APPENDIX A
EMDRIA Definition of EMDR

(https://www.emdria.org/emdr-training-education/become-an-emdr-training-provider/emdr-international-association-definition-of-emdr/)

1.0A. Purpose of Definition – This definition serves as the foundation for policy development and implementation of EMDR International Association'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.

1.0B. Definition – EMDR is an evidence-based, clinician led, psychotherapy for Posttraumatic Stress Disorder (PTSD). In addition, successful outcomes are well-documented in the literature for EMDR treatment of other psychiatric disorders, mental health problems, and somatic symptoms. The model on which EMDR is based, Adaptive Information Processing (AIP), posits that much of psychopathology is due to the maladaptive encoding of and/or incomplete processing of traumatic or disturbing adverse life experiences. This impairs the client's ability to integrate these experiences in an adaptive manner. The eight-phase, three-pronged process of EMDR facilitates the resumption of normal information processing and integration. This treatment approach, which targets past experience, current triggers, and future potential challenges, results in the alleviation of presenting symptoms, a decrease or elimination of distress from the disturbing memory, improved view of the self, relief from bodily disturbance, and resolution of present and future anticipated triggers. EMDR therapy is a therapeutic intervention that must be administered by an EMDR trained clinician or those who are currently participating in an EMDR International Association Approved training.

BI. Foundational Sources and Principles for Evolution – Shapiro's (2001) Adaptive Information Processing model, guides clinical practice, explains EMDR's effects, and provides a common platform for theoretical discussion. The AIP model provides the framework through which the eight phases and three prongs (past, present, and future) of EMDR are understood and implemented. The evolution and elucidation of both mechanisms and models are ongoing through research and theory development.

BII. Aim of EMDR – In the broadest sense, EMDR is an integrative psychotherapy approach intended to treat psychological disorders, to alleviate human suffering and to assist individuals to fulfill their potential for development, while minimizing risks of harm in its application. For the client, EMDR treatment aims to achieve comprehensive treatment safely, effectively, and efficiently, while maintaining client stability.

BIII. Framework – Through EMDR, resolution of traumatic and disturbing adverse life experiences is accomplished with a unique standardized set of procedures and clinical protocols which incorporates dual focus of attention and alternating bilateral visual, auditory and/or tactile stimulation. This process activates the components of the memory of disturbing life events and

facilitates the resumption of adaptive information processing and integration. The following are some of the AIP tenets which guide the application of EMDR, i.e., planning treatment and achieving outcomes:

BIIIa. Adverse life experiences can generate effects similar to those of traumatic events recognized by the *Diagnostic and Statistical Manual of Mental Disorders* (APA, 2000) for the diagnosis of Posttraumatic Stress Disorder (PTSD) and trigger or exacerbate a wide range of mental, emotional, somatic, and behavioral disorders. 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 perceptions, attitudes, emotions, sensations, and action tendencies.

BIIIb. Traumatic events and/or disturbing adverse life experiences can be encoded maladaptively in memory resulting in inadequate or impaired linkage with memory networks containing more adaptive information. Pathology is thought to result when adaptive information processing is impaired by these experiences which are inadequately processed. Information is maladaptively encoded and linked dysfunctionally within emotional, cognitive, somatosensory, and temporal systems. Memories thereby become susceptible to dysfunctional recall with respect to time, place, and context and may be experienced in fragmented form. Accordingly, new information, positive experiences and affects are unable to functionally connect with the disturbing memory. This impairment in linkage and the resultant inadequate integration contribute to a continuation of symptoms.

BIV. EMDR Psychotherapy Guidelines: EMDR procedures facilitate the effective reprocessing of traumatic events or adverse life experiences and associated beliefs, to an adaptive resolution. Specific procedural steps are used to access and reprocess information which incorporates alternating bilateral visual, auditory, or tactile stimulation. These well-defined treatment procedures and protocols facilitate information reprocessing. EMDR utilizes an 8-phase, 3-pronged, approach to treatment that optimizes sufficient client stabilization before, during, and after the reprocessing of distressing and traumatic memories and associated stimuli. The intent of the EMDR approach to psychotherapy is to facilitate the client's innate ability to heal. Therefore, during memory
reprocessing, therapist intervention is kept to the minimum necessary for the continuity of information reprocessing.

BIVa. Based on available relevant research, treatment fidelity to the 8 phases (Shapiro, 2001) produces the best results. However, in certain situations and for some populations, the following procedures may be implemented in more than one way as long as the broad goals of each phase are achieved.

BIVai. In the **Client History Phase (Phase 1)**, the clinician begins the process of treatment planning using the concept of incomplete processing and integration of memories of adverse life experiences. The clinician identifies as complete a clinical picture as is prudent before offering EMDR reprocessing. The clinician determines the suitability of EMDR therapy for the client and for the presenting problem and determines whether the timing is appropriate. Based on the presenting issue, the clinician explores targets for future EMDR reprocessing from negative

stress disorder: A theoretical analysis. *British Journal of Psychiatry, 169(5),* 571-579. doi:10.1192/bjp.169.5.571

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Minamimoto, T., & Kimura, M. (2002). Participation of the thalamic CM-Pf complex in attentional orienting. *Journal of Neurophysiology, 87*(6), 3090–3101.

Richardson, R., Williams, S. R., Hepenstall, S., Gregory, L., McKie, S., & Corrigan, F. (2009). A single-case fMRI study EMDR treatment of a patient with posttraumatic stress disorder. *Journal of EMDR Practice and Research, 3(1),* 10–23.

Servan-Schreiber, D. (2000). Eye movement desensitization and reprocessing. Is psychiatry missing the point? *Psychiatric Times 17(7),* 36-40.

Stickgold, R. (2002). EMDR: A putative neurobiological mechanism of action. *Journal of Clinical Psychology, 58,* 61-75.

Van den Hout, M., Muris, P., Salemink, E., & Kindt, M. (2001). Autobiographical memories become less vivid and emotional after eye movements. *British Journal of Clinical Psychology, 40,* 121-130. *- Tested their theory that eye movements change the somatic perceptions accompanying retrieval, leading to decreased affect, and therefore decreasing vividness. Eye movements were superior to control conditions in reducing image vividness. Unlike control conditions, eye movements also decreased emotionality.*

Van den Hout, M.A., Eidhorf, M.B., Verboom, J., Little, M., & Engelhard, I.M. (2013). Blurring of emotional and non-emotional memories by taxing working memory during recall. *Cognition and Emotion,* doi: 10. 1080/02699931. 2013. 848785.

orienting response and neural systems linkage as to preclude mutual exclusion. Future findings will, undoubtedly, shed increasing light on their interrelationship.

Andrade, J., Kavanagh, D., & Baddeley, A. (1997). Eye-movements and visual imagery: a working memory approach to the treatment of post-traumatic stress disorder. *British Journal of Clinical Psychology, 36,* 209-223.
- Tested the working memory theory. Eye movements were superior to control conditions in reducing image vividness and emotionality.

Armstrong, M.S., & Vaughan, K. (1996). An orienting response model of eye movement desensitization. *Journal of Behavior Therapy & Experimental Psychiatry, 27*, 21-32.

Barrowcliff, A.L., Gray, N.S., Freeman, T.C.A., & MacCulloch, M.J. (2004). Eye movements reduce the vividness, emotional valence and electrodermal arousal associated with negative autobiographical memories. *Journal of Forensic Psychiatry and Psychology, 15(2)*, 325-345.

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Friedman, D., Goldman, R., Stern, Y., & Brown, T. (2009). The brain's orienting response: An event-related functional magnetic resonance imaging investigation. *Human Brain Mapping, 30(4),* 1144–1154.

Hout, M.A., Engelhard, I.M., Smeets, M.A., Hornsveld, H., Hoogeveen, E., and de Heer, E. (2010).
Counting during recall: taxing of working memory and reduced vividness and emotionality of negative memories. *Applied Cognitive Psychology, 24*(3), 303-311.

Kavanagh, D. J., Freese, S., Andrade, J., & May, J. (2001). Effects of visuospatial tasks on desensitization to emotive memories. *British Journal of Clinical Psychology, 40*, 267-280.
- Tested the working memory theory. Eye movements were superior to control conditions in reducing within-session image vividness and emotionality. There was no difference one-week post.

Lilley, S.A., Andrade, J., Turpin, G., Sabin-Farrell, R., & Holmes, E.A. (2009). Visuospatial working memory interference with recollections of trauma. *British Journal of clinical psychology, 48* (3), 309-321.

Lipke, H. (1999). Comments on "thirty years of behavior therapy..." and the promise of the application of scientific principles. *The Behavior Therapist, 22,* 11-14.

MacCulloch, M.J., & Feldman, P. (1996). Eye movement desensitization treatment utilizes the positive visceral element of the investigatory reflex to inhibit the memories of post-traumatic

APPENDIX C
Mechanism of Action
(Shapiro, 2018 Chapter 12)

A commonly proposed hypothesis is that dual attention stimulation elicits an orienting response. The orienting response is a natural response of interest and attention that is elicited when attention is drawn to a new stimulus. There are three different models for conceptualizing the role of the orienting response in EMDR: cognitive/information processing (Andrade, Kavanagh, & Baddeley, 1997; Lipke, 1999), neurobiological (Bergmann, 2000, 2008; Servan-Schreiber, 2000; Stickgold, 2002) and behavioral (Armstrong & Vaughan, 1996; MacCulloch & Feldman, 1996). These models are not exclusive; to some extent, they view the same phenomenon from different perspectives. Barrowcliff, Gray, Freemen, & MacCulloch (2004) posit that the orienting in EMDR is actually an "investigatory reflex," that results in a basic relaxation response, upon determination that there is no threat; this relaxation contributes to outcome through a process of reciprocal inhibition. Others suggest that the inauguration of an orienting response may disrupt the traumatic memory network, interrupting previous associations to negative emotions, and allowing for the integration of new information. It is further possible that the orienting response induces neurobiological mechanisms, which facilitate the activation of episodic memories and their integration into cortical semantic memory (Stickgold, 2002). It is additionally possible that EMDR's sensory stimulation and procedures repair thalamic and thalamo-cortical function, facilitating the repair of maladaptive neural linkage of information processing (Bergmann, 2008). This theory has lately obtained experimental support (Richardson et al., 2009). Further, studies have shown a direct relationship between the orienting response and thalamic activation (Friedman, Goldman, Stern, & Brown, 2009; Menon, Ford, Lim, Glover, & Pfeff erbaum, 1997; Minamimoto & Kimura, 2002), findings that are highly consistent with information processing. Further research is needed to test these hypotheses.

There are several research studies (e.g., Andrade et al., 1997; Kavanaugh, Freese, Andrade, & May 2001; van den Hout, Muris, Salemink, & Kindt, 2001) indicating that EMs and other stimuli have an effect on perceptions of the targeted memory, decreasing image vividness and associated affect. Two possible mechanisms have been proposed to explain how this effect may contribute to EMDR treatment. Kavanaugh et al. (2001) hypothesize that this effect occurs when EMs disrupt working memory, decreasing vividness, and that this results in decreased emotionality. They further suggest that this effect may contribute to treatment as a "response aid for imaginal exposure" (p. 278), by titrating exposure for those clients who are distressed by memory images and/or affect. Similar hypotheses have been proposed by Lilley et al. (2009), Hout et al. (2010), and van den Hout et al. (2013). Van den Hout et al. (2001) hypothesize that EMs change the somatic perceptions accompanying retrieval, leading to decreased affect, and therefore decreasing vividness. They propose that this effect "may be to temporarily assist patients in recollecting memories that may otherwise appear to be unbearable" (p. 129). This explanation has many similarities to reciprocal inhibition.

The majority of the speculative models can be seen from a theoretical perspective to possibly dovetail with each other. The underlying physiologies of temporal binding, neural mapping, hippocampal remapping, limbic depotentiation, frontal lobe activation, reciprocal ACC suppression, and REM systems activation are sufficiently interrelated with respect to the

APPENDIX B

EMDR Differentiated from Other Models

(Shapiro, 2018 – Chapter 1)

I. **Differentiate from other models:** Highlight how pathology and treatment are viewed differently from other orientations. The trainer should be prepared to highlight and/or to answer questions regarding how EMDR and the Adaptive Information Processing Model contrast and compare with other psychotherapeutic approaches. This might include the view of pathology and health, case conceptualization, and how change occurs. Examples would include:

A. Cognitive—
   1. Irrational thoughts are the basis of pathology
   2. Cognitions are changed through reframing, self-monitoring, and homework exercises

B. Psychodynamic—
   1. Explores the impact of Family of Origin, Object Relations
   2. Change is created by insight or "working through"
   3. Goal is to make the unconscious conscious

C. Family Therapy—
   1. Problems and solutions are interactional
   2. Exploration and evaluation of family dynamics
   1. Change through education and role realignment

D. Behavioral—
   1. Cannot see within the "blackbox" (the brain)
   2. Learned behavior is changed through conditioning, exposure, modeling, etc. (learning processes)

E. "Third wave" of CBT—
   2. Suffering is inevitable
   3. Change is through acceptance, commitment, and mindfulness exercises

F. Experiential –
   1. Facilitates client self-healing
   2. Affect and body are central
   3. Uses relationship, "two-chair," "meaning bridge"

state change: A shift in emotion/sensation/psychological state induced by a thought or exercise (e.g., deep breathing to relax when experiencing tension).

stop signal: The client's signal to stop processing.

a. designed not to be confused with clients relieving a traumatic experience e.g., yelling at a perpetrator to stop the assault

b. during restricted or contained processing, when an experience other than the agreed upon experience, comes up during processing

subjective units of distress scale (SUDS): A 0–10 scale used to measure levels of disturbance, where 0 is neutral or no disturbance, and 10 is the highest level of disturbance (Wolpe, 1969).

target: The term used to describe the incident that is chosen to be the focus of processing.

Target plan: An outline of disturbing incidents needing processing related to the client's negative core beliefs derived from presenting complaints or from the client's life span (i.e., past incidents, present triggers, and future anticipated triggers)

three-pronged procedures: For full EMDR treatment effects, (1) past incidents, (2) present triggers, and (3) future anticipated triggers need to be fully processed.

touchstone memory: The earliest *identified* incident that resonates with the client's presenting complaints (e.g., emotions, sensations, and irrational belief).

trait change: An adaptive shift in a client's emotions, sensations, and beliefs so that "state change" interventions are no longer needed for previously triggering experiences (e.g., no longer needing to do a breathing exercise when getting on an elevator).

validity of cognition (VOC): The measurement from 1–7 where 1 **feels** totally false and 7 **feels** totally true (Shapiro, 1989 based upon Likert scale, 1939)

window of tolerance: optimal range for reprocessing. **Over accessing:** 80% or more in the experience

- **hyper-arousal:** high levels of emotional response; fight / flight - exceeding the window of affect tolerance necessary for processing. (e.g., terror)

- **hypo-arousal:** high levels of emotions causing freeze / shutdown - exceeding the window of affect tolerance necessary for processing. (e.g., numbing)

- **Optimal:** 50% in the experience, 50% in the office Client maintains dual awareness, present orientation, responsiveness, ability to manage and tolerate stress / affect.

- **Under accessing:** 80% in the office Client is unable to get started with the processing experience.

client's life span: past, present, and future. *Let whatever happens, happen, there are no "suppose to's."*

Explicit memory: Conscious autobiographical recall, narrative, beginning at about 2-3 years of age.

Float back: An intervention strategy (Browning, 1999; Zangwill, 2002) to use a client's belief and affect to identify past experiences relating to a client's present experience. *Think of the experience, the associated emotions and belief, and allow yourself to float- back to a time when you felt this way before. What comes up?*

Implicit memory: Unconscious, automatic, emotions, sensations, present at pre-birth up to about 2-3 years of age

Negative cognition (NC) = Negative belief: terminology for a client's self-reported cognition related to the targeted incident.

Negative core belief: A belief that resonates with the client's presenting complaint and their entire "life script."

node: Any incident that, when recalled, carries some level of positive or negative emotion or sensation. May be selected for skill building or processing.

original target: The incident that is selected as the focus of a processing intervention.

Positive cognition (PC) = Positive Belief: A client's that resonates with the client's adaptive belief about self-identified in relation to the negative belief associated with the maladaptively linked negative experience.

positive core belief: A held positive belief schema developed during EMDR's targeting sequence plan that resonates with the client's desired, adaptive resolution to their presenting complaint.

Processing: BLS/DAS-activated integration of negative isolated memory networks into more current, adaptive positive memory networks.

set: The term used to describe the duration (number of seconds) of BLS applied by the clinician during reprocessing.

schema: An organized pattern of thought, also often described as a mental structure of pre-conceived ideas. Belief schema is an approach (Roy Kiessling) used to develop the EMDR target sequence plan to treat the client's presenting complaint(s).

sensory stimulation (BLS): The term used for any stimulation modality, i.e., eye movement, tapping, auditory, drawing, dancing, drumming, etc.

with the target memory, and to rate the selected positive belief on the VOC scale of 1 to 7. The therapist then continues alternating bilateral stimulation until the client's rating of the positive belief reaches the level of 7 (or an ecologically valid rating) on the VOC Scale.

BIVavi. In the **Body Scan Phase (Phase 6)**, the therapist asks the client to hold in mind both the target event and the positive belief and to mentally scan the body. The therapist asks the client to identify any positive or negative bodily sensations. The therapist continues bilateral stimulation when these bodily sensations are present until the client reports only neutral or positive sensations.

BIVavii. The **Closure Phase (Phase 7)** occurs at the end of any session in which unprocessed, disturbing material has been activated whether the target has been fully reprocessed or not. The therapist may use a variety of techniques to orient the client fully to the present and facilitate client stability at the completion of the session and between sessions. The therapist informs the client that processing may continue after the session, provides instructions for maintaining stability, and asks the client to observe and log significant observations or new symptoms.

BIVaviii. In the **Reevaluation Phase (Phase 8)**, the clinician, utilizing the EMDR standard three-pronged protocol, assesses the effects of previous reprocessing of targets looking for and targeting residual disturbance, new material which may have emerged, current triggers, anticipated future challenges, and systemic issues. If any residual or new targets are present, these are targeted, and Phases 3-8 are repeated.

BV. Innovation, Flexibility and Clinical Judgment as Applied to Particular Clients or Special Populations

BVa. To achieve comprehensive treatment effects a three-pronged basic treatment protocol is generally used so that past events are reprocessed, present triggers desensitized, and future adaptive outcomes explored for related challenges. The timing of addressing all three prongs is determined by client stability, readiness, and situation. There may be situations where the order may be altered or prongs may be omitted, based on the clinical picture and the clinician's judgment.

BVb. As a psychotherapy, EMDR unfolds according to the needs, resources, diagnosis, and development of the individual client in the context of the therapeutic relationship. Therefore, the clinician, using clinical judgment, emphasizes elements differently depending on the unique needs of the particular client or the special population. EMDR treatment is not completed in any particular number of sessions. It is central to EMDR that positive results from its application derive from the interaction among the clinician, the therapeutic approach, and the client.

American Psychiatric Association (2000), *Diagnostic and Statistical Manual of Mental Disorders Fourth Edition*, Washington DC.

Shapiro, F. (2001). *Eye Movement Desensitization and Reprocessing, 2nd edition*, N.Y.: The Guilford Press

events in the client's life. The clinician prepares a treatment plan with attention to past and present experiences, and future clinical issues. It is also important to identify positive or adaptive aspects of the client's personality and life experience. The clinician may need to postpone completing a detailed trauma history when working with a client with a complex trauma history until the client has developed adequate affect regulation skills and resources to remain stable. The clinician may need to address any secondary gain issues that might prevent positive treatment effects.

BIVaii. In the **Preparation Phase (Phase 2)**, the clinician discusses the therapeutic framework of EMDR with the client and gives sufficient information so the client can give informed consent. The therapist prepares the client for EMDR reprocessing by establishing a relationship sufficient to give the client a sense of safety and foster the client's ability to tell the therapist what s/he is experiencing throughout the reprocessing. The client develops mastery of skills in self-soothing and in affect regulation as appropriate to facilitate dual awareness during the reprocessing sessions and to maintain stability between sessions. Some clients may require a lengthy preparation phase for adequate stabilization and development of adaptive resources prior to dealing directly with the disturbing memories. It may be important, especially for those clients with complex trauma, to enhance the ability of the individual to experience positive affect through promoting the development and expansion of positive and adaptive memory networks, thus expanding the window of affect tolerance, and stimulating the development of the capacity for relationship.

BIVaiii. In the **Assessment Phase (Phase 3)** the clinician identifies the components of the target/issue and establishes a baseline response. Once the memory or issue (with a specific representative experience) has been identified, the clinician asks the client to select the image or other sensory experience that best represents it. The clinician then asks for a negative belief that expresses the clients currently held maladaptive self-assessment that is related to the experience, a positive belief to begin to stimulate a connection between the experience as it is currently held with the adaptive memory network(s) and the validity of the positive belief, utilizing the 7-point Validity of Cognition (VOC) scale. Finally, the clinician asks the client to name the emotions evoked when pairing the image or other sensory experience and the negative belief, to rate the level of disturbance utilizing the 0 to 10 Subjective Units of Disturbance (SUD) scale and to identify the location of the physical sensations in the body that are stimulated when concentrating on the experience.

BIVaiv. During the **Desensitization Phase (Phase 4)** the memory is activated, and the clinician asks the client to notice his/her experiences while the clinician provides alternating bilateral stimulation. The client then reports these observations. These may include new insights, associations, information, and emotional, sensory, somatic, or behavioral shifts. The clinician uses specific procedures and interweaves if processing is blocked. The desensitization process continues until the SUD level is reduced to 0 (or an ecologically valid rating). It is important during this phase to assist the individual in maintaining an appropriate level of arousal and affect tolerance.

BIVav. In the **Installation Phase (Phase 5)**, the therapist first asks the client to check for a potential new positive belief related to the target memory. The client selects a new belief or the previously established positive cognition. The clinician asks him/her to hold this in mind, along

APPENDIX D
Glossary of EMDR Therapy Terms

Adaptive information processing model (AIP): the model that describes the brain's drive toward emotional health and represents the foundation of EMDR's approach to clinical practice and psychotherapy. AIP guides clinical case conceptualization and treatment planning.

Affect scan: A strategy developed by Shapiro (1995) intended to assist the client in identifying previous experiences.

Back to target: When a clinician directs the client to recall the original incident that was the focus of processing.

Bilateral stimulation (BLS): Stimulation that includes alternating eye movement, auditory or tactile means as a way to activate both left and right hemispheres of the brain.

Bundling: Identifying experiences of similar symptoms (i.e., core belief schema, emotions, affect, etc.) to be used in developing a targeting sequence plan.

Channels of Association: Events, incidents/memories, emotions, sensations, and/or insights that may spontaneously occur during reprocessing of targeted incident.

Cognition: Term used in EMDR by Shapiro to represent a belief, positive or negative.

Core belief: A verbalization of an emotional, sensory-activated memory that resonates with a common belief schema: (Negative): *I am not good enough.* (Positive): *I am okay as I am.*

Dual attention stimulation (DAS): The use of some form of activity while thinking of a disturbing incident apparently taxes working memory, thereby allowing the adaptive information system to process the disturbance. Also known as BLS

Ecologically sound: The "good as it is going to get" value for the subjective unit of disturbance (SUD) or how true the positive belief feels (VoC) his/her reported measurement makes sense (to them and to the clinician); e.g., A soldier going back into the combat zone may have a SUD = 2 and VoC = 5.

Eight phases: The treatment phases of EMDR Standard Procedures as outlined by Shapiro are: Phase 1 - History, Phase 2 - Client preparation, Phase 3 - Assessment, Phase 4 - Desensitization, Phase 5 - Installation, Phase 6 - Body scan, Phase 7 - Closure, Phase 8 - Reevaluation

EMD: Shapiro's term for restricted processing of a specific incident where the client is repeatedly asked alternately to focus on the disturbing incident, while eye movements are administered, then asked to report its level of disturbance.

EMDR: Shapiro's preferred implementation of unrestricted processing that, while eye movements are being administered, invites the client to have total free association across the