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Love, Marriage & Life COUNSELING

EMDR Packet

for Clients of Elizabeth Davis, MA, LPC-S

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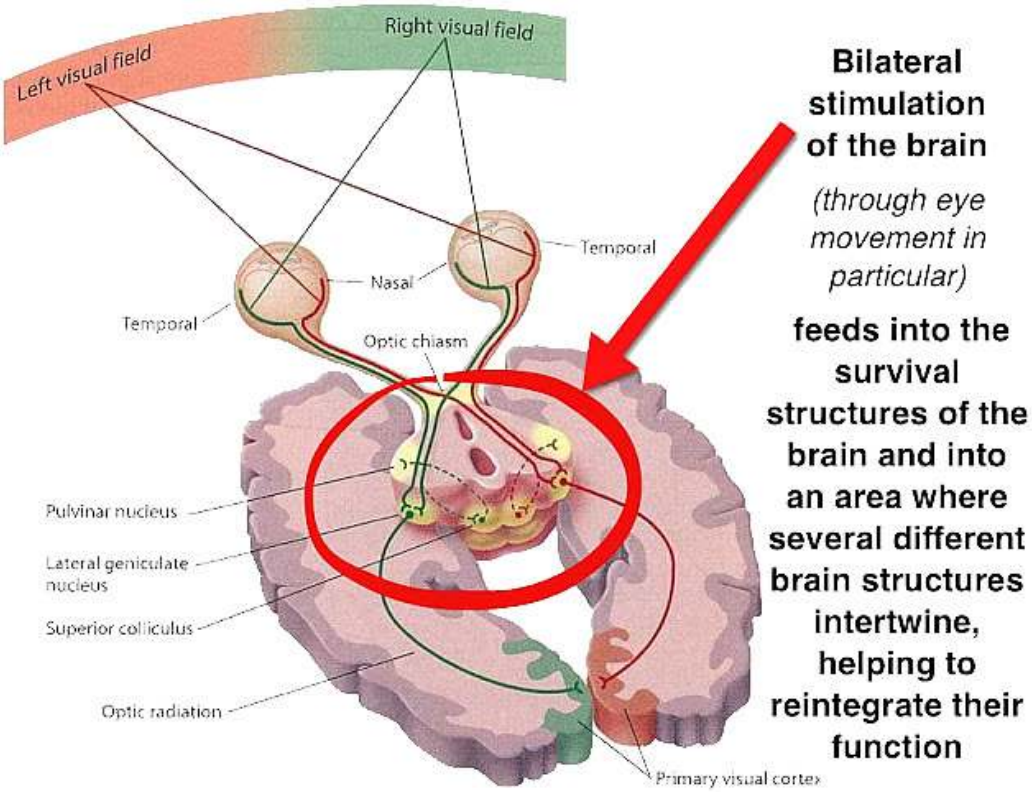
EMDR Information



EMDR. treatment for PTSD. and trauma processing in military and civilian clients of Elizabeth Davis, MA, LPC

Internet Resources: www.EMDRIA.org and www.EMDR.com.

1. **What is EMDR. and what is its historical development?**

This technique was developed by ***Francine Shapiro, Ph.D.*** quite by accident when, as a graduate student, she was working with Vietnam era combatant diagnosed with PTSD. in a California V.A. treatment center. In May 1987, Dr. Shapiro discovered, while on a walk, that her eye movement from side to side could actually evoke a deep sense of relaxation and calm. Through trial and error over the next several months she developed a treatment protocol that has developed into what has become the core of the techniques that is used today in a variety of settings.

What was originally a means of quieting the mind has become a revolutionary (and weird) treatment that has been endorsed by the Department of Defense, the American Psychological Association, and a number of professional societies outside the United States. As you professionals know PTSD. is a diagnosis given to anyone who has witnessed another person's

death (or near death) or have themselves been severely injured by another person or an event that was outside the normal range of human experiences. These traumatic events might include battlefield injuries or the witnessing of another's injuries. Or perhaps it may be a more mundane event such as a motor vehicle accident, physical abuse, or even a repressed childhood memory of severe abuse.

The personal impact of such events varies widely from person to person. It has been noted that only about seven percent of all workplace trauma (ie. deaths of a coworker) result in the development of symptoms that are diagnosable as PTSD. However, for those individuals who do develop symptoms the results can be devastating. These may be in the form of panic attacks, hypervigilance, nightmares, flashbacks, or any of the myriad other symptoms of PTSD.

There are certain cautions that must be considered before employing EMDR. and proper screening the client is the first step in determining whether or not this technique will be appropriate for use with the client. More will be said about client screening later in the presentation.

2. The details of the EMDR. technique:

As such the EMDR. therapist will first of all take a complete biopsychosocial history of the client to get as complete an understanding as is possible of the traumatic events that may have affected the client from childhood to their present age. The movement of stimuli, originally using the therapists fingers moving before the client's eyes, as also evolved into a variety of techniques that stimulate alternate sides of the brain. The rapid metabolizing and processing of the negative effects of trauma is facilitated by what has come to be called B.L.S. (bilateral stimulation of the brain). This pattern of stimulation initiates an unusual response of what Shapiro called A.I.T. (advanced information processing) of the various aspects of the traumatic experience.

The memories of the traumatic event are viewed, in this model, as being stores as four separate, but interrelated, experiences that often interfere with the client's ability to optimally function in their everyday activities. Those clients diagnosed with PTSD. are frequently troubled by disturbing thoughts, emotions, bodily sensation, and images that may intrude on their experience at any given moment either during the day or at night.

The basic components of the EMDR procedure include understanding these four elements: the internal image of the trauma, the negative cognition involving the often pessimistic view of themselves and the nature of life, associated bodily sensations with the traumatic memory, and the various negative emotions triggered by the traumatic memory. These four elements are closely examined by the therapist so that each one is clearly delineated and then monitored as to the changes that occur in each element during the process of treatment.

Internal Image: This is the image that has been recorded by the client as being the sensual record of the traumatic event. It may consist of visual, auditory, kinesthetic, olfactory, or gustatory cues. The image may be entirely recorded as being only one of the five senses or some combination of them. Often time the nature of this recording determines the type of trigger that sets of the PTSD symptomology. For example, a woman may first recall a childhood sexual abuse incident by the triggering of a certain type of touch or smell with her lover that may resurrect a memory that has remained forgotten for decades. Or perhaps a combatant may be watching a movie or reading a novel about war that may trigger a forgotten incident of seeing a battle buddy

die that had been repressed for many years. It may be something as simple as the look on someone's face or the sound of a belt buckle being undone that provokes a huge reaction in the client because it is part of their internal imagery associated with their personal trauma.

Cognition associated with the trauma: The client is also asked to describe in detail what their perception of themselves was at the moment of the trauma and this is then recorded as their *N.C. (negative cognition).* This thought is often a distorted perception of the traumatic event as it was interpreted at the time (ie. "I am a bad person", "I am not good enough", "It was all my fault", "I don't deserve to be happy"). Often this N.C. leads the client to have a chronic level of anxiety, depression, or neurotic guilt for reasons that are not always apparent to themselves or even their therapist. The deep seated nature of trauma related beliefs about themselves or the nature of life (ie. "Something bad is always going to happen to me", "I will never get a break in life") may manifest itself in persistent self-defeating behavior in addition to the normal symptoms of PTSD.

The client is also invited to create a statement that describes a perception that they would like to have of the traumatic event that is less threatening and much more egosyntonic. In other words, the client is encouraged to develop a statement that they would choose to think if and when the traumatic memory is reactivated. For example, the client might choose to develop the thought or *P.C. (positive cognition)* that the situation is from the distant past and the danger is gone (ie. "It is over and I am safe now"). This P.C. is assessed periodically during the treatment by asking the client, "On a scale of 0-7 how true is your positive cognition?"

In other words, once the client has the new more rational and positive thought to reframe their trauma how much do they actually believe on an emotional level? Often during the course of the treatment a P.C. will start as a 0/7 and end the session as 7/7; the meaning being of course that the P.C. has become completely true on an emotional level. The change in the N.C. is usually much more rapid and is the focus of the treatment until the S.U.D.S. is down to a 1or 0/10. Then the focus changes to moving the P.C. upward until it reaches a 7/7.

Emotional discomfort scale: The scale used to describe the intensity of the emotional discomfort associated with the trauma is known as the S.U.D.S. (selective units of discomfort scale). The client is asked, "When you think about the trauma today what emotion do you feel? If you were to rate the intensity of discomfort from 0-10 how high would that number be?"

Physical discomfort scale: The client is then asked similar questions regarding their level of physiological discomfort that they experience when the trauma is recalled during the session. The areas of the body that become tense or painful are then noted and will be monitored during the course of the session.

Activating the Advanced Information Processing System: Once the therapist has established with the client what the nature of each of the above elements of the traumatic memory consists of, the B.L.S. will begin. Assuming that the therapist has determined that the client has been extensively educated as to the nature of EMDR. and is appropriate, then they are ready for EMDR. The therapist will careful to have trained the client, by this time, in deep relaxation and "safe place" imagery so that the client will have the capacity for bringing themselves into a relaxed state both before and after the EMDR. treatment during the session.

The therapist will also have taught the client to change the memory of the trauma so that it can be viewed via guided imagery from the third person.

In other words, the client may now remember the trauma as if it were a video or a movie that could be seen from the point of view of a more distant observer and not from their former perspective in the first person. The therapist will also have done some training, using the "safe place exercise" in training the client in developing the skill of "dual attention". This simply means that the client has the capacity to be aware that they are in the session with their therapist (and not dissociated) yet they are also paying very close attention to their internal imagery and the four elements of the trauma.

The traditional means of doing EMDR meant that the client would side opposite of the therapist and the latter would position their first two fingers of their dominant hand approximately 12-18 inches from the client's face. The therapist would then quickly move their entire hands back and forth horizontally. One bidirectional movement would be from extreme right-to-left-to right from one side of the client's vision to the other. This would occur silently and quickly with the therapist making 24 bidirectional movements in a brief period of time.

After this first set of movements, the therapist would stop and ask the client, "What do you notice now?" In other words the therapist is asking, "Are their changes in any of the four elements of the NC, SUDS, body sensation, or image?" Normally what happens is the client will report a high level of discomfort (ie. SUDS = 9/10) at the remembering of the image. However, after the first set the client will often report an increase in discomfort as the full impact of the trauma is felt once again. In effect EMDR. is an "exposure therapy" because the client is allowing him/herself to be re-exposed to the memory of the trauma without the usual ego defenses of denial or repression. By not avoiding the imagery and associated emotions the client finds that by the second or third set that the remembering experience has begun to change.

Typically the client will report a change in either the image or the S.U.D.S. That is to say, that the emotional intensity often begins to drop dramatically (ie. from a 9/10 to perhaps a 7/10 or even less by the fourth set). Coincidently the image often begins to morph into something less threatening. For example the perpetrator may seem to shrink in size to a less intimidating form and the client may simultaneously gain in stature. Depending on the nature of the trauma, the client may also find that in the middle of a set that their perception of themselves, the NC., begins to change so that they no longer view themselves as a victim but rather as simply the observer of an unfortunate event.

3. How does EMDR. differ from other treatment modalities?

Actually EMDR. incorporates elements of a number of other modalities into a comprehensive treatment protocol. The basic assumption of cognitive behavioral therapy, C.B.T., is that thought is the prime trigger for emotional responses. That is to say that C.B.T. therapists seek to build an awareness in their clients of their own "thought life" and with that awareness begin to notice the impact of their thoughts on their emotions, behavior, and even their physiological responses. The same awareness is cultivated in EMDR. clients as part of the preparation for their B.L.S. treatment. It is an assumption of both modalities that once awareness is developed in clients they can begin to exercise choice in what they think about and in doing so

change their emotional reaction to previously stressful events in their present and past environments.

In addition, EMDR. therapists teach relaxation training (in my practice I teach my clients biofeedback and guided imagery work) again as preparation for the B.L.S. sessions that will follow when the client is ready. Additional preparation for the client would include whatever is necessary to empower them to a stable condition so that they will have the necessary ego strength to endure remembering, and to a certain extent reliving, the traumatic memories of their past. This might include stress management, family therapy, group therapy, psychoactive medication, meditation training, or treatment for addictions.

The client must be in a stable life situation and have good rapport with their therapist. Rogerian therapy is always useful in the beginning stages of EMDR. treatment to establish a solid therapeutic alliance. Developing a P.C. for the trauma allows the client to develop a cognitive reframe of the experience which is similar to the basis of Neuro-linguistic Programming (N.L.P.) as well as hypnotic suggestion therapies. Encouraging the client to state what they want instead of what they don't want is empowering and affirming that the client does have a choice in how they wish to perceive the world and themselves.

4. **How does EMDR. compare to other therapies in terms of symptom reduction?**

You may choose to review the huge number of studies that are enumerated on the EMDR. website. One study that I am familiar with that was most impressive to me was completed in 2007 by Bessel Van der Kolk with several colleagues in Boston. It was published in the Journal of Clinical Psychiatry, 68, pp.37-46. They compared the effects of EMDR. treatment (eight sessions) with daily dosages of Prozac (fluoxetine) and a placebo. What they discovered was that Prozac and EMDR. both reduced the symptoms of depression associated with PTSD. However, in a six month follow-up to the study it was found that the Prozac treated clients had most of their symptoms return while the EMDR. treated clients not only did not have their symptoms return but actually had fewer symptoms of PTSD. than when the study ended six months previously. I have experienced many clients reporting that their symptoms have been resolved after four or five session of EMDR. This is not uncommon with type 1 PTSD. but less common among complex PTSD. cases.

5. **What other diagnoses has EMDR. been successful in treating besides PTSD.?**

The studies done as of this date do not confirm that EMDR. is any more effective than C.B.T. in treatment of panic disorder with or without agoraphobia. However, my own experience is that EMDR. can be an effective treatment if the client is given extensive preparation and it is used on an every other session or every third session basis. Interestingly EMDR. has been shown to be somewhat effective in increasing empathy between intimate partners. The technique is modified so that one of the partners is an observer to the other partner's work on their own traumatic issues. This technique often provides both parties with insight as to the nature of their respective triggering situations.

6. **How does a therapist integrate EMDR. into a treatment plan?**

The answer is "very carefully". I have never found a technique that was as powerful or intense as EMDR. For that reason it is always advisable to make absolutely certain that the client is in every way ready for treatment and as stable as possible in their work, support system, and

medication if necessary. There are a number of ways to do B.L.S. now that offer conveniences rather than doing strict eye movement. Many clients prefer the use of “tappers” or “tapping” on their hands or knees. A number of EMDR. therapists use software instead of their arms to provide the client with a target to follow with their eyes.

7. **What are the training requirement to be properly trained in EMDR.?**

You may wish to consult the websites noted at the top of this outline. Training is available to those who have a Masters Degree in a mental health field, to graduate students who are enrolled in their internship portion of their program, and to R.N.s who have a Masters Degree.

EMDR-Prep Checklist

Client:

Checklist Date:

- ❑ Discuss Basics of EMDR Date: __/__/20__
- ❑ DES-II < 35 Date: __/__/20__
- ❑ Trauma History taken and place on Trauma Date: __/__/20__
- ❑ After session support in place Date: __/__/20__
- ❑ Medical Clearance for EMDR (in chart) Date: __/__/20__
- ❑ Discuss Informed Consent & signed Date: __/__/20__
- ❑ 2 weeks of daily app "Autogenic Training" Date: __/__/20__
- ❑ 2 weeks of daily app "Anxiety Relief" Safe Place Date: __/__/20__
- ❑ 2 weeks use of Gaia supplements, if approved Date: __/__/20__
- ❑ Safe Place Installed Date: __/__/20__
- ❑ Container Installed Date: __/__/20__
- ❑ At least One Nurturing Resource Installed Date: __/__/20__
- ❑ 5-Senses Stabilization Skills in place Date: __/__/20__
- ❑ Grounding skills in place Date: __/__/20__

Date cleared to begin EMDR Trauma Processing: __/__/20__

EMDR Medical Authorization, Part I

for clients of
Elizabeth Davis, MA, LPC-S

To be completed by the Authorized Health Care Provider (AHCP)
(Physician, Nurse Practitioner, Physician's Assistant, Neuropsychologist)
& returned / faxed to:
Elizabeth Davis, MA, LPC - S
Embrace New Life, LLC
Tel: 972.979.3988 Email: elizabeth@EmbraceNewLife.com

Client Name:

DOB:

SS#:

Dissociative Experiences Scale –II (DES-II) Score:

The above named client is being considered for **Eye Movement Desensitization and Reprocessing (EMDR). EMDR was developed by Dr. Francine Shapiro in 1987 as a complex psychotherapy technique using bilateral stimulation to process trauma.**

Please refer to http://www.emdria.org/associations/12049/files/EMDRIA%20Definition%20of%20EMDR.pdf for clinical definition of EMDR.

Medical issues that would contraindicate EMDR include:

- ❑ **epilepsy or other seizure related illness(es)**
- ❑ **medications that may lead to seizure**
- ❑ **cardiovascular or neurological disease**
- ❑ **medications like benzodiazepines that may reduce EMDR effectiveness**
- ❑ **long-term amphetamine abuse or recent crack cocaine use**
- ❑ **active alcohol use**
- ❑ **in the case of eye disease, an alternate bilateral stimulation will be used like tapping**
- ❑ **recent head injury**
- ❑ **ongoing medical legal issues**

I certify that above-named client is medically cleared to begin EMDR psychotherapy.

Signature: _____ Date: _____

EMDR Medical Authorization, Part II

for clients of
Elizabeth Davis, MA, LPC-S

To be completed by the Authorized Health Care Provider (AHCP)
(Physician, Nurse Practitioner, Physician's Assistant, Neuropsychologist)
& returned / faxed to:
Elizabeth Davis, MA, LPC-S
Embrace New Life, LLC
Tel: 972.979.3988 Email: elizabeth@EmbraceNewLife.com

Client Name:

DOB:

SS#:

In processing trauma, the body may experience an increase in stress load. In my work with stress-related mental health issues, clients report that the following supplements are useful in maintaining adaptive functioning through EMDR and CBT trauma processing:

❑ I approve the above client's use of the gaia "Adrenal Health" supplement.

❑ I approve the above client's use of the gaia "Stress Response" supplement.

Signature: _____ **Date:** _____

Eye Movement Desensitization& Reprocessing (EMDR) Informed Consent

EMDR was developed in the late 1980's. It currently has more scientific research as a treatment for trauma than any other method (except medications). The experience with EMDR by clinicians using it suggests that it may be a very effective tool and that rapid progress may be made with improved processing of traumatic information. It seems in many instances to assist in a different kind of processing of traumatic information with better integration and perspective. It also appears that it may avoid some of the long and difficult abreactive work often involved in the treatment of anxiety, panic attacks, post- traumatic stress symptoms (such as intrusive thoughts, nightmares, and flashbacks), dissociative disorders, depression, phobias, identity crisis, and other traumatic experiences.

Repressed memories surface more by use of EMDR than with other modalities. It is not unusual for a target memory to be linked to other, unexpected material. It is important to note that traumatic material retrieved in any psychotherapy may or may not be historically accurate and is subject to a variety of contamination as are all memories. EMDR does not, in itself, guarantee the accuracy of the retrieved material but may process information whether it is accurate or not. The only way to actually validate retrieved material as historically accurate would be through independent verification. Individuals have been experienced information so vividly that they have complete confidence in it as accurate memory. Psychotherapy and EMDR cannot absolutely differentiate between memories that are accurate, distorted, or false based on reports alone in the absence of corroborating data.

Those with limiting or special medical conditions (pregnancy, heart conditions, ocular difficulties, etc.) should consult their medical professional before participating in this therapeutic method. The client will provide the therapist with a written medical clearance from OB/GYN, cardiologist or other specialist before EMDR can be administered.

For some people, this method may result in sharper memory, for others fuzzier memory will follow treatment. If you are involved in a legal case and need to testify, your therapist will find alternative trauma stabilization techniques. EMDR use will be postponed.

I have been specifically advised of the following:

(a) Not to participate in any EMDR session until the Safe Place self-control technique has been mastered by the client. The client will need this technique to stabilize self in, at the conclusion of, and outside of the EMDR session.
(b) Distressing, unresolved memories might surface through the use of the EMDR procedure.
(c) Some clients have experienced actions during the treatment session that neither they nor the administering clinician may have anticipated, including a high level of emotion or physical sensations.
(d) Subsequent to the treatment session, the processing of incidents/material may continue and other dreams, memories, flashbacks, feelings, etc., may surface. If this happens, write them down in your journal and bring to the next session.
(e) Reprocessing traumatic memories can be uncomfortable as with any other therapeutic approach. The client agrees to make arrangements for assistance driving home after an EMDR session if the client determines that he or she is unable to drive home safely.

Before commencing EMDR treatment, I have thoroughly considered all of the above. I have obtained whatever additional input and/or professional advice I deemed necessary or appropriate to having this treatment. By my signature below I hereby give my Informed Consent to receiving EMDR treatment free from pressure or influence from any person or entity.

_____ _____

Client Signature Date

_____ _____

Elizabeth Davis, MA, LPC-S Signature Date

Smart Phone APPS recommended during EMDR

Autogenic Training
by 01 Digitales Design GmbH

Use Daily
Muscle Relaxation

Anxiety Release with Bilateral Stimulation
by trauma and pain management srvs pty ltd

Use Daily
Safe Place

Trauma Ladder

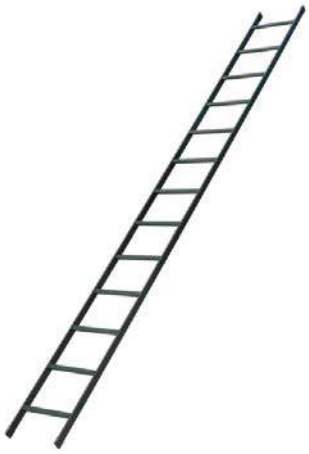
Part I: Trauma History:

As best as you can, ***briefly*** recall the trauma in your life by age group. Please wait to complete the "SUDS" and "Subjective Rank" section with the therapist. Add rows and use additional paper if needed. If at any time this becomes overwhelming, please turn it over and work on it as you can. Take as long as you need to, use the "Healthy Activities" list that follows for ideas of healthy coping distractions should you become overwhelmed.

Age Range	Trauma(s) & Milestones	SUDS (1-10, worst)	Subjective Rank
0-3			
3-5			
5-10			
10-15			
15-20			
20-25			
25-30			
30-35			
35-40			
40-45			

Part II: The Trauma Ladder:

Please save this section for completion with therapist in session.



7	**Worst** – Age
6	Age
5	Age
4	Age
3	Age
2	Age
1	**Least** –Age

Healthy Activities

The following is a list of activities that you can use to stimulate ideas on pleasurable ways to distract yourself from intense emotions, negative thought, obsessive thought or compulsions. **Note**: *Trauma is known to zap interest and energy. If depression is an issue for you, work with your doctor to stabilize the depression first, then begin to increase your level of healthy activity. Chronic isolation works against healthy functioning. Chronic overstimulation also works agains healthy functioning so what we are looking for is* B A L A N C E!

Circle the ones you're willing to try and add your own ideas:

1. Visit a local natural history museum and find out what artifacts and science is unique to your town. Invite a friend.
2. Visit the American National History Museum or Smithsonian online and view interesting artifacts. Tell a friend.
3. Visit a local art museum and check out new exhibits. Invite a friend.
4. Go to a movie. Life-affirming and funny movies are highly recommended. Invite a friend.
5. Visit your local hobby or craft store and see what hobbies are featured in your area. Do any interest you?
6. Find a local or nearby park that has been awarded for its beauty. Invite a friend and stroll the park.
7. Buy a new indoor or outdoor plant and create a new living space for it.
8. Create an indoor terrarium in a lantern cloche, glass cloche, bell jar, canning jar, wardian case, cold frame or aquarium.
9. Enroll in a karate, yoga, or ceramics class. Invite a friend.
10. Fly a kite. Look online at the variety of kite designs. Organize a local 'kite festival', proceeds to a charity.
11. Visit a local pet store. If you are in need of a pet, visit your local shelter or contact the SPCA. If you are not in need of a pet but pet-time, think about volunteering at the SPCA.
12. Pick a foreign language. Divide a piece of paper in half. On one side write the words 'one' through 'ten', the days of the week, and a list of your favorite things. On the other side, find and write the word translation. Memorize this list.
13. Find out what water sport activities are available at a local lake or river. Do any interest you? Invite a friend, put on safety vests and enjoy!
14. Visit a travel agency. Browse travel brochures. Ask about a dream vacation. Get details. Plan. Check out the Mexican Caribbean and scuba or snorkeling trips. Create a vacation budget and savings plan. Invite friends.
15. Visit your local library. Get a library card. Check out one or two books, one or two movies or audio CDs. Get a list of their free services and activities. Anything interesting? Make a new library friend.
16. Visit your local airport. If allowed, view takeoffs and landings.
17. Visit your local home improvement store. Take a look at featured merchandise. Is there a home improvement project you can break into small steps and begin making progress on? New color on a wall? A new fixture maybe?
18. Visit local scenic areas or neighborhoods known for beautiful architecture. Take a sketch pad. Draw what you catches your eye. Find an interesting chimney pot, cupola, finial, oriel window, outdoor fireplace, pergola, rose window or veranda.
19. Buy a bag of native wildflower seed in early spring. Open your car window; toss them along a country roadside. Check out Guerilla Gardening – the art of transforming abandoned, vacant or otherwise derelict areas. Launch wildflower seeds in biodegradable helium balloons.
20. Visit a local zoo. Adopt a zoo animal or get involved with animal conservation activities.
21. Visit a busy local park and journal the sounds you hear. Record digitally for later distraction use.
22. Visit a local coffee shop. Take a magazine, book, newspaper, Sudoku or crossword puzzle, portable dominoes or checkers, and enjoy a good cup of herbal tea.
23. Join a local book club.
24. Take a college or continuing education course in a subject that interests you.
25. Take the local train through town and back.
26. Take a digital picture of a sunrise and a sunset.
27. Turn a Psalm into a prayer and pray it with a friend.
28. Join a Christian meditation group. Walk a labyrinth.
29. Call friends - go bowling, play card games or board games. Take a stack of post-it notes. Have each friend write a positive message on a post-it note and ask them to post theirs in a unique public place.
30. Call a local CASA, homeless shelter, nursing home or other humanitarian agency. Ask what donations or volunteer help is needed. Decide if you can contribute and if so, what is doable at this time.
31. Launch a prayer in a bottle at a local lake. Launch a prayer in a helium balloon. Use your first name only, no contact information.