for the client and for the presenting problem and determines whether the timing is appropriate. Based on the presenting issue, the clinician explores targets for future EMDR reprocessing from negative events in the client's life. The clinician prepares a treatment plan with attention to past and present experiences, and future clinical issues. It is also important to identify positive or adaptive aspects of the client's personality and life experience. The clinician may need to postpone completing a detailed trauma history when working with a client with a complex trauma history until the client has developed adequate affect regulation skills and resources to remain stable. The clinician may need to address any secondary gain issues that might prevent positive treatment effects.

BIVaii. In the **Preparation Phase (Phase 2**), the clinician discusses the therapeutic framework of EMDR with the client and gives sufficient information so the client can give informed consent. The therapist prepares the client for EMDR reprocessing by establishing a relationship sufficient to give the client a sense of safety and foster the client's ability to tell the therapist what s/he is experiencing throughout the reprocessing. The client develops mastery of skills in self-soothing and in affect regulation as appropriate to facilitate dual awareness during the reprocessing sessions and to maintain stability between sessions. Some clients may require a lengthy preparation phase for adequate stabilization and development of

adaptive resources prior to dealing directly with the disturbing memories. It may be important, especially for those clients with complex trauma, to enhance the ability of the individual to experience positive affect through promoting the development and expansion of positive and adaptive memory networks, thus expanding the window of affect tolerance, and stimulating the development of the capacity for relationship.

BIVaiii. In the **Assessment Phase (Phase 3)** the clinician identifies the components of the target/issue and establishes a baseline response. Once the memory or issue (with a specific representative experience) has been identified, the clinician asks the client to select the image or other sensory experience that best represents it. The clinician then asks for a negative belief that expresses the client's currently held maladaptive self-assessment that is related to the experience, a positive belief to begin to stimulate a connection between the experience as it is currently held with the adaptive memory network(s) and the validity of the positive belief, utilizing the 7 point Validity of Cognition (VOC) scale. Finally, the clinician asks the client to name the emotions evoked when pairing the image or other sensory experience and the negative belief, to rate the level of disturbance utilizing the 0 to 10 Subjective Units of Disturbance (SUD) scale and to identify the location of the physical sensations in the body that are stimulated when concentrating on the experience.

BIVaiv. During the **Desensitization Phase (Phase 4)** the memory is activated and the clinician asks the client to notice his/her experiences while the clinician provides alternating bilateral stimulation. The client then reports these observations. These may include new insights, associations, information, and emotional, sensory, somatic or behavioral shifts. The clinician uses specific procedures and interweaves if processing is blocked. The desensitization process continues until the SUD level is reduced to 0 (or an ecologically valid rating). It is important during this phase to assist the individual in maintaining an appropriate level of arousal and affect tolerance.

BIVav. In the **Installation Phase (Phase 5**), the therapist first asks the client to check for a potential new positive belief related to the target memory. The client selects a new belief or the previously established positive cognition. The clinician asks him/her to hold this in mind, along with the target memory, and to rate the selected positive belief on the VOC scale of 1 to 7. The therapist then continues alternating bilateral stimulation until the client's rating of the positive belief reaches the level of 7 (or an ecologically valid rating) on the VOC Scale.

BIVavi. In the **Body Scan Phase (Phase 6),** the therapist asks the client to hold in mind both the target event and the positive belief and to mentally scan the body. The therapist asks the client to identify any positive or negative bodily sensations. The therapist continues bilateral stimulation when these bodily sensations are present until the client reports only neutral or positive sensations.

BIVavii. The **Closure Phase (Phase 7)** occurs at the end of any session in which unprocessed, disturbing material has been activated whether the target has been fully reprocessed or not. The therapist may use a variety of techniques to orient the client fully to the present and facilitate client stability at the completion of the session and between sessions. The therapist informs the client that processing may

continue after the session, provides instructions for maintaining stability, and asks the client to observe and log significant observations or new symptoms.

BIVaviii. In the **Reevaluation Phase (Phase 8),** the clinician, utilizing the EMDR standard three-pronged protocol, assesses the effects of previous reprocessing of targets looking for and targeting residual disturbance, new material which may have emerged, current triggers, anticipated future challenges, and systemic issues. If any residual or new targets are present, these are targeted and Phases 3-8 are repeated.

BV. Innovation, Flexibility and Clinical Judgment as Applied to Particular Clients or Special Populations

BVa. To achieve comprehensive treatment effects a three-pronged basic treatment protocol is generally used so that past events are reprocessed, present triggers desensitized, and future adaptive outcomes explored for related challenges. The timing of addressing all three prongs is determined by client stability, readiness and situation. There may be situations where the order may be altered or prongs may be omitted, based on the clinical picture and the clinician's judgment.

BVb. As a psychotherapy, EMDR unfolds according to the needs, resources, diagnosis, and development of the individual client in the context of the therapeutic relationship. Therefore, the clinician, using clinical judgment, emphasizes elements differently depending on the unique needs of the particular client or the special population. EMDR treatment is not completed in any particular number of sessions. It is central to EMDR that positive results from its application derive from the interaction among the clinician, the therapeutic approach, and the client.

American Psychiatric Association (2000), *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition*, Washington DC.

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing, 2nd edition,* N.Y.: The Guilford Press.