Basic Training Curriculum Requirements

OBJECTIVE: The purpose of the EMDRIA Basic Training Curriculum is to assist providers in meeting the minimum standards for EMDRIA Approved Basic Training in EMDR therapy. The goal is to create a complete integrated training program that provides the clinician with the knowledge and skills to utilize EMDR therapy, a comprehensive understanding of case conceptualization and treatment planning, and the ability to integrate EMDR therapy into their clinical practice. At a minimum, the Basic Training Curriculum requires instruction in the current explanatory model, methodology, and underlying mechanisms of EMDR therapy through lecture, practice, and integrated consultation. It is recommended that the syllabus present the strengths and limitations of Shapiro's EMDR therapy model including up to date research.

While the EMDRIA Approved Basic Training Curriculum outlines the minimum requirements which need to be met, the developer of a specific curriculum can enhance or expand any portion as they see fit.

REQUIREMENTS:

- **I.** Three sections with a minimum time and content requirement
  - **A.** Instructional (20 hours)
  - **B.** Supervised Practicum (20 hours)
  - **C.** Consultation (10 hours)
- **II. Faculty:** EMDRIA Approved Consultants, as specified. Consultants in Training can also be used under consultation of an EMDRIA Approved Consultant.
- **III. Required Text:** Shapiro, F. *Eye Movement Desensitization and Reprocessing (EMDR) Therapy, Basic Principles, Protocols and Procedures.* (Latest Edition). New York: The Guilford Press.
- **IV.** Syllabus must be consistent with the above listed text and EMDRIA's definition of EMDR therapy.
- **V. Supplemental material:**
  - **A.** Access to the EMDRIA definition of EMDR therapy can be found online at www.emdria.org/resource/resmgr/Definition/EMDRIADefinitionofEMDR.pdf
  - **B.** Access to a current list of EMDR related research citations can be found online at http://www.emdria.org/?page=EMDRResearch
  - **C.** Contact information for EMDRIA Approved Consultants can be found online at http://www.emdria.org/search/custom.asp?id=2337
- **VI.** Trainees are required to complete the entire basic training program to receive a certificate of completion.

SECTION ONE: INSTRUCTIONAL

The goal of the Instructional Section of the training is to provide information and understanding in each of the following areas. Although EMDRIA is not regulating the amount of time spent on any one portion, it is expected that the majority of time will be spent teaching the Method section as well as case conceptualization and treatment planning. The curriculum developer may determine the order in which the material is presented.

Minimum Required Time: 20 hours

I. History and Overview

The goal of this section is to review the historical evolution of EMDR therapy from its inception through validation by randomized controlled studies. This includes, but is not limited to:

A. Origin:

1. Shapiro's chance observations which led to empirical observations and the development of EMDR therapy methodology.
2. The publication of Shapiro (1989) pilot study through the validation of EMDR therapy's effectiveness through controlled studies.
3. Current inclusion in Treatment Guidelines

B. Switch from EMD to EMDR therapy: Understanding the significance of the shift in name and model from EMD to EMDR therapy, both in terms of revised theoretical model and procedure.

1. Switch from Desensitization model to Adaptive Information Processing (AIP) model
2. The effect of EMDR therapy is not desensitization in and of itself, but includes the multifaceted impact of reprocessing all aspects of negative, maladaptive information to adaptive, healthy, useful resolution (e.g., change of belief, elicitation of insight, increase in positive affects, change in physical sensation, and behavior).

C. Current EMDR therapy-related Research: The Provider must include information about the representative studies to give the trainees a general grasp of the EMDR therapy literature.

1. A current annotated bibliography of EMDR therapy-related theory and research supporting your program's content that you deem foundational to your students' understanding of EMDR therapy's efficacy, model, mechanism, and method should be included in the handouts. This list need not be exhaustive. It should be reviewed no less than yearly, and updated when needed.
2. Resource sites where this material can be located and updated on the internet should be provided – with website addresses verified and updated no less than yearly.

II. Distinguish Model, Methodology, and Mechanism

This section of the curriculum explains these three aspects of EMDR therapy and distinguishes among them. The Adaptive Information Processing model (AIP) is the underlying explanatory **model** of EMDR therapy. It is important that trainers have a full understanding of this model as outlined in Shapiro (2001). The AIP model provides the theoretical foundation of EMDR therapy. The **methodology** section includes the eight-phase treatment procedures of the basic EMDR therapy protocol, plus safeguards, ethics, and validated modifications for specific clinical situations. The **mechanism** section includes current hypotheses regarding how or why EMDR therapy works on the neurobiological level, plus current research exploring mechanisms of action. Although hypotheses regarding the mechanism of action are speculative at present, an introduction of these hypotheses is important. With a clear understanding of the AIP model, the specific aspects of the method, and current thinking regarding mechanism, the participants should be well informed regarding the study and practice of EMDR therapy.

94 **A. Model – Adaptive Information Processing (AIP):**
95 Shapiro adapted and applied the Adaptive Information Processing (AIP) model as the
96 underlying explanatory model of EMDR therapy. EMDR therapy is based, therefore,
97 on a distinct information processing model which incorporates specific principles and
98 treatment procedures. The AIP model guides history taking, case conceptualization,
99 treatment planning, intervention, and predicts treatment outcome. (See Appendix A
100 for information about antecedent information processing models.)
101
102 **1. Basic hypotheses concepts of AIP:**
103 **a.** The neurobiological information processing system is intrinsic, physical, and
104 adaptive
105 **b.** This system is geared to integrate internal and external experiences
106 **c.** Memories are stored in associative memory networks and are the basis of
107 perception, attitude and behavior.
108 **d.** Experiences are translated into physically stored memories
109 **e.** Stored memory experiences are contributors to pathology and to health
110 **f.** Trauma causes a disruption of normal adaptive information processing which
111 results in unprocessed information being dysfunctionally held in memory
112 networks.
113 **g.** Trauma can include DSM 5 Criterion A events and/or the experience of
114 neglect or abuse that undermines an individual's sense of self worth, safety,
115 ability to assume appropriate responsibility for self or other, or limits one's
116 sense of control or choices
117 **h.** New experiences link into previously stored memories which are the basis of
118 interpretations, feelings, and behaviors
119 **i.** If experiences are accompanied by high levels of disturbance, they may be
120 stored in the implicit/nondeclarative memory system. These memory
121 networks contain the perspectives, affects, and sensations of the disturbing
122 event and are stored in a way that does not allow them to connect with
123 adaptive information networks
124 **j.** When similar experiences occur (internally or externally), they link into the
125 unprocessed memory networks and the negative perspective, affect, and/or
126 sensations arise
127 **k.** This expanding network reinforces the previous experiences
128 **l.** Adaptive (positive) information, resources, and memories are also stored in
129 memory networks
130 **m.** Direct processing of the unprocessed information facilitates linkage to the
131 adaptive memory networks and a transformation of all aspects of the memory.
132 **n.** Nonadaptive perceptions, affects, and sensations are discarded
133 **o.** As processing occurs, there is a posited shift from implicit/nondeclarative
134 memory to explicit/declarative memory and from episodic to semantic
135 memory systems (Stickgold, 2002)
136 **p.** Processing of the memory causes an adaptive shift in all components of the
137 memory, including sense of time and age, symptoms, reactive behaviors, and
138 sense of self
139
140

141 **2. Clinical Implications: The AIP guides case conceptualization, treatment**
142 **planning, intervention, and predicts treatment outcome**
143 **a.** Clinical complaints that are not organically based or are caused by insufficient
144 information are viewed as stemming from maladaptively stored and
145 unprocessed information which has been unable to link with more adaptive
146 information.
147 **b.** Earlier memories which are maladaptively stored increase vulnerability to
148 pathology including anxiety, depression, PTSD, and physical symptoms of
149 stress and may interfere with healthy development of an individual's sense of
150 self worth, safety, ability to assume appropriate responsibility for self or other,
151 or limits one's sense of control or choices
152 **c.** The information processing system and stored associative memories are a
153 primary focus of treatment
154 **d.** Procedures are geared to access and process dysfunctional memories and
155 incorporate adaptive information
156 **e.** The intrinsic information processing system and the client's own associative
157 memory networks are the most effective and efficient means to achieve
158 optimal clinical effects
159 **f.** Targeted memories must be accessed as currently stored so the appropriate
160 associative connections are made throughout the relevant networks
161 **g.** Unimpeded processing allows the full range of associations to be made
162 throughout the targeted memory and the larger integrated networks
163 **i.** Interventions to assist blocked processing should mimic spontaneous
164 processing
165 **ii.** All interventions change the natural course of processing and potentially
166 close some associated pathways
167 **iii.** Following any intervention, the target needs to be reaccessed and fully
168 processed in the original form
169 **h.** Processing shifts all elements of a memory to shift to adaptive resolution
170
171 **3. Differentiate from other models:** Highlight how pathology and treatment are
172 viewed differently from other orientations (see Appendix B).
173
174 **4. Applications:** It is well documented that trauma can contribute to a wide range
175 of presenting problems, not just PTSD. The curriculum provides an
176 understanding of the wide range of applications for EMDR therapy, when the
177 overall clinical picture (i.e., presenting problems, symptoms, and character
178 structure and life stressors) is framed within the AIP model. This section also
179 provides another opportunity for teaching how the AIP model guides case
180 conceptualization, treatment planning and overall clinical practice.
181 **a.** Scientifically-validated applications
182 **b.** Non-validated applications still needing research
183
184 **B. Methodology** – The curriculum explains and teaches the method of EMDR therapy.
185 Although the Basic EMDR therapy protocol is taught, other such issues surrounding
186 the practice and professionalism of EMDR therapy are to be included in the
187 curriculum.

188 **1. 8-Phases:** EMDRIA requires that the latest edition of the Shapiro text and the
189 EMDRIA Definition of EMDR therapy guide the teaching for all 8 Phases of
190 EMDR therapy. EMDRIA also requires that participants must have exposure to
191 all 8 phases through lecture, demonstration, and practice. It is imperative that
192 trainees understand how case formulation and treatment planning are incorporated
193 into each of the 8 phases.
194
195 **a. History Taking, Case Conceptualization & Treatment Planning (Phase**
196 **1):** The curriculum provides instruction on what information is gathered from
197 the client and how this information is used. That information with the
198 evaluation of current level of functioning, character structure, and treatment
199 goals are used to assess appropriate client selection, client readiness, target
200 selection based on the three-pronged protocol and treatment planning.
201 **i.** Focus on areas of history taking unique to EMDR therapy
202 practice/processing
203 **ii.** Offer variety of ways to take a history of traumatic events, abuse, neglect,
204 or thematic negative cognitions
205 **iii.** Offer an understanding of the impact of trauma and neglect on healthy
206 development and assessment of potential developmental holes or
207 maladaptively stored information that underlies current problems or
208 symptoms
209 **iv.** Introduce three-pronged approach and methods to identify appropriate
210 targets as treatment planning methodology
211 **v.** Explain the treatment planning aspect of the selection and ordering of
212 memories to be processed
213 **vi.** Introduce appropriate techniques used to identify earliest associated
214 memories
215 **vii.** Introduce case conceptualization issues, such as degree of stabilization,
216 affect intolerance, assessment of adequacy of skills and resources,
217 duration of issues/dysfunction
218 **viii.** Client selection criteria and indications of client readiness.
219 **ix.** Client's ability to sustain Dual Attention
220 **x.** Explore issues that might impede or interfere with processing and
221 readiness, such as:
222 a) Secondary gain issues
223 b) Present-day stressors (personal, work-related, medical)
224 c) Timing issues (e.g.,. unavailability of clinician)
225 d) Medical concerns
226 e) Legal issues, (e.g. impending testimony)
227
228 **b. Client Preparation (Phase 2):** The goal of this section of the curriculum is
229 to assure that the client is informed about EMDR therapy, prepared for EMDR
230 therapy, and to help the client establish the necessary ability to maintain a
231 Dual Awareness during processing and the ability to manage affective
232 reactions between sessions. These activities include but are not limited to:
233 **i.** Education about EMDR and its effects

234 **ii.** Assess/develop therapeutic rapport
235 **iii.** Address client's concerns
236 **iv.** Explain the details of the EMDR therapy procedure
237 **a)** Seating arrangement
238 **b)** Dual Attention Stimulus in the form of bilateral eye movements, taps,
239 or tones (e.g., different types, testing speed & distance)
240 **c)** Accurate observation and reporting
241 **d)** Setting expectations and utilization of the "Stop" signal
242 **v.** Client Safety and Stability:
243 **a)** Assess/develop client's stabilization skills
244 **b)** Knowledge of commonly used procedures to enhance safety and self-
245 control for issues related to safety and stability.
246 **c)** Appropriate use of Safe Place, containment skills and Resource
247 Development
248 **vi.** Review client selection criteria and precautions
249
250 **c. Assessment (Phase 3):** All aspects of the assessment of targets are taught.
251 The curriculum explains and teaches the function and importance of each
252 component of the assessment, and how to obtain them, (e.g., distinguish
253 between appropriate and inappropriate cognitions), and the rationale for the
254 order of the assessment.
255 **i.** Image
256 **ii.** Negative Cognition (NC)
257 **iii.** Positive Cognition (PC)
258 **iv.** Validity of Cognition (VOC)
259 **v.** Emotions
260 **vi.** Subjective Units of Disturbance Scale (SUDS)
261 **vii.** Sensations
262
263 **d. Desensitization (Phase 4):** In this section, the curriculum provides
264 instruction on all aspects and expectations of what and how the processing
265 occurs and evolves.
266 **i.** Explain channels of processing
267 **ii.** Explain the application of all forms of Dual Attention Stimulus (DAS),
268 provided in the form of bilateral eye movements, taps, or tones (offered) in
269 discrete intervals, and circumstances when alternatives to eye movement
270 may be necessary
271 **iii.** Note types of processing to expect (e.g., visual, emotional, sensations)
272 **iv.** Emphasize the importance of therapist maintaining empathic
273 connectedness while allowing the client to process without unnecessary
274 therapist intrusion
275 **v.** Emphasize the importance of following the client's processing in
276 determining the length of DAS sets.
277 **vi.** Reinforce the three-pronged approach
278 **vii.** Note themes and plateaus or difficulties in processing such as self worth,
279 appropriate responsibility for self and other, safety, and choices

280 **viii.** Explain working with abreactions
281 **ix.** Note how to work with the emergence of new memories that
282 spontaneously occur during processing which may need additional
283 targeting
284 **x.** Identify the selection of appropriate clinical interventions for ineffective
285 or blocked processing which include but are not limited to: change of
286 DAS, return to target, maximize or minimize assessment components
287 **xi.** Explain Cognitive Interweave
288 **xii.** Identify methods to link to early events that are blocked or not conscious,
289 such as the use of the Affect Bridge, Float Back or Touchstone events
290 **xiii.** Explain timing of re-accessing and reassessing the target
291 **xiv.** Explain therapist characteristics or responses that may interfere with
292 adequate processing
293 **xv.** Explain client perceptions of therapist characteristics or responses that
294 may interfere with adequate processing
295
296 **e. Installation (Phase 5):** The curriculum instructs when, how and why the
297 Installation phase is completed.
298
299 **f. Body Scan (Phase 6):** The curriculum instructs when and how to conduct the
300 Body Scan, as well as the importance of the information gained during the
301 Body Scan.
302
303 **g. Closure (Phase 7):** The curriculum instructs the purpose of closure for both a
304 single therapy session as well as closure to the processing of a given EMDR
305 therapy target. Rationale and methods to ensure client stability in the event of
306 incomplete processing of a specific target must be emphasized.
307
308 **h. Reevaluation (Phase 8):** The curriculum instructs on the rationale of
309 "checking your work" of the previous session. It provides information on the
310 status of a fully processed memory. A fully processed memory needs to have
311 processed the past memory, present triggers, and future template. If the
312 memory is not fully processed phase 8 instructs on how to reengage the target
313 for continuing processing. A re-evaluation of all targets occurs at the
314 conclusion of therapy.
315
316 **2. Three Pronged Model – Future Template**
317 The curriculum includes instruction on the Three Pronged Model. To achieve
318 comprehensive treatment effects a three-pronged basic treatment protocol is
319 generally used so that past events are reprocessed, present triggers desensitized,
320 and future adaptive outcomes explored for related challenges. The timing of
321 addressing all three prongs is determined by client stability, readiness and
322 situation. There may be situations where the order may be altered or prongs may
323 be omitted, based on the clinical picture and the clinician's judgment.
324 **3. Advanced Methodology:** Procedural modifications are shown to produce better
325 outcomes in specific situations. The curriculum must include the rationale for any

326 modifications of the EMDR therapy basic protocol. This also provides another
327 opportunity to discuss case conceptualization and treatment planning from the
328 framework of the AIP. (**Please Note:** Details on procedural modifications which
329 are adequately researched and substantiated by EMDRIA will be incorporated
330 into the curriculum as they are made available. Upon approval, updated
331 information will be forwarded to providers.)
332
333 **a. Protocols and Procedures for Special Situations**
334 **i.** Recent events
335 **ii.** Anxiety and Phobia
336 **iii.** Illness and somatic disorders
337 **iv.** Grief
338 **v.** Self-use
339
340 **b.** The curriculum introduces working with specific populations and encourages
341 additional training for those who work in these areas
342 **i.** Children
343 **ii.** Couples
344 **iii.** Addictions
345 **iv.** Sexual Abuse Victims
346 **v.** Complex PTSD or DESNOS
347 **vi.** Dissociative clients
348 **vii.** Military
349
350 **4. Professional, legal, ethical issues**: This curriculum provides an opportunity to
351 remind trainees of the general principles and issues necessary for excellence in
352 practice. It can also provide information about EMDRIA, the need for ongoing
353 continuing education and other professional or practical issues (e.g., insurance
354 reimbursement).
355 **a.** Scope of practice: Within their competency level (i.e., education, training,
356 and professional experience) and licensure status.
357 **b.** Standards of practice of your professional discipline.
358 **c.** Issues of informed consent.
359
360 **C. Hypothesized Mechanisms of Action and Neurobiological aspects of EMDR**
361 **therapy** (see Appendix C).
362 **1. The curriculum must provide the most current information in these or any**
363 **emerging explanatory models.**
364
365 **SECTION TWO: SUPERVISED PRACTICUM**
366 The goal of Supervised Practicum is to facilitate the demonstration and practice of the EMDR
367 therapy methodology as outlined above in the Shapiro text, and the EMDRIA Definition of
368 EMDR therapy.
369
370 **Time Requirement:** 20 Hours
371 The supervised practicum should be appropriately scheduled to allow adequate teaching time for

372 the full explanation of the component to be demonstrated and practiced.
373 **Faculty Requirement:** EMDRIA Approved Consultant or Consultant in Training under the
374 consultation of an Approved Consultant. The ratio of practicum supervisor to trainees should not
375 exceed 1:10 to allow for direct behavioral observation of each trainee.
376
377 **I. Practice Exercises**
378 **A.** To achieve the goals of the Supervised Practicum, practice may be done in dyads or
379 triads.
380 **1.** The role of the clinician is required.
381 **2.** The role of clinical recipient is required.
382 **3.** The role of "observer" is preferred but not mandatory. EMDRIA recognizes that
383 it is not always possible to fill the role of Observer during the supervised
384 practicum.
385 **B.** It is imperative that trainees receive direct behavioral observation and feedback.
386 **C.** Whenever appropriate, trainees practice with real life experiences.
387 **D.** Ample practice is recommended before introducing/teaching the Cognitive
388 Interweave.
389 **E.** Practice should be included for each phase of the procedure as outlined in the
390 Instructional Section. Special attention should be given to the following:
391 **1. Phase One: History taking**
392 **a.** Case conceptualization
393 **i.** Appropriate techniques are used to identify the earlier associated targets
394 **ii.** Target identification is associated with primary presenting complaints
395 **b.** Treatment planning
396 **i.** Selection and ordering of targets to be processed
397 **ii.** Three pronged approach
398 **4. Phase Four: Desensitization**
399 **a.** Application of all forms of DAS, provided in the form of bilateral eye
400 movements, taps, or tones (offered) in discrete intervals, and circumstances
401 when alternatives to eye movements may be necessary.
402 **b.** Types of processing to expect (e.g., visual, emotional, sensations)
403 **c.** Importance of allowing the client to process without unnecessary therapist
404 intrusion.
405 **d.** Note the emergence of new memories that spontaneously occur during
406 processing that may need additional targeting
407 **e.** Timing of re-accessing and re-assessing the target
408 **f.** Working with abreactions
409 **g.** Selection of appropriate clinical interventions for ineffective or blocked
410 processing which include, but are not limited to:
411 **i.** Change of DAS, return to target, maximize or minimize assessment
412 components
413 **ii.** Cognitive Interweave
414 **iii.** Affect Bridge or Float Back technique to identify earlier disturbing
415 memories that need to become the focus of processing
416 **iv.** Re-accessing the target and processing in undistorted form.
417 **h.** Each trainee practices the basic elements of EMDR therapy (Target

Assessment, Desensitization, Installation, Body Scan and Closure) – including closing off incomplete sessions – during the practicum sessions. It is understood that trainers will have different ways of implementing this practice, but it is recommended that every effort be made to include each aspect of the three pronged protocol – Past, Present and Future. In addition, it is recommended that trainees work on their own issues to the extent consistent with participant safety.

k. Additional areas that may be explored when they arise:
   i. Therapist characteristics or responses that may interfere with adequate processing
   ii. Client perceptions of therapist characteristics or responses that may interfere with adequate processing

SECTION THREE: CONSULTATION

Consultation is a required content area which has to be added into the Basic Training curriculum. By having consultation, trainees will be able to safely and effectively integrate the use of EMDR therapy into their clinical setting. Consultation provides an opportunity for the integration of the theory of EMDR therapy along with the development of EMDR therapy skills. During consultation trainees receive individualized feedback and instruction in the areas of case conceptualization, client readiness, target selection, treatment planning, specific application of skills, and the integration of EMDR therapy into clinical practice. Ethical and professional guidelines already call for clinicians to obtain consultation when incorporating new methods into their clinical practice. Requiring Providers to include consultation as a component of Basic Training will raise the professional stature of EMDR therapy training and assure consistent adherence to this guideline. A variety of mechanisms can be employed by different Providers to include consultation. Consultation increases the use of EMDR therapy by those who have received training, reduces the formation of bad habits and the risks of problematic use of EMDR therapy. It also allows the clinician to develop and integrate EMDR therapy skills creatively into their other skills in a way that enhances clinical efficiency and effectiveness in helping a wider range of clients meet their goals for change. If a behavioral sample of a trainee's work with actual clients is required by the Provider, consultation provides an excellent forum in which that activity can take place.

Time Requirement: 10 hours of consultation are required and are provided in developmental increments to extend over the course of the training.
Faculty Requirement: EMDRIA Approved Consultant or Consultant in Training under the consultation of an Approved Consultant. The ratio of consultant to trainees should not exceed 1:10 (smaller consultant to trainee ratios are encouraged).

I. Consultation addresses, but is not limited to, the following content:
   A. Use of EMDR therapy within a structured treatment plan
   B. Application of the standard EMDR therapy procedural steps
   C. Case conceptualization and target selection
   D. Client readiness including inclusion, exclusion and cautionary criteria for EMDR therapy

464 **E.** Client safety and effective outcomes using the standard EMDR therapy procedural
465 steps
466 **F.** Integration of EMDR therapy into their existing clinical setting or in an alternate
467 clinical setting
468 **G.** Specific application of skills
469 **H.** Consultation is about real cases and not experiences that occur in practicum
470 **II.** Consultation provides opportunity for the faculty to assess the strengths and weaknesses
471 of each trainee's overall understanding and knowledge of EMDR therapy and the practice
472 of EMDR therapy skills and the opportunity to tailor further learning experiences to
473 address deficits.
474 **III.** Consultations sessions are appropriately scheduled to allow adequate time for teaching,
475 practicum and clinical use of EMDR therapy, to maximize the discussion of case
476 conceptualization, client readiness, target selection, treatment planning, specific
477 application of skills, and the integration of EMDR therapy into clinical practice.
478 **IV.** Consultation may be integrated into an extended training format or consultation may be
479 provided by local Approved Consultants and reports of completion sent to the Provider.
480 In the latter case, the Approved Consultant must furnish the Provider with written
481 documentation that the Consultation requirement has been met (i.e., feedback may be in
482 the form of a simple feedback form which is completed and submitted to Provider).
483 **V.** Acceptable Consultation Formats
484 **A.** Individual: One-on-one time between participant and consultant.
485 **B.** Group: Group consultation could involve discussions of issues that have a generic
486 interest, but should not replace the intimate formats that allow for individualized
487 feedback. As a general guideline, groups should allow a ratio of 15 minutes per
488 individual participant. A group of four would meet with at least one consultant for no
489 less than one hour; a group of eight would meet with at least one consultant for no
490 less than two hours. Participants would receive credit for the total time spent in the
491 group.
492 **C. Combinations of Individual and Group:** Any combination of Individual
493 Consultation and Group Consultation that meets the time guideline suggested above
494 and provides a total of ten hours of consultation time.
495
496 **Appendix A**
497 **I. Antecedent, historical models of emotional information processing:**
498 **A.** Peter J. Lang (1977, 1979, 2000)
499 **B.** Stanley Rachman (1980)
500 **C.** Gordon Bower (1981)
501 **D.** Edna Foa and Michael J. Kozak (1986)
502
503 **Appendix B**
504 **I. Differentiate from other models:** Highlight how pathology and treatment are viewed
505 differently from other orientations. The trainer should be prepared to highlight and/or to
506 answer questions regarding how EMDR therapy and the Adaptive Information Processing
507 Model contrast and compare with other psychotherapeutic approaches. This might
508 include the view of pathology and health, case conceptualization, and how change occurs.
509 Examples would include:

510 **A.** Cognitive—
511 **1.** Irrational thoughts are the basis of pathology
512 **2.** Cognitions are changed through reframing, self-monitoring, and homework
513 exercises
514 **B.** Behavioral—
515 **1.** Cannot see within the "black box" (the brain)
516 **2.** Learned behavior is changed through conditioning, exposure, modeling, etc.
517 (learning processes)
518 **C.** "Third wave" of CBT—
519 **1.** Suffering is inevitable
520 **2.** Change is through acceptance, commitment, and Mindfulness exercises
521 **D.** Psychodynamic—
522 **1.** Explores the impact of Family of Origin, Object relations
523 **2.** Change is created by insight or "working through"
524 **3.** Goal is to make the subconscious conscious
525 **E.** Family Therapy—
526 **1.** Problems and solutions are interactional
527 **2.** Exploration and evaluation of family dynamics
528 **3.** Change through education and role realignment
529 **F.** Experiential –
530 **1.** Facilitates client self-healing
531 **2.** Affect and body are central
532 **3.** Uses relationship, "two-chair," "meaning bridge"
533
534 **Appendix C**
535 **Hypothesized Mechanisms of Action:** Access to the Hypothesized Mechanisms of Action can
536 be found online at http://www.emdria.org/?page=Mechanism
537 **Neurobiological aspects of EMDR therapy**: Access to the Neurobiological aspects of EMDR
538 therapy can be found online at http://www.emdria.org/?page=Neurobiological
539
540 **References**
541 Bower, G. (1981). Mood and Memory. *American Psychologist, 36*(2), 129-148.
542
543 Foa, E. B., & Kozak, M. J. (1986). Emotional Processing of Fear: Exposure to Corrective
544 Information. *Psychological Bulletin, 99(1),* 20-35.
545
546 Lang, P. J. (1977). Imagery in therapy: An information processing analysis of fear. *Behavior*
547 *Therapy, 8,* 862-886.
548
549 Lang, P. J. (1979). A bioinformational theory of emotional imagery. *Psychophysiology, 16,* 495-
550 512.
551
552 Lang, P. J., Davis, M., & Ohman, A. (2000). Fear and anxiety: animal models and human
553 cognitive psychophysiology. *Journal of Affective Disorders, 61(3),* 137-159.
554
555 Rachman, S. (1980). Emotional processing. *Behaviour Research and Therapy, 14,* 125-132.

556 Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of
557 traumatic memories. *Journal of Traumatic Stress, 2,* 199-223.
558
559 Shapiro, F., (2001). Eye movement desensitization and reprocessing: Basic Principles, Protocols
560 and Procedures. (2nd Edition) New York: The Guilford Press.
561
562 Stickgold, R. (2002). EMDR: A putative neurobiological mechanism of action. *Journal of*
563 *Clinical Psychology, 58,* 61-75.