Panel: Dilemmas and Challenges in EMDR Consultation

Consultant Day Handout – March 24th, 2023

Karen Alter-Reid – Bill Brislin - Mary French – Marlene Kenney –- Sharon Rollins

<u>Dilemma: How do you support consultees who are only doing resourcing because they are afraid to move to reprocessing? By Karen Alter-Reid</u>

- Determine source of anxiety/fear
- Consider suggestion that consultee do a floatback on their own reluctance to move to
- reprocessing. Floatback on NC, emotion, sensation. Consider 'worst case scenario'
- Determine what trainer taught them about reprocessing phases and readiness criteria
- Review Case Conceptualization on consultee's case with AIP Model
- Strengthen their understanding of the AIP Model
- Emphasize centrality of the therapeutic relationship and the importance of holding onto
- their therapeutic style
- Emphasize Francine Shapiro's teaching of getting to source of volcano
- Consider possibility that consultee needs review of window of tolerance concepts

<u>Dilemma: How to work with risk when presented in consultation - By Marlene Kenney</u>

- Clinicians often leave basic training with the **impression that suicidal ideation, and risk disqualifies** a client from proceeding with EMDR therapy. Consultants can remain consistent with the training recommendation for client selection includes assessing for risk so that we can do proper AIP treatment planning, this should not indicate that suicidal ideation, a history of suicidal ideation or suicide attempts disqualifies a client from EMDR therapy. Rather this indicates that safety planning must be part of the Preparation Phase. (I will give information about safety plans and safety planning here).
- There is a link between Adverse Childhood experiences and suicidal ideation and trauma and suicide risk. Consultation is an opportunity to give consultees resources for assessment and suicide prevention as part of preparation for EMDR therapy. Use Adverse Childhood Experiences Checklist as an assessment resource for clinicians.
- **When clinicians report suicide attempt or loss in client's history how to case conceptualize?** See it as a potential to understand how it may be connected to the client's presenting issue. Find out what age the event occurred. Have they had any other suicide losses, ideation or attempts since the reported time. Suicide attempts and suicide loss are traumatic and can be risk factors for clients.

- Other risks and ethical dilemmas: homicidal/duty to warn in consultation. Client self determination as an ethical concern with clients who are not yet ready to engage fully with reprocessing. **How do you help consultees deal with this when it comes up in phase 4? Do you stop the processing etc.**

Additional resources:

- **The SP App** developed by the NYS Office of Mental Health and Columbia University
- **The Virtual Hope Box** https://apps.apple.com/us/app/virtual-hope-box/id825099621 (An app for more emotional regulation connected to safety planning).
- **988 Samaritans crisis text line: https://988lifeline.org/**
- **nowmattersnow.com** DBT oriented website for at risk people to get information, watch videos and build community around emotional regulation and decreasing risk
- Stacy Freedenthal, (2018). Helping the Suicidal Person. Routledge.

Dilemma: When a consultee is not competent to be certified and they have completed 20 hours of consultation. How do you define competency? How do you have this conversation? By Mary French

- Consultant role as educator (mentor role) and **evaluator.**
- Parallel process with client's phase 1 treatment contract.
- Be clear on your expectations/and the consultee's expectations.
    - Outline in contract
        - EMDRIA guidelines vs. your expectations
        - Fidelity scale or evaluative expectations
        - Self-assessment
        - Requirements for the written recommendation
    - Address verbally
    - Track and review throughout the consultation follow up with email.
    - Reparative evaluation meeting, recontract.

Dilemma: What is the difference between consultation for CIT, Certification, Basic Training? By Bill Brislin

EMDR consultation is a collaborative process of integration and growth. The consultant advises the consultee regarding the effective utilization of EMDR therapy. It differs from supervision in that the consultee maintains primary responsibility for the decisions involving treatment of their clients.

My style is both supportive and challenging and the goal is to help consultees feel comfortable to explore their own questions, competencies, and difficulties. Ultimately, I desire to impart

excitement for EMDR therapy and assist in honing necessary skills to use this treasure effectively.

The following cascade, as excerpted from the EMDRIA 2020 Consultation Packet, will be discussed:

- **EMDR basic training consultation** – "The EMDR basic training consultation hours are focused on implementation and initial application of standard EMDR therapy and the AIP model in work with actual client cases".
- **EMDRIA Certification consultation** – "The certification consultation hours are focused on demonstrating proficiency and fidelity to the standard EMDR therapy and also demonstrating an awareness of situations in which modifications to standard EMDR therapy are necessary in order to safely and effectively treat the client."
- **Consultation-of-consultation** – "The feedback is focused on the CIT's skills and ability to provide consultation to other clinicians… Although co-leading consultation groups and shadowing… are significant and valuable for the CIT process, these activities themselves do not directly count as consultation-of-consultation hours."

In **basic consultation**, I see myself as a cheerleader providing fairly direct guidance. So, when working with my basic training consultees (or at the beginning of consultation process for certification), I am usually instilling hope that there are MANY things that you can do with EMDR and the AIP model. However, you might need more experience and practice before doing so. I urge them to start practicing the protocol with the clients that are more stable (with more internal and external resources) and with the ones that they have the closest therapeutic relationship so they can learn from the process and then move to other clients with more complex presentations. Some consultees just want to start working with the most complex cases without having enough skills or confidence yet and they just drown themselves in the process…. It's more effective to master walking before attempting to run.

In **certification consultation**, the focus is more on assessing current skills and knowledge as the consultees are empowered to use available resources as needed. More often, I refer them to sections of the Third Edition of the standard text or to the *Francine Shapiro Library* to report back to me or the group what they have gleaned. Additionally, I have come to value seeing video examples of consultees work. Speaking the language of AIP fluently does not necessarily correlate with applying the Standard Protocol effectively. Consultees increase their confidence when their actual work has been reviewed.

When they are **CITs**, I work with them in how they can guide others… what questions they can ask? And I check if they are solid in the Standard Protocol… do they know the eight phases? How do they conceptualize clients with the AIP model? Are they sensitive to cultural considerations during consultation? Do they guide consultees rather than telling exactly what

to do? If a CITs' knowledge or skills have significant deficits, we should return to *consultation* and insist on re-reading the standard text until the CIT is better suited to provide guidance to others. In consultant formation, it's important to maintain focus on their consultation skills, particularly articulating AIP principles succinctly and appropriately.

Dilemma: How do you support Consultees who are hesitant to utilize EMDR virtually? By Sharon Rollins

Guidelines for Virtual EMDR Therapy: https://www.emdria.org/wp-content/uploads/2020/04/virtual_tg_report_for_member.pdf

See the above guidelines for considerations for safety, ethics, technology tips, mechanics, and more. Both client and therapist need a private setting free from distraction. Secure emergency contact information in the region where they reside prior to reprocessing. Make a plan for safety and consent just as you would with an in person session.

But, can I use Eye Movements? Yes! You CAN use Eye movements for Virtual Work! Practice makes perfect. When speaking with the client, put the webcam right next to the live picture of them on your screen (move it if needed) and look into the camera as much as you can when speaking to them. When you start the eye movements, move your face out of the screen so they have the full screen to track the eye movements. You can still watch them, but they will be less distracted by you. Use a rolling chair to move back and forth if you need to switch arms. (Online programs are available, but the "old timey" arm movements work just fine. You can stay attuned by offering occasional and gentle verbal support? If they must use a phone or small device, ask them to turn it on its side and bring it closer to their face so they get a broader sweep of the eye movements.

But, can I use Tactile Stimulation? Yes! You CAN use Tactile Stimulation for Virtual Work! Teach them how to do the **Butterfly Hug** (Lucy Artigas, https://emdrfoundation.org/toolkit/butterfly-hug.pdf). You can either mirror it for them in the video so they can see when to start and stop, or you can verbally guide them with "Left...Right...Left...Right...Pause and let it go...What do you notice now?"

But, can I use Auditory Stimulation? Yes! You CAN use Auditory Stimulation for Virtual Work! Guide the client in self-tapping on their shoulders or gently on the sides of their face by their ears. Or, have them open and close their hands so that their fingers tap their palms by their ears. Even these soft movements can generate auditory stimulation.

But, what if the bandwidth is "glitchy?" Make sure you have a phone number so you can connect by phone if the internet goes out. Have a plan ahead of time for what you and the client will do. Know emergency numbers for the region the client resides. Have an emergency

contact number on file along with consent. If the screen freezes or lags, instruct the client to continue moving the eyes back and forth across the screen from side to side even if your hand is frozen and pause when you verbally instruct or they feel they need to check in or pause. Be sure you both close other open browsers, programs, and another items which might be using up the bandwidth or working memory of the device. Adding an ethernet cable directly connected to the Wifi, asking your internet company to improve your bandwidth, and/or moving as close to your Wifi box as you can may help. As therapists, light behind you should be dimmed, and light in front of you should be brighter but without a glare. Use headphones or a headset to achieve the best sound level.

But, what if they start to Abreact? Use your calm therapist voice and look directly into the camera while asking them to find your voice and remind/reassure them "It's scenery on the train...you've been carrying this for a long time...it's not happening now...let it move through...that's right, I'm right here with you this time...." Use the same tools to help them move through it as you would if they were in your office in person.Have your emergency contact information nearby.

But, what if they start to dissociate? Ask them to open their eyes (if they have them closed) and find your eyes. Look directly into the camera so they can find your eyes. Shorten the sets and slow them down. Pause if needed. Ask them to find your voice. Help them ground themselves by feeling for two different textures or wiggling their toes. Have them find five colors in your office. If you know they are prone to dissociation because you've done proper screening, ask them to have peppermints, aromatic lotions, different textures, a cooling fan, brighter lights so they can reconnect with their senses and body. Remind/reassure them "It's scenery on the train...it's not happening now...that's right, I'm right here with you this time...." Use the same tools to help them move through it as you would if they were in your office in person. Have your emergency contact information nearby.

If you have a visual representation of the person's "Container" or "Safe Place" and a cue word, you can "Share Screen" to help them return to a more stable place at the end of the session. Or, they can have it in front of them at home or be reminded of these with the cue word as you end the session. Make sure they are oriented to time and place before ending the session. Set a time to check in verbally by phone after the session if needed.

But, what if I work with Children? Use the white board or Jamboard to allow for interactive and more engaging forms of expression. They can have toys, art supplies, even a small sand or rice tray with their own toys if they need to interact with the characters to add distance for the work. Paper bag puppets can be created by both therapist and child for supportive figures and main characters. The sky and a child's imagination are the limit. There are programs online such as "Simply Sand Play" which offer interactive sand play settings in which children can build their stories. Include trusted caregivers in the process when appropriate to assist the child if needed

and to be available in case more safety is needed. Create and send an EMDR toolbox (or have the guardian help create one at home) for processing, safe place, container, resourcing, and dissociation.

Still fearful or reluctant? Practice will lend to confidence and improvement. AND, picture the image of the worst possible moment which comes up when you are considering using EMDR virtually with your client. What is the negative belief about yourself that goes with that picture? And, what would you like to believe about yourself? How true does that feel? And, what are the emotions you notice when you consider the disturbing picture and the negative cognition? And how disturbing are they? And where do you notice that in your body? Now...find an EMDR clinician ***and notice that!***