

A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants

Second Edition

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| Preface to the Second Edition

The Pace of Change

The pace of publication about EMDR therapy in peer-reviewed journal articles and professional books has been brisk over the last 6 years. Since the first edition of *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants* appeared in 2009, 22 scholarly books have appeared in English about EMDR therapy—not counting books on more general topics containing chapters about EMDR therapy. During this same period, more than 600 peer-reviewed journal articles related to EMDR therapy have appeared in English.

Despite the vigorous pace of publication, the fundamentals of EMDR therapy theory, principles, and procedures remain unaltered. As a result, the basic framework of *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants* remains unchanged, with the same chapter structure as the first edition. Nevertheless, much has changed, and these changes made a second edition both necessary and timely.

The scope of application of EMDR therapy has continued to broaden, with important studies showing that EMDR therapy now appears equally effective as prolonged exposure for treating individuals with psychoses, as well as for those with panic—with and without agoraphobia—as well as for cancer patients—both after and during medical treatment. Although it has been known for many years that EMDR therapy has significant effects on reducing or eliminating symptoms of depression in those with posttraumatic stress disorder (PTSD) or partial PTSD, two controlled studies published in the last 2 years indicate that EMDR therapy may be an effective treatment for major depressive disorder. In both of these controlled studies, patients received EMDR therapy for unipolar depression in addition to treatment as usual (psychodynamic therapy in one study and cognitive behavioral therapy in the other). Those receiving EMDR therapy showed significantly greater reductions in their depressive symptoms both at the end of treatment and on follow up (Hase et al., 2015; Hofmann et al., 2014). With multisite randomized controlled studies of EMDR therapy for depression now underway in Europe, such findings foreshadow a potential sea change in the treatment of depression and the scope of recognition of EMDR therapy. These and other advances in the application of EMDR therapy are covered in [Chapter 1](#)—The History and Evolution of EMDR Therapy. Research on the neurophysiology and neuropsychology of EMDR therapy has dramatically expanded along with a series of articles exploring theories on the mechanisms behind EMDR therapy. This led to a major rewriting of the portions of [Chapter 2](#)—The Adaptive Information Processing Model—focused on hypothesized mechanisms of action. In fact,

every chapter of *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants* has been significantly rewritten to update references and the state of the field.

All references to diagnoses and their descriptions were updated to align the text with the *DSM-5*, which was published in 2013. The Glossary was expanded from 28 entries to 60. The references list has been updated with more than 250 new or revised entries. All four of the appendices have been updated with additional procedural scripts, forms, resources, and current references to websites. However, in spite of best efforts, due to the rapid changes of website structure, some web references may not remain accurate. A number of technical errors in nomenclature, descriptions of alternative procedures, and copyediting issues from the first edition were rectified. Thanks to those members of the EMDRIA Training and Standards committee who in 2009 identified several of these errors and provided helpful feedback.

English is no longer the only edition for *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants*. My heartfelt thanks go to Olaf Holm who worked tirelessly to refine the Spanish translation of the first edition published by Desclée De Brouwer in 2013—*Guía de protocolo estándar de EMDR para terapeutas, supervisores y consultores*—and to my colleagues in Japan and in France who stand ready to begin work on translations of the second edition.

My deep appreciation goes to Louise Maxfield whose masterful skills as editor of the *Journal of EMDR Practice and Research* helped me mature as author, editor, and student of research design during my service in 2012 and 2013 as guest editor for volume 7 issue 3. My continuing evolution as an EMDR therapist and scholar has also been influenced during these intervening years by a series of collaborations with Anabel Gonzalez and my friend Dolores Mosquera as well as by the insightful periodic comments of Onno van der Hart and discussions with Jim Knipe.

While I have worked diligently this year to assure that this second edition fulfills the highest standards of scholarship and the evolving nature of EMDR therapy, the remaining flaws, omissions, and other shortcomings in this work are my responsibility alone.

| Preface to the First Edition

My Professional Development With EMDR Therapy

Every book has a beginning. This one began when I completed parts 1 and 2 of the basic EMDR therapy training in 1991. A number of successful early experiences with applying EMDR therapy in my private practice gave me a growing sense of confidence in EMDR therapy. In late 1991, I began serving as a training supervisor for the practice portion of EMDR therapy trainings. The opportunity to supervise the clinical practice of EMDR therapy at trainings deepened my understanding of EMDR therapy both conceptually and procedurally. I observed an incredible number of both common and rare deviations from the standard EMDR therapy procedures. Having to find the words to clarify not only the standard EMDR therapy procedures, but also to be able to offer a rationale from the theoretical model, strengthened my teaching skills and my conceptual understanding of EMDR therapy.

In 1993, I began leading EMDR therapy trainings throughout the United States and Canada and later in Europe and Japan. Through 2008, I led EMDR therapy basic trainings for more than 15,000 clinicians. This has been an incredibly rewarding experience. With the help of A. J. Popky, from 1996 to 2000, I served as the founding moderator of an EMDR therapy e-mail discussion forum. I read more than 15,000 e-mails from EMDR therapy-trained clinicians from all over the world and sent more than 2,500 e-mails in reply on topics including standard EMDR therapy procedures, treatment planning, and the growing body of EMDR literature. From 2001 to 2003, I served on the EMDRIA Standards and Training Committee and from 2003 to 2005 as elected member of EMDRIA's Board of Directors. Since 2003, I have compiled a summary of recently published EMDR research that appears in each quarterly issue of the *EMDRIA Newsletter*. These many years of service to the EMDR community and with EMDRIA have been essential in strengthening my understanding of EMDR therapy.

Although I am profoundly indebted to all of my colleagues who have helped me evolve in my understanding of EMDR, the flaws, omissions, and other deficiencies in this work are my responsibility alone.

| Acknowledgments

I am deeply indebted to all my colleagues who have contributed to my understanding of EMDR. Space does not permit me to name them all. First and foremost, I am grateful to Francine Shapiro for the gift of EMDR. EMDR has transformed my clinical work and opened doorways for professional development that I could never have imagined. I am also grateful for the community of EMDR trainers, training supervisors, and clinicians trained in EMDR. My dear friends and colleagues Carol York, Sandra Foster, and Curt Rouanzoin have been loyal comrades through many adventures. Carol York has been a steady source of support and intellectual stimulation in the evolution of my understanding of EMDR. Deborah Korn and I took turns sitting in each other's conference presentations for many years, finally teaching together in 1998 and coauthoring a paper in 2002. I have matured through their teaching and consultations over these many years. Other colleagues who have supported me directly or indirectly in ways that affect this book include Robbie Adler-Tapia, Nancy Errebo, Ulrich Lanius, Jennifer Lendl, Marilyn Luber, Philip Manfield, and Carolyn Settle.

Masaya Ichii and his colleagues, Masako Kitamura and Masamichi Honda, in Japan gave me the opportunity to teach annually in Japan over a span of 10 years. The opportunity to teach with the exceptional translators/clinicians—Tomoko Osawa and Akiko Kikuchi—in Japan challenged me to find the essence of EMDR that would fit in half the speaking time and to develop illustrations for key EMDR concepts. Mark Russell has been an inspiration and a strong supporter to carry this project to completion. Louise Maxfield inspired me with her dedication and scholarship, invited me to serve on the editorial board for the *Journal of EMDR Practice and Research*, persistently encouraged me to write, and introduced me to key staff members at Springer Publishing Company. Rosalie Thomas, Wendy Freitag, Mark Dworkin, and many other colleagues with whom I served on the EMDRIA Board and the Standards and Training Committee helped enlarge my perspective about the needs of the larger EMDR community and the future of EMDR. My understanding of EMDR and the global evolution of EMDR has been profoundly affected by the support, teaching, and publications of my European colleagues, Ad de Jongh and Arne Hofmann.

I am deeply indebted to Ted Nardin, former CEO of Springer Publishing Company, who first encouraged me to place this manuscript with Springer when we met in 2006, to Sheri Sussman—an extraordinary editor, raconteur, and dancer—who supported me at crucial points and helped me to realize my vision for this book, and to Deborah Gissinger, who shepherded me through the challenges of the publishing process of my first book.

I am grateful to my wife, Deborah Taylor-French, and daughter, Alexandra Leeds, who have patiently endured my closeting of myself in my office for so long during the preparation of this book. My wife also gave much helpful feedback at critical junctures in this process, and my daughter contributed the illustration for [Figure 7.1](#).

This book is intended to provide an easy-to-use guide to the standard, research-supported EMDR therapy protocols for graduate students, clinicians, consultants, supervisors, instructors, and researchers. It is intended to supplement the following requirements for all EMDR therapy clinicians: a thorough reading of Francine Shapiro's (2001) text—*Eye Movement Desensitization and Reprocessing, Basic Principles, Protocols and Procedures*; an EMDRIA-approved basic training in EMDR therapy; and consultation in the use of EMDR therapy from an EMDRIA-approved consultant.

Since the publication of the first edition of Francine Shapiro's standard text in 1995 and the founding of EMDRIA, the role of consultation on the use of EMDR therapy has expanded, becoming required in both basic training in EMDR therapy and in EMDRIA's certification program, yet little has been published to offer guidance on the consultative process for EMDR therapy-trained clinicians and consultants. EMDR finds a growing role in organized treatment programs in colleges and universities, nonprofit agencies, and community mental health centers where clinical supervisors need ways to document EMDR treatment planning, process, and outcomes. This book provides an orientation to these issues as well as forms that offer a starting point for documenting the clinical process with EMDR therapy.

The Plan of This Book

In planning this guide to standard EMDR therapy protocols, decisions had to be made in selecting which areas of application to include and which to exclude. Several factors were considered, including the degree and nature of evidence of empirical validation, congruence with well-accepted principles of treatment in the behavioral literature, content required for EMDRIA-approved basic training in EMDR therapy, and the need to keep the manual to a practical length. A significant number of proposed EMDR therapy procedures and protocols for additional clinical applications that show promise, but did not meet some of these criteria, were omitted.

[Section I](#) of the book covers The Conceptual Framework for EMDR Therapy, including The History and Evolution of EMDR Therapy in [Chapter 1](#), The Adaptive Information Processing Model in [Chapter 2](#), and An Overview of the Standard Eight-Phase Model of EMDR Therapy and the Three-Pronged Protocol in [Chapter 3](#). The three chapters in [Section II](#) cover Case Formulation, Treatment Planning, and Preparing Patients for EMDR Reprocessing.

[Section III](#), six chapters in all, covers Phases 3 to 8 of the Standard Protocol for PTSD. The standard EMDR therapy protocol for PTSD can be applied with equal effectiveness for patients who meet partial criteria for PTSD and whose symptoms develop after a range of adverse life events that do not meet criterion A (American Psychiatric Association [APA], 2013; Mol et al., 2005; Wilson, Becker, & Tinker, 1997). These procedural steps and the standard protocol for PTSD apply to patients with primary structural dissociation (van der Hart, 2007), which is always present to some degree in PTSD. Patients with secondary structural dissociation—including those with complex PTSD, borderline personality disorder, or other specified dissociative disorder (OSDD)—or with tertiary structural dissociation—dissociative identity disorder (DID)—will need additional interventions and a more complex treatment plan not covered in this text.

[Section IV](#) covers The Application of EMDR Therapy to Conditions Other than PTSD with chapters devoted to specific phobias and panic disorder. Note that the standard EMDR therapy PTSD protocol can be applied to patients with comorbid substance abuse when sufficient stabilization has been achieved—as described in [Chapter 6](#)—and when the case conceptualization is that the substance abuse is secondary to the PTSD. When the substance abuse appears to be the primary condition—that is when it began first—and PTSD, if present, appears to be secondary, alternate EMDR therapy approaches may be more suitable as the initial focus of attention needs to be the treatment of the substance abuse itself. The Desensitization of Triggers and Urge Reprocessing (DeTUR) protocol (Popky, 2005; Vogelmann-Sine, Sine, Smyth, & Popky, 1998) continues to be the most widely used EMDR therapy approach for treatment of primary substance abuse, but research on DeTUR and other approaches to applying EMDR therapy to substance abuse (Brown & Gilman, 2007; Brown, Gilman, & Kelso, 2008; Hase, 2010; Hase, Schallmayer, & Sack, 2008) is still at too early of a stage for inclusion in this guide. Only Cravex (Hase, 2010) has support from preliminary controlled research (Hase et al., 2008).

[Section V](#) addresses issues of Professional Development in EMDR therapy as clinicians go through the basic training in EMDR therapy and obtain consultation or supervision on their clinical application of EMDR therapy. The appendices provide sections with fidelity checklists, forms, and resources referred to in the text.

The Path to Proficiency

Over many years of conducting training in EMDR therapy, I have at times been surprised at the number of clinicians who returned for the next phase of their training months or years later and who disclosed that they have used EMDR therapy rarely or not at all. When I served on the EMDRIA Board of Directors, I supported policies—subsequently implemented—to require inclusion of consultation on trainees’ actual clinical use of EMDR therapy as part of basic training in EMDR therapy. As a trainer, I also sought ways to motivate and encourage training participants to get started early and persist in practicing EMDR therapy. While teaching in Japan I developed the following metaphor for the process of learning EMDR therapy. If you have ever seen a student and experienced potter each working with clay at a wheel and throwing a pot, perhaps you have seen what I try to convey in this guide: *EMDR therapy, when done well, looks simple, but it is not easy.*

The student wedges the clay but introduces air bubbles. When fired, the pot made from this clay explodes. The student struggles to center the clay. Instead, it slides off the edge of

the wheel. The student becomes frustrated and less able to concentrate. After gaining skills at centering, the student still cannot control the thickness of the pot, which collapses on one side and must be discarded or is too thick and lacks grace.

The experienced potter wedges the clay while avoiding trapping air bubbles. She firmly centers the clay on the turning wheel. Then, she raises the sides, thinning them evenly while retaining stability and grace in the form. In moments, making only simple motions, the pot is done.

It appears simple, but it is not easy. How does the student become proficient? Practice and more practice. Central to learning is the willingness to let others with more experience observe and give feedback on one's work. Only by being willing to reveal one's mistakes, accept feedback, and by working together can we find the simplicity that yields graceful and lasting results. Scientific progress, our consultees, our students, and most importantly our patients deserve no less.