Brief Adjunctive EMDR

Editorial Note: The Clinical Q&A is a regular *Journal of EMDR Practice and Research* feature in which master clinicians answer a question posed by a reader who is requesting assistance with clinical challenges. In this issue's column, the response is written by Suzanne S. Borstein, who is a licensed psychologist and an EMDRIA-approved consultant in Cranston, Rhode Island, USA. Readers can send questions for future issues to journal@emdria.org.

Question: *How can I provide brief adjunctive EMDR as a consultation service to other therapists' clients?*

ANSWER FROM SUZANNE S. BORSTEIN:

Eye movement desensitization and reprocessing (EMDR) has been demonstrated to be an effective treatment for posttraumatic stress disorder (PTSD), and its application to other psychological problems has been documented as well (Maxfield, 2007). As the effectiveness of EMDR is increasingly documented not only in the professional literature but also in the popular press, therapists and clients alike have become curious about whether EMDR might be helpful in their work.

Many EMDR-trained clinicians report that they have been asked to provide EMDR to their colleagues' clients. However, very little has been written on the implementation of adjunctive or consultative EMDR treatment. Zangwill (1998, 2007) describes a model of brief EMDR consultation, usually limited to three 90-minute sessions, after several sessions to secure client history and prepare them for EMDR. Zangwill offers a perspective for consultation, describes commonly encountered pitfalls, and suggests guidelines for dealing with these issues. Parnell (2006) briefly addresses the application of EMDR in a consultative role and warns of some circumstances that reduce the chance of good outcomes. Forgash (2008) devotes a chapter to describing "collaborative therapy," a closely related approach, which she feels may be clinically advantageous in the provision of ego state therapy and EMDR with traumatized individuals.

Other forms of adjunctive or collaborative psychotherapy have been utilized and described in the literature, most notably in dialectical behavior therapy

(Linehan, 1993) where clients are expected to attend both a skills group and individual therapy, and the individual and group therapists are expected to actively collaborate.

However, the most common belief among psychotherapists is that a client can have only one therapist. There is concern that splitting will occur, with the client viewing one therapist as "good" and the other as "bad," pitting the therapists against each other. It is feared that clinical material will be shared with one therapist and spared from the other or that therapists will not be on the same page, resulting in confusion and conflict within the client or conflict between therapists. The proposed model of brief adjunctive EMDR is expressly collaborative, has clearly articulated boundaries, and includes guidelines to build and maintain active, reciprocal communication between the primary therapist and the EMDR therapist. These qualities work directly against the possibility of splitting.

The proposed model also offers criteria for identifying appropriate referrals, evaluating the target symptoms pre- and posttreatment, anticipating and avoiding potential pitfalls, and dealing with possible ethical issues.

Brief Adjunctive EMDR: Definition and Rationale

When painful feelings about a single incident continue to intrude or interfere with otherwise productive psychotherapy, a short trial of EMDR may indeed resolve the impasse. However, it may not be a good idea to jettison a secure, otherwise productive therapy relationship in order to try out EMDR. By narrowly targeting specific traumatic memories or intrusive

material, brief adjunctive EMDR can accelerate progress in traditional therapy, help the client and the primary therapist to resolve stuck points, and enrich their ongoing work.

Brief adjunctive EMDR therapy is a focused application of standard EMDR treatment, provided by an EMDR-trained clinician (hereafter referred to as the consultant) to clients who are already engaged in some other form of individual psychotherapy with another therapist. It is intended to be brief, commonly 4 to 12 sessions (including screening, preparation, processing, and follow-up), and it is narrowly focused on a clearly articulated referral issue. In this model, adjunctive EMDR does not replace or interrupt ongoing therapy. It is complementary to the primary therapy relationship, and it is provided in active collaboration with the primary therapist.

Benefits of Brief Adjunctive EMDR

This model of short-term, collaborative EMDR may be beneficial when a single symptom is not resolving, despite insight, motivation, and good treatment. Symptoms that might warrant adjunctive EMDR include nightmares or intrusive memories, as in this clinical example:

John, a married father of three children under the age of 10, was in therapy after the death of his oldest child, a daughter with a chronic disease, who died suddenly of an unanticipated complication. John had dealt well with his grief and no longer was seriously depressed but was troubled by intrusive memories of the moment of his daughter's death and the negative belief that he had not done enough to take care of her. Rationally, he knew that there was nothing that he or other family members or the medical team could have done, but he could not shake the visual images that plagued him. Referred for adjunctive EMDR, John was able to reprocess the last day of his daughter's life. After four sessions, he remained appropriately sad over the loss of his child, but he no longer experienced distressing intrusive images and excessive guilt; he was able to recall treasured memories and was able to engage in pleasant activities with his family.

Brief adjunctive EMDR may be useful when good psychotherapy is stuck, as in the following example:

Mary was referred by her therapist, whom she saw for individual and couples therapy after her husband admitted having had an affair. According to the referring therapist, Mary and her husband had worked hard to talk through their grievances and repair trust. Mary's husband appeared to be doing everything asked of him, and there were long stretches of times when

the relationship was mutually satisfying. However, Mary sometimes was triggered into suspicion or found herself reliving details of her discovery of the affair, and insight-oriented psychotherapy was not resolving this. Adjunctive EMDR illuminated negative cognitions and unresolved grief from her family of origin, which were interfering with Mary's ability to trust her husband and to fully engage in rebuilding her sense of family with him. Twelve sessions were needed to fully process these issues.

I have also found that brief adjunctive EMDR can accelerate progress in traditional psychotherapy when both client and therapist are puzzled about their work becoming stagnant, yet some aspect of the clinical goals have not been achieved, as in this example:

Michael, a single 22-year-old professional, sought EMDR when his primary therapy began to feel "stale" to him. Michael said initially his therapy had felt invaluable, helping him deal with profound depression over a rupture in a romantic relationship and a significant work problem. While he still had substantial ambivalence about work and relationships, Michael felt his therapy was not helping in the same way it had but rather was going over the same ground. (In EMDR terms, this might be described as "looping.") His therapist agreed that they were at a plateau; unfamiliar with EMDR but open to collaboration, the primary therapist endorsed a short trial of adjunctive EMDR.

Standard protocol (Shapiro, 2001) was used to target current conflicts. The floatback technique was used to identify childhood experiences that had similar emotional, cognitive, and somatic valence and which may have been touchstone events underpinning Michael's unresolved issues. Recognizing the relevance of these earlier events enriched his primary therapy, and these events were also processed with EMDR. The future template step of the standard protocol provided Michael with a new way to envision his therapy goals. His EMDR treatment was completed in 10 sessions.

Finally, providing brief adjunctive EMDR to the clients of one's professional colleagues can benefit more than the particular clients involved. This type of well-focused and clearly defined collaboration will enhance awareness in our professional communities of the effectiveness of EMDR, and it may encourage more clinicians to become trained in the method as well.

Criteria for Appropriate Referrals for Brief Adjunctive EMDR

This model developed out of my experience of more than 5 years with more than 30 referrals for adjunctive EMDR. Lacking any written guidelines, relying on

basic training and consultation with other clinicians, I responded to each referral as a unique experience. As I began to notice patterns in the way treatment proceeded, I developed hypotheses about what contributed to the likelihood of successful brief treatment, which cases might require a different type of collaboration, and which cases might not be appropriate for EMDR at all. After a year and with encouragement of EMDR International Association's Research Committee, I began to collect outcome data on each new referral. While the results of that study will be reported separately, the following criteria are based on that experience and that data.

Good candidates for brief adjunctive EMDR are generally well-functioning individuals who have a good working relationship with a therapist, and this therapist has indicated interest and willingness to actively collaborate with the EMDR consultant. Furthermore, in an appropriate referral, the client and his or her therapist can identify a clear target or stuck point they wish to have addressed with EMDR.

A generally well-functioning individual has a stable living arrangement, is not actively abusing substances, and is not actively suicidal or self-injuring. Individuals who are prone to paranoid thinking or who have impaired reality testing are not good candidates for brief adjunctive EMDR. The categorical approach to determine readiness for EMDR proposed by Zangwill, Kosminsky, and Browning (2004) may also be helpful in selecting good candidates for adjunctive EMDR. (For a discussion of client readiness for the standard EMDR protocol, see Shapiro [2001] and Parnell [2007]).

Individuals with complex PTSD or a dissociative disorder may benefit from EMDR but likely will do better in longer-term treatment where EMDR is integrated rather than adjunctive. (For consultants who are well grounded in working with these more complicated cases, Forgash [2008] describes a model of brief collaborative EMDR.)

It is important in this model that *the client has a good connection with his or her primary therapist* because the model explicitly does not interrupt, interfere with, or replace the primary therapy; instead, it requires active collaboration with the primary therapist. Material that is activated in EMDR sessions should be discussed and worked through with the primary therapist so that anything new or changed as a result of EMDR can be integrated into the context and support of the ongoing therapy. Lacking a strong alliance to a primary therapist elevates the potential for certain pitfalls, which are discussed later in this article.

I require that the client sign an informed consent form so that I may contact the primary therapist

before engaging in brief adjunctive EMDR; if a client is unwilling to agree to this, collaboration is impossible, and something may be amiss in the primary therapy relationship.

Similarly, *willingness on the part of the primary therapist to actively collaborate* is an essential indicator that the primary therapist is supportive of this consultation and is interested in integrating into their treatment any new material that surfaces during EMDR. Active collaboration is necessary to allow the EMDR work to be brief and narrowly focused. While active collaboration does not eliminate the need for the consultant's independent assessment of the client, it does provide added background information and context for the referral issue.

In order to formulate a clearly focused and brief treatment plan, *the client and his or her primary therapist need to be able to identify a specific target or stuck point* on which to focus the EMDR. In the clinical examples cited previously, John had intrusive images of his daughter's death, and he had unnecessary guilt despite apparently good grief work with his primary therapist. Mary was easily triggered into apparently unwarranted suspicion and would then ruminate on traumatic memories of discovering her husband's affair. Michael's stuck point was somewhat vague until the standard protocol and floatback method were applied, and then several clear targets emerged. Clear conceptualization of the referral issue suggests that the client and therapist have a shared understanding of the purpose of adding EMDR to their ongoing therapeutic process and is a strong indicator of appropriateness of the referral.

Evaluating Target Symptoms Pre- and Posttreatment

Consultants should conduct their own screening and history taking, even if clients are referred by trusted colleagues. In addition to the assessment recommended in basic EMDR training (Shapiro, 2001), consultants are advised to use standardized measures to identify and establish baseline measures of symptoms related to the targets for EMDR treatment. These same measures can also be used to measure change after completion of treatment, and resulting data can be used to document the efficacy of the intervention.

In my practice, I routinely administer measures of anxiety, depression, PTSD, and dissociative disorders. In addition, I ask the primary therapist to complete a simple form that allows them to identify and rate the severity of up to three problems related to the referral issue (Figure 1). I share the results of this assessment with the client and their primary therapist to help

Adjunctive EMDR
Referring Therapist Feedback Form

Referred Client: _____

Referring Therapist: _____ Date of Feedback: _____

In an effort to evaluate the usefulness of adjunctive EMDR, I would appreciate you taking a few minutes to complete this form. Please consider the reason you made the referral, the primary symptom or issue to be the focus of the adjunctive treatment, and other important symptoms that may be relevant (e.g. disturbed sleep, hypervigilance, mood disturbance).

The reason for referral is: _____

Using a scale from 0 to 10, with 0 signifying no problem, problem completely resolved, and 10 signifying the worst you've known with this client, please rate the intensity of your client's symptoms.

1. Referring problem 0 1 2 3 4 5 6 7 8 9 10
2. Other symptom #1 0 1 2 3 4 5 6 7 8 9 10 (describe: _____)
3. Other symptom #2 0 1 2 3 4 5 6 7 8 9 10 (describe: _____)

Thank you for completing this form. I will ask you to complete a similar form at the conclusion of adjunctive treatment. If treatment is longer than 6 to 8 sessions, I may ask you to complete a form in the interim. If there is anything else you feel it is important for me to know, please feel free to add it below.

I appreciate the opportunity to collaborate with you on this case.

FIGURE 1. Adjunctive EMDR referring therapist feedback form.

ensure that we all agree on the nature and severity of the problems to be addressed. The same measures are used at the conclusion of treatment. This provides feedback to the client, primary therapist, and consultant regarding the effectiveness of their collaborative work.

Possible Pitfalls and Red Flags

In my experience thus far, I have noticed five common types of obstacles that may occur if referrals are not carefully scrutinized. Approaches to avoid or reduce

the likelihood of each of these obstacles are addressed later in the section "Creating and Maintaining a Collaborative Relationship With the Primary Therapist."

1. Splitting People: Pitting therapist against consultant, by the client

It is possible that a client may come to differentially value his or her experiences with the primary therapist and the consultant. The intensity and speed with which EMDR can work sometimes results in a client devaluing the prior work with his or her primary

therapist. The trauma focus of an EMDR-trained clinician may elicit in the client a sense of being understood in a novel way. If the possibility of this kind of experience is not anticipated, discussed directly, and managed, a rupture could occur in the primary therapy, damaging the primary therapeutic alliance; causing distrust by the client, the primary therapist, or both; and possibly leaving the client without his or her “home base” of treatment.

2. **Splitting Content:** Attempting to separate traumatic material from the rest of the clinical picture, either by the client or by the therapist

Occasionally, an EMDR therapist will be asked by another therapist to “do the trauma part,” as if problems of daily living had nothing to do with traumatic experiences. While it might be entirely appropriate to refer for brief adjunctive EMDR when an ongoing client experiences an isolated trauma, such as a car accident or a mugging, it is not appropriate to split the treatment for early abuse or neglect from the treatment of current relationship issues, depression, or anxiety symptoms. Nor is it helpful if the client wishes to share traumatic material with the EMDR consultant but does not discuss that same material with the primary therapist.

3. **The Jump:** An unspoken plan by the client to leave the primary therapy

Sometimes a request for brief adjunctive EMDR is a disguised effort to transfer therapy without having to explicitly terminate with the current therapist. While clients are most certainly permitted to change therapists, it is preferable for this process to be clear and up front. By discussing this potential risk explicitly, EMDR consultants reduce the chance that they will unintentionally pick up an ongoing case when they intended to provide consultation; more important, declining to accept a “jump” clarifies both to the client and to the primary therapist that you are not engaging in poaching other therapists’ clients.

4. **The Dump:** Unarticulated desire on the part of the primary therapist to transfer or end treatment

When the primary therapist describes the potential for EMDR as a “last resort” or, perhaps, “the next stage,” it is best to regard this as a potential red flag. In such an instance, if the therapist really is seeking a transfer, you may decide to accept the referral, but then you would be embarking on traditional EMDR treatment, not brief adjunctive EMDR, and all parties should agree to this up front before beginning EMDR treatment.

5. **The Stumped:** Unbridgeable differences in case conceptualization between primary therapist and EMDR consultant

When a colleague refers a client because he or she feels “stumped,” baffled about what to do next, or frustrated that “nothing has worked,” be alert to the possibility that there may be a problem in the way the primary therapist views the case. This may take the form of misdiagnosis (e.g., minimizing the presence of personality disorder or missing the presence of significant dissociation), lack of adequate treatment for a chronic condition (e.g., untreated substance abuse, addiction, or phobia), or inadequate case conceptualization (e.g., lack of clear treatment goals, lack of recognition of attachment issues, or affect tolerance deficits). It is likely going to be difficult to establish an active collaborative stance with a clinician in whom one does not have confidence or mutual respect. This kind of challenge may be reduced or avoided by accepting referrals only from known, trusted colleagues.

Creating and Maintaining a Collaborative Relationship With the Primary Therapist

Collaboration with the client’s primary therapist is a cornerstone of brief adjunctive EMDR. Not only does collaboration greatly reduce the possibility of the pitfalls described previously, but it enhances the efficiency of treatment, allowing the consultation to be as brief as possible.

It is not uncommon that an EMDR client will want to discuss the impact of a particular EMDR session, in order to better integrate new learning, to consider how new insight or changed responsiveness may impact their daily life and relationships, or to identify and address skill deficits that may have been noted. Brief adjunctive EMDR relies on the primary therapist to assist his or her client in these processes in the context of the preexisting therapeutic context. This collaborative division of therapeutic activity supports a clear differentiation of roles, reinforces the centrality of the primary therapeutic relationship, and decreases the number of sessions needed with the consultant.

In many cases, the EMDR consultant will have to educate the primary therapist about EMDR. It is helpful to have a resource packet available, including perhaps the EMDRIA booklet (EMDR International Association, 2003), a suggested reading list, and some recommended Web sites. Videotapes are now available that offer a good orientation to EMDR (e.g., Donovan, 1999). For some clients and their therapists, it has been helpful to invite the primary therapist to a processing session.

Some clear system for regular communication between consultant and primary therapist is necessary to maintain the collaborative relationship. The "Referring Therapist Feedback Form" (Figure 1) is one simple way of recording the issues that brought the client to brief adjunctive EMDR as well as documenting the intention to collaborate. This form can be used periodically to rate degree of change as well.

Usually, periodic telephone conversations are sufficient to keep the channels of communication open, but on occasion I have provided copies of my clinical notes to the primary therapist. In brief adjunctive EMDR, it is important for the consultant to initiate contact and accept responsibility for keeping the primary therapist informed. From time to time, shifts can occur in primary therapy (see the previous section "Possible Pitfalls and Red Flags") that the client may not report; the EMDR consultant should be sharing enough information and getting enough feedback from the primary therapist so that both are aware of important changes in the treatment.

Because this model is intended to support primary treatment, not to interrupt or replace it, EMDR sessions are best followed by one or more sessions with the primary therapist once screening is complete and processing is begun. This ensures that the client will have the opportunity to discuss his or her EMDR experience with their primary therapist. While a simple alternation between EMDR and primary therapy is the most common pattern in my practice, some clients have preferred more time to integrate the material that gets stirred up with EMDR. As is the custom with my regular EMDR practice, brief adjunctive EMDR sessions may be conducted in the 50-minute hour or longer sessions if resources permit.

Ethical Issues

Three types of ethical concern are discussed here: the scope of informed consent, the delineation of the consultant's role as compared to the primary therapist's role, and the importance of respect for the primary therapy relationship.

Informed consent for brief adjunctive EMDR involves not only a thorough explanation of EMDR, including reasonable expectations and alternatives to treatment, but also a clear description of the role of the consultant, the type of information that may be shared with the primary therapist, and the methods for sharing information. As stated earlier, collaboration between the primary therapist and the EMDR consultant is maintained by active, reciprocal communication,

initiated by the EMDR consultant, and always with express permission by the client.

In brief adjunctive EMDR, the role of the primary therapist is just that: primary. The consultant is advised to explain the different roles of consultant and therapist at the outset. This includes clarifying that it is the therapist, not the consultant, who is the therapist of record, bearing responsibility for handling crisis calls or responding in case of client emergency. The consultant is responsible for monitoring the impact and effectiveness of EMDR both in the EMDR sessions and as it is reported to impact the primary therapy.

Another ethical issue is the importance of respect for the primary therapy. Consultants must avoid even the appearance of attempting to poach another clinician's client or interfering with or undermining the primary therapy. That is why I have an explicit policy of refusing to accept as a client anyone I have treated in brief adjunctive EMDR. If a client decides that he or she wants to terminate primary therapy in order to begin ongoing EMDR treatment, I will encourage him or her to discuss this with his or her primary therapist, and I will assist in providing referrals if appropriate.

Consultants must be prepared to consider their ethical obligations if they should suspect or become aware of problems in the primary therapy. The American Psychological Association's Code of Ethical Conduct (American Psychological Association, 2002) recommends approaching one's colleague directly, if possible, to discuss the concern. While such issues may be rare, a consultant should be aware of the ethical, clinical, and legal issues that may ensue.

Conclusion

This model of brief adjunctive EMDR is offered as one way to think through requests to provide EMDR to individuals who are already engaged in therapy with another clinician. It suggests criteria for identifying appropriate referrals, and it proposes ways to define the scope of the work. It highlights possible pitfalls and some practical ways to reduce or avoid them. This model does not attempt to address issues attendant to longer-term collaborative consultation, which might be indicated for more severe or more complex clinical presentations.

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