

# EMDR and temporary assistance to needy families (TANF) Recipients:

## A case study of trauma treatment in the home

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### Author's Introduction

*This article, in case study format, seeks to expand how we think about and use EMDR in agency and community mental health settings. EMDR has been slow to grow in agency settings, and this article challenges the stereotype that EMDR is impractical in community mental health settings by describing the use of EMDR in a time-limited, home-based, solution-oriented framework within a non-profit community family service agency. The client was a Temporary Assistance to Needy Families (TANF) recipient who had been the victim of domestic violence and who had developed post traumatic stress disorder.*

In 1996, President Clinton signed The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) into law. This legislation repealed, replaced, and amended several major public assistance programs. Temporary Assistance To Needy Families (TANF) replaced the Aid to Families with Dependent Children (AFDC) program; while this landmark legislation was created to provide financial assistance to eligible families, it placed a much stronger emphasis on work. Temporary Assistance To Needy Families (TANF) recipients have a lifetime maximum benefit of five years of public assistance.

As result of domestic violence, many TANF recipients present with posttraumatic stress disorders (PTSD) and other anxiety disorders, as well depressions, and agoraphobias. (According to Kimberly Shepard, Director of Job Readiness Services at Familystrength, “20-40% of clients report a history of domestic violence, either at intake or during the counseling”.) Their unresolved histories of family violence have created barriers to their being able to meaningfully participate in the supports and programs that could help them achieve employment and self-sufficiency. These families often feel trapped in the public support system, while their five-year limit for benefits simultaneously wind down.

Public policy in New Hampshire provides a wide array of services to help TANF recipients move from public assistance to self-sufficiency. For the past three years, one of these programs has been is in-home, strength-based and solution-oriented counseling provided by Familystrength, a state-wide, non-profit agency in 12 sites, with a staff of 100, which provides brief treatment (35 hours) to families who can design with their family counselor the frequency and intensity of services.

When the case starts, the Familystrength counselor meets with the family at home to assess the situation, design a service plan and implement services. If a trauma is identified then EMDR is discussed with the client, and if the client elects to use EMDR, it will be offered in the home environment. A home-based psychosocial assessment allows the client to feel comfortable in their own home and will minimize professional distance and the power differential between counselor and client. The home is a rich source of assessment information – neighborhood environment, family pictures, natural family relationship patterns, extended family, friends and even the physical environment of the home.

While counselor and client sit at the kitchen table, the assessment can proceed at a natural pace – often over a cup of coffee or tea. This informal relationship building process allows the client to evaluate the family counselor and provides ample opportunities to review all informed consent materials. The client can then make an informed decision if they want to continue with the counseling process – to “hire or fire”. Many clients have strong feelings about the social service system and need to relate their feelings of frustration, anger or disempowerment. If this process is adequately addressed, it sets the stage for an engaged consumer who becomes an active collaborator in the design of their service plan.

The service plan helps to clarify in writing the goals, steps and objectives of the counseling process. Once the client identifies trauma and elects to use EMDR, a second informed consent process takes place. While seated at the kitchen table, the client reviews a written description of EMDR and learns what to expect in the treatment process. The clinical work is designed to reduce or eliminate the barriers that prevent the client from making progress toward making use of employment supports, education and obtaining a job. Scaling questions, using a “0 to 10” scale, are used to evaluate the progress that is made towards the achievement of individualized goals.

EMDR in the home provides both opportunities and challenges! Most clients feel more comfortable working on trauma in the safety of their own home. Some have used office-based services in the past and prefer the informality of the home setting. Before home based EMDR can proceed, clients must be able to distance themselves from the batterer, have an effective safety plan in place and not currently be in an abusive relationship. Home-based service resolves the issue of transportation and minimizes the occurrence of missed appointments. However, clinicians must be able to help the family set some boundaries around the treatment process and yet retain the flexibility and comfort of the home setting. This may include counselors creatively not answering the doorbell/phone, ensuring adequate privacy, establishing norms about involvement of family members, making friends with the family dog and being flexible about the beginning and ending time of sessions in the home. In some cases it has been necessary to conduct EMDR in alternative setting to the home – community agency, office setting, etc.

Clients can be seen for two-hour appointment twice a week or perhaps a one and one half hour appointment every other week. (Some families elect to use this latter schedule either because of their rural location and/or as a way to maximize the time interval over which a set number of sessions can be provided.)

Because clients are active participants in the design and monitoring of the available treatment time, more positive outcomes are generated.

A case example will help to illustrate the power and effectiveness of using home based EMDR with TANF families:

Paula Raymond is a twenty eight year old single parent and lives with her six year-old son Jake. She is an attentive parent who relates to her son in a positive manner. She was referred for home-based counseling by her New Hampshire Employment counselor, with the goal of identifying the barriers that were preventing her from becoming and remaining employed.

Ms. Raymond has been separated from the father of her son for over three years. They separated due to domestic violence, which included assaulting her in front of their son on several occasions and stalking her in the community. Paula served her former boyfriend with a restraining order. In addition, he was convicted of domestic assault and served time in jail. Jake's father lives out of state and has very little contact with his son.

Paula attended outpatient counseling in the past, to work on issues related to the trauma and anxiety that she experienced subsequent to the domestic violence. She reports that the counseling did not alleviate her anxiety and fear concerning her personal safety in public settings. This fear has prevented her from taking sufficient advantage of work training and work opportunities in her community.

During the first home-based appointment, Ms. Raymond shared information freely, completed a family genogram and expressed interest in the use of EMDR. However, she did state that she thought EMDR "was a little weird" and she was somewhat skeptical. The brief treatment, 35 maximum hour model was reviewed and a frequency plan for sessions was discussed. Ms. Raymond appreciated the opportunity to design the frequency and length of the sessions and stated: "this is great...it actually fits with my schedule".

In the second session, at the kitchen table, a service plan was developed. Ms. Raymond shared that she was comfortable and found it much easier to meet in her home, than in an office. She decided to go forward with the counseling, actively participated in planning her treatment, and additionally, she gave permission for all in home sessions to be videotaped.

Ms. Raymond described symptoms connected to the repeated violence by her former boyfriend which met the diagnostic criteria for PTSD ( including: currently experiencing high anxiety, intrusive memories, heart palpitations, scanning of the environment, psychological distress during cue events, hypervigilance and sleep difficulties).

Three solution-oriented objectives were jointly developed by Paula and her home based family counselor, as a part of the service plan: 1. Assess present strengths and family supports, 2. Develop simple relaxation techniques, and 3. Target uncomfortable memories and feelings about domestic violence via EMDR.

Then a series of steps were crafted and implemented:

- Learn and apply "safe place visualization"
- Use EMDR to resolve traumatic memories – Subjective Units of Disturbance Scale (SUDS) will be a zero
- Practice progressive relaxation – audio tape provided by family counselor
- Increase frequency of work lunch contacts at her job training site to develop greater comfort with socialization
- Meet jointly with Wanda Elton, New Hampshire Employment Program counselor to assess progress
- Maintain a journal
- Maintain contact with her Familystrength family counselor, in between appointments, via a paging system.
- Continue with job search activities

She identified the worst picture of the first target event as being her boyfriend “swinging his hand toward her face”. The Negative Cognition was “It’s my fault” and the Positive Cognition was “I did the best I could”. The Validity of Cognition was a “2”. On the Subjective Units of Disturbance Scale she picked “10”. Her emotions included both “fear and anger”. The location of body sensations of the event include both a tingling in her upper chest and on the left side of her face.

Ms. Raymond made excellent progress and used EMDR during five of her appointments! She was relaxed in her home and indicated that she felt safe there.

The processing moved at a consistent pace with a significant amount focused on her body reactions during the treatment. The tension in her chest consolidated to the middle of her chest, split into two “streams”, went to her shoulders, down her arms, pooled in her palms and finally “shot out of her fingers”. While the client initially found this difficult to describe, as processing continued she became more and more able to accurately verbalize her experience. “This stuff is weird, but I feel better” she said.

By the end of treatment, the Subjective Units of Disturbance had dropped to a “0” and the Validity of Cognition “I Did the Best I Could” was a “7”. The tingling in her face turned out to be related to the memory of being punched by her boyfriend. While initially uncomfortable with this insight and feeling, she courageously stayed with processing and this sensation diminished and then was eradicated. She was surprised by the consistent desensitization and how quickly she became more comfortable at her job-training site and pursuing training activities. She started to be active in the community, was more social in her neighborhood and felt safe when she ventured outside of her home. A planned termination was scheduled - a total of 23 brief treatment hours were used, fewer than the allotted 35 hours.

Ms. Raymond also evaluated her progress by using a written numerical, scaled response, tool, which helps Familystrength counselors obtain better treatment and termination feedback from families. The development of this tool was influenced by the work of Insoo Kim Berg, MS. (Ms. Berg is the Executive Director of the Brief Family Therapy Center in Milwaukee and co-developer of the solution- focused brief therapy model.) The scale starts at number “1” (goal unmet), “6” is mid point, “10” is goal met and “11” is goal exceeded. One goal was to “develop simple relaxation techniques”. This goal she scaled at number “10”, goal met. The second goal evaluated was “target uncomfortable memories/feelings about domestic violence via EMDR.” Ms. Raymond scaled this goal at number “11”, goal exceeded. Her comments about EMDR included: “It was very helpful” and “I recommend it to others”. A final case-planning meeting was held with Ms. Raymond, Wanda Elton, the New Hampshire Employment Program counselor and the family counselor. Ms. Raymond and the family counselor jointly presented the progress that Paula made during her counseling and this included showing one of the videotapes of home-based, EMDR sessions!

EMDR and home-based counseling are a powerful combination to use in community mental health practice. This innovative service offers TANF recipients an opportunity to receive cutting edge services, use brief treatment effectively, resolve specific barriers to employment and leave the public support system for meaningful employment. ❖

## **Resources**

Shapiro, F. (1995). Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols and Procedures (2<sup>nd</sup> ed.). New York, Guilford Press.

The EMDR Institute, [www.EMDR.com](http://www.EMDR.com)

Berg, I. K. (1994). Family Based Services. W.W. Norton.

Brief Family Therapy Center, [www.brief-therapy.com](http://www.brief-therapy.com)

## **About the Author**

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