# Special Applications of EMDR: Treatment of Performance Anxiety, Sex Offenders, Couples, Families, and Traumatized Groups

**Ronald J. Ricci**
**Cheryl A. Clayton**
**Sandra Foster**
**Ignacio Jarero**
**Barry Litt**
**Lucina Artigas**
**Sara Kamin**

This article presents four brief reports that illustrate EMDR's potential in addressing a range of pathologies and problems. These include traumatized groups, families and couples, sex offenders, and individuals with performance anxiety. Each brief report provides a short summary of the research, highlights current EMDR research, and points out what is needed for future investigations. Preliminary results suggest that the EMDR–integrative group treatment protocol may be an effective means of providing mental health care to large groups of people affected by critical incidents. The report titled "EMDR in Couples and Family Therapy" provides an overview of the field and describes the various ways in which EMDR is being incorporated. The presenting issue with performance anxiety is debilitating *evaluation anxiety* at the prospect of having to perform some important activity in front of an audience that matters a great deal to the client. Sex offender treatment is enhanced by an effective means of resolving psychological mechanisms that contribute to the dynamics of the offense chain.

**Keywords:** EMDR; group treatment; couples and family therapy; performance anxiety; sex offender treatment

Since its initial dissemination by Shapiro in 1989, eye movement desensitization and reprocessing (EMDR) has established itself as efficacious in the treatment of posttraumatic stress disorder (PTSD). It captured the imaginations of therapists around the world, as they became intrigued with its possibilities and potential, and various new applications have been developed. While research is still needed to evaluate the effectiveness of these applications, some promising preliminary results have been reported in disparate areas.

The purpose of this article is to provide a brief summary of these applications of EMDR, with experimental use with groups, families, sex offenders, and individuals with performance anxiety. In some cases, the application involves a modified protocol; in other cases, standard EMDR protocol is used.

EMDR is a standardized psychotherapy with an 8-phase treatment approach. Phases 1 and 2, history taking and preparation, are similar to those used in most therapies. Phase 3 involves the identification and accessing of a distressing memory. The client is asked to rate the distress elicited by the memory, using the Subjective Units Of Disturbance Scale (SUD; Shapiro, 2001), where 0 = no disturbance and 10 = worst possible disturbance, and to rate the validity of a preferred positive self-referencing cognition, using the validity of cognition scale (VOC; Shapiro, 2001), where 1 = not true and 7 = completely true. Then in phases 4, 5, and 6 the client processes the disturbing material, using a dual attention protocol in which he or she focuses on the memory or other identified material while simultaneously attending to an external stimulus, such as eye movements or bilateral tactile or audi-


 DOI: 10.1891/1933-3196.3.4.279

tory stimulation (commonly referred to as BLS). At the end of processing, the client typically reports that all memory-related distress has been resolved, the positive cognition feels valid, and all related somatic disturbance has been relieved. The subsequent session starts with a re-evaluation of previous work (phase 8). EMDR addresses past, present, and future (anticipatory) experiences that are related to the presenting problem.

In the following sections, the authors describe the application of EMDR for various problems. In most cases, a modification of the basic protocol is described.

## Reference

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York: Guilford Press.

---

# EMDR and the Treatment of Performance Anxiety

**Sandra Foster**
*Korn/Ferry International, London, UK*

**Sara Kamin**
*York University, Toronto, Canada*

Why would a person become anxious or avoidant when planning to do something he or she truly desires to do? What are the mechanisms that prompt a person to experience anticipatory anxiety when planning to do something important even when the skills are present in the person's repertoire?

Those who work with performing artists, athletes, and business people in the public eye know that the degree of preperformance anxiety plays a key role in the overall execution of that performance (Beck, Emery, & Greenberg, 2005). While a certain degree of anxiety can be beneficial as an activator of engagement with the audience or a strong incentive to train and rehearse, many performers experience such a profound increase in anxiety that it impairs their ability to perform at an optimal level (Beck et al., 2005; Hays, 2009). Performance anxiety can have an adverse impact on performers from all domains including music, dance, sport, business, and high-risk professions such as surgery and flying aircraft (Hays & Brown, 2004) and is often a response to the various stressors that accompany most performance scenarios.

Beck and his colleagues (2005) conceptualized performance anxiety as an "evaluation anxiety" and theorized that the performer's desire for approval (both from the self and others) or to win in competition were key elements. Other stressors associated with performance anxiety are suboptimal performance conditions (e.g., tension among team members, problems with audio-visual equipment, or even inclement weather) and predisposition to physiological reactivity (excessive sweating, blushing, or rapid heart rate).

As noted in the earlier reference to physiological reactivity, the manifestations of performance anxiety are acutely and uncomfortably physiological—quickened heart rate, trembling knees, or clammy hands. However, the symptoms are also cognitive, as in difficulty with focus and concentration, and emotional as experienced in heightened fear and worry (Beck et al., 2005; Greenberger & Padesky, 1995). In addition, behavioral responses often involve an attempt to avoid or escape the stressful scenario (Beck et al., 2005; Greenberger & Padesky, 1995; Young, Klosko, & Weishaar, 2003). Unfortunately, avoidance of anxiety-inducing situations only serves to reinforce the anxious response in the future (Greenberger & Padesky, 1995).

## EMDR Treatment of Performance Anxiety

While cognitively based therapies combined with one or more other interventions such as relaxation, meditation, biofeedback, or imagery (Beck et al., 2005; Greenberger & Padesky, 1995; Hays, 2009; Hays & Brown, 2004) have typically been used to treat performance anxiety, the EMDR standard protocol has been applied to alleviate precompetition anxiety in athletes (Crabbe, 1996; Graham, 2004), test anxiety (Maxfield & Melnyk, 2000), and audition anxiety in actors (Grand, 2009). The peak performance protocol (Foster & Lendl, 1996) was also developed to help clients enhance and broaden their existing behavioral repertoires and to be better able to overcome so-called performance deficits, as when the skill was present but negative emotions inhibited the deployment of skillful action. A series of case studies (Foster & Lendl, 1996) showed the protocol was helpful to an experienced pilot returning to a flight simulator following a failed exam and to a business leader in managing his distress and feelings of failure following a significant setback.

***EMDR Standard Protocol Applications.*** In accordance with Shapiro's adaptive information processing (AIP) model (2001), application of the EMDR standard

protocol involves processing the historical event that is assumed to be the etiological cause of the performance anxiety. For example, in their test anxiety study, Maxfield and Melnyk (2000) used the current fear as the initial target, and then had participants identify the earliest occasion that they had experienced similar affect, cognitions, and sensations. Participants identified events such as being humiliated by a teacher or criticized by a parent because of poor grades. Distress related to the earlier incidents was then reduced using EMDR's standard processing phases. After this, the participants focused on current and future fears. The study used a waitlist control group and found that one session of EMDR produced significant changes on the Test Anxiety Inventory and the Fear of Negative Evaluation Scale. Results were replicated with subsequent treatment of the waitlist group. Improvement was maintained at follow-up, with participants' scores on the Test Anxiety Inventory showing a decrease from the 90th percentile at pretreatment to the 50th percentile at 2-month follow-up. These results provide preliminary evidence and suggest that performance anxiety can be reduced by processing early related events with EMDR.

***The Peak Performance Protocol.*** The peak performance protocol was developed specifically to treat performance anxiety and has been deployed with encouraging results (Foster & Lendl, 1995, 1996, 2009). This special protocol adheres to the steps in the basic EMDR protocol with some key differences: the initial focus is on *present day* performance issues and preparing for optimal *future* performance rather than beginning with the first and worst instance of the trauma.

Resource development and installation (RDI; Leeds, 2009) is a key part of the peak performance protocol. When RDI is used with traumatized patients in clinical applications of EMDR, it emphasizes safety, client stabilization, and ego strengthening. However, in peak performance applications, the focus of resource installation is the generation of hope and possibility, including the attainment of cherished goals. The peak performance protocol is also informed by the use of sport psychology performance-enhancement techniques.

The EMDR peak performance protocol uses homework assignments and rehearsal in the actual setting before deploying the performance in front of the audience. Part of the clinician's work when using the peak performance protocol is making certain that the requisite skills are present in the client's repertoire and supporting the client in developing those skills if they are not. For example, a client facing work-related anxiety can engage trusted colleagues as mentors to enhance skills in communicating, running meetings, and delegating effectively. If the client is anxious about enacting skills that he or she does not possess, attempts to reprocess the anxiety will not be fully successful.

In providing EMDR peak performance work, a practitioner may encounter a client whose false self is challenged at work or on the stage (see Kernberg, 1975, and Masterson, 1981). A crisis may be precipitated by a business loss or the fear of being exposed as an impostor. The peak performance protocol can help clients shift to a new perspective of *informing rather than performing*, coming to terms with the evaluation anxiety associated with seeking approval. With the symptoms of the anxiety reprocessed, clients can embrace the possible satisfaction that can come from making a contribution, or expressing oneself from a place of higher purpose, or collaborating with others rather than competing.

### Recommendations

Research is needed to evaluate the treatment of performance anxiety with EMDR. There is some evidence that the use of the standard EMDR protocol to treat early memories of failure and humiliation may help with current anxiety about performance. There is also evidence that focusing on maximizing the client's peak performance may be sufficient to alleviate the pathology. Research comparing these two approaches would make a substantial contribution in evaluating effectiveness and in clarifying the optimal approach. Further, it is possible that certain types of clients or certain types of presenting anxiety may be more responsive to one approach compared to the other. EMDR applications should also be compared to standard cognitive behavioral therapy, which often uses in vivo exposure to anxiety-provoking situations. Standard EMDR applied to performance anxiety does not require the use of homework and does not include in vivo exposure. A comparison of the outcomes of these different treatments would be informative, and relevant to researchers, theorists, and clinicians.

## References


Beck, A. T., Emery, G., & Greenberg, R. L. (2005). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books, Harper and Row.

Crabbe, B. (1996, November). Can eye-movement improve your riding. *Dressage Today,* 28–33.

Foster, S., & Lendl, J. (1995). Eye movement desensitization and reprocessing: Initial applications for enhancing

performance in athletes. *Journal of Applied Sport Psychology, 7*(Suppl.), 63.
Foster, S., & Lendl, J. (1996). Eye movement desensitization and reprocessing: Four case studies of a new tool for executive coaching and restoring employee performance after setbacks. *Consulting Psychology Journal: Practice and Research (pp. 277-396), 48*(3), 155–161.
Foster, S., & Lendl, J. (2009). Peak performance protocol. In M. Luber (Ed.), *Eye movement desensitization and reprocessing (EMDR) scripted protocols* (pp. 277–396). New York: Springer Publishing.
Graham, L. (2004). Traumatic swimming events reprocessing with EMDR. *www.Thesportjournal.org, 7*(1), 1–5.
Grand, D. J. (2009). Audition anxiety. In K. F. Hays (Ed.), *Performance psychology in action* (pp. 121–138). Washington, DC: American Psychological Association.
Greenberger, D., & Padesky, C. (1995). *Mind over mood*. New York: Guilford Press.
Hays, K. F. (2009). Performance anxiety. In K. F. Hays (Ed.), *Performance psychology in action* (pp. 101–120). Washington, DC: American Psychological Association.
Hays, K. F., & Brown, C. H. (2004). *You're on: Consulting for peak performance*. Washington, DC: American Psychological Association.
Kernberg, O. (1975). *Borderline conditions and pathological narcissism*. New York: Jason Aronson.
Leeds, A. M. (2009). Resources in EMDR and other trauma focused psychotherapy: A review. *Journal of EMDR Practice and Research, 3(3),* 152–160.
Masterson, J. F. (1981). *The narcissistic and borderline personalities*. New York: Bruner/Mazel.
Maxfield, L., & Melnyk, W. T. (2000). Single session treatment of test anxiety with eye movement desensitization and reprocessing (EMDR). *International Journal of Stress Management, 7,* 87–101.
Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York: Guilford Press.
Young, J. E., Klosko, M. E., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide.* New York: Guilford Press.

## Application of EMDR With Sex Offenders in Treatment

**Ronald J. Ricci**
**Cheryl A. Clayton**
*Resources For Human Development, Inc.*
*Philadelphia*

Contemporary sex offender treatment theory considers the role of unresolved trauma in the etiology of sexual offending (SO) and re-offense risk (Ward & Siegert, 2002). Attention is also given to the moral, ethical, and practical issues of addressing the victimization histories of sexual offenders themselves (Ward & Moreton, 2008). These ideas invite continued examination of incorporating trauma resolution techniques into standard SO treatment programs. Over the past decade practitioners have considered EMDR as a treatment enhancement for programs targeting adolescent and adult sex offenders (e.g., Gates, 2002; McMulin, 1998). EMDR can address many of the same issues targeted in SO-specific treatment (e.g., cognitive restructuring, emotion regulation, skill enhancement).

Ward and Siegert's (2002) pathways model of sexual offending attributes clinical phenomena evident in sexual offenders to five interactive psychological mechanisms: intimacy and social skills deficits; distorted sexual scripts; offense-supportive beliefs; emotional dysregulation; and a fifth etiological pathway that incorporates the prior four mechanisms with deviant sexual scripts, usually reflective of a history of sexual abuse. EMDR has the potential to address, at least in part, several of these mechanisms. Social skills and intimacy, for example, rely on the ability and motivation to attach to others, while an insecure or avoidant attachment may be a primary cause of interpersonal functioning problems. Childhood trauma ruptures basic attachment that can have lasting effects on empathic abilities (James, 1989). Resolving related trauma, therefore, paves the way for healthy interpersonal experiences and the development of improved social and interpersonal skills. Datta and Wallace (1994, 1996) added EMDR to standard treatment for juvenile sexual offenders who had themselves been sexually abused and found increases in victim empathy for those offenders. Similar improvement was reported for victim empathy (Ricci, 2004; Ricci, Clayton, & Shapiro, 2006) as well as general empathy following EMDR treatment with child molesters (Ricci & Clayton 2008).

Distorted sexual scripts and offense-supportive beliefs are oftentimes a by-product of early life experiences. Ward (2000) considers this in terms of implicit as well as explicit belief systems. These beliefs may not necessarily be a conscious choice, but a manifestation of dysfunctionally stored memories. EMDR processes these stored memories, eliminating associated sensations and transforming cognitive and affective components into an adaptive form (Shapiro, 2001). The neurobiological underpinnings of EMDR processing have been posited as a shift from implicit sensory information to consolidated explicit memories (Siegel, 2002; van der Kolk, 2002), and from episodic to semantic memory systems (Stickgold, 2002).

Post-EMDR reductions in cognitive distortions were noted both qualitatively and quantitatively in child molesters with known histories of sexual victimization (Ricci & Clayton 2008; Ricci et al., 2006). Finley (2002) also found a statistically significant reduction in offense justifications after EMDR treatment directed at the offender's own prior victimization.

Boyer (2007) qualitatively analyzed emotional dysregulation in sexual offenders. The emergent core theme of emotional processing was cited as beneficial (to the goals of SO treatment) for the EMDR treatment group but not for the comparison treatment group. The related theme of emotional recognition and management emerged from the qualitative analysis of EMDR-treated child molesters (Ricci, 2004; Ricci & Clayton 2008).

Deviant sexual arousal has emerged as a major risk factor concerning sexual recidivism (Hanson & Morton-Bourgon, 2005). Hanson and Bussiere's (1998) study cites deviant sexual interest in children as measured by phallometry as the largest single predictor of sexual recidivism. In the Sex Offender Treatment and Evaluation Project (SOTEP) longitudinal study (Marques, Wiederanders, Day, Nelson, & van Ommeren, 2005), arousal to children was the only in-treatment measure differentiating between those who did and those who did not recidivate. Ricci et al. (2006) found a statistically significant reduction in deviant sexual arousal to the age and gender of the offender's victim(s) of conviction in EMDR-treated participants, as measured by phallometry, while there was no significant reduction in deviant arousal in the ad hoc control group.

The adaptive information processing (AIP; Shapiro, 2001) model inherent in EMDR suggests that the intense affect associated with traumatic experience interferes with the brain's ability to process the information to an adaptive resolution. Consequently, perceptual information associated with the traumatic event, including affect, cognitions, images, and bodily sensations, becomes dysfunctionally stored and essentially isolated within the memory network. Similar events encountered subsequently serve to trigger this material, causing the individual's view of the present to be influenced by affective and cognitive distortions. EMDR treatment is predicted to decrease or eliminate somatic responses, thoughts of the event, and thus emotional triggers. Sexual arousal is one aspect of the memory that would remain somatically stored until processing had occurred.

The literature reviewed here suggests that incorporating EMDR into standard SO treatment can resolve dysfunctionally stored memories and restructure the implicit belief systems that promote and justify sexual offending behavior. It also helps to restructure the problematic thoughts and feelings that trigger the offense cycle, increases empathic responses often deficient in sexual offenders, and reduces and potentially eliminates the somatic responses (deviant sexual arousal) known to be a primary factor in sexual re-offense risk.

## References


Boyer, W. R. (2007). *An exploratory study of the effects of EMDR on state/trait anxiety and anger in adult male sex offenders*. Unpublished doctoral dissertation, Argosy University, San Francisco, CA.

Datta, P. C., & Wallace J. (1994, May). *Treatment of sexual traumas of sex offenders using eye movement desensitization and reprocessing*. Paper presented at the 11th annual Symposium in Forensic Psychology, San Francisco, CA.

Datta, P. C., & Wallace, J. W. (1996, June). *Enhancement of victim empathy along with reduction in anxiety and increase of positive cognition of sex offenders after treatment with EMDR*. Paper presented at the annual meeting of the EMDR International Association, Denver, CO.

Finley, P. (2002). Eye movement desensitization and reprocessing (EMDR) in the treatment of sex offenders. *Dissertation Abstracts International, 63*(10), B. (UMI No. 3068413).

Gates, D. P. (2002, June). *Using EMDR with juvenile sex offenders and sexually reactive children*. Paper presented at the EMDRIA Conference, San Diego, CA.

Hanson, R. K., & Bussiere, M. T. (1998). Predicting relapse: A meta-analysis of sexual offender recidivism studies. *Journal of Consulting and Clinical Psychology, 66,* 348–362.

Hanson, R. K., & Morton-Bourgon, K. E. (2005). The characteristics of persistent sexual offenders: A meta-analysis of recidivism studies. *Journal of Consulting and Clinical Psychology, 73*(6), 1154–1163.

James, B. (1989). *Treating traumatized children: New insights and creative interventions*. Lexington, MA: Lexington Books.

Marques, J. K., Wiederanders, M., Day, D. M., Nelson, C., & van Ommeren, A. (2005). Effects of a relapse prevention program on sexual recidivism: Final results from California's sex offender treatment and evaluation project (SOTEP). *Sexual Abuse: A Journal of Research and Treatment, 17,* 79–107.

McMulin, T. (1998). Combining EMDR with relapse prevention programs to enhance treatment outcomes with sex offenders. *EMDRIA Newsletter, 3*(2), 20–24.

Ricci, R. J. (2004). *Trauma resolution treatment as an adjunct to standard treatment for sexual offenders*. Unpublished doctoral dissertation, Virginia Polytechnic Institute and State University, Blackburg, VA.

Ricci, R. J., & Clayton, C. A. (2008). Trauma resolution treatment as an adjunct to standard treatment for child

molesters: A qualitative study. *Journal of EMDR Practice and Research 2*(1), 41–50.

Ricci, R. J., Clayton, C. A., & Shapiro, F. (2006). Some effects of EMDR on previously abused child molesters: Theoretical reviews and preliminary findings. *Journal of Forensic Psychiatry and Psychology, 17*(4), 538–562.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York: Guilford Press.

Siegel, D. J. (2002). The developing mind and the resolution of trauma: Some ideas about information processing and an interpersonal neurobiology of psychotherapy. In F. Shapiro (Ed.), *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism* (pp. 85–122). Washington, DC: American Psychological Association Press.

Stickgold, R. (2002). EMDR: A putative neurobiological mechanism of action. *Journal of Clinical Psychology, 58,* 61–75.

van der Kolk, B. A. (2002). Beyond the talking cure: Somatic experience and subcortical imprints in the treatment of trauma. In F. Shapiro (Ed.), *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism* (pp. 57–84). Washington, DC: American Psychological Association Press.

Ward, T. (2000). Sexual offenders' cognitive distortions as implicit theories. *Aggression and Violent Behavior: A Review Journal, 5,* 491–507.

Ward, T., & Moreton, G. (2008). Moral repair with offenders: Ethical issues arising from victimization experiences. *Sexual Abuse: A Journal of Research and Treatment, 20*(3), 305–322.

Ward, T., & Siegert, R. J. (2002). Toward a comprehensive theory of child sexual abuse: A theory knitting perspective. *Psychology, Crime, and Law, 8,* 319–351.

## EMDR in Couples and Family Therapy

**Barry Litt**
*Human Dynamics Associates, Inc.*
*Concord, New Hampshire*

Couples and family therapy (CFT) is a diverse field into which EMDR has only recently been incorporated. To better understand EMDR's place in this field, it will be helpful to briefly review the history and breadth of CFT. Beginning in the 1930s, marriage counseling was not a mental health discipline per se, but rather a psychoeducational service for nondiagnosed couples seeking advice on normative, life-cycle issues (Gurman & Fraenkel, 2002). Astonishingly, 30 years after its inception, only 15% of marriage counseling cases were seen conjointly, and it was not until 1970 that conjoint therapy was the predominant modality for treating marital distress (Gurman & Fraenkel, 2002).

In the 1960s, the new discipline of family therapy emerged (Nichols & Schwartz, 1998), subsuming couples therapy in its wake (Gurman & Fraenkel, 2002). Based on the new epistemological paradigm of general system theory (Bertalanffy, 1950), therapists began to explore for the first time how the relationship system influences the individual, not just the reverse. Characterized by creativity and innovation, the family therapy movement offered a new and important challenge to the prevailing psychodynamic schools of thought and practice.

Although many of the original theorists in this movement had psychoanalytic roots (e.g., Ackerman, 1970; Boszormenyi-Nagy, 1965; Framo, 1965; Wynne, 1965), the field itself has been described as a reaction to—and renunciation of—traditional therapeutic theory and technique (Fraenkel, 1977; Gurman, 2001). If the early psychoanalytic thinkers erred on the side of emphasizing the individual over the interpersonal, the family therapists did the opposite. Railing against the psychological determinism inherent in traditional psychotherapy, the early family therapists created their own brand of systemic determinism, casting the individual aside in favor of the system as its own anthropomorphic agent (Boszormenyi-Nagy & Krasner, 1986; Litt, 2007b). Interaction patterns were deemed the dominant force shaping self-experience, and interventions were aimed at changing behavioral and communication patterns (Gurman & Fraenkel, 2002; Nichols & Schwartz, 1998). Significantly, individually focused interventions like EMDR would be considered antithetical or even iatrogenic by the intellectual architects of this period (Kaslow, 2007). More recently, the trend in both couples and family therapy has been more integrative with attention to both intrapsychic and interpersonal/systemic factors (Gurman & Fraenkel, 2002; Kaslow, 2007; Lebow, 1987; Wachtel & Wachtel, 1986).

CFT has become a pluralistic field that encompasses multimodal, multilevel, and integrative approaches. In addition, CFT may be used to treat individuals, relationship systems, or both. For this discussion, a multimodal approach is one that combines individual and conjoint sessions. For example, Stowasser (2007) described a domestic violence case in which she used both couples and individual therapy (including EMDR).

Multilevel therapy (e.g., Scheinkman, 2008) is an approach in which two or more levels of hierarchical organization (e.g., biological, psychological, familial, social, or cultural) are explored in turn,

but not necessarily integrated. For example, Taylor (2002) described the multilevel treatment of a child with reactive attachment disorder. Individual EMDR sessions with the child and supportive educational therapy for the parents and family were combined as side-by-side treatments. A hybrid variation was described by Moore (2007) in her treatment of "Bobby," a 1-year-old brain-injured child, and his parents. Moore provided EMDR successively to the parents—to work through their grief— then to Bobby, to work through his trauma. Bobby's individual treatment was conducted in a conjoint session with his mother.

Integrative CFT examines the interactions among different levels of organization in keeping with the systemic axiom that the whole is greater than the sum of its parts. Moore's (2007) treatment of "Jonathan," a 12-year-old boy with leukemia who presented with a needle phobia, is exemplary of a multilevel, multimodal, and integrative treatment. Moore's formulation of the case illustrated how each level of the system—psychological, familial, and extrafamilial—is recursively interrelated such that pathology was amplified. The treatment plan included individual EMDR sessions for the child and his mother, family sessions to restructure the parent–child hierarchy, and case management interventions that promoted cooperation between the mother and her employer, and the family and the cancer clinic.

Close followers of the epistemology wars in the family therapy field will observe that Moore's case formulation did not portray Jonathan's needle phobia as *functional* (i.e., critical to the homeostasis of the family system). Once a veritable litmus test for a truly systemic formulation (e.g., Haley, 1963), the theory of functionality has come under both theoretical (Roffman, 2005) and empirical scrutiny (Gurman & Fraenkel, 2002). By contrast, Litt's (2007a) integrative treatment of adolescent depression proposed that the teenage girl's depression did serve to maintain her emotional availability to her parents—a homeostatic function—but he did not imply that the family *caused* her depression. This therapy included individual sessions (including EMDR) and antidepressant therapy for the child; conjoint, individually focused EMDR sessions for each parent (with the spouse present); couples therapy; and family therapy sessions for the trio. No doubt symptom functionality is a continuous variable that plays more or less of a role in some families and no role in others. It is an important consideration for the individually oriented therapist (practicing EMDR or not) because it speaks to the relational consequences of symptom change as potential inhibitors to healing and growth (for a critique, see Roffman, 2005).

Finally, CFT, originally conceived as a treatment for relational distress (Gurman & Fraenkel, 2002; Sander, 1979, cited in Kaslow, 2007), has been utilized and empirically tested in the treatment of individual pathologies such as affective disorders, anxiety disorders, conduct disorders, domestic violence, severe mental illness, and substance abuse, to name just a few (Sprenkle, 2003). In these instances, CFT approaches may be disorder-specific—treating relational functioning that maintains or is adversely affected by the disorder, or partner-assisted treatments in which the nondiagnosed partner guides, supports, or offers modified response contingencies to mitigate the symptoms of the diagnosed partner (Snyder & Wishman, 2004). In sum, CFT has evolved into a comprehensive approach to psychotherapy that assesses and treats both intrapsychic and interpersonal functioning across multiple levels of systemic organization, and may utilize both individual and conjoint modalities.

## EMDR and CFT

Since 1996, the Francine Shapiro Library has added approximately 50 chapters or journal articles about CFT and EMDR, the most significant being the *Handbook of EMDR and Family Therapy Processes* (Shapiro, Kaslow, & Maxfield, 2007). Fifteen authors describe their use of EMDR with couples, child and family problems, attachment relationships, and community disasters. Most of these authors describe multimodal, multilevel, and integrated treatments complete with case examples. The *Handbook* goes further than journal-based case studies in providing a bridge between the adaptive information processing (AIP) model (Shapiro, 2001) and various dominant family systems and couples therapy models.

While CFT has made great strides in becoming an evidence-based discipline, there is still a long way to go in bridging the gap between research and practice (Sprenkle, 2003). And so it is true for EMDR/CFT hybrid treatment: there is no evidenced-based research on this growing trend. However, EMDR has been shown to be effective in treating various components of successful relational therapy. Increasing distress tolerance is critical to managing conflict (Gottman & Notarius, 2000; Protinsky, Sparks, & Flemke, 2001), and the relational sequelae of trauma are well documented (for a review, see Nelson Goff & Smith, 2005). Finally, at least one model of couples therapy that is increasing in popularity and has been empirically vali-

dated in a number of studies has been partnered with EMDR. Emotionally focused couple therapy (EFT; Greenberg & Johnson, 1988) is an approach that, like EMDR, can be subjected to randomly controlled studies. Articles by Moses (2007), Errebo and Sommers-Flanagan (2007), and Protinsky et al. (2001) describe various integrations of these two therapies. EMDR/EFT therapy is logically positioned to be the first such hybrid to be empirically studied.

## References


Ackerman, N. W. (1970). Family psychotherapy today. *Family Process, 9,* 123–126.

Bertalanffy, L. (1950). An outline of general systems theory. *British Journal for the Philosophy of Science, 1,* 139–164.

Boszormenyi-Nagy, I. (1965). A theory of relationships: Experience and transaction. In I. Boszormenyi-Nagy and J. Framo (Eds.), *Intensive family therapy: Theoretical and practical aspects* (pp. 33–86). New York: Harper & Row.

Boszormenyi-Nagy, I., & Krasner, B. (1986). *Between give and take: A clinical guide to contextual therapy.* New York: Brunner/Mazel.

Errebo, N., & Sommers-Flanagan, R. (2007). EMDR and emotionally focused couple therapy for war veteran couples. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and family therapy processes* (pp. 202–222). Hoboken, NJ: Wiley.

Fraenkel, P. (1997). Systems approaches to couple therapy. In W. K. Halford & H. J. Markman (Eds.), *Clinical handbook of marriage and couples interventions* (pp. 379–414). New York: John Wiley & Sons.

Framo, J. L. (1965). Rationale and techniques of intensive family therapy. In I. Boszormenyi-Nagy and J. Framo (Eds.), *Intensive family therapy: Theoretical and practical aspects* (pp. 143–212). New York: Harper & Row.

Gottman, J. M., & Notarius, C. I. (2000). Decade review: Observing marital interaction. *Journal of Marriage and the Family, 62,* 927–947.

Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples.* New York: Guilford.

Gurman, A. S. (2001). Brief therapy and family/couple therapy: An essential redundancy. *Clinical Psychology: Science and Practice, 8,* 51–65.

Gurman, A. S., & Fraenkel, P. (2002). The history of couple therapy: A millennial review. *Family Process, 41,* 199–260.

Haley, J. (1963). Marriage therapy. *Archives of General Psychiatry, 8,* 213–234.

Kaslow, F. W. (2007). Family systems theories and therapeutic applications: A contextual overview. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and family therapy processes* (pp. 35–75). Hoboken, NJ: Wiley.

Lebow, J. L. (1987). Integrative family therapy: An overview of major issues. *Psychotherapy: Theory, Research and Practice, 24,* 584–594.

Litt, B. (2007a). The child as identified patient: Integrating contextual therapy and EMDR. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and family therapy processes* (pp. 306–324). Hoboken, NJ: Wiley.

Litt, B. K. (2007b). EMDR in couples therapy: An ego state approach. In C. Forgash & M. Copeley (Eds.), *Healing the heart of trauma and dissociation with EMDR and ego state therapy* (pp. 267–293). New York: Springer Publishing.

Moore, M. V. (2007). Medical family therapy. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and family therapy processes* (pp. 365–384). Hoboken, NJ: Wiley.

Moses, M. D. (2007). Enhancing attachment: Conjoint couple therapy. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and family therapy processes* (pp. 146–166). Hoboken, NJ: Wiley.

Nelson Goff, B. S., & Smith, D. (2005). Systemic traumatic stress: The couple adaptation to traumatic stress model. *Journal of Marital and Family Therapy, 31,*145–157.

Nichols, M. P., & Schwartz, R. C. (1998). *Family therapy: Concepts and methods*. Boston: Allyn & Bacon.

Protinsky, H., Sparks, J., & Flemke, K. (2001). Using eye movement desensitization and reprocessing to enhance treatment of couples. *Journal of Marital and Family Therapy, 27*(2), 157–164.

Roffman, A. (2005). Function at the function: Revisiting the idea of functionality in family therapy. *Journal of Marital and Family Therapy, 31,* 259–268.

Sander, F. M. (1979). *Individual and family therapy: Toward integration.* New York: Aronson.

Scheinkman, M. (2008). The multi-level approach: A road map for couples therapy. *Family Process, 47,* 197–213.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (2nd ed.). New York: Guilford Press.

Shapiro, F., Kaslow, F. W., and Maxfield, L. (2007). *Handbook of EMDR and family therapy processes.* Hoboken, NJ: Wiley.

Snyder, D. K., & Wishman, M. A. (2004). Treating distressed couples with coexisting mental and physical disorders: Directions for clinical training and practice. *Journal of Marital and Family Therapy, 30,* 1–12.

Sprenkle, D. (2003). Effectiveness research in marriage and family therapy: Introduction. *Journal of Marital and Family Therapy, 29,* 85–96.

Stowasser, J. (2007). EMDR and family therapy in the treatment of domestic violence. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and family therapy processes* (pp. 243–263). Hoboken, NJ: Wiley.

Taylor, R. J. (2002). Family unification with reactive attachment disorder: A brief treatment. *Contemporary Family Therapy: An International Journal, 24*(3), 475–481.

Wachtel, E. F., & Wachtel, P. L. (1986). *Family dynamics in individual psychotherapy.* New York: Guilford Press.

Wynne, L. (1965). Some indications and contraindications for exploratory family therapy. In I. Boszormenyi-Nagy & J. Framo (Eds.), *Intensive family therapy: Theoretical and practical aspects* (pp. 289–322). New York: Harper & Row.

# EMDR Integrative Group Treatment Protocol

**Ignacio Jarero**
**Lucina Artigas**
*AMAMECRISIS, México City, México*

While the psychological footprint of disaster easily dwarfs the physical footprint, the more widely televised dramatic physical destruction often overshadows the overwhelming evidence of substantial psychological consequences (Cohen, Fojt, & Wagner, 2008). In a longitudinal study of the effects of floods and mudslides in Mexico, a team of international researchers found a high prevalence of posttraumatic stress disorder (PTSD) among disaster survivors (24% on average, ranging from 14% at one site to 47% at another) and a high incidence of major depressive disorder (Norris, Murphy, Baker, & Perilla, 2004). Postdisaster data gathered in 6-month intervals allowed Norris et al. to observe the progress of PTSD symptoms and how natural healing can be painfully prolonged. These researchers concluded that their findings support a call for "early and ongoing interventions that provide mental health care to disaster victims in a way that is culturally appropriate and feasible for places" with little access to mental health resources (pp. 290–291). Other studies have shown that early psychological intervention may mitigate acute distress and reduce the need for more intensive psychological services (e.g., Everly & Mitchell, 2008).

EMDR (Shapiro, 2001) has established efficacy in the treatment of PTSD (For a review, see Schubert & Lee, 2009). However there is only preliminary evidence for its effectiveness in treating severe distress subsequent to recent experiences of overwhelming terror, loss, and despair, and in helping restore function and stability to individuals and devastated communities (for a review, see Shapiro, 2009).

## The EMDR Integrated Group Treatment Protocol

The EMDR integrative group treatment protocol (EMDR-IGTP) was developed by members of AMAMECRISIS (Mexican Association for Mental Health Support in Crisis) when they were overwhelmed by the extensive need for mental health services after Hurricane Paulina ravaged the western coast of Mexico in 1997 (Jarero, Artigas, & Lopez Lena, 2008; Jarero, Artigas & Hartung, 2006). This protocol is also variously known as The Group Butterfly Hug Protocol, The EMDR Group Protocol, and the Children's EMDR Group Protocol.

This protocol combines the eight standard EMDR treatment phases with a group therapy model and utilizes the Butterfly Hug originated by Artigas as a form of self-administered bilateral stimulation (Artigas, Jarero, Mauer, López Cano, & Alcalá, 2000). During the desensitization phase, each individual draws a personal picture of the traumatic event and rates his or her level of subjective units of disturbance (SUD). The participants then look at the picture while doing the butterfly hug (crossing their arms and tapping themselves on the chest in a bilateral alternating fashion). After this, they draw another picture, rate its level of disturbance, and then look at that picture while doing the butterfly hug. The sequence is repeated several times. See Jarero et al. (2008) for a full description of the complete protocol. The protocol was originally designed for working with children and was later modified for use with adults. It is hypothesized that the resulting format offers more extensive reach than individual EMDR applications and that the treatment may produce a more effective outcome than that expected from traditional group therapy.

## Effectiveness of the EMDR-IGTP

Because of its utility, the EMDR-IGTP has been used in its original format or with adaptations to meet the circumstances in numerous settings around the world (Gelbach & Davis, 2007). Case reports documented its effectiveness with earthquake survivors in Turkey (Korkmazlar-Oral & Pamuk, 2002); in Sri Lanka with tsunami survivors (Errebo, Knipe, Forte, Karlin, & Altayli, 2008); in Germany with Kosovar-Albanian refugee children (Wilson, Tinker, Hoffmann, Becker, & Marshall, 2000); and in Italy with children who witnessed an airplane crash (Fernández, Gallinari, & Lorenzetti, 2004). In addition, results from a case series with Palestinian children from a refugee camp city in Bethlehem indicated that the protocol appeared to foster resilience for eight children exposed to ongoing war trauma (Zaghrout-Hodali, Ferdoos, & Dodgson, 2008).

Three field study reports used the Child's Reaction to Traumatic Events Scale (CRTES; Jones, 1997) to collect pre- and posttreatment scores. The studies provide preliminary evidence for the protocol's efficacy and utility, showing significant alleviation of posttraumatic symptoms as measured on the CRTES. They also reported significant decreases of participants' SUD ratings, indicating immediate large decreases in emotional distress at the end of the treatment session. A study with 124 child victims of a flood in Santa Fe, Argentina reported significant within-session SUD score reductions and significant improvement on the CRTES 3 months after administration of the IGTP (Adúriz, Knopfler, & Bluthgen, 2009). In Mexico, Jarero and his colleagues (2006) provided the IGTP to 44 children affected by the Piedras Negras flood with a significant

decrease of within-session SUD scores and significant improvement on the CRTES at 1 month posttreatment. Similarly, Jarero and colleagues (2008) provided IGTP to 16 children whose fathers had died in a mine collapse in Coahuila, Mexico, with significant within-session SUD reductions and significant decreases in CRTES scores measured 1 week posttreatment. Treatment effects were maintained at 3-month follow-up. Although results are promising, controlled research is needed to more rigorously assess these effects and to determine the efficacy of this protocol.

### Recommendations

Natural recovery following disasters may be painfully prolonged, and many survivors experience impairment with clinical or subclinical symptoms. Preliminary results suggest that the EMDR-IGTP may be an effective means of providing mental health care to large groups of people affected by critical incidents. There are a number of advantages to using the EMDR-IGTP protocol. The group administration can involve large segments of an affected community and reach many people in a time-efficient manner. It can be used in nonprivate settings such as a shelter, an open-air clinic, or even under a mango tree. Clients in the group do not have to verbalize information about the trauma. Therapy can be done on subsequent days and there is no need for homework between sessions. The treatment identifies individuals with more severe symptoms who may require individual attention. This protocol is easily taught to both new and experienced EMDR practitioners. It seems to be equally effective cross-culturally. It can be administered by a single clinician with the assistance of paraprofessionals, teachers, or family members, which allows wide application of this protocol in societies with few mental health professionals. Despite the challenges involved in conducting structured research in the chaos of disasters and war, controlled research is needed to establish the efficacy of this intervention.

## References


Adúriz, M. E., Knopfler, C., & Bluthgen, C. (2009). Helping child flood victims using group EMDR intervention in Argentina: Treatment outcome and gender differences. *International Journal of Stress Management, 16*(2), 138–153.

Artigas, L., Jarero, I., Mauer, M., López Cano, T., & Alcalá, N. (2000, September). *EMDR and traumatic stress after natural disasters: Integrative treatment protocol and the butterfly hug*. Poster presented at the EMDRIA Conference, Toronto, Ontario, Canada.

Cohen, M., Fojt, D., & Wagner, J. (2008). A systematic, integrated behavioral health response to disaster. *International Journal of Emergency Mental Health, 10*(3), 219–223.

Errebo, N., Knipe, J., Forte, K., Karlin, V., & Altayli, B. (2008). EMDR-HAP training in Sri Lanka following the 2004 tsunami. *Journal of EMDR Practice and Research, 2,* 124–139.

Everly, G., & Mitchell, J. (2008). *Integrative crisis intervention and disaster mental health*. Ellicot City, MD: Chevron.

Fernández, I., Gallinari, E., & Lorenzetti, A. (2004). A school-based intervention for children who witnessed the Pirelli building airplane crash in Milan, Italy. *Journal of Brief Therapy, 2,* 129–136.

Gelbach, R., & Davis, K. (2007). Disaster response: EMDR and family systems therapy under communitywide stress. In F. Shapiro, F. W. Kaslow, & L. Maxfield (Eds.), *Handbook of EMDR and family therapy processes* (pp. 387–406). New York: Wiley.

Grainger, R. D., Levin, C., Allen-Byrd, L., Doctor, R. M., & Lee, H. (1997). An empirical evaluation of eye movement desensitization and reprocessing (EMDR) with survivors of a natural disaster. *Journal of Traumatic Stress, 10,* 665–671.

Jarero, I., Artigas, L., Lopez-Lena, M. (2008). The EMDR integrative group treatment protocol: Application with child victims of mass disaster. *Journal of EMDR Practice and Research, 2,* 97–105.

Jarero, I., Artigas, L., & Hartung, J. (2006). EMDR integrative group treatment protocol: A post-disaster trauma intervention for children and adults. *Traumatology, 12,* 121–129.

Jones, R. (1997). Child's reaction to traumatic events scale (CRTES). In J. Wilson & T. Keane (Eds.), *Assessing psychological trauma and PTSD*. New York: Guilford Press.

Korkmazlar-Oral, U., & Pamuk, S. (2002). Group EMDR with child survivors of the earthquake in Turkey (ACCP Occasional Papers Series No. 19). Academy of Child & Adolescent Psychiatry (1998). *Journal of the American Academy of Child and Adolescent Psychiatry, 37,* 47–50.

Norris, F., Murphy, A., Baker, C., & Perilla, J. (2004). Postdisaster PTSD over four waves of a panel study of Mexico's 1999 flood. *Journal of Traumatic Stress, 17,* 283–292.

Schubert, S., & Lee, C. W. (2009). Adult PTSD and its treatment with EMDR: A review of controversies, evidence, and theoretical knowledge. *Journal of EMDR Practice and Research, 3*(3), 117–132.

Shapiro, E. (2009). EMDR treatment of recent trauma. *Journal of EMDR Practice and Research, 3*(3), 141–151.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing. Basic principles, protocols, and procedures* (2nd ed.). New York: Guilford Press.

Wilson, S., Tinker, R., Hofmann, A., Becker, L., & Marshall, S. (2000, November). *A field study of EMDR with Kosovar-Albanian refugee children using a group treatment protocol.* Paper presented at the annual meeting of the International Society for the Study of Traumatic Stress, San Antonio, TX.

Zaghrout-Hodali, M., Alissa, F., & Dodgson, P. (2008). Building resilience and dismantling fear: EMDR group protocol with children in an area of ongoing trauma. *Journal of EMDR Practice and Research, 2,* 106.