Appendix 1A - Executive Limitation Policy Appendix:

This appendix contains the following:

Policy Reference – 1.0

EMDRIA Definition of EMDR
Date of Adoption: 5/26/03, 10/18/03, Revised 10/25/09

1.0A EMDRIA has a dynamic definition of EMDR to meet the informational needs of consumers, practitioners, health care providers, EMDRIA education programs, researchers, and administrators of programs.

A1. Tier 1 **Global Definition** - EMDR is a phased, scientifically validated, and integrative psychotherapy approach based on the theory that much of psychopathology is due to traumatic experience or disturbing life events. These result in the impairment of the client's innate ability to process and to integrate the experience or experiences within the central nervous system. The core of EMDR treatment involves activating components of the traumatic memory or disturbing life event and pairing those components with alternating bilateral or dual attention stimulation. This process appears to facilitate the resumption of normal information processing and integration. This treatment approach can result in the alleviation of presenting symptoms, diminution of distress from the memory, improved view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers.

A2. Tier 2

A2A. **Purpose of Definition** - The purpose of this definition is to serve as the foundation for the development and implementation of policies in all 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.

A2B. **Foundational Sources and Principles for Evolution** - Francine Shapiro, Ph.D., developed EMDR based on clinical observation, controlled research, feedback from clinicians whom she had trained, and previous scholarly and scientific studies of information processing. The original source of EMDR is derived from Shapiro's Accelerated Information Processing as it is described in her writings (Shapiro, 1995). EMDRIA adopted Shapiro's (2001) Adaptive Information Processing (AIP) model as a working model to guide clinical practice, explain EMDR's effects, and provide a common platform for theoretical discussion. Other information processing models such as the Transfer-Appropriate Processing model, the Cortical Reinstatement model, the Parallel-Distributed/Connectionistic model, and the Thalamocortical-Temporal Binding model, have added further potential for understanding the neurophysiologic underpinnings of the EMDR process. The elucidation of both mechanisms and models is understood to be an on-going and open process.

A2C. **Aim of EMDR -** In the broadest sense, EMDR is intended to alleviate human suffering and assist individuals and society to fulfill their potential for development while minimizing risks of harm in its application. For the client,

the aim of EMDR treatment is to achieve the most profound and comprehensive treatment effects in the shortest period of time, while maintaining client stability within a balanced family and social system.

A2D. **Framework** - EMDR is an approach to psychotherapy that supports the premise that most people have both an innate tendency to move toward health and wholeness, and the inner capacity to achieve it. It consists of a unique standardized set of procedures and clinical protocols which are combined with the unique element of dual attention/bilateral stimulation. This process activates the components of the memory of disturbing life events and appears to facilitate the resumption of normal information processing and integration. Intervention by the therapist is kept to the minimum that is necessary to keep that processing moving until resolution is reached. EMDR is compatible with elements from various psychotherapies (e.g., psychodynamic, cognitive-behavioral, interpersonal, person-centered, and body-centered.)

The following are current tenets of information processing theory which guide the application of EMDR, i.e., guide treatment planning and predict outcomes:

A2DI. Life events can generate effects similar to traumatic events recognized by DSM for diagnosis of PTSD.

A2DII. 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 beliefs, expectations and potential fears.

A2DIII. When a memory is accessed adaptively, it is linked with emotional, cognitive, somatosensory, and temporal systems which facilitate its accuracy and appropriateness with respect to time, place, and contextual situation.

A2DIV. When traumatic or fearful events are encoded maladaptively, experiences tend to be dysfunctionally linked to existing neural networks, precluding processing into adaptive resolution.

A2DV. Pathology results when the linkage or binding components of the information processing system are impaired. Consequently, experiences are inadequately processed and remain dysfunctionally linked within emotional, cognitive, somatosensory, and temporal systems, thereby becoming susceptible to dysfunctional recall with respect to time, place, and context and to experience in fragmented form.

A2DVa. Accordingly, new information, positive experiences and affects are unable to functionally connect with the disturbing memory. This impairment in linkage leads to a continuation of symptoms and to the development of new triggers.

A2DVI. EMDR procedures facilitate access to dysfunctionally linked experiential components, allowing them to be integrated/linked within appropriate emotional, cognitive, somatosensory, and temporal systems. This facilitates the effective processing of traumatic or disturbing life events and associated beliefs, to an adaptive resolution. As a result of effective EMDR treatment, previously impaired linkage or binding mechanisms in the information processing system are repaired, facilitating real-time access to appropriately linked emotional, cognitive, somatosensory, and temporal systems. As a result, accessing of adaptively linked

information is experienced as integrated, whole and appropriate to the immediate situation.

A2E. **Method** - EMDR uses specific psychotherapeutic procedures to 1) Access existing information, 2) introduce new information, 3) facilitate information processing and 4) inhibit accessing of inappropriate information. Unique to EMDR is the view that incomplete processing and incomplete integration of memories of trauma and/or disturbing life experience are a primary basis of psychopathology. Specific procedural steps are used to access and process information and incorporate alternating bilateral sensory stimulation. These well-defined treatment procedures and protocols are intended to create states of dual attention to facilitate information processing. EMDR utilizes an 8-phase approach to treatment that ensures sufficient client stabilization before, during, and after the processing of distressing and traumatic memories and associated stimuli. The intent inherent in EMDR therapy is to facilitate the client's innate ability to heal. Therefore, therapist intervention is kept to the minimum necessary to the continuity of information processing.

A2EI. In Phases 3 – 6, standardized steps should be followed to achieve fidelity to the method, as fidelity to these steps has been demonstrated by research to improve outcome. Phases 1, 2, 7 and 8 may be conceptualized and achieved in more than one way, but the broad goals of each phase should be achieved. These guidelines correspond to generally accepted best trauma treatment but do have aspects which are unique to EMDR and EMDR cannot be responsibly practiced without attention to the goals of these phases.

A2EIa. In the Client History Phase (Phase 1), the clinician attempts to identify as complete a clinical picture as is prudent before attempting to treat the client, including looking through the lens of incomplete processing and incomplete integration of memories of trauma and/or disturbing life experience as a basis of psychopathology. Determination is made regarding the suitability of EMDR therapy for the presenting problem and for the client, as well as appropriate timing. Targets from positive and negative events in the client's life are explored for future processing and a treatment plan prepared, with attention to past, present, and future treatment issues (see also A2EII.) With more complex trauma histories, detailed trauma history may need to be postponed. Any secondary gain issues that might prevent treatment effects should be addressed.

A2EIb. In the Preparation Phase (Phase 2), the client is made aware of the therapeutic framework of EMDR and receives sufficient information to give informed consent. The clinical preparation for EMDR processing includes the establishment of sufficient rapport to give the client a sense of safety and foster the ability to tell the therapist what is being experienced throughout the processing. The client develops mastery of self-soothing and affect regulation skills as appropriate to facilitate stability during the processing phases. Some clients will require a lengthy preparation phase for adequate stabilization prior to dealing directly with the memories of trauma.

A2EIc. In the Assessment Phase (Phase 3) the standardized steps are carried out as follows: the clinician identifies the components of the target/issue and establishes a baseline response; once the memory or issue has been identified, the client is asked to select the sensory image that best represents it; a negative cognition is chosen that expresses the currently held maladaptive self-assessment that is related to the issue or event; a positive cognition is chosen that will tentatively be used to replace the negative cognition during Installation Phase (Phase 5); the validity of the positive cognition is assessed, utilizing the 7 point VOC Scale; the emotions attached to this target/issue are identified; the level of

disturbance is assessed, utilizing the 0 to 10 SUD Scale; the client identifies the location in the body of physical sensations that are stimulated when concentrating on the event or issue.

A2EId. During the Desensitization Phase (Phase 4) the client is asked to notice, while experiencing alternating bilateral stimulation, his reactions to the processing. This phase of treatment encompasses all responses, including new insights and associations, regardless of whether the client distress level is increasing, decreasing or stationary. This process continues until the SUD level is reduced to 0 or 1 (when ecologically valid).

A2EIe. In the Installation Phase (Phase 5), the client is asked to hold the most appropriate positive cognition in mind, along with the target memory. Bilateral stimulation is continued until the client's rating of the positive cognition reaches the level of 7 (or ecologically valid rating) on the VOC Scale.

A2EIf. In the Body Scan Phase (Phase 6), the client is asked to hold in mind both the target event and the positive cognition and scan the body mentally from top to bottom. The client is asked to identify any residual tension or discomfort in the form of bodily sensations. When present, these bodily sensations are targeted with bilateral stimulation until the discomfort is resolved.

A2EIg. In the Closure Phase (Phase 7), therapist and client may use a variety of techniques to facilitate client stability at the completion of the EMDR session and between sessions. The client should be made aware that processing may continue after the session.

A2EIh. In the Reevaluation Phase (Phase 8), the clinician assesses the effects of previous processing of targets, looking for residual disturbance, new material which may have emerged, current triggers, systemic issues, etc.

A2EII. To achieve comprehensive treatment effects a three-pronged basic treatment protocol is generally used. Past events are first processed. After adaptive resolution of past events, current stimuli still capable of evoking distress are processed. Finally future situations are processed to prepare for possible or likely circumstances. There may be situations where the order may be altered or prongs may be omitted, based on the clinical picture.

A2EIII. As EMDR is a process, not a technique; it unfolds according to the needs, resources, diagnosis, and development of the individual client in the context of the therapeutic relationship. For instance, when working with children, especially with young children who might be preverbal or unable to determine a Negative Cognition, drawings might be used instead. A dissociative or learning disabled client might also be unable to determine a Negative Cognition but could instead articulate a somatic or affective aspect of the target. Therefore, different elements may be emphasized or utilized differently depending on the unique needs of the particular client or of special populations. When a training program, presentation, or workshop makes changes to the standard protocol, the changes should be supported by research and/or clinical rationale which includes a substantive literature review.

A2F. **Fidelity in application through training and observation:** It is central to EMDR that positive results from its application derive from the interaction between clinician, therapeutic approach, and client. Therefore, graduate education in a mental health field (e.g., clinical psychology, psychiatry, psychiatric nursing, social work, counseling, or marriage and family therapy) leading to eligibility for licensure, certification or registration, along with supervised training, are considered essential to achieve optimal results. Meta-analytic research indicates that the degree of fidelity to the standard EMDR protocol is highly correlated with the outcome of EMDR treatment. Evidence of fidelity in procedure and appropriateness of protocol is considered central to both research and the clinical application of EMDR.