3 strategies from EMDR

Which can enhance your practice

Mark Grant MA

Mark Grant

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Overview

- What is EMDR?
- ~~3~~4 strategies to enhance your practice;
  1. Trauma-informed case conceptualization
  2. Working Experientially
  3. Working with ego-states
  4. Resource Development & Integration (RDI)

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What is EMDR?

"During EMDR therapy, the client attends to emotionally disturbing material in brief sequential doses while simultaneously focusing on an external stimulus. Therapist directed lateral eye movements are the most commonly used external stimulus but a variety of other stimuli including hand-tapping and audio stimulation are often used."

Shapiro, 1991.

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What is EMDR?

'In EMDR therapy, the emphasis is on allowing the information processing system of the brain to make the internal connections needed to resolve the disturbance… According to the theory, the memory is then transferred from episodic memory, which holds the emotions, physical sensations and beliefs that were stored at the time of the original event, into semantic memory networks, where the person has "digested" the experience so that the accurate personal meaning of the life event has been extracted and those negative visceral reactions no longer exist.'

- Francine Shapiro Phd

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What is EMDR?

1. AIP Model
2. Eight Phases
3. Protocols (three-pronged approach)
   'The robust and well-researched sequence of the standard protocol guarantees a safe and efficacious treatment for the majority of clients'
4. EMDR procedures
   'Manualised approaches to modify memories'
5. Dual attention bilateral stimulation (DABLS)
6. Clinical interventions
   …used to facilitate processing if the client is blocked in processing or if the therapist wants to add tracks of information to optimize treatment effects'

Dominguez & Schubert, 2023, Hase 2021

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What is EMDR?

'Many authors have advocated the incorporation of other treatment modalities within the application of EMDR and AIP, or have developed specific EMDR protocols that combine EMDR with other approaches, such as ego states, attachment theory, hypnosis, family therapy … sensorimotor psychotherapy etc. This ability to assimilate elements from other approaches has been present from the inception of EMDR and certainly strengthens its description as an integrative psychotherapy approach.'

- Rydberg & Machado, 2019

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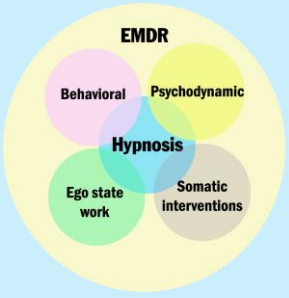
What is EMDR?



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What is EMDR? (Core skills)

1. Trauma-informed case conceptualization
2. Selecting appropriate EMDR 'targets'
3. Knowledge of AIP model
4. Working experientially
5. Therapeutic alliance
6. Ability to recognize dissociation (+ working with ego states)
7. Resource development
8. Dual attention/bilateral stimulation (BLS)
9. Facilitating new associations
10. Reintegration (posttraumatic growth)

EMDR Reprocessing

Royal College Psychiatry

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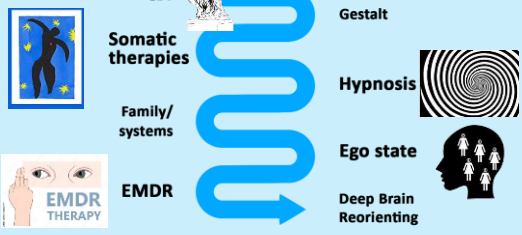
More than EMDR…
(My 40-year learning odyssey)



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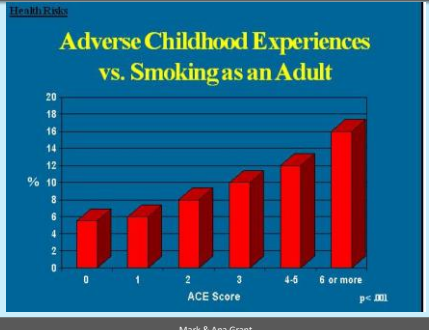

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Trauma-informed case conceptualization

'PTSD is associated with possibly the highest frequency of ill-defined medical symptoms among all psychiatric disorders.'

Andreski et al., 1998.

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Trauma-informed case conceptualization

- 'the trauma spectrum could also be called the 'neglect spectrum' – neglect and attachment better predicts severity of pathology than trauma.

  John O'Neill, 2023
- 'Anxious and avoidant attachment are more strongly associated with health problems and increased pain respectively.'

  McWilliams & Bailey, 2010

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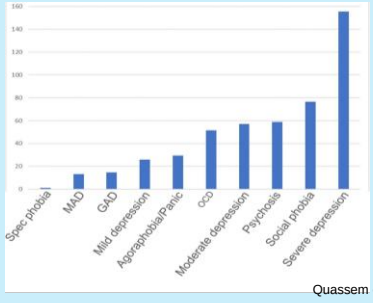
1. Trauma-informed case conceptualization



Quassem et al, 2020

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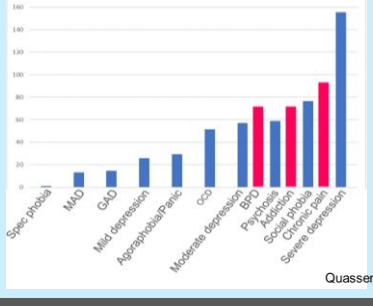
Trauma-informed case conceptualization



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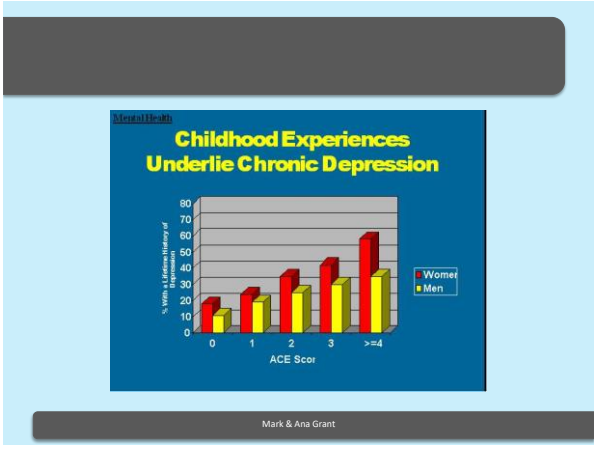

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Trauma-informed case conceptualization

'Attachment problems are also a strong risk factor for PPS with 56-62% of sufferers of medically unexplained symptoms found to have anxious or avoidant attachment.'

Schroeter et al., 2015; Mc Williams, 2017

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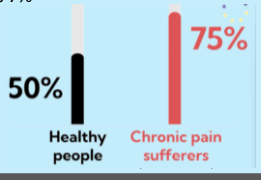
Trauma informed case conceptualization

Attachment problems and somatization/chronic pain

- 50% normal population have an attachment issue vs
- 75% chronic pain sufferers
- Anxious attachment; 10% (CP) vs 6%
- Avoidant/dismissive; 20% (CP) vs 7%
- Secure; 30%(CP) vs 50-60%



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Trauma-informed case conceptualization

The trauma model

- Locus of control shift
- The problem is not the problem
- Propensity for addictions
- 'What's wrong with you' vs 'what happened to you?'
- Dissociation is ubiquitious
- Therapeutic relationship
- 3-stage model

Colin Ross, 2006

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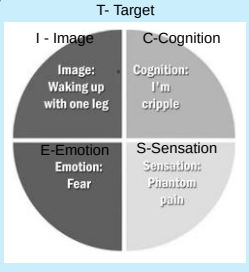
Trauma-informed case conceptualization

EMDR 'targets'

'TICES'
T - Target
I - Image
C – Negative cognition
E - Emotion
S - sensation



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Trauma-informed case conceptualization

EMDR 'target'

1. Link current symptoms (present) with unresolved trauma/adverse experiences (past).
2. Isolate causes of diverse symptoms.
3. Give meaning to unexplained symptoms. (Connect elements of B.A.S.K.*)
4. Identify common themes based on multiple trauma/adverse events, eg; "I am worthless, weak, etc."
5. Partitioning.
6. Case conceptualization/treatment-planning

* Behavior. Affect. Sensation. Knowledge

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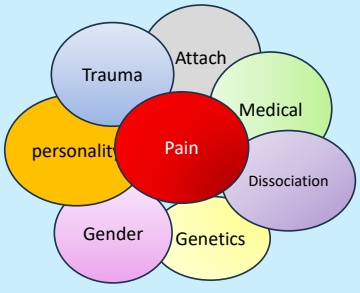
But … its not all about trauma



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2. Working experientially

"Although EMDR may produce cognitive shifts that help patients reprocess their traumatic memories or otherwise relate to them more adaptively, EMDR's physiological profile may also serve as a curative factor."

Gunter & Bodner, 2009

"Physiological studies have found that the EMs are associated with a de-arousal response driven by increased parasympathetic relative to sympathetic changes."

Landin-Romero, 2018

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Working experientially

- EMDR 'target'; visual, sensory and cognitive elements of experience
- Desensitization/Reprocessing; Dual attention/Bilateral stimulation (BLS)
- Titration - using the smallest amount of activation possible (vs exposure)
- Attention to effects of Dual attention/BLS
- Cognitive processes involve interpreting feelings - not driver of change

Peter Levine

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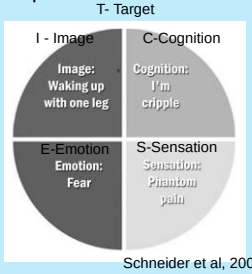
EMDR 'Target'

Phantom limb pain

Key elements:
T - Target
I - Image
C – Negative cognition
E - Emotion
S – sensation
(TICES)



Schneider et al, 2008

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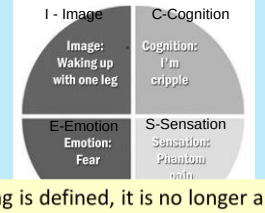
EMDR 'Target' (partitioning)

Phantom limb pain

Key elements:
T - Target
I - Image
C – Negative cognition
E - Emotion
S



'The moment something is defined, it is no longer a fluid reality.' Short et al, 2005

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Working experientially

Dual attention/Bilateral stimulation

"Bottom-up processing, by itself, does not resolve trauma, but if the patient is directed to track and articulate sensorimotor experience while consciously inhibiting emotions, content and interpretive thinking, it can gradually be assimilated. … Bilateral stimulation is likely to act on subcortical processes that have little or nothing to do with insight and understanding."

van der Kolk 2002

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Working experientially

Effects of BLS

- BLS significantly increased "accessibility" to positive memories ($p = 0.022$) and "relaxation" ($p = 0.020$).
- A trend towards significance was observed for "increased vividness" ($p = 0.074$).
- The majority of subjects felt BLS was more effective than non-tactile stimulation for enhancing memory recall.

Armano & Toichi, 2016

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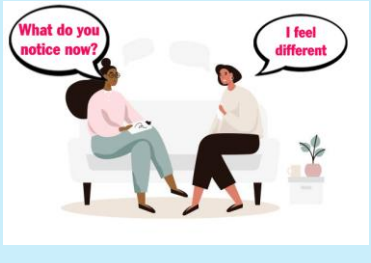
Working experientially

EMDR check-in



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Working experientially

"If we can help our patients tolerate their own bodily sensations, they'll be able to process the trauma themselves,"

- van der Kolk

"Somatic awareness within EMDR Therapy gives us a way to work with nervous system states and the dysregulation that is associated with trauma."

- Dr Arielle Schwartz

"EMDR reprocessing starts and ends with the body."

- Catherine Livov

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"the two most important phrases in therapy, as in yoga, are "Notice that" and "What happens next?" Once you start approaching your body with curiosity rather than with fear, everything shifts. The greatest sources of our suffering are the lies we tell ourselves."

Bessel Van der Kolk

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3. Working with ego states

"Like Janet's (1965; 1977) model of psychopathology, EMDR is based on a structural dissociation in which traumatic affect, cognition, and memory are stored in a dissociated compartment of the psyche. In Van der Hart, Nijenhuis and Steele's (2006) elaboration of Janet's theory, the dissociated compartment is required to contain a part-self or ego state with a subjective sense of its own separate identity. This requirement is not present in EMDR's adaptive information processing model, but can be accommodated within it quite easily."

Colin Ross 2000

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Working with ego states

- "Rather than a unitary place the unconscious might be better understood as containing parts that have all kinds of longings… "
- "We are moving towards a conception of mind as a non-linear, dialectical process of meaning construction… a view of the mind as a configuration of discontinuous, shifting states with varying degrees of access to perception and cognition."

Bromberg, 1998

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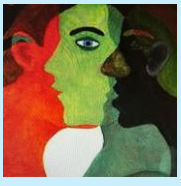
Working with ego states

Vertical vs horizontal models consciousness

Repression



Dissociation

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Working with ego states

'The conflict between the will to deny horrible events and the will to proclaim them aloud is the central dialectic of psychological trauma.'

Judith Herman

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Ego state work and EMDR

The therapeutic impasse requiring the cognitive interweave is caused by a covert "resistant" ego state which is opposed to allowing a therapeutic shift. … The therapist, without directly identifying that covert, resistant ego state or its cognition, attempts to challenge and shift that ego state by systematically offering it cognitions from adult ego states which hold contrary cognitions. In effect, an implicit dialogue is occurring between the resistant ego state with its negative cognition and a more adult ego state with a positive cognition. The EMDR processing diminishes the dissociative barrier between the cognitive components of these two otherwise previously unconnected ego states.

Lawrence, 1999

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Working with ego states

Accessing an ego state via Cognitive interweave

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Working with ego states

Accessing an ego state directly

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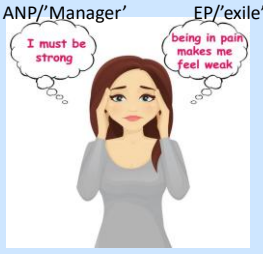
Working with ego states

Ego-state/parts work

ANP/'Manager' EP/'exile'



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4. Resourcing

Resource development and installation (RDI)

"Resource development emphasizes stabilization, reparation attachment and affect regulation deficits, development of coping skills and strengthening of self capacities."

Korn & Leeds, 2002

"RDI encompasses a wide range of interventions, such as skills building, use of metaphors, art therapy, imagery, and hypnosis for developing resources used before applying BLS as well as the application of brief sets of BLS for the installation or strengthening of these resources."

Leeds, 1996.

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6 resourcing strategies in EMDR treatment

1. 'Front loading' (Shapiro, 1995)
   Light-stream, safe place, +'ve or functional memories
2. RDI (Leeds, 1995)
   Therapeutic relationship, skills development. Imagery +BLS
3. Interweaves
   Cognitive, process, content, relational
4. Dyadic resourcing (Manfield, 2010)
   Internal resource dyad (loveable child + loving adult)
5. Resources based on somatic effects BLS
6. Resources based on positive bodily states

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Resourcing based on +'ve bodily states

1. Check for +'ve bodily states during processing/bodyscan
2. Direct attention to +'ve bodily state
   (assuming no other material present)
3. Install x stimulate with slow BLS
   (6-12 slow Ems/set)
4. Check in
5. Restimulate until complete
6. Re-evaluate

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Resourcing based on +'ve bodily states

- [redacted]

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Key points

- Target: Neutral body state → BLS
  (" life feels bearable")
  ↓
- Physiological resp. "I stopped breathing"
  Feeling "Fresh"
  ("Everything's in the past")
  ↓ BLS

Physiological resp. Felt sick
"Like I'm going to throw up"
"but I don't know why"
"

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Recalls being labelled bad because of autistic behavior

"It was hammered into me to be normal"

"I don't know who I was – it was lost"

(Remembering how he was mistreated vs letting to of that).

"My whole life I was told you're not supposed to."

Sick feeling – "it feels protective,"

"Its not a bad thing to have"

(Feelings about being mistreated)

"I don't have to hold that defence"

(not remembering feelings about being mistreated)

"I just need to stand true"

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The aim of therapy

"The client learns to " endure every experience as such without tying it up causally, totally or finally with the rest of his life, or with what goes on in the world at all. The person then lives more in the present, in the moment, without the longing to make it eternal. Therapy works experientially: If the fullness of living can be felt in therapy, it can be felt in life. All therapeutic endeavours … ought to aim towards life itself."

Otto Rank, 1941, p. 278 .

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