Navigating the EMDR special protocols

Jenny Ann Rydberg
Edinburgh
EMDR Europe conference 2014
When, why, how, and which ones to use?
Basic training

• EMDR and the AIP model challenge conventional diagnostic wisdom

• Case conceptualisation is not based on current symptoms or diagnosis but rather on the underlying unprocessed experiences in the form of dysfunctionally stored memory networks
One size fits all?
CPE: protocols & procedures for special populations & situations

• After strictly adhering to the standard protocol, clinicians go on to discover specific protocols for specific populations and situations

• We then have people asking “I have this new client with symptom/diagnosis so-and-so, is there a protocol for that?”
CPE: protocols & procedures for special populations & situations

• Does this mean that the standard protocol only applies to single incident PTSD?
• Or that we need to customise the standard protocol for each diagnosis, population, or context?
What is standard protocol?
How do we teach EMDR?
How do we present these adapted or special protocols and procedures in the research literature?
• Do we want to suggest that each diagnosis, each clinical population, each particular context or circumstance requires its own specific protocol?

• Or that the standard protocol may be used for most if not all psychological and psychosomatic symptoms – albeit with a set of “standard variations”, which are part of the basic principles, protocols, and procedures of EMDR?
Types of “special” protocols

- Stabilisation and emotional regulation
- Recent events/early intervention
- Early/preverbal memories
- **Developmental** (C&A, intellectual disabilities)
- **Physical/somatic** (illness, pain)
- **Diagnosis-based** (phobia, addiction, OCD)
- **Population-based** (first responders, military, minors)
- **Complexity-based** (complex trauma/DESNOS and dissociative disorders, comorbidity)
- Positive psychology
- **Integrated** (headaches, hypnosis, ego state, couples)
In her basic text, Francine Shapiro described a number of protocols and procedures for special situations: was she saying that the standard protocol cannot/shouldn’t always be applied?
EMDR Basic Principles, Protocols, and Procedures

The standard EMDR procedure is applied to various clinical problems by means of a number of specific protocols [...] Any of these protocols and procedures may be applicable to an individual client (e.g., a trauma survivor may need treatment that combines the protocols for specific traumas, phobias, and illness, a treatment that is positioned appropriately within the standard three-stage protocol. (Shapiro, 2001, p.221)
EMDR Basic Principles, Protocols, and Procedures

Specific protocols are a means of applying the standard 11-step EMDR procedure within the standard three-stage protocol.
A reminder:
the 11-step procedure

1 Image
2 Negative cognition
3 Positive cognition
4 VoC
5 Emotion
6 SUD
7 Location of body sensation
8 Desensitisation
9 Installation
10 Body scan
11 Closure
The original “special” protocols

- Protocol for a single traumatic event
  - memory of traumatic event
  - flashback scene
  - dream/nightmare image
  - present stimuli

Target selection
The original “special” protocols

- **Protocol for current anxiety and behaviour**
  - initial or earliest memory
  - most recent/representative present anxiety-provoking situation
  - future projection of a desired emotional and behavioural response

**Target selection**
The original “special” protocols

- Protocol for recent traumatic events:
  1. narrative history
  2. target most disturbing aspect
  3. target remaining aspects chronologically
  4. visualise entire sequence (video), eyes closed, reprocess remaining disturbance
  5. visualise (eyes open) + install PC
  6. body scan
  7. process present stimuli (if necessary)
The original “special” protocols

- Protocol for recent traumatic events:

  Target selection: targeting fragments of unconsolidated memory and finish with “global” PC

  Video technique
The original “special” protocols

- **Protocol for phobias**
  - teach self-control procedures (fear of fear)
  - target and reprocess memories
    (antecedent/ancillary, 1st, most disturbing, most recent, associated present stimuli, physical sensations/manifestations of fear)
  - positive template
  - contract for action
  - run mental video of sequence/reprocess
  - process targets revealed between sessions
The original “special” protocols

- Protocol for phobias:

  **Extra preparation**
  
  **Target selection**
  
  **Contract for action**
  
  **Video technique**
  
  **Update target sequencing plan**
The original “special” protocols

- Protocol for excessive grief
  - actual events
  - intrusive images
  - nightmare images
  - present triggers
  - issues of personal responsibility, mortality, or previously unresolved losses

Target selection
The original “special” protocols

- Protocol for illness and somatic disorders
  - action plan to address real needs
  - process relevant memories, present situations, and fears of the future (personal/physical constraints, social issues, medical experiences)
  - run video of the next 1-5 years
  - Simonton-type imagery
  - identify PC; link image and PC
  - assign self-use procedure
  - log and self-care procedures
The original “special” protocols

- Protocol for illness and somatic disorders

  Extra preparation and continuous Phase 2 work (action plan to address real needs & on-going attention to self-care)

  Target selection

  Video technique

  Integrate supplementary techniques
The original “special” protocols

- **Summary**: “standard options”
  - Extra preparation & continuous Phase 2 work
  - Target selection/target sequencing plan
    - Past events (ancillary, 1st, worst, recent), present stimuli (intrusions, nightmares, triggers, physical manifestations), fears of the future and positive template
    - Fragments of unconsolidated memory
    - Update TSP

**Video technique**

**Integrative approach**
What about the other protocols?

• Could we look at them the same way?
• Are there any other common or recurring additions or modifications?
• Which ones can you think of?
Phase 1 (examples to inspire you)

- **Target selection and representation**
  - **Drawing the target** (E Carvalho)
    To narrow down a target, instead of a concrete scene, draw a picture of a negative belief or self-perception
  - **Parade of faces** (R Adler-Tapia)
    For first responders: tell me about the calls that haunt you even now
  - **Addiction memory** (M Hase)
    As another type of dysfunctionally stored memories (cravings, drug compensation, relapse)
Phase 1 (examples to inspire you)

- Target selection and representation
  - Feeling state
    - Positive affect tolerance and integration (A Leeds): a discrete behavioural state of shared positive emotion
    - Feeling-state addiction protocol (R Miller): a feeling-state as a fixed linkage between an event and a feeling
Phase 1 (examples to inspire you)

• Target selection and representation
  • Two method approach (De Jongh & Ten Broeke)
    • 1st method: memories of etiological & aggravating events (time line)
    • 2nd method: memories that underlie the client's dysfunctional core beliefs
Phase 1 (examples to inspire you)

- Modified sequencing
  - Inverted protocol (A Hofmann)
  - R-TEP (E Shapiro & B Laub)
  - OCD (J Marr)
  - DeTUR (AJ Popky)
Phase 3 (examples to inspire you)

Reduced assessment

- **Blind-to-therapist (D Blore et al.)**

  No cognitions in Phase 3; a keyword is used to designate the target (image not described)

Rationale: reassertion of control among “executive decision makers” - Shame/embarrassment - Minimizing risk of vicarious traumatization - Cultural issues: avoiding distress being witnessed by a fellow countryman (translator) - Prevention of information “leakage” - Client with severe stammer
Phase 3 (examples to inspire you)

Reduced assessment

- **OCD: Adapted phobia protocol (J Marr)**
  
  No cognitions in Phase 3
  
  Rationale: all triggers, fears, and memories are treated as one complex multiple event, with each aspect representing a part of the whole; that whole target is desensitised before moving to cognitive installation. The cognitive work is left to the end because of the potential for the obsessive thoughts to disrupt the emotional and somatic processing.
Phase 3 (examples to inspire you)

Reduced assessment

- **Pain protocol (M Grant)**
  No cognitions if the pain is not associated with a traumatic event; instead the target is described in terms of size, shape, colour…

- **Pain protocol (C de Roos & S Veenstra)**
  No cognitions
  Target is described in terms of colour, shape, temperature, texture…
  SUP (subjective units of pain)
Phase 3 (examples to inspire you)

Reduced assessment

• Dysfunctional positive affects (unwanted defences, procrastination, unrequited love, codependence) (J Knipe)

  Image + LOUA/LOPA + body sensations

  No cognitions or VoC
Phase 3 (examples to inspire you)

Redefinition of the SUD scale

- SUP (subjective level of pain) - de Roos & Veenstra
- LOU (level of urge to use) - AJ Popky
- LOUA (level of urge to avoid) – J Knipe
- LOPA (level of positive affect) – J Knipe

Level of maladaptive affect and/or sensation?
Phase 4 (examples to inspire you)

- Telescopic processing: EMD – EMDr - EMDR (R-TEP, E Shapiro & B Laub)
- “Rerun the video” rather than “back to target” (OCD, Adapted phobia protocol w/ video playback, J Marr)
- Techniques for maintaining dual attention
  - Back-of-the-head scale & CIPOS (Knipe)
  - Picture-in-the-picture (J Twombly)
Phase 5 (examples to inspire you)

- It should be noted that most authors who omit cognitions in Phase 3 will elicit and install a PC in Phase 5.
- For recent events, or several parts considered a whole, a global or general PC is often installed once the fragments have been processed & integrated.
- Pain protocols recommend using a PC as a resource, coping or antidote statement.
How can we use these examples?
Could we use them much in the same way as our set of strategies for blocked processing that we may use as appropriate?
Strategies for blocked processing

• Altering DAS
• Focusing on body sensation (unspoken words, using movement, pressing location…)
• Scanning (scan incident for sthg more upsetting now – visual/sounds/dialogue)
• Alterations (change image, visualise the perpetrator not his actions, change time/distance, redirect to image/NC, add positive statement, check PC)
• Interweaves

Standard options or variations

• Selected targets seen as manifestations of dysfunctional/maladaptive information (feeling state, addiction memory, drawing, defence, sensation, etiological, aggravating, contributory)
• Modified sequencing (chronological, inverted, or “ecological” – what comes 1st/is approachable)
Strategies for blocked processing

- Altering DAS
- Focusing on body sensation (unspoken words, using movement, pressing location…)
- Scanning (scan incident for sthg more upsetting now – visual/sounds/dialogue)
- Alterations (change image, visualise the perpetrator not his actions, change time/distance, redirect to image/NC, add positive statement, check PC)
- Interweaves

Standard options or variations

- Minimum assessment elements: target keyword or sensory representation, SUD (or equivalent), body
- Scan entire event/episode, telescopic processing, rerun video
- Techniques for maintaining dual attention
- Video technique (for narrative of event, scanning for targets, visualising future desired reaction)
Am I suggesting that we drop “special” protocols?
No!
• What I am suggesting is that we think of these protocols as potential – or sometimes optimal – **combinations of these standard options or variations**

• So that we begin to think about which particular “option” works for what reason, rather than worrying about which protocol is “correct”

• “Special protocols” and procedures are a great way to **inspire** us into **thinking** about what we’re doing and how EMDR works!
Thank you for your attention!

Jenny Ann Rydberg
jarydberg@gmail.com