What Is EMDR Therapy? Past, Present, and Future Directions

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Since its inception in 1989, eye movement desensitization and reprocessing (EMDR) therapy has evolved from a simple desensitization technique to treat posttraumatic stress disorder to a comprehensive psychotherapy approach that treats a broad range of clinical problems in a variety of contexts and with diverse populations. This position paper is the result of a two-year project by the Council of Scholars' "What is EMDR?" workgroup that was tasked with the particular challenge of defining EMDR therapy, as innovations in the field continue to develop and the need for a consensus definition has become essential. In addition to proposing categories of EMDR therapy, that is, EMDR psychotherapy, EMDR treatment protocols, and EMDR-derived techniques, we identified core elements of EMDR therapy that can serve as a guideline to evaluate future innovations. Additionally, with concepts and procedures evolving over the years, some of the language needed revising to be consistent with current practices. The adoption of these three categories of treatment by the EMDR community would have broad-reaching implications that would generate more qualitative as well as quantitative studies in all categories. For training and clinical practice, it offers clinicians the opportunity to train with a focus on their particular treatment setting in addition to the foundational training that would be universal to all EMDR-trained clinicians. Finally, the interplay in the Council of Scholars between the "What is EMDR?" workgroup and the research, clinical practice, and training and accreditation workgroups will lead to further developments as these areas all inform one another.

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In 2018, the Council of Scholars of the Future of EMDR Therapy Project (Bowers, 2018) began work to advance the future of EMDR therapy. The council was composed of about 40 international expert EMDR scholars and researchers. Workgroups were formed to address specific challenges in four domains: research, clinical practice, training and accreditation, and defining "what is EMDR." The first product of the Council of Scholars was the research workgroup's position paper (Matthijssen et al., 2020), which identified five areas other than adult posttraumatic stress disorder (PTSD) where additional more rigorous research was needed to improve the chances that EMDR therapy would be recommended in future treatment guidelines.

The current article is the second product of the Council of Scholars. It is the position paper of the "What is EMDR?" workgroup and it outlines the group's process and resulting conclusions regarding EMDR's definition, categories, and terminology.

The Council of Scholars Steering Committee endorsed the definition of EMDR therapy, categories of EMDR treatment, and the glossary of terms as articulated within this position paper. For the council, it serves as the basis for its next phase of work. The council intends on making recommendations to the global EMDR community about possible future paths for EMDR therapy and encourages implementation of their work, which will be freely available, by the global EMDR community. As the council develops further projects, tests their work through research, and engages in dialogue, they invite EMDR colleagues in national and regional associations to provide feedback so together we can work to build the future of EMDR therapy. We welcome all comments.

The "What Is EMDR?" Workgroup

The mission of the "What is EMDR?" workgroup has been to define and operationalize EMDR therapy. Given the evolution of this treatment model over the last 30 years, it is understandable that a more cogent definition of EMDR therapy is needed, along with a consistent way to determine whether a protocol/procedure labeled as EMDR therapy actually meets a specific set of criteria to be defined as a modification, an experimental innovation, or a complete departure from what is defined as EMDR therapy. Our community stands at a crossroads, where a lack of agreed-upon guidelines endangers the essential, unique elements of EMDR therapy, and a rigid traditional stance risks losing important developments and innovations essential to keeping the model dynamic, which has been a core value in the EMDR community from its inception.

The initial goals of our workgroup were to define EMDR therapy and to develop a mechanism that could be used to assess current and future versions of EMDR therapy by identifying common components as points of convergence and divergence. We shared our early formulations with the Council of Scholars (Laliotis et al., 2020) and received feedback

> EMDR therapy is an integrative, client-centered approach that treats problems of daily living based on disturbing life experiences that continue to have a negative impact on a person throughout the lifespan. Its Adaptive Information Processing theory hypothesizes that current difficulties are caused by disturbing memories that are inadequately processed, and that symptoms are reduced or eliminated altogether when these memories are processed to resolution using dual attention bilateral stimulation. The resolution of these targeted memories is hypothesized to result in memory reconsolidation. The standard application of EMDR therapy is comprised of eight phases and a three-pronged approach to identify and process: (a) Memories of past adverse life experiences that underlie present problems; (b) Present-day situations that elicit disturbance and maladaptive responses; and (c) Anticipatory future scenarios that require adaptive responses. There is strong empirical evidence for its use in the treatment of posttraumatic stress disorder, and it has also been found to be an effective, transdiagnostic treatment approach for a wide range of diagnoses in a variety of contexts and treatment settings with diverse populations.

Figure 1. Definition of EMDR therapy.

recommending that we clarify and refine the terminology related to EMDR therapy treatment.

This article charts the progress of the "What is EMDR?" workgroup and presents a position paper based on our findings as well as offers recommendations for the future. In our review of existing materials, we looked at the history of EMDR therapy and its evolution, as well as how EMDR therapy is provided in clinical practice, research, and training. We also examined the terminology that is used to describe the treatments and their components. Following our summary of findings, we make several recommendations.

This group asserts that a consensus definition of EMDR therapy and its core elements is necessary in order to inform research, clinical practice, and training and accreditation for researchers, clinicians, and consumers worldwide. We provide a detailed definition of EMDR therapy and propose that there are three distinct categories of treatment in the field of EMDR therapy—EMDR psychotherapy, EMDR treatment protocols, and EMDR-derived techniques. We have also developed a glossary of terms as a basis to aid in developing templates for defining the core elements of these three categories as well as provide parameters for future innovations. Figure 1 outlines the proposed definition of EMDR therapy based on the model's recent evolution.

History and Evolution of EMD to EMDR to EMDR Therapy

EMDR therapy has been evolving since its inception in 1987. Francine Shapiro's now famous walk in the park led to the clinical observation that spontaneous bilateral eye movements created conditions that were associated with a reduction in distress when she focused on disturbing material. This observation led to clinical trials with trauma survivors to determine if findings were replicable. Shapiro named the approach EMD, a simple desensitization procedure, and a randomized control trial (RCT) was conducted. In 1989, Shapiro published this initial study that included sexual assault survivors and veterans. The results revealed a significant desensitization and symptom reduction (Shapiro, 1989).

Shapiro's continued experimentation and exploration of EMD led to the observations that other, unintended therapeutic benefits were simultaneously occurring during the desensitization procedure. These included spontaneous access to memories of similar experiences and the generalization of the treatment effects to other memories that were not the focus of the procedure. Shapiro hypothesized these observations to be byproducts of adaptive processing, so in 1991, she changed the name from EMD to EMDR to reflect a paradigm shift from the initial formulation of a simple desensitization technique to a reprocessing of memories (Shapiro, 1991, 2001, 2018). In 1995, Shapiro offered a theoretical framework to explain treatment effects and guide clinical practice. She initially called this accelerated information processing model (Shapiro, 1995) and renamed it the Adaptive Information Processing (AIP) model in 2001. The AIP model serves as the theoretical framework that defines EMDR therapy today.

In 2010, Shapiro changed the name from "EMDR" to "EMDR therapy" (Shapiro, 2010). Although, in her texts (1995, 2001, 2018), she always considered it as a comprehensive approach to psychotherapy with the potential to treat the whole person, addressing the full clinical picture in individual, relational, and behavioral domains, the term EMDR therapy did not appear in her writing until 2010.

These evolutions: from observation to technique; from technique to therapy; from desensitization to reprocessing; from reprocessing to integration; from treating PTSD to treating different clinical populations across various clinical contexts; from treating recent traumatic events to longstanding developmental trauma and attachment-based issues; from individual to group treatments; and from offering treatment in a professional office to a disaster site, have all contributed to the evolution of EMDR therapy from a simple desensitization technique to a comprehensive psychotherapeutic approach. This model continues to use AIP theory as its foundational cornerstone to guide case conceptualization and treatment and to predict clinical outcomes.

Types of EMDR Treatment Currently Used in Clinical Practice, Research Studies, and Training

Since the introduction of EMD by Francine Shapiro in 1987 that led to the development of EMDR therapy, clinical practice observations and research have proliferated. These have resulted in theoretical and conceptual paradigms, shaping and catalyzing new EMDR strategies and approaches. It appears that it is possible to utilize EMDR's powerful treatment components in various ways to treat a range of problems. New innovations abound. However, it can be difficult to determine if a clinical innovation, which incorporates some of EMDR's elements, should be considered a modification of EMDR therapy, or something entirely different.

In our review of clinical practice, research, and training, we discovered that many variations occur when practitioners use, research, and teach EMDR therapy. The following describes some of our findings.

EMDR Treatment in Clinical Practice

Over the years, there has been a proliferation of EMDR treatment protocols and techniques. The important question for this work group was how many of these protocols were actually following Shapiro's procedures and protocols with just slight modifications for situation or population and how many were major departures from the EMDR framework? How far off from Shapiro's standards and procedures were practitioners needing to go to improve results for their clients or did the EMDR framework hold up for excellent treatment outcomes? For example, Luber's seven "EMDR Scripted Protocols" books (e.g., Luber, 2009, 2019) contain more than 65 full protocols and Luber used them as the basis for her analysis on the core elements of these scripted protocols.

Luber's Protocol Analysis. Luber (Laliotis et al., 2019) examined the components included in the 65 specialized protocols that were published in her books. Her goal was to determine to what extent the protocols adhered to Shapiro's (2001) description of EMDR therapy (as these protocols were written prior to the publication of Shapiro's 2018 text). All protocols included in Luber's books used an AIP-informed history-taking and case conceptualization. Many protocols had been developed for different types of presenting problems, and some of these protocols were well established. These protocols were modified versions of standard EMDR procedures for special populations or issues to include recent events, stress, anxiety, obsessive-compulsive, mood, and eating disorders; chronic pain; and medical and somatic-related disorders. Sometimes EMDR procedures were modified so that EMDR could be integrated and/or combined with another treatment modality or conceptual framework such as cognitive behavioral therapy (CBT), for example.

Luber's analysis (Laliotis et al., 2019) identified that modifications were related to special populations served or situations. Her findings showed that minor modifications occurred in these areas:

- Identifying positive treatment goals at the outset of therapy
- Additional resource interventions in the Preparation phase geared to special needs
- Target memory selection for different populations or situations
- Procedural steps inclusion/exclusion in the Assessment phase
- Specified negative and positive cognitions for an issue or clinical population
- Ways of applying the Installation phase
- Future template work

Luber concluded that overall, the core elements of EMDR therapy that have been traditionally recognized in research and practice were present in these specialized treatment protocols (Laliotis et al., 2019).

Types of EMDR Treatment in Research Studies

By 2019, there were more than 30 published RCTs on the treatment of adults and children with PTSD symptoms (De Jongh et al., 2019). Many meta-analyses have reported that EMDR therapy is an efficacious treatment for PTSD and it is recommended in numerous treatment guidelines.

PTSD, Traumatic Stress, and Early Intervention. The types of EMDR used in the studies varies greatly. For example, the length of treatment across the 30 adult RCTs ranged from one to 16 sessions (De Jongh et al., 2019). In addition, the types of protocols varied, and many RCTs did not check treatment fidelity (see Khan et al., 2018).

Similar heterogeneity is found in the studies which investigated EMDR early interventions designed to treat recent trauma (Matthijssen et al., 2020). Although often considered to be one treatment type when combined in reviews and meta-analyses, these protocols differed from one other in numerous ways. More importantly, which exact protocol and what specific components used are rarely discussed in review articles written about EMDR early interventions.

Disorders Beyond PTSD. EMDR's effectiveness has expanded to many disorders and problems far beyond PTSD (Valiente-Gomez et al., 2017). More than 28 RCTs provide preliminary evidence that EMDR therapy may be effective for major depressive disorder, bipolar disorder, psychosis, anxiety disorders, obsessive-compulsive disorder, substance use disorder, and pain (Maxfield, 2019). In her analysis, Maxfield reported:

> *In 75% of these studies, EMDR treatment was provided using F. Shapiro's (2018) standard eight-phase, three-pronged EMDR protocol, which processed the events related to the onset of the disorder*

or its distressing aspects. The modified procedures used in the other studies include (non-standard) types of targets, methods of target selection, sequential order of processing, and the addition of other elements, such as CBT techniques. (Maxfield, 2019, p. 242)

EMDR Therapy Training Programs

Regional associations throughout the world, such as EMDR Asia, EMDR Europe, and the EMDR International Association (EMDRIA), provide accreditation for EMDR training programs and individual providers who meet certain requirements based on content from Shapiro's (2018) textbook. Other associations are in the process of establishing their own credentialing system or adopting one currently used by other associations. National and/or regional criteria for trauma instruction, content and practicum hours of the basic training and format, as well as consultation content and hours, may differ. These courses often provide instruction in various protocols. The training providers instruct trainees in the application of EMDR therapy as well as training in special populations, clinical issues, and special situations. While many of these training offerings follow the basic tenets of EMDR therapy, others do not and may not even be accredited by a national or regional EMDR association. They create their own interpretation of EMDR therapy and teach variations of protocols and techniques that are often untested. While they may offer anecdotal reports of their efficacy, they are more

EMDR Psychotherapy

EMDR psychotherapy is the comprehensive application of EMDR therapy that treats the whole person, addressing the full clinical picture to include individual, relational and behavioral domains. It is intended to optimize the client's capacity to respond adaptively to life challenges resulting from developmental trauma while building/restoring resilience and promoting personal growth. It regards the therapeutic alliance as an integral part of the therapy. It treats presenting symptoms, low self-esteem, attachment issues, developmental deficits, and/or other personal characteristics that are mutually elaborated as goals for treatment across different diagnostic categories. It is a collaborative, evidence-based practice approach that is based on the Adaptive Information Processing model and incorporates EMDR treatment protocols and EMDR-derived techniques as part of a comprehensive treatment plan that incorporates the eight phases and the three-pronged approach of past, present and future.

EMDR Treatment Protocols

EMDR treatment protocols are protocols for individuals or groups that are consistent with the definition of EMDR therapy and are intended to treat specific disorders or symptoms, or to address special clinical situations. The goal is partial or complete reprocessing of memories that contribute to the client's presenting problems. Protocols can be used as a stand-alone approach, or as part of a more comprehensive psychotherapy. Protocols that contain more than a simple modification of the standard eight-phase, three-pronged approach are considered innovations until backed by research to support their efficacy.

EMDR-Derived Techniques

EMDR-derived techniques are truncated protocols and procedures that use core elements of EMDR therapy, and which are used as either a stand-alone brief intervention or as a supplement to EMDR therapy. These techniques have one or more goals that may include desensitization of a disturbing memory or part of a memory, reducing distress, increasing stability, improving capacity for emotional self-regulation, and preparation for memory reprocessing, as well as strengthening positive experiences. These EMDR techniques can be used in the field and in clinical sessions, and can be self-administered by the client. The techniques may also be used as part of a clinical assessment to evaluate client motivation and readiness as well as the client's emotional capacity to respond to memory processing demands.

Figure 2. Categories of EMDR therapy.

often a representation of their own professional brand of EMDR therapy. Without a clear consensus definition of EMDR therapy, we are at risk of imitations that use the name but omit some of EMDR therapy's core elements that distinguish this approach from other therapies.

There are hundreds of accredited workshops every year. EMDRIA staff S. Tolino (personal communication, July 19, 2021) provided the following information about approved trainings in the United States and Canada. In 2020, approvals were given for 503 advanced workshops and over 200 EMDR therapy Basic Trainings (both in-person and virtual). In 2021 (as of July 31) EMDRIA had approved more than 391 Basic Training offerings.

Terminology Used to Describe EMDR Therapy

In our review of clinical treatment, research, and training practices, we discovered that the terminology was inconsistently applied and often confusing. A certain term would be used in different contexts to mean different things. It was apparent a clear definition of terminology was needed. The following are some examples.

The Term "Protocol"

The word "protocol" is defined as "a set of rules" and a "treatment protocol" is understood to be "a plan for a course of medical treatment" (www.collinsdictionary.com/dictionary/english/protocol). While some "protocols" appear to describe an in-depth psychotherapy approach to EMDR, other "protocols" appear to describe a technique. Based on this observation, the group identified the need to further define and distinguish between EMDR psychotherapy, EMDR treatment protocols, and EMDR-derived techniques as categories of EMDR therapy and offer definitions for each category. See Figure 2.

The Term "Dual Attention Bilateral Stimulation"

In 2008, Maxfield wrote: "There is a lot of confusion about the role of eye movements and tactile and auditory stimulation. The confusion is apparent even with the name: Should they be called bilateral stimulation or dual attention stimuli? Or something else altogether? The two terms suggest two different mechanisms of action." (Maxfield, 2008, p. 234). Today, this confusion still abounds. In Shapiro's 1995 text, she referred to bilateral stimulation; in the 2001 book, she changed the name to dual attention stimulation; and in 2018, she combined the two terms, using dual attention bilateral stimulation. See Figure 2.

The existing research on bilateral stimulation does not address the confusion in the field. While there is a large body of literature showing the effects of working memory taxation in laboratory studies, supporting the term "dual attention stimulation" (Van den Hout & Engelhard, 2012), to date, no clinical trial, providing a full course of treatment with diagnosed patients, has been conducted to investigate whether higher levels of working memory taxation produce better treatment outcomes. While there may be some limited research evidence for the term "bilateral stimulation," brain studies have found little evidence for interhemispheric coherence (Pagani et al., 2013). The evidence to date seems to support Shapiro's (2018) view that EMDR therapy has many mechanisms. It is generally agreed that dual attention, which refers to simultaneously maintaining two distinct focuses, allows for the client to process their experience in a more detached manner. Although bilateral stimulation lacks conclusive research as a mechanism of action in EMDR therapy, its provision is an established clinical practice since its inception and remains the clinical standard.

Our Position

The growth of EMDR therapy has been rapid and expansive in its 30-year history, with thousands of clinicians worldwide contributing to its evolution through research, training, and clinical practice. It is essential that all practitioners have a clear understanding of what EMDR therapy is and that there are core elements that are identified and can be used in research, clinical practice and training, and accreditation. It is our position that ensuring the integrity of the core elements of EMDR therapy is essential to its future. Having a consensus on what EMDR therapy is, how it is taught, and how it is applied clinically will promote best research, training, and practice, and provide a base from which future innovations in the field can be evaluated.

In addition to offering a definition of EMDR therapy, we propose three categories of EMDR therapy: EMDR psychotherapy, EMDR protocols, and EMDR-derived techniques. We have identified what we believe are the core elements of EMDR therapy, and have written a glossary of terms that reflects the current nomenclature. The overall goal is to establish guidelines that define what is considered to be EMDR therapy and what is not, and whether a

clinical innovation is a modification of EMDR therapy or something entirely different, even though it may incorporate some elements of the model. See Figure 2 and Appendix.

Identifying EMDR's Core Elements

The "What is EMDR?" workgroup is composed of nine EMDR experts who have many years experience with clients, teaching, and/or doing research. We identified the core elements of EMDR therapy through a process of reading Shapiro's texts (1995, 2001, 2018) and academic discussion. Our goal was to preserve the integrity of her vision of EMDR as a psychotherapeutic approach. This task was particularly challenging given the evolution of EMDR across time, as it progressed from a technique to a protocol, to a comprehensive psychotherapy. In order to improve validity, we used Shapiro's 2018 text to define our terms whenever applicable and to stay faithful to her vision and the AIP perspective.

The purpose of the original glossary of terms was to define the core elements as they currently exist with minor modifications to a few terms in order that they reflect current applications. To improve our reliability, we distributed the glossary of terms to the Council of Scholars to elicit their feedback and see if we could achieve consensus (Laliotis et al., 2020). With their feedback, the original glossary of terms was revised and expanded, so that all the language could be defined and clarified. The document went through multiple versions, using an iterative process of cycling between our group and feedback from the Council of Scholars, while staying both faithful to the model created by Shapiro and integrating what we have learned in order to maintain the scientific rigor in our work. This process helped us clarify our terms, refine our language to achieve greater consensus, and incorporate current developments.

The glossary of terms included in this article contains the core elements we believe are essential and unique to EMDR therapy in their aggregate form, as opposed to independent elements. See Appendix.

The Core EMDR Therapy Scale

In the future, this workgroup plans to develop the Core EMDR Therapy Scale (CETS), using items from the glossary of terms that will incorporate some of the recommendations itemized in the "Recommended Changes" section of this article. The workgroup will continue to seek counsel and ongoing support from the complete membership of Council of Scholars in the service of developing this scale to propose to the larger international EMDR community. The purpose of this scale will be to rate the level of EMDR elements in a specific intervention. The CETS will help evaluate innovations in EMDR therapy and distinguish acceptable modifications from treatments that do not meet the threshold to be classified as EMDR therapy, EMDR psychotherapy, EMDR treatment protocols, or EMDR-derived techniques. The CETS will also establish guidelines that can determine if the innovation being evaluated is within the parameters of EMDR therapy or one of its categories. It will provide a means to examine future developments in the field and to determine what would be considered an advancement that meets the core definitions, or a departure from the fundamental core elements that constitute EMDR therapy.

Implications for the Future of EMDR Therapy

The work of the "What is EMDR?" group, as well as other working groups of the Council of Scholars, has the potential of making a significant impact on the future of EMDR therapy. As is evidenced from the above recommendations, there is much to discuss as a community. The model has evolved and innovations continue, but the question remains: What is the future of EMDR therapy? Below are the implications for the future based on the findings and the recommendations

Implications for Clinical Practice

The impact of all these possible changes on clinical practice could potentially result in EMDR therapy being one of the leading therapies of the 21st century. EMDR therapy will continue to develop into new areas within the mental health field, but as important will be its growth in the medical/mind-body sectors. More recently, the medical field is accepting ideas regarding the impact of trauma and stress on health and illness (Van der Kolk, 2015), which opens the door for EMDR therapy to become an integral part of both inpatient and ambulatory care of medical conditions (Luber, 2019).

The AIP model of EMDR therapy, its theoretical underpinning, is a model of human development, and as such has broader applications beyond the field of mental health. EMDR therapy is already used—albeit in a very limited way—in the fields of education, social welfare, performance enhancement, and the workplace. Its potential to make an impact in these fields, as well as many others, is significant.

The three proposed categories—psychotherapy, protocol, and technique—will have substantial effects on clinical practice. While setting clear boundaries regarding what is and what is not EMDR therapy, the categories suggest that we include EMDR psychotherapy, EMDR treatment protocols, and EMDR-derived techniques as a way of highlighting the varied clinical applications and interventions. Using categories will facilitate better communication between therapist, client, and third-party payers as to which category of treatment is best suited or available for a particular client or diagnostic category. It will also allow for better treatment planning and for clearer expectations about the nature of treatment and anticipated outcomes.

EMDR Psychotherapy: Transformative Change Within the Therapeutic Relationship. EMDR psychotherapy is, by definition, focused primarily on personal growth and change beyond the remission of symptoms. Most EMDR therapists who consider themselves psychotherapists are treating complex developmental trauma. They are helping clients with low self-esteem, difficulties in relationships, and self-regulation issues that are often long-standing. They are not just treating the client's symptoms; they are addressing formative attachment wounds and facilitating developmental repair. That requires a different stance on the part of the therapist both in and out of memory reprocessing that is more relational. While keeping in mind the traditional notion of minimal intervention on the part of the therapist, the EMDR psychotherapist is also looking for moments of opportunity to facilitate the client's reprocessing by judiciously adding tracks of information, sometimes reflecting back to the client their experience, or making it more of a shared moment, as these types of memories have historically been experienced alone and without a consensus reality. While these are common experiences that take place in many forms of psychotherapy, the moment of meeting between a client and therapist during a memory reprocessing session is beyond what is considered a resolution to the target memory. It is often described as healing as well as transformative, not just because of the memory reprocessing but also because of the relationship between the therapist and client, and the shared experience of going through it together.

EMDR Treatment Protocols: Accessible, Affordable, and Effective. The standard protocol of targeting formative past experiences in EMDR therapy is considered a "protocol." It is a stand-alone treatment that was developed to treat PTSD with the goal of complete reprocessing of related disturbing memories. In the Mavranezouli et al. (2020) network meta-analysis, EMDR therapy was found to be the most cost-effective of all interventions for PTSD in adults. This conclusion was based on its brief treatment (six 90-minute sessions) and high clinical effectiveness in EMDR research studies.

The benefits of protocol treatment are that it is short-term, effective, accessible, and affordable. Protocols offer the advantage of reducing and eliminating symptoms. As we have already pointed out, many EMDR treatment protocols have been developed to address particular symptoms or situations. Some well-known examples include early interventions for treatment of recent traumas, and the depression treatment protocols. The vast majority of specialized protocols contain minor modifications to standard EMDR procedures. These modifications are designed to best meet the unique clinical demands of a specific client population. The core elements of these protocols utilize basic EMDR procedures and do not stray far from what we know results in significant treatment effects. Although the expected treatment outcome is an improvement of presenting symptoms, the AIP model predicts that treatment may generalize to other problems, and may produce a transformative effect.

EMDR-Derived Techniques: Versatile and Brief. Research indicates that there may be substantial benefits from incorporating some EMDR components into treatment preparation and stabilization phases and/or by integrating an EMDR technique with another treatment. For example, we know that performing eye movements while focusing on a memory results in desensitization and reduced distress. We know that the butterfly hug seems to increase stability and that the use of the safe-calm place exercise seems to enhance emotional regulation. It is recommended that brief techniques be developed which can be self-administered or used within the therapy session. It is expected that such techniques may have the potential of augmenting treatment effects.

There are a number of resource-based EMDR-derived techniques. Most are untested strategies and most are used to augment EMDR's preparation phase. Leeds wrote:

> *The . . . use of resources by EMDR-trained clinicians of various procedures incorporating bilateral stimulation for ego strengthening, resource installation, and performance enhancement across a range of clinical and nonclinical populations suggests that they are widely viewed as an effective set of interventions . . . While resource-focused interventions*

> *. . . and other ego-strengthening interventions may improve the functioning of patients with PTSD and related disorders in the short term, they are not a substitute for comprehensive trauma resolution with the standard EMDR PTSD protocol. (Leeds, 2009, pp. 155–156)*

Recently, Karadag et al. (2021) developed an EMDR self-help children's book. An RCT found it was significantly helpful in reducing symptoms of posttraumatic stress. The treatment provided children with a 20-minute intervention, completed three times in one week. It incorporated the safe-calm place, resourcing, and future template as techniques.

Implications for Future Research

This article recommends that future EMDR research identify the category of the intervention. This will provide clear communication about the type of treatment being provided in the study. It is also recommended that all modifications to standard procedures be clearly articulated.

Psychotherapy Research. The "psychotherapy" category of EMDR therapy includes expected outcomes of change in self-related cognitions. Shapiro included an assessment of changes to the positive cognition with her unique Validity of Cognition (VOC) scale. Although there is substantial evidence from thousands of cases in various research studies that EMDR therapy increases the validity of positive cognitions related to traumatic memories, no study has yet collected and analyzed this data. Increased resilience and global changes in personal growth and quality of life are predicted by the AIP model when approaching treatment as a comprehensive EMDR psychotherapy. Some of these outcomes have been evaluated in EMDR qualitative studies (Marich et al., 2020), but few quantitative assessments of these variables in EMDR treatment have yet been done. It is recommended that studies of EMDR therapy investigate outcomes using quantitative measures such as those used in the field of positive psychology, to assess positive changes such as global self-esteem and overall life satisfaction. In addition, it would be useful to study the differences in life quality and symptom outcome measures when comparing outcomes of EMDR therapy applied as a comprehensive approach to psychotherapy versus a protocol-based approach focused on symptom elimination.

EMDR psychotherapy is often applied with clients who experienced childhood trauma and who present with pervasive difficulties in self-esteem, relationships, and self-regulation. While research has shown the effectiveness of standard EMDR protocol treatment for this population, some findings suggest that a longer course of therapy is indicated (e.g., Van der Kolk et al., 2007). It would be valuable to compare standard EMDR protocol treatment with EMDR psychotherapy to see if lengthier treatment produced better results and if psychotherapy resulted in more changes across more domains than protocol treatment.

If we consider that EMDR psychotherapy is about treating the whole person, then it is imperative that we investigate the client's subjective experiences of the treatment through qualitative studies (Marich et al., 2020). Such studies identify and measure the client's experience, collect their evaluation of the treatment effects, and invite them to reflect on their personal growth and unanticipated positive changes beyond the remission of their symptoms. If EMDR therapy is considered to be an evidence-based approach to psychotherapy, the client and clinician variables that are evaluated in evidence-based practice research (Norcross & Lambert, 2019) must be studied and included in EMDR research designs.

Other important considerations for future research include neurobiological variables. As neuroscience continues to evolve, it will help us better understand the changes that occur as a byproduct of EMDR therapy and offer a more thorough understanding of the positive treatment effects that are routinely observed.

Research on EMDR Protocols. As noted earlier in this article, the vast majority of EMDR research studies have evaluated the effects of EMDR protocols, often without clearly identifying modifications to standard procedures and without assessing treatment fidelity (Khan et al, 2018). Future researchers are encouraged to clearly specify the treatment targets and other aspects of the intervention to advance our knowledge of EMDR therapy. Expanding the types of outcome measures would provide a full understanding of the range, limits, and types of effects. In understanding the treatment effects of an approach it is essential that one can identify exactly what treatment was provided, and to know whether the treatment was provided consistently and with fidelity. The EMDR Fidelity Rating Scale (EFRS; Korn et al., 2018) was developed to ensure that clinicians adhered to EMDR therapy's standard eight-phase treatment approach and three-pronged protocol. The EFRS has been revised and expanded after feedback from

researchers and raters who used the scale. It would make sense for the EFRS to be used when conducting any EMDR-related research.

Research on EMDR-Derived Techniques. Research on EMDR-related techniques is sparse. In order to be used effectively and to be appropriately evaluated, originators of techniques are encouraged to specify the purpose of the technique and its anticipated effects. Techniques can be used to achieve various outcomes – for example, to create short-term emotional change and to increase affect-regulation skills. Originators of techniques are also encouraged to conduct appropriate research before marketing and teaching their technique to other EMDR clinicians.

Implications for EMDR Training and Accreditation

The core elements of EMDR therapy described in this article will provide a significant focus for training, and the clearly defined categories and definitions of terms offer a clearer view of the divergence and convergence between EMDR therapy and other therapy approaches. We strongly believe that all trainees should demonstrate competency in using the range of EMDR therapy as explained in Shapiro's text (2018) and should have a solid working knowledge of the AIP model for case conceptualization and treatment planning.

When looking at the suggested categories of EMDR therapy described in this article, we can immediately see the potential impact on EMDR therapy trainings. Currently, the majority of basic EMDR therapy training programs provide a protocol-based curriculum based on Shapiro's text. Their purpose is to instruct trainees in the EMDR therapy model and its standard procedures, and to ensure that trainees are competent in the treatment of traumatic stress. Perhaps a classification system that is recognized by all regional accreditation organizations could require all advanced training providers and EMDR conferences to identify their programs as "protocol" or "psychotherapy" offerings. This would support the existing EMDR basic training paradigm as the foundational course that is internationally recognized, and allow clinicians to pursue advanced training based on their interests as well as their clinical practice context.

EMDR Psychotherapy Training. Looking at both the core elements and categories, one can envision a multi-year, in-depth EMDR therapy training curriculum that will produce EMDR psychotherapists who are well-trained to offer a broad range of clinical services in different contexts. A more intensive training curriculum that would include additional case consultation hours, would be in line with other comprehensive approaches such as somatically-based therapies, hypnosis trainings, ego-parts trainings, and other, more psychodynamically and analytically oriented training programs. A more in-depth curriculum may also enable university-based programs to teach EMDR therapy as a framework for students who are just beginning their psychotherapy education/training, as well as provide advanced training for licensed clinicians.

EMDR Protocol Training. EMDR trainings currently offer a protocol-focused approach. Perhaps it would be beneficial if they specified that the purpose of the training is to ensure that trainees are expert in short-term applications and that they have knowledge of a number of diverse effective protocols. This circumscribed training may appeal to mental health therapists seeking to add a new tool to their toolbox, and who wish to provide accessible and affordable treatment. Additionally, this model could serve as a gateway for clinicians who are interested in being trained in EMDR therapy but are uncertain or unable to commit to a more intensive training program. It could also be an ideal choice for clinicians who work in settings where only brief interventions are offered, such as an employee assistance program.

Proposed Changes to Outdated or Inaccurate Language

As EMDR therapy has evolved, we now have many applications across different clinical populations and in a variety of clinical contexts. While concepts and procedures have evolved, some of the language has remained the same but no longer represents its current application or its meaning and is considered to be inaccurate. The following are some recommendations to change the outdated language to better represent the concepts and the treatment goals.

Desensitization Phase

After EMD became EMDR, the anticipated treatment outcomes as a result of memory reprocessing went far beyond a simple desensitization. Instead, we routinely expect and see more comprehensive additional treatment effects that include insights, a shift in the clients' perception of self and others, a shift in their orientation to the experience, a more adaptive understanding of what happened, and often an ability to

assign a new meaning to that experience or set of experiences. Consequently, it would make sense to refer to phase four as the "Reprocessing" phase, which includes desensitization along with other byproducts, resulting in a more integrated, present orientation to a target memory.

Installation Phase

"Installation" refers to linking an adaptive belief about the self to the newly resolved target memory using multiple sets of bilateral stimulation. This process continues until the client reports a strong sense of the cognition's believability. During this phase, clients frequently report associating to other positive experiences where they felt similarly about themselves. This continued processing is hypothesized to strengthen the client's new, more adaptive belief about themselves, making it more available for the future. "Installing" a positive belief about the self implies a cognitive restructuring. We propose instead, that this phase is termed, "Strengthening."

SUD Score of 0

In the procedural steps to reprocessing a target memory, the SUD measures the client's level of distress at the outset and at resolution. The 0-10 SUD scale is defined as, "0 is neutral or no disturbance and 10 is the highest disturbance you can imagine." While the treatment goal of EMD is to desensitize the target memory to a SUD of 0, the completion of a target memory in EMDR therapy is to bring it to an adaptive resolution which may not be emotionally neutral. As is often the case, clients will frequently have some emotions related to the target memory, and while their response is adaptive, it may not be "neutral." For example, an adult survivor of an early abuse memory at the hands of a parent can feel hurt, sadness, and a sense of betrayal. These emotions are understandable by adult standards but are not neutral. Most clinicians consider a present orientation to the target memory and a calm body sensation as an indication of complete reprocessing effects. A SUD of 0 needs to be redefined as "ecologically appropriate," that is, what one would consider a realistic response to a similar experience.

Three-Pronged Protocol

Another holdover from the early EMDR technique is the notion of the three-pronged protocol. The three-pronged protocol currently refers to the past, present, and future, beginning treatment with targeting past experiences that inform the client's current difficulties (Shapiro, 1995, 2001, 2018). As evidenced by Luber's analysis on EMDR treatment protocols, past, present, and future targets are consistently found in EMDR treatment protocols but not necessarily in the traditional order where foundational memories are addressed first. Our recommendation would be to add the term, "three-pronged *approach,"* which would refer to past, present, and future as a central precept of EMDR therapy, but not necessarily applied in the order of the standard protocol which specifies the sequence in that order. Then the term "standard protocol" could continue to refer to the traditional sequence of first addressing past experiences and would be classified as "the Standard Three-pronged Protocol" of EMDR therapy. Our workgroup is proposing that we use the term "three-pronged approach," as defined in the glossary of terms, as an umbrella term that reflects the current status of EMDR therapy training and practice, and incorporates the categories of EMDR psychotherapy and EMDR treatment protocols where the order of targeting can vary.

Processing and Reprocessing

Although the name EMDR contains the word "reprocessing," many people refer to the treatment effects as the results of memory "processing." As our group considered these words we concluded that the term "processing" is best used to refer to the innate, naturally occurring phenomena involved with integrating changes in emotions, cognitions, and body sensations, resulting in assigning new meaning to experiences. The term "reprocessing" is descriptive of the formal process in EMDR therapy, which consists of phases four to six of the eight phases. In EMDR therapy, inadequately processed memories are reprocessed, resulting in changes in the way the memory is encoded and subsequently experienced.

Phases of EMDR Therapy

EMDR therapy consists of eight phases: phase one: History-taking; phase two: Preparation; phase three: Assessment; phase four: Desensitization; phase five: Installation; phase six: Body Scan; phase seven: Closure; and phase eight: Reevaluation. The word "phase," according to Webster's definition, refers to "a part or a step in a process; one part in a series of related events or actions," implying that each "phase" is a step in a sequence. In EMDR therapy, some of the phases are actual stages of treatment that can take place over a period of time, for example, History-taking,

Preparation, Reevaluation, while other phases are part of the target memory sequence of scripted procedures that are specific to memory reprocessing. Perhaps the target memory procedures should be a separate category unto themselves. We recommend that EMDR therapy treatment be conceptualized as having three *parts:* Part One: History-taking and Preparation; Part Two: Memory Reprocessing; and, Part Three: Reevaluation and Reconsolidation; and, that these parts are understood to occur concurrently as well as consecutively over the duration of treatment. The History-taking phase currently includes treatment planning, which is a process that takes place in the initial phases of treatment, but also evolves over time. In the glossary of terms, we suggest that, in the short term, we refer to the History-taking phase as History-taking and Treatment Planning to further clarify the goals of this phase.

Summary

In this position paper, we offered a definition of EMDR therapy; categories that distinguish among EMDR psychotherapy, EMDR protocols, and EMDR-derived techniques; and a glossary of terms. We hope that clarifying these core concepts and this essential terminology will facilitate communication about EMDR therapy on every level – for consumers, clients, clinicians, third-party payers, researchers, trainers, and trainees. We also hope that it will assist in maintaining the integrity of the EMDR therapy approach while encouraging innovations and dialogue about EMDR therapy's core elements. We look forward to the interplay between the council's workgroups: research, clinical practice, and training and accreditation, and how these areas overlap and inform one another. Additionally, we hope to inspire national and regional associations to collaborate with us in our efforts to achieve consensus on the core elements of EMDR therapy that will serve as the model's foundation.

We leave on the table more questions than answers. While we have made recommendations for the present day as well as the future, it is our intention that this position paper serve as a platform to stimulate much-needed discussion on the growth pains that EMDR therapy will continue to have. It is these conversations that brought EMDR therapy to where it is today. It is our hope that this article will inspire the reader to get involved in shaping the future of EMDR therapy, as it is now in the hands of the future generations.

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APPENDIX

Glossary of Terms and Categories

The Glossary of Terms is organized into several sections:

1. EMDR Therapy Model
2. Components of EMDR Therapy - Defining Terms
3. Components of EMDR Therapy - Goals of the Eight Phases
4. Delivery of Services
5. Clinical Goals and Outcomes of EMDR Therapy
6. Evidence-Based Categories

1. **EMDR Therapy Model**
   - 1a. **Adaptive Information Processing** – the theoretical basis for EMDR therapy that regards psychopathology as rooted in memories of traumatic or adverse life experiences that are inadequately processed and maladaptively encoded. Identifying and reprocessing these memories are the focus of EMDR treatment. It is hypothesized that targeted memories and their associations are transmuted when they integrate with more adaptive information. Effectively reprocessing these memories will reduce or eliminate symptoms. Treatment results and improvement in one's mental health are posited to be the byproduct of adaptive processing.
   - 1b. **Three-Pronged Standard Protocol** – refers to the traditional, standard EMDR protocol of initially targeting past foundational memories relating to current difficulties, followed by present triggers and future templates of action.
   - 1c. **Three-Pronged Approach** – refers to the central precept of EMDR therapy that identifies and targets past memories, present triggers and situations, and future situations in various sequences, depending on the goal.
   - 1d. **Eight Phases** – EMDR therapy is a comprehensive approach to psychotherapy that consists of: History-taking, Preparation, Assessment, Desensitization, Installation, Body Scan, Closure, and Reevaluation.
   - 1e. **Principles** –
     - **Therapeutic Alliance** – collaboration between therapist and client about treatment goals and the tasks to be used, and when possible, establishment of a therapeutic connection.
     - **Minimal Intervention During Memory Processing** – trusting the client's innate capacity to reprocess memory and their associations to the extent possible. Clinical interventions are applied as needed to unblock processing and to facilitate desired treatment effects.

2. **Components of EMDR Therapy – Defining Terms**
   - 2a. **Dual Attention** – holding two different states in awareness or engaging in two or more different tasks, for example, moving one's eyes and focusing on the memory at the same time, which is posited to facilitate information processing.
   - 2b. **Bilateral Stimulation** – consists of alternating eye movements, typically left and right across the midline of the body, and/or alternating auditory and/or tactile stimulation, which is posited to facilitate information processing.
   - 2c. **Dual Attention Bilateral Stimulation** – also involves the client in bilateral eye movements, tactile, and/or auditory stimulation while simultaneously focusing on aspects of the targeted memory and other associations that are accessed. This stimulation is posited to activate and facilitate the innate information processing system.
   - 2d. **Target Memory** – any life experience specifically identified for reprocessing that is considered inadequately processed and maladaptively encoded, generating symptoms in the present. It can also include any combination of cognitions, emotions, somatic sensations, and urges in present time, or an anticipated future event.
   - 2e. **Processing** – refers to the innate, naturally occurring phenomena involved with integrating changes in emotions, cognitions, and body sensations, resulting in assigning new meaning to experiences.
   - 2f. **Reprocessing** – a formal process consisting of phases four to six of the eight phases, initiated in the Desensitization phase where the innate, naturally occurring mechanisms are stimulated through a set of standardized procedures using the current components of the target, and its related associations. Results in changes

in the way the target memory is encoded and subsequently experienced.

2g. **Associations** – material that is reported or observed that is accessed during reprocessing. May include other memories, changes to the targeted memory, emotions, thoughts, somatic sensations, perceptions, and other related information.

2h. **Desensitization** – a process in which the client's level of disturbance related to the targeted memory is reduced or eliminated as a byproduct of reprocessing.

3. **Components of EMDR Therapy – Goals of the Eight Phases**

3a. **History-Taking and Treatment Planning** – identify the presenting problem(s), collect background information, formulate an AIP understanding of the client's problem, and develop a treatment plan that is collaborative and ongoing.

3b. **Preparation Phase** – education on EMDR therapy and mechanics including informed consent; establish a therapeutic alliance, and assess readiness for processing. Provide stabilization strategies as needed.

3c. **Assessment Phase** – identify baseline measurements and activate client's current experience of the target memory and includes: Image, NC, PC, VOC, Emotions, SUD, and Location of Body Sensations. To distinguish this phase, it is recommended that it is referred to as the "Target Memory Assessment Phase."

3d. **Desensitization Phase** – initiates processing of the target memory, using sets of dual attention BLS to activate the client's information processing system, which begins to decrease the client's level of disturbance while increasing access to channels of associations that facilitate integration and new learning.

3e. **Installation Phase** – links the newly processed memory to the adaptive belief about the self, using dual attention BLS to strengthen connections to adaptive memory networks and optimize new learning. Strengthens validity of desired belief about the self.

3f. **Body Scan Phase** – checks complete processing effects by holding the memory and the positive belief in mind while scanning the body. Sets of dual-attention BLS are applied as needed to ensure somatic congruence with the processing effects.

3g. **Closure** – shifts client focus of attention away from memory work and reorients to present day context. Clients are prepared for the possibility of continued processing and the use of stabilization strategies as needed.

3h. **Reevaluation Phase** – reviews treatment results of previous processing session(s) to identify overall changes and optimize generalization of treatment effects. Assesses the client's experience of the target memory and identifies next steps in the treatment plan.

4. **Delivery of Services**

4a. **Modality** – Individual. Couple. Family. Group. Inpatient. Outpatient. Intensive.

4b. **Course of Treatment** – Refers to length of treatment ranging from brief to long term.

4c. **Clinician-Administered** – treatment provided by the clinician encompasses an interaction of client, professional, and method.

4d. **Self-Administered** – protocol or technique used by the client in between therapy sessions as part of their treatment plan.

4e. **Guided Self-Help** – protocol or technique may be guided or assisted by the clinician, who provides instructions, encouragement, and support; live or asynchronous; delivered individually or in groups. The level of guidance can be adjusted to the needs of the clients, intended for mild or moderate symptoms, with appropriate safeguards.

4f. **Stand-Alone Approach** – EMDR therapy is used independently of other approaches.

4g. **Used in Conjunction** – EMDR therapy is used as part of an integrative treatment approach with other modalities.

5. **Clinical Goals and Outcomes of EMDR Therapy** –

5a. **Symptom Reduction** – Brief, focused treatment to achieve appropriate, adaptive, and ecological resolution of the client's presenting problems through memory reprocessing.

5b. **Comprehensive Treatment** – intended to optimize the client's internal and external capacity to respond adaptively in the current context of their lives by incorporating new skills, behaviors, and beliefs about the self and others, resulting in personal growth and change beyond the resolution of symptoms.

6. **Evidence-Based Categories:**

6a. Approach has been found effective in systematic review of RCTs published in peer-reviewed journals and the reviews found moderate homogeneity or better.

6b. Approach has been found effective in one or two RCTs, published in a peer-reviewed journal.

6c. Approach has been found effective in well-designed case control studies or non-randomized quasi-experimental design, for example, convenience block sampling.

6d. Approach has been evaluated in a published study using systematic methodology with standard qualitative analyses in a peer-reviewed journal.

6e. Approach is supported by expert opinion only.