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What does embedding EMDR actually mean? And when/why/how does one embed?

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Sheffield

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- Shapiro
- Embedding?
- EMDR Association accreditation criteria
- EMDR or TF CBT or Both?
- Outcome data: 700 referrals for PTSD treatment
- Case studies
- Small group discussions and recommendations

What is embedding?

- fix (an object) firmly and deeply in a surrounding mass: he *had an operation to remove a nail **embedded in** his chest; : to **embed stones** in cement.*
- **implant** (an idea or feeling) so that it becomes ingrained within a particular context: *the Victorian values **embedded in** Tennyson's poetry*
- to **incorporate** or contain as an essential part or characteristic: *A love of colour is **embedded** in all of her paintings*

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Case study

Female 45, fearful accident. PTSD, no physical injury – 12 sessions. 6 TF CBT for preparation and emotional regulation, 6 EMDR for dealing with the trauma

Excellent outcome, PTSD resolved and anxiety in the normal range

Why are we concerned about how/why/when we embed?

"Genuine science is not a craving to be correct, but rather a *craving to learn where we are wrong so that our errors can be eliminated. It is through error elimination that knowledge grows*. Thus, the best and most efficient way of rooting out error in our beliefs is to expose them to severe criticism and strong empirical tests"

- (Borkovec & Bauer, 1982; Borkovec & Castonguay, 1998; Hazlett-Stevens & Borkovec, 1998; Platt, 1964).

" Severe criticism is manifested in the use of rigorous methodological controls so that one does not make the mistake of believing that the therapy causes improvement when it does not"

We want to be able to show that what we do in EMDR has a scientific grounding and not be accused of being a "pseudo-science"

SCIENCE AND PSEUDOSCIENCE IN THE DEVELOPMENT OF EYE MOVEMENT DESENSITIZATION AND REPROCESSING:IMPLICATIONS FOR CLINICAL PSYCHOLOGY
James D. Herbert et al. Clinical Psychology Review, Vol. 20, No. 8, pp. 945–971, 2000

Counselling psych's "embedding strategy":

RTA in person with no pre-morbid problems: 1 session EMDR; 10-11 CBT

RTA in person with pre-morbid trauma: 2-3 sessions EMDR; 8-9 CBT

EMDR Association UK and Ireland: requirement for practitioner accreditation

- Supervisee demonstrates an understanding of PTSD and traumatology

- Supervisee demonstrates an understanding of using EMDR as part of **a comprehensive therapy intervention**

EMDR Association UK and Ireland: requirement for Consultant accreditation

- **Focuses in supervision on following issues: (excerpt)**
- **Acknowledge recognition to other approaches or treatment plans and interventions**
- Demonstrate an ability to answer supervisees' questions effectively, considering the following:
  - Explore and clarify the question
  - Answer from a theoretical background
  - Answer on a practical level
  - Give specific hints and suggestions for specific case
  - Teach about differential diagnosis **and / or alternative treatments**

Case Study

Female, 32. Severe PTSD and co-morbid depression. Death of a child after road accident. 14 sessions of 'EMDR and CBT'. Session 1, 2, 3, 4 desensitisation (Phase 4). Client refused to attend further sessions with that clinician or ever having EMDR again

- Moving Minds Psychological Service Provider
- Bulk referrals from Insurers, Law Companies, Employers for assessment and treatment
- Moving Minds does not influence treatment recommendations, the assessing clinician (internal or external) makes treatment recommendations

Outcome data: Sample of referrals for PTSD 2005-2011

- 2005 - when NICE Guidelines for treatment of PTSD were published

- The first 100 referrals as of 1 January every year with diagnosis of PTSD included in sample between 2005 and 2011

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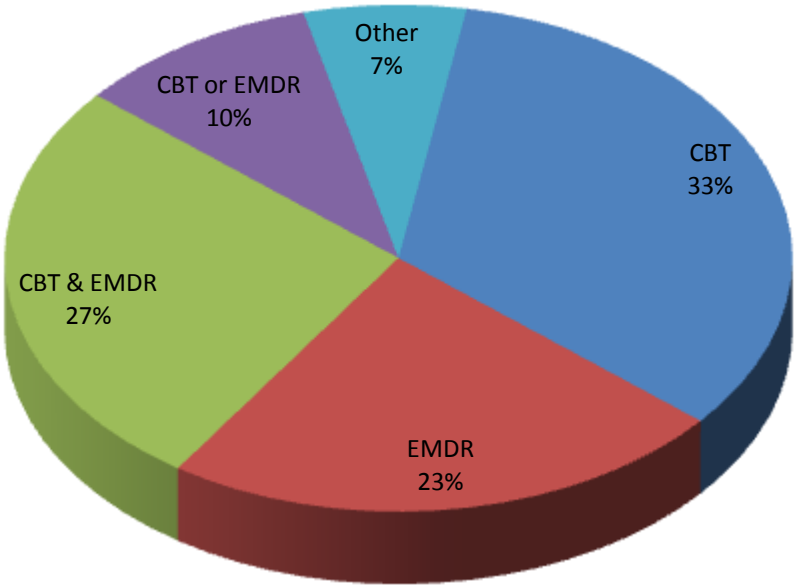
Before March 2005... Pre-NICE



CBT most recommended treatment (33%) in 2005 before NICE recommended EMDR and Trauma Focused CBT as treatments of choice for PTSD.

23% of clinicians recommended EMDR.

27% recommended combination of CBT and EMDR

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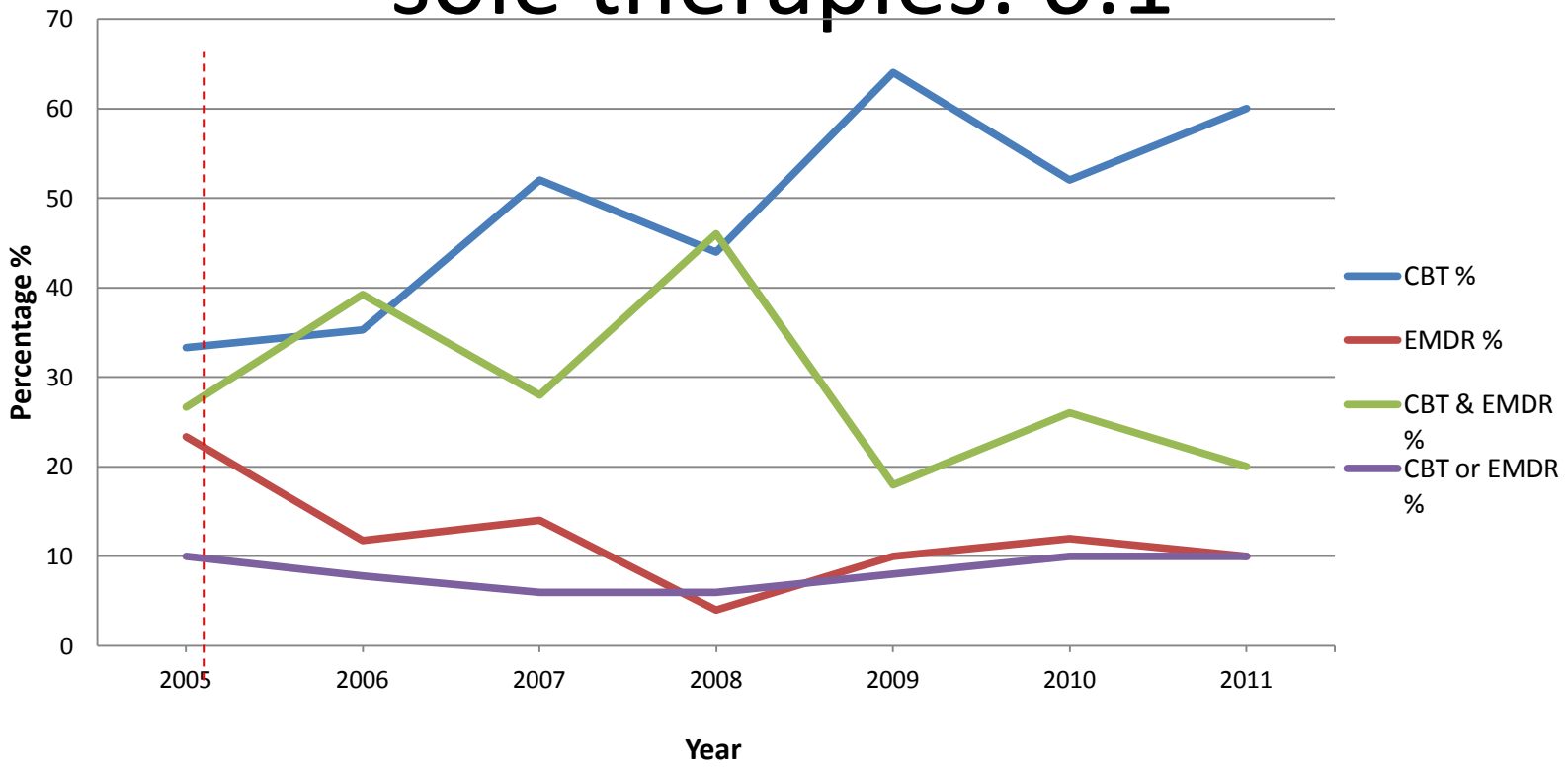
2011: Ratio between CBT and EMDR as sole therapies: 6:1



The graph demonstrates that recommendations for CBT treatment has been on the increase, while recommendations for EMDR is declining

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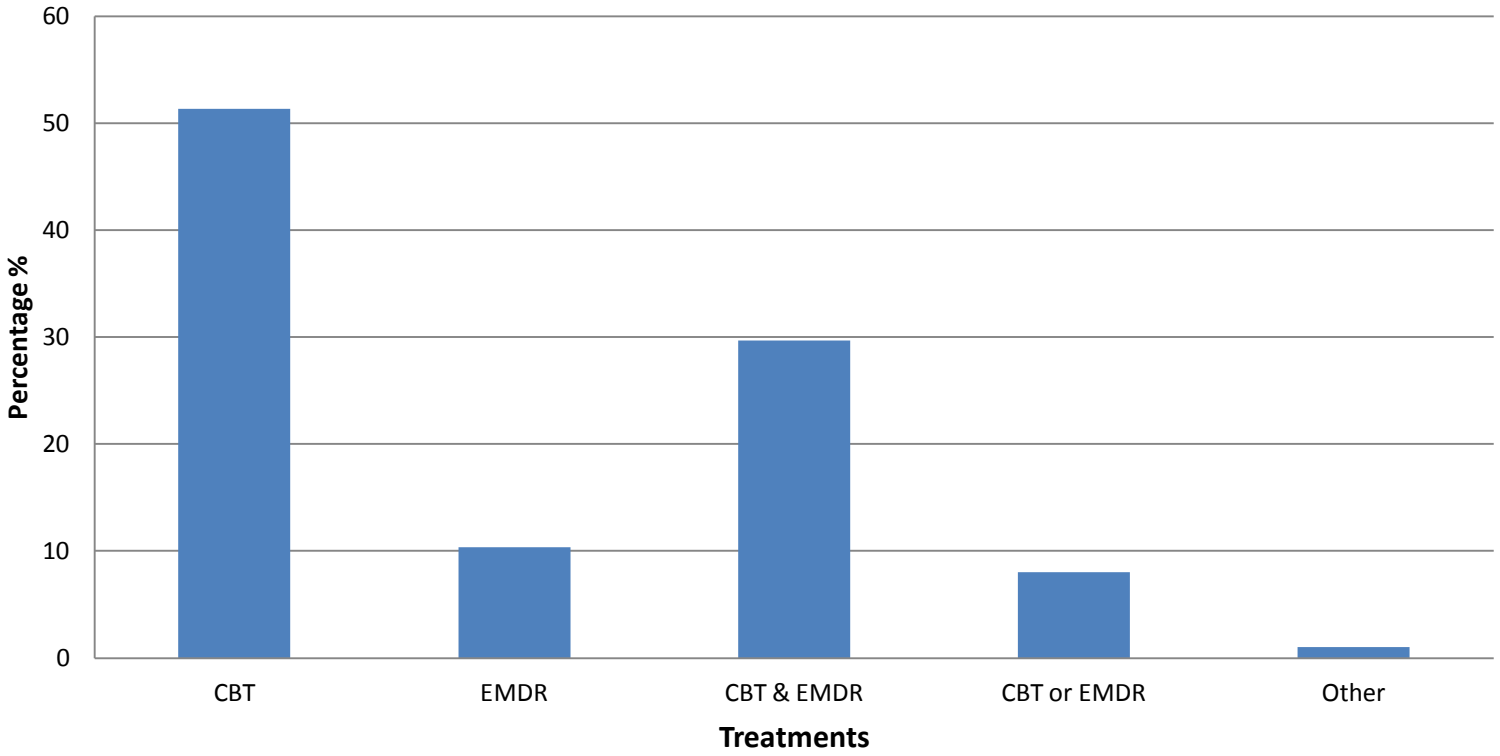
Summary



CBT is the most recommended treatment for patients with PTSD, regardless of the year. However there is also a rise in CBT being recommended in combination with EMDR. On the contrary, EMDR does not appear to be recommended as the first line of treatment and this trend is growing

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EMDR as a sole treatment:

Clinical Psychologists

Counselling Psychologists

Psychotherapists

“EMDR Therapists”

Case Study

64 year old man, lost wife and then was assaulted 6 months after. PTSD and still grieving

12 sessions of CBT recommended. After session one, refused to return or have further treatment

Clinician reported that client was so clearly traumatised that assault targeted in session 1 with Phase 4 of EMDR without safe place “to get it over with quickly”

2004: 540 individuals with PTSD

"Switching" took place when one treatment approach did not seem to work midway through treatment

This did not improve treatment outcome

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Clinical Examples of recommendations for PTSD (N – 300)

- 10% - 2 sessions of EMDR; 10 sessions of CBT
- 20% - 6 sessions of EMDR; 6 sessions of CBT
- 40%- Between 2 and 6 sessions of EMDR, remainder CBT
- 25% - 3 sessions of EMDR, remainder CBT
- 5% - 1 session of EMDR, remainder CBT

Case Study

Unstable young male who self harmed.

Accident at work, hospitalisation for 4 weeks due to physical injury. PTSD and problems with containing anger

14 sessions of TFCBT and EMDR. 10 sessions of (non TF)CBT to assist with impulsivity and negative thinking followed by 4 sessions of EMDR

Good outcome

Should embedding be random/ spontaneous/intuitive or part of treatment planning and goal setting?

Guidelines for how and when to ‘embed’ and how to develop these?

Small Group Analysis and Recommendations

1. What are the advantages of 'embedding' EMDR into other therapies?

2. What are the disadvantages of "Embedding" for a) the client and b) the future of EMDR as an independent, developing treatment?

3. What are the clinical indications for "Embedding?"

4. On what basis is the decision made for the number of sessions from each treatment approach?

5. Which of the 8 phases are more likely to benefit from Embedding, and how is that decision made?

6. Is "Embedding" eroding away EMDR as a free-standing therapy?

7. Is Embedding Desensitisation?

8. Think of a treatment plan, past, present, future for a person with PTSD which only includes EMDR strategies

Summary

- There is a strong and growing trend for TFCBT to be recommended above EMDR for PTSD
- Clinicians do not seem to have the confidence to use EMDR independently?
- This has strong implications for strategic planning
- In the UK and I there is an urgent need for a more thoughtful investigation of the way CBT and EMDR could be integrated and, indeed, whether this is needed.

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