FACTORS IMPACTING CLINICIANS USE OF EMDR

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Research[1] has demonstrated that there are three challenging contributors to new trainees not using their EMDR basic training: 1) struggling to introduce EMDR therapy to their clients; 2) coping with unexpected and intense trauma reactions during treatment; and 3) lack of adequate EMDR consultation when stuck. This second blog post will suggest how to cope with the intensity that often comes up in trauma treatment.

2) COPING WITH UNEXPECTED AND INTENSE TRAUMA REACTIONS DURING TREATMENT

If you have extensive training in trauma and dissociation, you are ahead of the curve in your use of EMDR therapy. Many graduate programs do not teach about these issues. If you are not trained in handling dissociation, you may not have seen anything like the kind of reaction a client might have in your office when they are triggered. You may not know how to respond. What if the client appears vacant or becomes unresponsive? Some things you see may be puzzling, and some might be frightening. The client's reactions give us information about the issues that need to be treated. However, if we are triggered ourselves, it's very difficult to make an appropriate assessment and treatment decision.

A client is triggered when they are reminded of an unprocessed traumatic memory by an associated component, such as the emotion, sensations, thoughts, image/sound/smell/sensory element, etc., from the past experience. When triggered, the brain "flips its lid," as described by Daniel Siegel's explanation[2] of the triune brain. The client may be triggered in your office, and the first goal is to get their "brain's lid" (aka, the prefrontal cortex) back online. Multiple grounding/state-change/containment exercises are available for the clinician teach the client and help the client practice during and between sessions. These skills include breathing, feet on the floor, 5-4-3-2-1, visualizations, the Four Elements, 4-7-8 breathing, etc. Only when the client's prefrontal cortex is back online can the client be in the present moment and out of the fight/flight/freeze response. Preparing and practicing these resources and skills in advance of processing trauma is part of Phase 2 of EMDR therapy and is also called "front-loading" resources.

If the client is dissociative, the clinician have taught strategies that the clinician can walk them through to connect to the parts that are dissociating or bring the client back to the present moment. Clients will be asked to practice grounding and soothing skills to return to the present moment. If the client has a more serious and intrusive dissociative disorder, the dissociation should be treated first. The clinician needs to have a conversation with the client dissociation, educate them on what is happening when they dissociate, and conduct a full assessment of the dissociative symptoms to ascertain the client's level of dissociation and if they meet diagnostic criteria for a disorder. The clinician should have more training in treating dissociation than was likely discussed during their graduate degree program and should learn enough to treat the dissociation. The client's symptoms can become stable enough to allow trauma processing but not likely eliminated, so they must be appropriately managed. Treating the dissociation is required prior to any trauma processing, including EMDR therapy.

Training in the treatment of dissociation may be found through the International Society for the Study of Trauma and Dissociation (ISSTD.com). Many training courses are available to learn how to integrate EMDR therapy in the treatment of those with serious dissociative disorders. Approved training courses also may be found at EMDRIA.org.

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[1] Grimmitt, J. & Galvin, M. (2015). Clinician experiences with EMDR therapy: factors influencing continued use. *Journal of EMDR Practice and Research*, 9(1), 3-16.

[2] Siegel, D. (2011). *Mindsight: The New Science of Personal Transformation.* Bantam Books: New York, NY.