

# UNITED WE STAND

## EMDR as an Integrative Psychotherapy

By Dr. Sarah Dominguez



Experts have suggested that there is a paradigm crisis in mental health (Sarris et al., 2014; Schenberg, 2018).

If you were asking a group of mental health therapists what the most effective intervention model for psychopathology is, you would likely get several opposing, firmly held views. The opposing nature of these debates results in *silos of knowledge*, which can be stifling for the progression of the mental health field (Wu et al., 2022).

Tensions between different psychological orientations is not new. There is a notable ongoing debate between psychodynamic and cognitive behavioral therapists regarding the conceptualization of depression, and more recently, there has been heated

discussion surrounding the use of psychedelics (Milton, 2001; Pilecki et al., 2015; Sarris et al., 2014). While healthy debate is critical for growth and change, the tension between psychological models sometimes can be likened more to a divisive and polarising ethical orientation rather than a scientific or theoretic perspective (Wachtel, 2018). In addition to possible silos of knowledge, this polarizing nature can confuse therapists and the public, decreasing confidence in the therapeutic process and perhaps even reducing the chance that clients will seek the support they need.

As all shadows require light, the polarising views some hold are countered by others. As such, many within the mental health field are curiously exploring the similarities and differences between orientations. The outcome of these explorations is a field of integrative psychotherapy where elements of differing therapeutic modalities are integrated based on client needs and an understanding of differing theoretical orientations (Wachtel, 2018). EMDR therapy is one such integrative approach (Shapiro, 2018). Of course, EMDR therapists are not immune to criticism regarding a passionate support from therapists and clients. However, while some psychological models aim to be purist, EMDR therapy, from its start, strongly focuses on integration, embodying the idiom concerning psychological therapeutic models that together, we are more than a sum of our parts.

In some of her early work, Dr. Francine Shapiro, the developer of EMDR, said that *“each school of thought in the field of psychology has an important contribution to make”* (2002, p. 4). As such, integration is at the core of EMDR therapy. This integrative tendency is evident when reflecting on the development of the therapy. While many models of psychological interventions began from a theoretical standpoint, Shapiro (2002) was clear that EMDR evolved from a clinical perspective based on her clinical experiences. Although acknowledging behavioral roots, rather than initially being fully embedded in a novel theory, EMDR was developed, in part, as an incorporation of aspects of a range of therapeutic modalities (Shapiro, 2002). However, while honoring the origins of the varied theoretical influences, this amalgamation appears to be providing results building on the efficiency and efficacy of current intervention options (Stanbury et al., 2020).

Integration in EMDR therapy is bidirectional. In addition to being guided by other theoretical models in the development, the last 30 years have shown that, in addition to being an effective therapy in its own right, elements of EMDR therapy can also enhance treatment outcomes for therapists using other therapeutic modalities. There is also evidence that EMDR can improve outcomes when delivered with standard treatment for various clinical presentations (Scelles & Bulnes, 2021). This includes, but is not limited to,

various clinical presentations (Gelles et al., 2021). This includes, but is not limited to, individuals with substance use disorder (Carletto et al., 2018), chronic pain (Suárez et al., 2020), and depression (Dominguez et al., 2021).

Dr. Shapiro said, *"No person is expendable, and no person is without worth. Can we make our treatments so comprehensive and so robust that no one will be lost?"* (2002, p. 6).

Following this spirit of unity and integration, this article focuses on ways EMDR therapy and alternative psychological therapies can be enhanced through integration. However, this integration does not need to be at the cost of treatment fidelity. Often used to describe the combination of clinical interventions, the term *eclectic psychology* refers to the combination of various therapeutic techniques, possibly without adequate training or theoretical understanding (Wasserman & Wasserman, 2017). Understandably, this term has negative undertones as the combination of techniques without clear rational or theoretical backing is seen as haphazard and contrary to evidencebased practice. Conversely, integrative psychotherapy moves beyond this ad hoc eclectic combination. An integrative psychotherapist would incorporate elements of differing intervention modes underpinned by client formulation and an understanding of the theory of the mode. The amalgamation of interventions in this client-centred, theory-driven way allows the therapist to remain faithful to treatment protocols while applying additional skills to improve treatment outcomes.

The nature of how this integration occurs will likely differ for each therapist and each client. However, by understanding the origins and theory that underpins our interventions, we are best placed to incorporate other skills or strategies that may increase client outcomes. The definition of EMDR therapy is currently evolving as our understanding of the applications grow (Hase, 2021; Laliotis et al., 2021). In the recent paper *'What is EMDR Therapy?'*, experts in the EMDR field distinguished three categories of EMDR therapy (Laliotis et al., 2021). Primarily, EMDR psychotherapy is a collaborative, all-inclusive psychotherapy driven by an adaptive information processing (AIP) formulation. While many therapists may use EMDR in this way, as their primary therapeutic model, skills from other models can also be used to enhance the intervention, as discussed below. Secondly, EMDR treatment protocols is the term to describe various EMDR interventions, all based on the standard EMDR protocol, that can be used across a range of therapeutic techniques to target key memories. For example, cognitive behavioral therapists may use the EMDR therapy standard protocol to target a key memory of an encounter of a phobic stimulus in conjunction with the traditional cognitive behavioral therapy (CBT) technique of systematic desensitization. And thirdly, the group identified EMDR derived techniques. These discrete interventions can often be used with therapists

from a range of disciplines to support the client's work, typically in supporting clients to understand their current symptoms, self-regulate, and build capacity to address experiential avoidance or close a session safely.

Considering this, the remainder of this article will investigate the various components of EMDR therapy and its theoretical and practical links with other evidence-based intervention models. The reader is encouraged to consider the definitions, as stipulated by the *"What is EMDR Therapy?"* paper, to build their understanding of how they currently use EMDR therapy and to ensure that further integration is theory driven and not just an eclectic mix. For ease of reference for the EMDR therapist, this will be broken down into the AIP model and the phases of the standard protocol. While the following is delineated into distinct components, many elements are evident across the standard protocol.

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## THE AIP MODEL AS AN INTEGRATIVE APPROACH

EMDR is underpinned by the AIP model, which posits that all individuals have the capacity to recover from traumatic or stressful events (Shapiro, 2018). According to the AIP model,



distressing memories are typically processed by the brain, resulting in less distress and decreased intrusions of the once-traumatic memory. For individuals experiencing psychological distress, the AIP model proposes that this innate process has somehow been blocked, resulting in distressing memories being left unprocessed and subsequently stored in their raw, unprocessed form. These dysfunctionally stored memories, in turn, influence future experiences, perpetuating painful thoughts, emotions, and body sensations. This can result in the current symptoms that have resulted in the client seeking psychological support.

Harnessing the empowering nature of the AIP model and highlighting the link with past experiences can help build client insight and motivation for therapy regardless of the interventions that follow. Further, several articles identify the links between the AIP model and the theory behind other psychological interventions (Balbo et al., 2019; Rydberg & Machado, 2020). The AIP model's focus on the strength and empowerment of the client is mirrored in many different psychological orientations, such as hypnosis, acceptance, and commitment therapy or also humanistic approaches (Gilligan, 2002; Hayes et al., 2011; Lambert et al., 2016). EMDR therapists, guided by the AIP model, would seek to understand the memories that are feeding the current symptoms of psychopathology and target these memories in the reprocessing phases of the intervention. Identifying distressing events that lead to the current difficulties has been noted as a factor in all psychological interventions (Balbo et al., 2019). To explain these present symptoms, the EMDR therapist uses the information processing model to identify memories, focusing, at least initially, on early life experiences. This identification of the critical role of our early life experiences is in line with both a psychodynamic and attachment theory orientation, which uses a developmental perspective to identify the crucial role of our early memories (Bowlby & Ainsworth, 2013; Levy et al., 2019).

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## Phase 1

### HISTORY TAKING

Like CBT, the history taking in EMDR therapy starts with identifying current symptoms that the individual has identified as causing distress or disturbance. Language and conceptualization tools from other modes can also assist the EMDR therapist in making sense of the client's presentation, building insight, and validating their concerns. Further, EMDR therapists will often use neurobiological explanations to assist clients in understanding the impact of their past.

EMDR therapists can also benefit from using assessment tools made primarily for other orientations. While there are too many tools to mention, tools like the Young Schema Questionnaire (Oei & Baranoff, 2007) or the Adult Attachment Interview (Hesse, 2008) can significantly add to the assessment process, broadening the case conceptualizing, allowing for more in-depth, personalized intervention. However, as with all aspects of integration, therapists should be mindful of why they use each particular assessment tool for each client.

In Phase 1 and throughout therapy, many EMDR therapists adopt a parts model to support their client's work. The term "parts" is used as it allows the client to identify various parts, states, traits, or alters within the client's self. Examples of some parts models are structural dissociation theory, internal family systems, schema therapy modes, and the ego states model. Although they emerge from varied theoretical backgrounds and often involve nuanced delivery, parts models can help therapists support clients across various complexities. For example, they can be helpful when working with ambivalence or building client motivation as well as giving therapists a framework to support clients in accessing all aspects of the client's self to decrease risk, increase capacity for informed consent and readiness for therapy, and improve treatment outcomes. Readiness for therapy can also involve using elements of motivational interviewing.

## Phase 2

### PREPARATION

While necessary in all phases of EMDR therapy, Phase 2 emphasizes the humanistic or Rogerian-like approach that the therapist is advised to take with the clients. It is critical that clients feel they can trust the therapist and are empowered in the process. Phase 2 also involves teaching self-soothing strategies to the client in preparation for the possible abreactions or distress that may accompany future reprocessing. Exercises such as diaphragmatic breathing or a safe/calm place are often used, and the therapist may enlist imagery basic activities similar to hypnosis or behavioral activities to demonstrate and build on the client's capacity to self-regulate (Gerge, 2018). There are also direct influences of mindfulness in many of these self-soothing strategies, as typically, the client is recommended to *just notice what they observe* rather than to seek to relax or actively try to eliminate fear or distress (Papies et al., 2015). This mindful stance is also used in later reprocessing phases. Further, some individuals may benefit from an extended Phase 2 involving distinct adjunct therapeutic interventions, such as dialectical behavioral therapy (DBT) or skills training in affect and interpersonal regulation (STAIR) programs (Snoek et al., 2020; Van Vliet et al., 2021).

EMDR therapists have developed many resourcing activities that have great utility for those using other treatment modalities. Knipe's Constant Installation of Present Orientation and Safety (CIPOS) is an EMDR-derived technique that can be used in EMDR therapy Phase 2 to prepare clients for Phase 4-6 work (Stingl et al., 2022). However, a recent trial suggests that the use of this technique outside the EMDR standard protocol

can be effective in reducing psychological distress, which may render CIPOS useful for therapists from a range of modalities (Stingl et al., 2022). Further, other oft-used techniques such as resource development and installation (Fisher, 2001; Korn & Leeds, 2002), Knipe's (2018) *Loving Eyes*, and Mansfield's (2010) *Dyadic Resourcing* all can be applied by therapists using a range of modalities to support clients in connecting with their resources to support trauma work.

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## Phase 3

### ASSESSMENT AND ACTIVATION

The start of Phase 3 demonstrates strong cognitive behavioral trends. The therapist begins by asking the client to bring to mind the worst part of the memory, addressing experiential avoidance per behavioral techniques. The client is asked to identify negative and positive self-referential thoughts related to the event. In determining these beliefs or thoughts, rather than addressing cognitive distortions, the therapist may often use the cognitive downward arrow technique of asking, “...and if that was true, what would that say about you?” to support clients in uncovering their core negative cognitions related to the memories. Identifying negative thought patterns is important as it helps the client activate the distress, allowing future reprocessing. Behavioral techniques perhaps guided the use of rating scales in Phase 3 and subsequent reprocessing stages to give the client an idea of change.



The importance of connection with the body, as outlined in somatic therapy, is a critical element of EMDR therapy in all phases and is explicitly identified in Phase 3. Once cognitions have been identified, the therapist guides the client to focus on the emotions and related location of the body sensations reminiscent of somatic or experiential therapies.

## Phases 4-6

### REPROCESSING PHASES

Psychodynamic theory tenants believe that some mental processes are not available to consciousness (Levy et al., 2019). This therapy holds at its core the concept of free association and thus recommends minimal interference from the therapist. Similarly, experiential and feminist therapists promote self-healing and see the client as the expert. This is also true in EMDR therapy reprocessing phases (phases 4-6).

In Phase 4, the clinician asks the client to focus on the now-activated negative content associated with the memory and follow the therapist's fingers (or engage in another engaging activity). The client is told to *'just notice'* and *'just let whatever happens happen.'* The minimal therapist interference in the reprocessing phases is crucial in EMDR therapy as it is underpinned by the belief that the client has the internal capacity to recover after trauma. This belief in the client's innate capacity to heal is also a critical element in hypnosis (Gilligan, 2002).

### WHEN REPROCESSING GETS STUCK: BLOCKS AND INTERWEAVES

While they should be used sparingly and only when the client has demonstrated that processing is blocked, interweaves are short and sharp pieces of information that the therapist offers clients to address gaps in their knowledge or experience (Shapiro, 2018). To use interweaves correctly, the therapist must understand the client's formulation. While the AIP model will drive this, therapists may incorporate other psychotherapeutic models to build their understanding of the client's difficulties. For example, a schema therapist may use their knowledge of clients' early maladaptive schemas to help clients understand why they are engaging in a particular pattern of thinking and behavior, what may be done to shift this, and what might get in the way.

Accordingly, when viewing videos of client sessions, a seasoned EMDR consultant will often be able to identify the therapist's psychological training before EMDR therapy by the interweaves that they used. For example, imagine a client who is reprocessing the memory of childhood abuse from a parent and is blocked by a feeling of shame and a

memory of childhood abuse from a parent and is blocked by a feeling of shame and a sense that it was the client's fault. Those who practice schema therapy or experiential psychology may often use imagery interweaves, such as, *"I want you to see that I am there in the memory with you, and I am holding your hand saying, This is not your fault. You are a wonderful child. I will stay and ensure you are safe because you are so important to me."* Alternatively, cognitive therapists may attend to distorted cognitions, e.g. *"I am confused; how could a four-year-old be in control of what the adults in the house do?"* For EMDR therapists who are attuned to the needs of their clients, having a theoretical understanding of other orientations can support the EMDR interventions to further build the attunement between the therapist and client and improve therapy outcomes.

## Phase 7

### CLOSURE

The EMDR therapist begins Phase 7 by acknowledging the excellent work that the client has done in the session, which is similar to humanistic work. Strong cognitive behavioral influences also appear in the closure phase. Like CBT and DBT, the clinician asks clients to record any related experience they may have in the days that follow the session. They are also encouraged to practice the self-soothing strategies learned in Phase 2. Further, the EMDR therapist may encourage the client to engage in behavioral activities, including exposure to previously feared stimuli, to complement the EMDR work done in the session. The EMDR therapist will also encourage clients to use any relaxation strategies taught to ensure they can self-soothe, if needed, between sessions.

## Phase 8

### REEVALUATION

Like other interventions such as schema therapy and DBT, after the initial session, EMDR therapy sessions start with Phase 8, which reviews how the client has been in the time since the last session and reviews any logs or additional work the client was going to undertake between sessions. The therapist may also use rating scales introduced in Phase 3 to assess if the memory addressed in the prior session requires further reprocessing.

As a therapist, therapeutic crosspollination and integration is fortunately unavoidable. The presence of integration allows growth and change. It encourages therapists to continually seek the best for their clients based on clinical needs rather than focusing solely on existing treatment manuals. A future focus on a theory-driven integrative

model, not only at the clinical level but also in teaching and learning institutions, will help ensure that EMDR theory and psychotherapy across all paradigms can continue to improve and redefine how best to meet our clients' needs. As said by Dr. Shapiro, "Only by sharing our perspectives so we can see each aspect from each angle can we have a full understanding of the whole." (2002, p. xviii)

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