Eye Movement Desensitization and Reprocessing (EMDR) Therapy

THIRD EDITION

Basic Principles, Protocols, and Procedures

Francine Shapiro



ebook

THE GUILFORD PRESS

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In memory of my grandparents,
Charles and Lena Sumner;
my parents, Daniel and Shirley Shapiro;
and my sisters, Debra and Marion

With gratitude for the
guiding lights of each generation
and for the loving support of my husband,
Bob Welch, one of my life's greatest blessings

Freedom is what you do with what's been done to you.
—Jean-Paul Sartre

About the Author

Francine Shapiro, PhD, the originator and developer of EMDR therapy, is Senior Research Fellow Emeritus at the Mental Research Institute in Palo Alto, California; Executive Director of the EMDR Institute in Watsonville, California; and founder and President Emeritus of the Trauma Recovery/EMDR Humanitarian Assistance Programs, a nonprofit organization that coordinates disaster response and pro bono trainings worldwide. She is a recipient of the International Sigmund Freud Award for distinguished contribution to psychotherapy, presented by the City of Vienna in conjunction with the World Council for Psychotherapy; the Award for Outstanding Contributions to Practice in Trauma Psychology from Division 56 of the American Psychological Association; and the Distinguished Scientific Achievement in Psychology Award from the California Psychological Association. Dr. Shapiro was designated as one of the "Cadre of Experts" of the American Psychological Association and the Canadian Psychological Association Joint Initiative on Ethnopolitical Warfare and has served as advisor to a wide variety of trauma treatment and outreach organizations and journals. She has been an invited speaker at psychology conferences worldwide and has written and coauthored more than 90 articles, chapters, and books about EMDR.

Preface

Blessed is he who has found his work;
let him ask no other blessedness.
—THOMAS CARLYLE

THE PATH OF DISCOVERY

The opportunity to introduce another edition brings to mind again a statement by the early philosopher Heraclitus: "You cannot step twice into the same river, for different and ever different waters flow down." This edition marks 30 years since I made the initial observation that led to the development of Eye Movement Desensitization and Reprocessing (EMDR) therapy, which is now internationally recognized as an empirically supported treatment for trauma. Since the early days of controversy over the effects of the eye movements, more than 30 randomized studies have verified their effects, and hundreds of published peer-reviewed articles have documented positive treatment effects for a wide range of populations. Given the ever-changing nature of health care, life, and thought, it is gratifying to see that most of the book has remained relevant to clinical practice. It has aged well.

At the same time, this revision has given me an opportunity to offer the latest theory and research governing EMDR therapy practice, to expand information on the treatment of various populations, and to describe additional procedures and protocols that have proven to be valuable additions to clinical practice. The extensive controlled research on EMDR therapy has been updated, and additional areas of potentially useful investigation are suggested. New appendices include a variety of clinical aids for both the practicing therapist and researcher, including questionnaires, forms, checklists, and treatment transcripts.

It has also been gratifying, over the last 15 years, to witness throughout the professional community practicing EMDR therapy the sustained international commitment to the healing of suffering. In fact, the first edition of this text appeared only a few days after the Oklahoma City bombing. At the request of an FBI agent who had undergone EMDR treatment, volunteers traveled at their own expense to offer assistance to the traumatized community. Those Oklahoma clinicians who had already been trained in EMDR opened their offices and spread word of the opportunity throughout the area. Over the subsequent 4-month period, two to three EMDR clinicians per week traveled to Oklahoma and offered pro bono services to those in need, starting with the traumatized mental health professionals, who then requested services for the frontline providers and survivors. At the end of the 4 months, a pro bono course of training was offered to all licensed mental health professionals in Oklahoma City, enabling them to continue the work. This spontaneous outpouring of service marked the inauguration of the Trauma Recovery/EMDR Humanitarian Assistance Programs (see Appendix F), emphasizing the need to combine scientifically evaluated treatments with heartfelt clinical service worldwide. Additionally, over the last decade, humanitarian projects from numerous local and national EMDR organizations have offered pro bono treatment after natural and human-made disasters. Research has supported the efficacy of the protocols used in these efforts, and they are described in later chapters. Clinicians are urged to learn the procedures and protocols to aid in relief efforts both domestically and internationally. As we join together and expand our efforts in this global commitment, we can truly fulfill our obligation as a profession.

To repeat my statement from the previous edition: We went from Kitty Hawk to the moon in little more than 50 years. Yet despite such monumental technological advances, millions of people suffer unremitting pain, and a cycle of violence continues unchecked worldwide. Surely, as a society, we need to redirect more of our vast resources and pay greater attention to the alleviation of global suffering. Surely we need to change our level of expectations regarding the potential for healing and interpersonal development. But part of the problem may also be caused by a variety of attitudes inherent within our profession. Although the integration of knowledge in the hard sciences has allowed for continued developments and refinement of applications, which have moved rapidly from Edison to the Internet, the field of psychotherapy has somehow not kept pace. The reason may be an insufficient sharing of information across disciplines. For despite the advent of many new psychological orientations, each has remained relatively distinct over this past century, with little cross-fertilization even between science and practice. A lesson may be that the psychological treatment of individuals demands a composite of knowledge from various approaches. I align myself fully with those who

believe that we strengthen clinical repertoires through integration, not through displacement or exclusion (Beutler, 2009; Beutler, Someah, Kimpara, & Miller, 2016; Norcross & Goldfried, 2005; Norcross & Shapiro, 2002; Stricker, 2010).

In this spirit, the development of EMDR therapy over the past 30 years has moved it from a simple technique to an integrated psychotherapy approach. Therapeutic applications have expanded from the treatment of posttraumatic stress disorder to a wide range of clinical complaints. Also, as we shall see, the emphasis is on not only the elimination of overt suffering, but also attention to the comprehensive clinical picture that incorporates multifaceted personal growth and integration into the wider social systems. For that reason, clinicians of all orientations will find commonalities between EMDR therapy and their clinical practices, as well as complementary aspects of other disciplines that may enhance their work. I believe it is in this synthesis that clients can best be served.

I made the initial observation that led to the development of EMDR therapy in 1987. However, the path to that discovery had begun nearly 10 years earlier. In 1979, I was completing a doctorate in English literature at New York University and had already published extensively in that field. I felt that this was important work; to be one of those who shed light on our culture and literature—with its delicate nuances, rich textures, and the intricate lives of characters—held me in constant fascination.

At the same time, I had long been interested in behavior therapy, owing to my early readings of Andrew Salter and Joseph Wolpe. The idea of a focused, predictable, cause-and-effect approach to human psychology seemed fully compatible with the concepts of literary character and plot development. After all, many well-known authors had intimated that if characters are drawn true to life and set loose, they then create their own plots. I had fascinating discussions with my English professors on the interaction between the multifaceted texts I was reading and the physiological cause-and-effect implications of behavioral formulations. But psychology was only a side interest of mine. I held staunchly with those authors who believed in the perfectibility of humankind. I reveled in the glory of human suffering transformed into art via the masterworks of English literature, and I looked forward to a long and fruitful career as a literary critic and scholar. Then, right before launching into my dissertation on the poetry of Thomas Hardy, I was diagnosed with cancer.

When a potentially fatal disease strikes, it can be a watershed that marks a change in the course of one's life. For me, time took on a new dimension. Life no longer stretched out endlessly before me. Suddenly, the behaviorists' "physiological cause and effect" took on new meaning. I became focused on the interplay of mind and external stressors. I also wondered why we had come so far technologically yet seemed unable to advance in ways to master our own minds and bodies.

Fortunately, I discovered the works of Norman Cousins and others in the field of psychoneuroimmunology, which was just emerging. The idea that there is a connection between disease and stress seemed obvious to me, but what to do about it was another matter. By this time, according to my physicians, my cancer was cured, but there was no guarantee it wouldn't happen again. I remember their communication to me as something like this: "Your cancer is gone, but *X* percent get it back. We don't know who and we don't know how, so good luck."

Now the question of which psychological and physiological methods actually worked to enhance physical health became primary. I believed there had to be some useful psychological and physiological approaches already developed, but why weren't they well known? Suddenly, finding these methods and disseminating information about them to others with life-threatening illnesses became more important to me than studying and communicating about 19th-century literature. I left New York in search of workshops and seminars on mind, body, and psychological methods to enhance physical and mental well-being.

After a while, I sponsored workshops myself for the general public on everything I found that offered tangible ways to help people lead less stressful lives. During that time, I also enrolled in a doctoral program in clinical psychology to complete my formal education. The eventful walk in the park that led to the discovery of the effects of the eye movements occurred just as I was beginning to look for a dissertation topic. In that single moment, my cross-country search for mechanisms of mental change and my need for a doctoral research project neatly converged.

The rest of the story of the development of EMDR is covered in Chapter 1. For now, suffice it to say that my discovery of the effects of the eye movements was followed by the development of a methodology that grew rapidly in complexity and application. Over the past three decades, positive clinical results with EMDR therapy have been reported consistently by the clinicians who have been trained in its use. Our clinical work with EMDR therapy shows us that suffering can be transformed—not only into art but into life.

This book is a product of 30 years of personal experience refining and teaching EMDR, as well as input from numerous seasoned clinicians and researchers; it includes research-based recommendations and case histories, as well as cautions derived from the experience of EMDR-trained practitioners.

THE NEED FOR TRAINING

Because the emphasis of my life since 1979 has been on learning, developing, and disseminating procedures that work to enhance mental health, it is no surprise that my primary concern now is with the client. Clients

are best served by clinicians who are guided by research and are willing to learn, expand their skills, and experiment with innovative methods. They are also clearly best served when clinicians are licensed in the field of mental health and trained in the therapies they are using, and when adequate research is done to validate and improve upon those methods. These beliefs are at the heart of EMDR therapy and are the foundation on which EMDR therapy's success—as well as its training policies—has been built. I have been blessed to have met many clinicians and researchers who share these beliefs.

EMDR therapy trainings are available worldwide through universities and freestanding postgraduate organizations. Clearly, they are not all equally thorough, so clinicians should refer to Appendix F for guidance. An explanation of EMDR training policies is the subject of a position paper of the original EMDR Professional Issues Committee, included in Appendix E, and specific parameters can be reviewed on the website (*www.emdria.org*) of the EMDR International Association (an independent professional association that oversees training and clinical practice in North America). EMDR research has demonstrated a correlation between treatment fidelity and positive clinical effects (Maxfield & Hyer, 2002) and, clearly, supervised training is the best way to achieve that goal. The rest of the rationale for these policies springs from logic and compassion. A survey of the first 1,200 clinicians trained in EMDR therapy indicated that only 2% considered the supervised training unnecessary. Moreover, results of this survey (which were reproduced in Appendix D of the 1995 edition; Lipke, 1994, 1995) indicated that 85% of the clinicians found that clients had more highly charged and previously forgotten memories emerge with EMDR than with any other methodology practiced at the time. The reasons for this phenomenon, which helps illuminate the very nature of psychopathology, are fully explained in this text, and when appropriately handled, the memories are quickly resolved. However, it seems reasonable to conclude that if dysfunctional memories emerge from EMDR sessions, complete with a possibly high level of disturbance, clinicians should be fully educated in the methodology that precipitates these memories and has the potential to resolve them. To reiterate more succinctly, clients are best served if their clinicians are trained. The clear objective is helping people.

Of course, training does not ensure success with every client. EMDR therapy is not a cure-all; treatment failures occur, as they do with any form of psychotherapy. However, the American Psychological Association ethics code states that training and supervision are necessary for a clinician to achieve competency before treating clients or doing research. Adequate training means greater likelihood of success—and less likelihood of harm. Therefore, although this book provides the necessary written instructions to begin using EMDR therapy, it should be employed in conjunction with appropriate supervision and training. I repeat this refrain throughout the text.

PRINCIPLES AND PROCEDURES

To paraphrase a well-known proverb, it is better to teach a hungry man how to fish than to give him a fish. Likewise, it is better to provide practitioners with a conceptual framework or model to serve as a guide to their clinical practice than merely to give them inflexible, step-by-step procedures for implementing EMDR therapy. Therefore, along with step-by-step directives, this text offers clinicians a new way of thinking about pathology and therapeutic treatment, in addition to a comprehensive set of therapeutic procedures that have evolved from clinical applications consistent with the theory. Understanding these principles will allow the clinician to customize treatment to the individual needs of each client. This applies whether a client is in the need of rapid treatment for an isolated trauma or comprehensive treatment that addresses the full clinical picture.

One of the basic premises of EMDR therapy is that most psychopathologies are based on early life experiences. The goal of EMDR treatment is to rapidly metabolize the dysfunctional residue from the past and transform it into something useful. Essentially, with EMDR therapy, the dysfunctional information undergoes a spontaneous change in form and meaning—incorporating insights and affect that are enhancing rather than self-denigrating to the client. Clinicians will find that the information covered in this book describes the components and strategies needed to provide effective treatment. These standardized procedures were developed to ensure optimal activation of the client's innate information-processing system and thus achieve full resolution of the presenting problem. The procedures have been widely tested in clinical trials, with consistent results demonstrating their value. A comprehensive meta-analysis (Maxfield & Hyer, 2002) indicated that the more rigorous the EMDR study, the larger the effects. In addition, there was a positive correlation between treatment fidelity and effect size. An important element of rigorous research is the fidelity check, which provides verification that the standardized procedures were properly applied. To that end, a fidelity checklist is included in Appendix C. However, understanding the principles on which the therapy procedures are based fosters appropriate and flexible application.

THE NAME OF THE THERAPY

Although EMDR was initially named for the eye movements, which in 1987 appeared to be the most salient part of the methodology, over the years, the name has appeared to unduly limit the appreciation and application of the approach. As this book indicates, EMDR therapy is a complex methodology that includes many components; in addition, other stimuli besides the eye movements have proven useful. If I had it to do over again, I would name it simply "Reprocessing Therapy." Nonetheless, because of

its extensive worldwide name recognition, I decided to maintain the abbreviation and the original designation, with the understanding that it serves ultimately to be of historical, rather than descriptive, significance. (There are plenty of other such historical names. For example, Coca-Cola was named after a cocaine derivative that was eliminated from the recipe long ago; the diagnostic category of schizophrenia persists even though it is no longer viewed as "split mind"; and American Telephone and Telegraph is still AT&T, though it no longer deals with telegraphs.) The abbreviation EMDR should therefore be used with the understanding that the eye movements are merely one of the bilateral dual attention stimuli used to activate the client's information-processing system and achieve treatment effects.

USE OF THIS BOOK

Only licensed mental health professionals, or those under direct supervision of licensed clinicians, should use the procedures and protocols in this book. This caution is important because, as a complex psychotherapy, EMDR should be used only within the context of a complete and detailed treatment plan, and with the appropriate safeguards that trained and licensed clinicians are schooled to be aware of. Instructors of clinical graduate students will probably want to engage their students in a supervised internship program before teaching the procedures to them. Suggestions for the form and timing of supervised practice in EMDR therapy are included in this book, but in all instances, a formal training course with licensed, trained, experienced EMDR instructors is considered the most appropriate forum for learning the approach. The guidelines for these trainings were originally formulated by the EMDR International Association and are now echoed by regional and national EMDR associations throughout North and South America, Europe, the Middle East, and Asia. All qualified instructors are urged to have their courses duly evaluated and registered with the national association in their area (see Appendix F). With courses thus identified, students and clinicians can best be guided to those that are appropriate, and clients can be assured that they are being provided with appropriate EMDR therapy protocols and procedures. Prospective students of university EMDR courses and private training centers should evaluate their course eligibility through the relevant professional association.

This book has been written with four kinds of readers in mind: academicians, researchers, clinicians, and clinical graduate students. I have attempted to make the language and organization appropriate for all. Those readers especially interested in the history, supportive data, research, theory, and placement of EMDR therapy in the field of trauma therapies will find Chapters 1, 2, and 12 of particular relevance. Although therapists concerned primarily with learning the procedures and protocols will find important clinical material throughout these three chapters (particularly

Chapter 2), such material is most heavily concentrated in the rest of the text.

GENDER

In order to avoid both sexism and the stylistic awkwardness of phrases such as "he or she," the personal pronouns have been alternated throughout the text.

RESEARCH AND EVOLUTION

The continued evolution of EMDR from a simple technique to a complex psychotherapy approach has been based largely on research and clinical observation. The need for controlled research to examine the EMDR therapy approach is indisputable, inasmuch as with any form of therapy, clinical evaluation is susceptible to many of the distortions and fallacies of personal observation. Currently, an extensive base of controlled research has been evaluated by independent task forces (including the World Health Organization and the International Society for Traumatic Stress Studies) and has established EMDR therapy as a standard, empirically supported, and effective treatment of psychological trauma. These studies and those for other disorders, along with research implications and suggestions for further investigation, are discussed in depth in Chapter 12. However, although EMDR therapy appears efficacious for the treatment of a wide variety of experientially based complaints, until extensive comparative research validates this approach for each of the disorders, it should be utilized only with appropriate information provided to the client for the purpose of informed consent. Naturally, this admonition applies to any form of therapy for any type of disorder.

In the meantime, while EMDR therapy continues to evolve through research and clinical observation, the primary principles and substance of current practice that have stood the test of time are presented in this book. As with any new exploration, the reader is urged to keep an appropriately skeptical, yet open, mind. Changing ingrained ways of doing psychotherapy may not be easy. This book is only the beginning of a learning process and, I hope, of a rewarding journey of discovery. And although clinical evaluations and personal observations are far from infallible, they are also indispensable to sound scientific findings—and to the joy of healing.

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Introducing an innovation to the psychology community is notoriously difficult, but I have been blessed with an expanding circle of openhearted, masterful clinicians and researchers whose ability and integrity reassure me that we are on the right path. To those EMDR therapy trainers, facilitators, and clinicians who had the vision to try something new and the courage to spread the word about their experiences—although it may seem like hubris to thank you for things you did out of a sense of personal responsibility and purpose—I am endlessly grateful.

Finally, for providing his scientific rigor, patience, and unswerving support, I thank my husband, Bob Welch.

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CHAPTER 1

Background

There is a principle which is a bar against all information, which is proof against all arguments and which cannot fail to keep a man in everlasting ignorance—that principle is contempt prior to investigation.

—Herbert Spencer

Since its initial development in 1987, Eye Movement Desensitization and Reprocessing (EMDR) therapy has been empirically supported by randomized controlled trials (RCTs) and is internationally recognized as an effective treatment for trauma and a wide range of experientially based disorders. The development of the therapy and its theoretical framework grew from an exploration of consistently achieved treatment effects, an exploration that refined the procedures and protocols into a comprehensive treatment approach. As we shall see, the standardized procedures and information-processing theory that guide clinical practice incorporate many aspects that should prove familiar to most clinicians, academicians, and researchers.

EMDR is best known and was initially named for the eye movements that are part of the procedures, and the positive effects of this component have now been confirmed by a meta-analysis of 26 randomized controlled studies (Lee & Cuijpers, 2013). However, it is vital that we view the therapy as a whole system. Eye movement is only one form of stimulation used and only one component of the complex approach. Furthermore, despite the term "desensitization" in its name, the goal of the therapy is not simply anxiety reduction. In fact, as noted in the Preface, if I had to do it over again, I would rename the approach "reprocessing therapy." Therefore,

although the initials EMDR are still the designated name of the therapy, the following points will be emphasized throughout this volume:

1. Bilateral dual attention stimulation is merely one component integrated with procedural elements unique to the therapy, as well as aspects synthesized from all the major psychological orientations.
2. As a comprehensive approach, careful attention is given to images, beliefs, emotions, physical responses, increased awareness, internal stability, resiliency, and interpersonal systems in achieving the effects of EMDR therapy.
3. Clinicians must use different EMDR protocols, depending on the types of pathology, and follow therapeutic procedures customized to the need of the client.
4. The purpose of the eight-phase EMDR therapy is to help liberate the client from the past into a healthy and productive present.

Mastery of the EMDR therapy basic principles, procedures, and protocols directs the clinician in assisting the client to transmute negative experiences into adaptive learning experiences. For example, when treating a victim of a single rape, the clinician identifies the different aspects of the trauma that are disturbing the client. These may include intrusive images; negative thoughts or beliefs the client has about herself or her role in the rape; negative emotions such as fear, guilt, or shame and their associated body sensations; and, conversely, the precise way the client would prefer to think about herself instead. The rape victim may begin by feeling intense fear and shame. She may have constant images of the rape intruding on her present life and may experience negative thoughts such as "I am dirty" or "It was my fault." After her clinician has effectively treated her using EMDR therapy procedures to focus on specific internal responses, the rape victim will be able to recall the rape without feelings of fear and shame. She may, in fact, feel empowered and be able to say, "I did very well. He was holding a knife at my throat, and I managed to stay alive." In addition to this positive change in her thoughts and beliefs, she will no longer have intrusive images of the rape. If she later recalls the event, her associated emotions, thoughts, and body sensations may be neutral or positive rather than disturbing. As one rape victim who received EMDR treatment said of her attack, "It's still an ugly picture, but not because I did anything wrong." In fact, the belief she internalized about herself was "I'm a strong, resilient woman."

As illustrated by this example, EMDR therapy catalyzes learning. When the target is a disturbing memory, the negative images, negative beliefs, and negative emotions become less vivid and less valid. The targeted memory appears to become linked with more appropriate information: The client learns what is necessary and useful from the disturbing past experience, and the event is restored into memory in an adaptive,

healthy, nondistressing form. But learning is a continuum. When the target is positive, such as an alternative desirable imagined future, the imagery, beliefs, and affects become more vivid, more enhanced, and more valid. Therefore, EMDR therapy is used to (1) help the client learn from the negative experiences of the past, (2) desensitize present triggers that are inappropriately distressing, and (3) incorporate templates for appropriate future action that allow the client to excel individually and within her interpersonal system.

Clearly, then, from this simple description of the standard three-pronged protocol, we see that EMDR therapy brings together aspects of many major psychological orientations: the attention to etiological events underscored by psychodynamic therapy, the conditioned responses highlighted by behavior therapy, the beliefs of cognitive therapy, the emotions of experiential therapies, the body sensations of somatic therapies, the imagery work of hypnotic therapies, and the contextual understanding of system's theory. We shall see this integration of salient orientations throughout the text.

As a comprehensive approach, all of EMDR's procedures and protocols are geared to contribute to positive treatment effects through an interaction of client containment and information processing (see also Shapiro, 1999, 2002a; Shapiro & Laliotis, 2011). Every treatment effect is an interaction of client, clinician, and method. Clinicians must understand how to prepare clients appropriately and stay attuned to their individual needs while keeping the information-processing system activated so learning can take place. Clinicians must take a comprehensive history to identify the appropriate targets for processing and the developmental deficits that may have to be addressed. EMDR therapy has proved highly successful in the treatment of major trauma (Bisson, Roberts, Andrew, Cooper, & Lewis, 2013; Watts et al., 2013; see Chapter 12), and observations of thousands of client sessions over the last 30 years show clearly that early disturbing experiences of all kinds can have similar negative and long-lasting effects.

For example, if we allow our minds to scan back into childhood and bring up a humiliating incident, many of us find that we still feel the flush of the emotion, or that the thought that was there at the time automatically arises. We feel our bodies flinch. According to the adaptive information processing model that guides EMDR therapy practice (see Chapter 2), we would say that this event has been insufficiently processed and that these automatically arising thoughts, emotions, and physical reactions may be inappropriately coloring our perceptions and actions in similar present circumstances. We may react negatively to authority, groups, new learning experiences, or whatever aspects are evident in that memory. These are not merely conditioned responses, they are responses inherent in the stored memory. When an event has been sufficiently processed, we remember it but do not experience the old emotions or sensations in the present. We are informed by our memories, not controlled by them.

As reviewed in detail in Chapter 2, the symptoms of posttraumatic stress disorder (PTSD) are clearly derived from dysfunctionally stored experiences of this type. The nightmares, flashbacks, intrusive thoughts, and high levels of arousal may be viewed as signs of this state-dependent storage. Victims clearly feel inappropriate levels of fear and powerlessness and behave accordingly. However, what EMDR therapy has shown us over the past years is that even ubiquitous events, such as childhood humiliations and disappointments, can leave comparable lasting negative effects. As I discuss in detail in the next chapter, research has supported these clinical observations. Although the adverse events may not breed the intrusive imagery of PTSD, the emotions, beliefs, and physical sensations arise in the body and mind, coloring present perceptions and leading to unhappiness and inappropriate behaviors in the present. In simple terms, the past is present. It therefore does not matter whether it is a "big T" traumatic event that precipitates PTSD or the more ubiquitous "small t" events that are rampant throughout childhood. There is a long-lasting negative effect on self and psyche. By dictionary definition it is a "trauma" and, in information-processing terms, it is posited to be dysfunctionally stored as an emotional/episodic memory, in a form that prevents it from subsequently evolving into a usable integrated/semantic memory. (For comprehensive discussions of memory systems see Alberini & LeDoux, 2013; Armony & LeDoux, 1997; Lane, Ryan, Nadel, & Greenberg, 2015; Schacter & Tulving, 1994; Squire, 2004; Stickgold, 2002; van der Kolk, 2014; van der Kolk, Hopper, & Osterman, 2001). The initial goal of EMDR therapy is to process these experiences and help liberate the client into the present.

For the practicing clinician, the important distinction between an adaptively processed and a dysfunctionally stored event is that in the former case, adequate learning has taken place and it is stored with appropriate emotions, able to guide the person in the future. The dysfunctionally stored memory still has within it some of the sensory perceptions and thoughts that were there at the time of the event. Essentially, the childhood perspective is locked in place and causes the person to perceive the present from a similar vantage point of defectiveness (e.g., "I'm unlovable/not good enough"), lack of safety, or lack of control. Clinicians observe this every day in their practices: Clients "know" they shouldn't be feeling hopeless or powerless or unlovable, but they do. They may slip into the intonation of childhood when speaking of earlier experiences. There is a split between what they want to do and what they can do; between the possibilities available and their ability to perceive and act on them. The EMDR clinician must therefore identify the events that have been dysfunctionally stored and are stunting and coloring the client's present perceptions (Shapiro, 2007, 2014a; Shapiro & Forrest, 1997/2016) and assist in processing them. Essentially, EMDR facilitates learning on multidimensional emotional, cognitive, and physiological levels.

Individuals suffering from traumatic events who participated in numerous controlled PTSD studies, and those who have experienced adverse life events contributing to other disorders, have attained rapid improvements through EMDR therapy, bringing them into the "normal" range on a wide variety of measures (see Chapter 12 for a research review). Indicators of self-efficacy and well-being have increased, while anxiety and depression have declined. The same indicators are apparent in general clinical practice and appear to support the theory that the processing of similarly dysfunctionally stored childhood experiences allows the client to become fully and comprehensively an adult; that is, it appears that most dysfunctional characteristics displayed across the full spectrum of psychological disorders may be viewed as being grounded in experiential contributors. Clearly, the interplay of genetic predisposition and the circumstances compromising resiliency, such as fatigue, substance abuse, and so on, all play a part in the full clinical picture. It is assumed that some disorders, such as certain forms of depression, may be caused purely by organic deficits and would not be appropriate candidates for EMDR treatment. But research and clinical experience indicate that most pathologies, including certain forms of depression, are forged by earlier experiences that contain affects of "helplessness," "hopelessness," or any of the full spectrum of emotions that constitute a sense of self-denigration and lack of personal efficacy. Although by no means a panacea, the specific role of EMDR therapy is to help metabolize the experiential contributors to present dysfunction, which may range from easily identified critical incidents such as rapes and assaults, through the more innocuous-seeming negative interactions with family, peers, teachers, strangers, and others that have left a lasting negative effect.

For many of our clients, it appears that simply processing these earlier experiences allows the appropriate cognitive and emotional connections to be made and adaptive behaviors to spontaneously emerge, along with insights and positive self-concepts. However, for clients who have been badly neglected and abused in childhood, it is also important to determine what developmental windows might have closed before important infrastructures were set in place. Did the traumatized child learn object constancy, or will it need to be taught during therapy? What will the clinician have to model for the client? What experiences will have to be engendered to allow healthy relationship patterns to emerge? Once such positive interactions are forged within the therapeutic relationship, they too become stored in memory and can be enhanced through the EMDR procedures.

As therapists, we must be careful to view our clients as complex beings functioning on all levels of sensing, thinking, feeling, acting, and believing. And we must not be satisfied with simply removing overt suffering. Our clients deserve more than that. They deserve the ability to love, to bond, to excel, and, if they choose, to find the desire to serve others. They deserve all the attributes that Maslow (1970) described as self-actualization. To that

end, we use a standard three-pronged EMDR therapy protocol to afford all clients a comprehensive treatment of past, present, and future. It is hoped that no one is considered expendable.

We have come a long way since the days when the mind was viewed merely as a "black box." Developmental neuropsychologists have demonstrated that neglect and lack of attachment during early childhood may lead to a lack of the cortical organization needed for self-soothing and self-regulation (Schore, 1997, 2001, 2015; Siegel, 2002, 2012, 2016). These and other findings have informed clinical practice and resulted in a stronger emphasis on the need for early stabilization of such clients and the use of EMDR protocols to enhance their access to positive affects and experiences (Korn, 2009; Shapiro & Laliotis, 2015; Wesselmann & Shapiro, 2013; see Chapter 11). Although the degree of remediation possible for the most severely abused clients has not yet been determined, it should be underscored that detrimental neurobiological findings are not necessarily permanent. With the advent of single-photon emission computed tomography (SPECT) scans, functional magnetic resonance imaging (fMRI), and a greater understanding of neurotransmitters, studies indicate that biological changes do take place subsequent to EMDR processing (e.g., Bossini, Fagiolini, & Castrogiovanni, 2007; Heber, Kellner, & Yehuda, 2002; Landin-Romero et al., 2013; Lansing, Amen, Hanks, & Rudy, 2005; Levin, Lazrove, & van der Kolk, 1999; see Chapter 12). The utility of EMDR therapy is found in its ability to afford relatively rapid change, so that interventions can be quickly assessed and therapeutic corrections made. However, the real strength of EMDR therapy is found in its integrated approach to treatment. The wisdom of all the psychology orientations is needed to make sure that no one is left behind. The goal of EMDR therapy is to achieve the most profound and comprehensive treatment effects possible in the shortest period of time, while maintaining client stability within a balanced system. However, these changes should optimally manifest on all levels of being and functioning. Our job as clinicians becomes more comprehensive and textured as we go beyond unilateral models and treat the whole person in the context of an interconnected social system.

Although many clinicians share the notion that they should foster the client's drive toward personal enhancement, a primary emphasis of the field of psychology has been directed to developing a standardized classification system of overt symptoms and specific disorders. Research has largely been directed to identifying patient characteristics and response styles and, secondarily, to the testing of various treatments for the designated disorders. Controlled research has shown EMDR therapy to be effective in the treatment of PTSD, and there is a clear need to evaluate EMDR and all other forms of psychotherapy in myriad other applications. Less than 20 years ago, independent reviewers of the American Psychological Association Division 12 Task Force on Empirically Supported Treatments (Chambless et al., 1998) indicated that of all the hundreds of diagnoses and therapies,

approximately 12 techniques were considered "well established" by controlled research for isolated conditions, which included "headaches" and "coping with stressors." In other words, at that time, almost every condition listed in the *Diagnostic and Statistical Manual of Mental Disorders* had no well-established, empirically supported treatment. To date, evaluations of treatments through randomized trials for a wide range of disorders are still in need of improvement (Beutler & Forrester, 2014; Huhn et al., 2014). Suggestions for such research are explored in Chapter 12 and Appendix C.

A CHANCE DISCOVERY

Although the role of eye movement had been well documented in connection with higher cognitive processes and cortical function (Amadeo & Shagass, 1963; Antrobus, 1973; Antrobus, Antrobus, & Singer, 1964; Gale & Johnson, 1984; Leigh & Zee, 1983; Monty, Fisher, & Senders, 1978; Monty & Senders, 1976; Ringo, Sobotka, Diltz, & Bruce, 1994), and indeed had previously been identified as correlated with a shift in cognitive content (Antrobus et al., 1964), its use in EMDR therapy is based on a chance observation I made in the spring of 1987. While walking one day, I noticed that some disturbing thoughts I was having suddenly disappeared. I also noticed that when I brought these thoughts back to mind, they were not as upsetting or as valid as before. Previous experience had taught me that disturbing thoughts generally have a certain "loop" to them; that is, they tend to play themselves over and over until one consciously does something to stop or change them. What caught my attention that day was that my disturbing thoughts were disappearing and changing without any conscious effort.

Fascinated, I started paying very close attention to what was going on. I noticed that when disturbing thoughts came into my mind, my eyes spontaneously started moving very rapidly back and forth in an upward diagonal. Again, the thoughts disappeared, and when I brought them back to mind, their negative charge was greatly reduced. At that point I started making the eye movements deliberately while concentrating on a variety of disturbing thoughts and memories, and I found that these thoughts also disappeared and lost their charge. My interest grew as I began to see the potential benefits of this effect.

A few days later, I started to try it out with other people: friends, colleagues, and participants in the psychology workshops I was attending. They had a wide range of nonpathological complaints and, like the rest of the population, had had varying amounts of psychotherapy. When I asked, "What do you want to work on?" people brought up disturbing memories, beliefs, and present situations, with complaints ranging from early childhood humiliations to present-day work frustrations. Then I showed them

how I had moved my eyes rapidly back and forth, and I asked them to duplicate those eye movements while simultaneously holding their problems in mind. The first thing I discovered was that most people do not have the muscle control to continue the eye movement for any length of time. Still determined to investigate, I asked them to follow my fingers with their eyes as I moved my hand back and forth, until their eye movements duplicated the speed and direction I had used that day in the park. This worked much better.

However, the next thing I discovered was that people would start feeling better but would then get stuck in the disturbing material. To overcome this difficulty, I tried different kinds of eye movements (faster, slower, in different directions) and asked people to concentrate on a variety of different things (e.g., different aspects of the memory or the way it made them feel). As we proceeded, I began to learn which strategies were most likely to get positive and complete results. In addition, I started to find standard ways of opening and closing the sessions that seemed to contribute to positive effects.

In short, by working with some 70 people over the course of about 6 months, I developed a standard procedure that consistently succeeded in alleviating their complaints. Because my primary focus was on reducing anxiety (as that had been my own experience with the eye movements) and my primary modality at that time was behavioral, I called the procedure "Eye Movement Desensitization" (EMD).

THE FIRST CONTROLLED STUDY

In the winter of 1987 I decided to see whether EMD would prove successful under controlled conditions. In my initial work I had used EMD most easily and most effectively with old memories. Therefore, I decided that for my first official study I wanted to find a homogeneous grouping of people who had difficulty with old memories. The people who first came to mind were rape victims, molestation victims, and Vietnam veterans who fit the diagnosis for PTSD as defined by the then-current third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III; American Psychiatric Association, 1980). Initially, this seemed an ideal population because of their old memories, but there was a catch: I did not know whether the procedures would prove effective in resolving traumatic memories, inasmuch as I had not yet tried them with any pathological conditions. What if the brain stored traumatic memories in a different way? What if they could not be accessed by the procedures in the way that disturbing but nontraumatic memories could?

To test whether EMD would work with people who had traumatic memories, I decided to find a volunteer who had suffered combat trauma. "Doug" was a counselor at a local Veterans Outreach program. Although

he was generally very well adjusted and successful, he had one recurring memory that continued to upset him tremendously. On a tour of duty in Vietnam in the 1960s, Doug had served as an infantryman. One day while he was unloading dead soldiers from a rescue helicopter, a buddy came up and gave him very upsetting news about one of the bodies he had just handled. I asked Doug to hold the memory of that moment in his mind while he followed my hand with his eyes. He did this, and after two or three sets of eye movements, he reported that the scene had changed: The auditory part of the memory had vanished. Instead, all he saw was his buddy's mouth moving; no sound came out. After several more sets of eye movements, Doug told me that the scene had been transformed in his mind's eye until it looked like "a paint chip under water" and that he now felt calm. "I can finally say the war is over and I can tell everyone to go home," he said. When I later asked him to think of Vietnam, the image that emerged was—instead of dead bodies—a memory of the first time he had flown over the country, when it had looked to him like "a garden paradise." This was the first time in 20 years that Doug had remembered that positive image of Vietnam. Our experience together was so successful that other veterans were referred to me for treatment at the Veterans Outreach Center. Over the next few months, I worked with a number of other veterans who had been suffering with PTSD symptoms for more than 10 years. Within a few sessions, they also achieved relief. Importantly, the effects lasted. For instance, 6 months later, when I checked back with Doug, he told me the positive effects had maintained. The disturbing image had not intruded since his treatment. Moreover, when he deliberately retrieved the memory, it looked like the "paint chip," and he felt no distress when he saw it.

My success with Doug and the other veterans at the center seemed to confirm that decades-old traumatic memories could be accessed and resolved by the method. With that encouragement, I began a controlled study with 22 victims of rape, molestation, or Vietnam combat who were suffering from traumatic memories. The subjects were randomly assigned to a treatment or control group.

I used EMD with the treatment group, and I gave the subjects in the control group a placebo by asking them to describe their traumatic memory in detail. I interrupted subjects in both groups approximately the same number of times for scoring the anxiety level and for feedback, using the same questions (e.g., "What do you get now?"). The purpose of having a control group was to allow for the possibility of positive effects resulting merely from the subjects' having the direct attention of a researcher and spending a similar amount of time exposed to the memory. This exposure, in which the subject holds the memory in focused consciousness for a prolonged time, might be regarded as a modified "flooding" condition, as it was known at the time, but I considered it a placebo condition, because positive treatment effects are not expected with direct therapeutic exposure (DTE) of a single session's duration (Keane & Kaloupek, 1982).

I asked individual subjects in both groups to tell me about the disturbing image of their traumatic memory, along with whatever negative thoughts and beliefs they had about the situation or their participation in it (e.g., "I'm dirty," "I'm worthless," or "I'm not in control"). I called this the "negative cognition." Then I asked subjects to recall the memory and the negative cognition and to rate their anxiety level using an 11-point Subjective Units of Disturbance (SUD) scale, in which 0 represents "neutral intensity" and 10 equals the "highest possible anxiety" (Wolpe, 1991). I also asked subjects to verbalize a positive thought or belief they would like to have about themselves (e.g., "I'm worthwhile," "I'm in control," or "I did the best I could"). Finally, I asked them to rate how true they felt this positive belief was by means of a 7-point semantic differential scale—designated the Validity of Cognition (VOC) scale—in which 1 represents "completely false" and 7 means "completely true." I cautioned subjects to use their gut feeling as the basis for their judgment rather than some intellectual analysis.

The treatment group showed two marked changes: Anxiety levels decreased, showing a pronounced desensitization effect, and there was a marked increase in the subjects' perceptions of how true their positive beliefs were, showing a strong cognitive restructuring. The control group initially showed increased anxiety, which was consistent with the responses to initial phases of flooding procedures found by other researchers (Boudewyns & Shipley, 1983). In addition, as the control subjects' anxiety increased, it was not unusual for their sense of self-efficacy to decrease. For ethical reasons, EMD was administered to the control group after they had participated in the placebo condition, and positive treatment effects were obtained with the delayed treatment condition. The positive treatment effects, maintained at 1- and 3-month follow-up, indicated that substantial desensitization, pronounced cognitive restructuring of perceptions regarding the traumatic event, and a decrease in primary symptoms had been achieved. For instance, complaints of sleep disturbances were greatly reduced. A subject who had a lifelong history of one or two violent, fearful dreams per week reported that he had a violent dream on the night following EMD treatment, but that on this occasion he had felt no fear and in the dream had "ritually bowed to [his] Samurai enemies." They had then "joined forces," and he had had no subsequent violent or fearful dreams. He stated that this was, as far as he could remember, the first period of his life in which he had no nightmares and felt consistently "good and confident, without breaks." His wife corroborated that he no longer thrashed around in bed. A Vietnam veteran who had had flashbacks, intrusive thoughts, and nightmares for 21 years about a particular incident also reported only one subsequent nightmare, one that had "no power to it." Moreover, he confided, "I realized that the person in the dream cutting my throat was me." He had had no other frightening dreams. He acknowledged that he had occasional intrusive thoughts but claimed, "None have power anymore." He also described himself as calmer on all related issues and memories.

Although the study was flawed by the lack of standardized measures and blind evaluations, only one other controlled study (with similar confounds) had been published with this population (Peniston, 1986). It had reported moderate effects after 45 sessions of biofeedback-assisted systematic desensitization. Therefore, along with two other studies on prolonged exposure therapy published the same year, which found a 30% symptom reduction, the EMDR pilot research became one of the first published controlled studies assessing PTSD symptomology (Shapiro, 1989a).

FURTHER CLINICAL AND EXPERIMENTAL OBSERVATIONS

During the 28 years since the initial pilot research (Shapiro, 1989a), more than 20 controlled randomized studies of EMDR have been published that substantiate its efficacy (see Bisson et al., 2013; Maxfield & Hyer, 2002; Rodenburg, Benjamin, de Roos, Meijer, & Stams, 2009; Watts et al., 2013; see also Appendix D). Consequently, the practice guidelines of the International Society for Traumatic Stress Studies designated EMDR therapy as an effective treatment for PTSD starting in 2000 (Shalev, Friedman, Foa, & Keane, 2000) and have continued to do so (Foa, Keane, Friedman, & Cohen, 2009), along with many other organizations, both domestic (e.g., Department of Veterans Affairs & Department of Defense, 2017) and international (e.g., World Health Organization, 2013). A review of the extant controlled research and suggestions for future investigations are covered in detail in Chapter 12, after the methodology is more fully explained.

In addition to the controlled research, successful clinical results achieved with EMDR indicate the wide range of its applicability (see also Appendix D). Since the initial efficacy study (Shapiro, 1989a), positive therapeutic results with EMDR have been reported with a wide range of populations, as documented in numerous case reports and studies (see also Chapter 12). These include the following:

1. Diverse PTSD populations suffering from war trauma, such as combat veterans from Desert Storm, the Vietnam War, the Korean War, and World War II, and terrorist victims and refugees.
2. Persons with phobias, panic disorder, and other anxiety disorders, who revealed a rapid reduction of fear and symptomatology.
3. Crime victims, police officers, and first responders who are no longer disturbed by the aftereffects of violent assaults.
4. People relieved of excessive grief due to the loss of a loved one or to line-of-duty deaths, such as engineers no longer devastated with guilt because their trains unavoidably killed pedestrians.
5. Children healed of the symptoms caused by the trauma of assault or natural disaster.

6. Sexual assault victims who are free of debilitating symptoms, enabling them to lead normal lives and have intimate relationships.
7. Accident, surgery, and burn victims who were once emotionally or physically debilitated and are now able to resume productive lives.
8. Victims of sexual dysfunction, who are now able to maintain healthy sexual relationships.
9. Clients at all stages of chemical dependency and other addictions, who now show stable recovery and a decreased tendency to relapse.
10. Clients with acute trauma and a wide variety of PTSD and trauma-based personality issues who experience substantial benefits.
11. People with performance anxiety and those seeking performance enhancement in business, performing arts, school, and sports activities who have benefited.
12. People suffering from somatic disorders or chronic pain, who have rapidly recovered.
13. Clients with diagnosed personality disorders or complex PTSD, who show increased stabilization and functioning.
14. Clients with depression and a wide variety of other diagnoses, who have experienced substantial benefit from EMDR.

SHIFT IN PARADIGM

As I noted in my earlier reports (Shapiro, 1989a, 1989b), numerous procedures that appeared to be responsible for the positive treatment effects I achieved in the initial study could not be included in the articles because of page constraints. The continued refinement of these procedures and the subsequent evaluation of hundreds of case reports from trained clinicians led to the full realization that the optimal procedures caused the simultaneous desensitization and cognitive restructuring of memories, the elicitation of spontaneous insights, and an increase in self-efficacy, all of which appeared to be by-products of the adaptive processing of disturbing memories. This realization led to my renaming the therapy Eye Movement Desensitization and Reprocessing (EMDR).

The change of name from EMD to EMDR in 1990 included a personal change in orientation from the initial behavioral formulation of simple desensitization of anxiety to a more integrative information-processing paradigm. This paradigm includes the application to clinical practice of the terminology and some of the concepts of information-processing and associative networks originally presented by Lang (1977) and Bower (1981). Although a number of other foundational information-processing theories have great merit (Barnard & Teasdale, 1991; Chemtob, Roitblat, Hamada, Carlson, & Twentyman, 1988; Foa & Kozak, 1986; Horowitz, 1979, 1998;

Litz & Keane, 1989; McClelland, 1995; Rachman, 1978, 1980; Teasdale, 1999), the EMDR-based information-processing model is generally both compatible with them and distinct in its elements and applications.

Although all the information-processing models are inherently speculative, they give rise, it is hoped, to a greater understanding of the underlying principles that govern perception and the integration of new information within extant conceptual and emotional frameworks. Their utility lies in their ability not only to explain but also to predict clinical outcomes. Yet although the individual model often dictates certain clinical applications, the success of the clinical applications does not "prove" the model to the exclusion of all others. Each model evokes a set of principles that may lead to positive treatment effects under predetermined conditions. The adventure lies in finding exceptions to the rule and formulating principles to explain and elicit clinical phenomena that lie outside predicted outcomes.

The behavioral desensitization formulation I initially used for EMD certainly resulted in positive effects, but I found that it could not explain a number of clinical phenomena sufficiently, nor could it account for the clinical success of a variety of procedural applications. This is not unusual. Overall, each model also predicts the types of clinical applications necessary for optimal effects, and a number of extant treatments have borne out their utility. For instance, the "mindfulness" applications elucidated by Teasdale (1999) have received empirical support in clinical application of mindfulness-based cognitive therapy (e.g., Piet & Hougaard, 2011; Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010), and the principles espoused by Rachman (1980) and Foa and Kozak (1986) have received empirical support through the application of prolonged exposure therapy, which has been empirically validated in numerous studies (see McLean, Asnaani, & Foa, 2015). However, although the principles and mindfulness practices espoused by Teasdale (1999) can be easily identified in EMDR practices (see Chapter 5), the other, also valuable theories, contraindicate practices that have proved sucessful in EMDR therapy.

For instance, Rachman (1978) lists silence, distractions, and brief presentations among those practices that would impede processing and vivid, long, and repeated presentations as promoting processing. These forms of clinical application are also proposed by Foa and Kozak (1986) and Foa and McNally (1996). However, as we shall see, EMDR uses silent, brief exposures to ever-changing and often diffuse internal stimuli, along with an external source of attention, which could be considered a "distraction." In fact, according to some exposure researchers, "in strict exposure therapy the use of many of ['a host of EMDR-essential treatment components'] is considered contrary to theory" (Boudewyns & Hyer, 1996, p. 192). Therefore, although in no way diminishing the importance of exposure therapies, the prevailing principles governing their use do not appear to predict or explain EMDR practices or the clinical phenomena that are generally observed (McCullough, 2002; Rogers & Silver, 2002; see Chapter 12 for

further discussion). The information-processing model that guides EMDR practice was based largely on these observed clinical phenomena, including the rapid amelioration of symptoms associated with previous resistant disorders such as body dysmorphic disorder (Brown, McGoldrick, & Buchanan, 1997), phantom limb pain (Shapiro & Forrest, 1997/2016), and PTSD (see Chapter 12).

The successful application of EMDR to cases of phantom limb pain may prove a useful point of context. Although it has been reported that as many as 85% of amputees suffer phantom limb pain (Hsu & Cohen, 2013; Melzack, 1992), few treatments have offered consistent or long-lasting results (Niraj & Niraj, 2014). The adaptive information processing model, however, predicted the possibility of positive treatment effects with the application of EMDR, which were later achieved clinically by independent practitioners (e.g., de Roos et al., 2010; Russell, 2008a; Schneider, Hofmann, Rost, & Shapiro, 2007; Wilensky, 2006). Basically, phantom limb pain can be viewed as a manifestation of the stored somatic memory. The fact that the pain is still perceived in an absent limb is a perfect example of dysfunctional memory storage. Once the etiological memory and the pain sensations are targeted with EMDR processing, the pain generally remits. This example of the need to catalyze the information processing of a stored memory can serve as an icon for general EMDR treatment. As long as the memory is dysfunctionally stored, the negative affect and physical sensations are maintained regardless of the cognitive awareness that there is no limb—or, in other pathologies, no need for fear and suffering.

Observation of many EMDR treatment sessions has identified certain patterns of information processing and memory association that have led to the formulation of certain principles, which in turn guided the continued development and refinement of the specific practice, protocols, and procedures of EMDR therapy. A principle that is crucial to EMDR practice (but not specified in other information-processing theories), and which is suggested by the consistent application of the procedures, is that there is a system inherent in all of us that is physiologically geared to process information to a state of mental health. By means of this system, negative emotions are relieved, and learning takes place, is appropriately integrated, and is available for future use. In other words, when the system is functioning properly, processing results in an adaptive resolution of the troubling or frightening memories. The system may become unbalanced because of a trauma or stress engendered during a developmental period, but once it is appropriately activated and maintained in a dynamic state by means of EMDR therapy, it can rapidly transmute information to a state of therapeutically appropriate resolution. Desensitization, spontaneous insights, cognitive restructuring, and association to positive affects and resources are viewed as by-products of the adaptive reprocessing taking place on a neurophysiological level.

The invocation of a neurophysiological level is a simple recognition that this is where all change ultimately occurs. It is not assumed to be specific to EMDR therapy; rather, any form of successful therapy is ultimately correlated with a neurophysiological shift. Such a neurophysiological shift is explicit in models informing prolonged exposure therapies (Foa & Kozak, 1986; Marks, Lovell, Noshirvani, Livanou, & Thrasher, 1998) and implicit in some psychodynamic models (Horowitz, 1979). The information-processing paradigm also subsumes my originally held behavioral orientation, which included a recognition of the interaction of learned material, conditioned responses, physiological concomitants, and the therapist's ability to intervene in a structured manner for behaviorally observable results. Indeed, many behaviorists may choose to interpret EMDR therapy solely in terms of conditioning and/or exposure (see Chapter 12 for a discussion of the exposure paradigm), and many tenets of conditioning and exposure are indeed compatible with EMDR therapy. However, research over the last decade has shed much light on the underlying mechanisms of EMDR therapy, and while there is more to be revealed, clinicians currently need the most useful clinical heuristic we can provide. The information-processing paradigm, which I have termed the "adaptive information processing model," provides a way both to explain EMDR therapy's treatment effects and successfully predict the appropriate application of the therapy to a variety of presenting problems. The parameters of that model are briefly described in the next section. A more extensive discussion is offered in Chapter 2.

ADAPTIVE INFORMATION PROCESSING

The adaptive information processing (AIP) model was developed to explain the rapidity with which clinical results are achieved with EMDR therapy and the consistency of the many patterns of response to it. On the basis of the observation of thousands of EMDR therapy processing sessions, the earlier desensitization paradigm was replaced by this model, which not only explains treatment outcomes more effectively but also accurately predicts more beneficial clinical effects when certain variations are used. Hence, the therapeutic application of principles, protocols, and procedures consistent with the AIP model results in greater treatment effects than those produced by the initially described EMD (Shapiro, 1989a, 1989b); that is, the principles that guide procedures often establish the parameters of the clinical applications.

Briefly stated, AIP regards most pathologies as derived from earlier life experiences that set in motion a continued pattern of affect, behavior, cognitions, and consequent identity structures. (I explore this in detail in Chapter 2.) The pathological structure is inherent within the static, insufficiently

processed information stored at the time of the disturbing event. Across the clinical spectrum, ranging from simple PTSD and phobias to more complex conditions such as panic disorders, some forms of depression, dissociation, and personality disorders, pathology is viewed as configured by the impact of earlier experiences that are held in the brain in state-specific form.

The continued influence of these early experiences is due in large part to the present-day stimuli eliciting the negative affect and beliefs embodied in these memories. Although a client's memory may be of an actual event and of behavior that may then have been appropriate for the disturbing situation, the lack of adequate assimilation means the client is still reacting emotionally and behaviorally in ways consistent with the earlier disturbing incident. For example, a child may understandably feel fear and lack of control when threatened by an adult, but an identical reaction by an adult to a similar situation is generally inappropriate. Likewise, an adult may feel fear and lack of control during a hurricane, but an identical reaction to a stiff breeze months later is pathological. The dysfunctional nature of traumatic memories, including the way in which they are stored, allows the negative affect and beliefs from the past to pervade the client in the present. EMDR therapy's processing of such memories spontaneously accesses physiological networks containing adaptive information (illustrated in Chapter 2) and allows the more positive and empowering present affect and cognitions to generalize to the associated memories throughout the neurophysiological network and leads spontaneously to more appropriate behaviors by the client.

Clinical pathologies are therefore viewed as amenable to change if the clinician appropriately targets the information that has been stored dysfunctionally in the brain. Even pronounced personality disorders are viewed as susceptible to change by virtue of reprocessing the memories that set in motion the dysfunctional characteristics; the memories targeted, for instance, may be those that cause a person with a paranoid personality to be suspicious of people or one with an avoidant personality to feel unsafe. In addition, of course, developmental and experiential deficits are addressed through appropriate processing and assimilation of positive information (see Chapter 8).

Adopting the AIP model can facilitate the ability of many EMDR-trained clinicians to achieve both substantial and comprehensive treatment effects. For some clinicians this may appear to be a natural integration of already held beliefs; for others it may demand a personal shift in clinical conceptualization. There are a number of critical elements of the proposed paradigm. I mention them here, but they are more thoroughly developed in Chapter 2.

1. *The possibility of direct, nonintrusive, physiological engagement with the stored pathological elements.* Observation of EMDR treatment effects suggests that pathologies are represented by dysfunctional

information that is physiologically stored and that can be accessed and transformed directly, without the use of medication. For instance, rather than addressing the client's *reaction* to the disturbing event—as biofeedback, exposure therapies, or relaxation training do—EMDR therapy focuses on the memory itself. The resulting transmutation of the information in the targeted memory appears to occur spontaneously, leading to a change in client reaction.

The observations of EMDR-produced shifts in the memory itself and the way it is stored are consistent with independent conjectures regarding the different manifestations of declarative (narrative) and nondeclarative memory (Lipke, 2000; Stickgold, 2002; van der Kolk, 2002, 2014). For instance, before EMDR treatment, the components of the traumatic target memory—picture, cognition, affect, physical sensations—often appear to be manifested in the state-specific and disturbing form in which they were acquired. Some researchers suggest that such traumatic memories are held in nondeclarative memory (e.g., van der Kolk, 1994, 2014; Stickgold, 2002). After effective EMDR treatment, however, the memories are stored with a less disturbing picture, a positive cognition, and an appropriate affect. In addition, there are no attendant disturbing physical sensations. Perhaps the processing of the information allows its appropriate storage in semantic memory, a development that also means freedom from pathological reactions.

2. *An information-processing system that is intrinsic and adaptive.* It appears that an innate information-processing system exists, and that pathologies occur because this mechanism is blocked. Therefore, if the traumatic memory is accessed and the system is activated, with EMDR therapy the information is taken to an adaptive resolution. The observations of thousands of EMDR processing sessions appear to bear out this conjecture. Apparently, the system is configured to process the information and restore mental health in much the same way the rest of the body is geared physiologically to heal when injured. This belief is the basis for the primarily client-centered model of EMDR therapy, which assumes that during EMDR processing the client's shifting cognitions and affects will become more appropriate and adaptive, and move to optimal levels, with minimal clinician intrusion.

The suggestion that trauma itself in some way causes an imbalance that prevents adequate processing was presented by Janet (1889/1973) and Pavlov (1927), and has been made in studies on the effects of neurotransmitters (Frick et al., 2016; Sullivan et al., 2013; van der Kolk, 1994, 2014; Watson, Hoffman, & Wilson, 1988; Zager & Black, 1985). In addition, the hypothesis that the traumatic information itself will move to a positive plateau once the system is activated has grown from the consistent observations of EMDR processing sessions. For instance, there are no reports of rape victims who are at peace with the event and subsequently move

through EMDR processing to a level of self-loathing. However, rape victims entering treatment in a state of shame and guilt have evolved with completed treatment to positive states, such as self-acceptance and peace. Although EMDR clients may break through feelings of dissociation and denial, and temporarily feel more disturbed, this is merely a transitional stage toward healthy resolution.

On the one hand, this movement toward a positive state when the information-processing system is maintained in dynamic form through the use of EMDR therapy is certainly consistent with conjectures by Rogers (1951) and Maslow (1970). On the other hand, it is also consistent with the assumptions of the medical model, wherein medications and interventions are used to unblock or accelerate the body's natural healing properties. In the EMDR treatment of trauma, an analogous healing is assumed if the information-processing mechanism is unblocked.

3. *A change in identity constructs as the embedded information shifts*. As the disturbing information is transformed, there is a concomitant shift in cognitive structure, behavior, affect, sensation, and so forth. Clinical experience has shown that once specific memories are reprocessed, the client's sense of self-worth and self-efficacy automatically shifts. This leads spontaneously to new, more self-enhancing, behaviors. The AIP model holds that underlying dysfunctional memories are primarily responsible for pathological personality characteristics, and that they can be structurally altered. The theory accurately predicts and is consistent with findings of EMDR clinicians (e.g., Brown & Shapiro, 2006; Fensterheim, 1996; Mosquera, Leeds, & Gonzalez, 2014) that even severe personality disorders (with the obvious exception of chemically or organically based conditions) may be amenable to comparatively rapid change through the targeting and reprocessing of key memories and attention to the remediation of developmental deficits.

4. *A release from previously accepted temporal limitations*. EMDR therapy has the ability to facilitate profound therapeutic change in much less time than has been traditionally assumed to be necessary, regardless of the number of years since the traumatic event occurred. In EMDR the clinical emphasis is on facilitating therapeutic effects through the adaptive connection of associative neurophysiological networks in the information-processing system. The close proximity of these physiological networks logically dictates that treatment outcomes need not be rigidly time-bound. For example, some controlled studies have indicated that 84–100% of single-trauma PTSD has been eliminated within 4.5 hours of treatment (see Chapter 12).

Because all clinical modalities can be defined as ultimately working with information stored in the brain, the information-processing paradigm provides an integrative approach that can include and interpret key

aspects of different modalities such as psychodynamic, behavioral, cognitive, Gestalt, and body-oriented therapies (including psychopharmacology).

THEORETICAL CONVERGENCES

The use of EMDR therapy can be fully compatible with most of the known psychological orientations (Norcross & Shapiro, 2002; Shapiro, 2002b). The importance of early childhood memories clearly fits into the psychodynamic model (Freud, 1900/1953; Jung, 1916; Wachtel, 2002), and the importance of focused attention to current dysfunctional reactions and behaviors is completely consistent with the conditioning and generalization paradigms of classical behaviorism (Salter, 1961; Wolpe, 1991). In addition to being a client-centered approach (Rogers, 1951) with a strong affective and experiential basis (Bohart & Greenberg, 2002; Greenberg, 2010; Greenberg & Safran, 1987), EMDR therapy addresses the concept of positive and negative self-assessments, which has firm roots in the field of cognitive therapy (Beck, 1967; Ellis, 1962; Meichenbaum, 1977; Young, 1990; Young, Zangwill, & Behary, 2002), and the emphasis on the physical responses related to a client's presenting dysfunction (van der Kolk, 2002, 2014) is an important element in its full therapeutic utilization.

Posttraumatic Stress Disorder

EMDR began as a therapy specifically for the treatment of people with PTSD. As such, the fundamental approach and a number of the treatment components were based on research reports regarding this population. For instance, studies done with Vietnam combat veterans called attention to the traumatic event itself, indicating that the psychological reactions to stress are expected to persist as a direct function of the magnitude of the stressor (Figley, 1978; Kadushin, Boulanger, & Martin, 1981; Laufer, Yager, Frey-Wouters, & Donnellan, 1981; McDermott, 1981; Strayer & Ellenhorn, 1975; Wilson, 1978). As we shall see, observation of EMDR treatment sessions indicates that premorbid events can have a tremendous influence on the predisposition to PTSD. This observation has been borne out in independent research (Afifi, Mota, Dasiewicz, MacMillan, & Sareen, 2012; Bernat, Ronfeldt, Calhoun, & Arias, 1998; Blanchard & Hickling, 1997; Breslau, Chilcoat, Kessler, & Davis, 1999; Bromet, Sonnega, & Kessler, 1998; Felitti et al., 1998; Heim, Plotsky, & Nemeroff, 2004; King, King, Foy, & Gudanowski, 1996; Teicher et al., 2010; Varese et al., 2012).

There is a consensus in the therapeutic community working with trauma survivors that the amelioration of PTSD is accomplished when the victim comes to grips with the traumatic incident. When EMDR therapy was developed, a wide range of treatment techniques were employed but, unfortunately, there were comparatively few controlled studies in the

literature to corroborate the efficacy of many of them (cf. Foa, Keane, & Friedman, 2000). At this point, EMDR therapy and trauma-focused cognitive-behavioral therapy (CBT) are widely recognized as the only two effective empirically supported treatment approaches for the treatment of PTSD (Bisson et al., 2013; Watts et al., 2013; World Health Organization [WHO], 2013). Nonetheless, it is useful to review how EMDR therapy theory and practice compare not only to CBT but also other major orientations prevalent in clinical practice.

Psychodynamic Approaches

Although research has failed to support psychodynamic therapy in the treatment of PTSD, it continues to be widely used in general clinical practice. EMDR treatment is highly compatible with the the psychodynamic information-processing model (Horowitz, 1979), which proposes that one's natural "completion tendency" continues to rework the traumatic information in active memory until it can be reconciled with one's internal models of the world. Unless the trauma can be incorporated into existing schemata, the information will remain in active memory and break through in intrusive thoughts. This process alternates with numbing and avoidance until some integration results.

The psychodynamic approach attempts to reintegrate the traumatic experience using a variety of techniques geared to specific stages of the disorder (or the therapeutic process), as well as to the personality development of the client (for comprehensive reviews, see Kudler, Krupnick, Blank, Herman, & Horowitz, 2008; Summers & Barber, 2009). Therapeutic interventions include "covering" techniques (e.g., stress management) for stages involving intrusive memories and "uncovering" techniques (e.g., psychodrama) during denial stages (Horowitz, 1973, 1974). The "completion tendency" theory is clearly compatible with the blocked-processing paradigm of EMDR therapy, and the utilization of various strategies for effective relief is consistent with the multifaceted approach of EMDR therapy, which includes self-control techniques, the incorporation of stages of imagined reenactment, and the adoption of alternative behaviors. Furthermore, as noted by Wachtel (2002), EMDR therapy, which employs free associative processes similar to psychodynamic therapy, appears to enhance the "working through" of the memory through both insight and integration. Solomon and Neborsky (2002) have also reported that EMDR therapy is fully compatible with the newer brief psychodynamic models.

Cognitive-Behavioral Approaches

The behavioral approach to PTSD was elucidated by Keane, Zimering, and Caddell (1985) in relation to treatment of combat veterans, and follows Mowrer's (1960) two-factor learning theory, which incorporates both

classical and operant conditioning. It was argued that there is an analogous relationship between the development of the fear and avoidance behavior found in PTSD and that found in laboratory-conditioned animals.

The first factor in Mowrer's theory involves learning by association, or classical conditioning, as in Pavlov's early experiments in which a bell, termed a conditioned stimulus (CS), was paired with a shock, or unconditioned stimulus (UCS). This pairing leads to an aversive emotional state (such as fear) at the sound of the bell (Pavlov, 1927). The second factor is instrumental learning, or avoidance behavior, which entails consistent avoidance by the organism of both the CS (bell) and the UCS (shock). In this paradigm, the fear generated by gunfire in wartime or by rape is associated with other presenting cues. All such cues, such as loud noises or dark streets, are then avoided by the victim whenever possible. Diagnostic criteria for PTSD include intrusive thoughts regarding traumatic events, flashbacks, and nightmares that include specific details of the trauma. Therefore, behavioral techniques were adapted to increase exposure to the CS in order to cause extinction of the concomitant anxiety/fear behavior and physiological arousal. Because the existence of the traumatic incident is the basis of the psychological and behavioral maladaptation, behavioral approaches employed DTE (Boudewyns & Shipley, 1983) techniques, also known as "flooding" (Malleson, 1959) and "implosion" (Stampfl, cited in London, 1964), for the alleviation of PTSD.

In the DTE treatment of PTSD, traumatic memories are often revivified over several sessions until the anxiety is reduced. The intention is to maintain the maximum amount of anxiety in the client for sustained periods. The treatment is based on the assumption that forced exposure that prohibits the usual avoidance response to an anxiety-producing stimulus (which is not reinforced by an unconditioned aversive stimulus) will cause the anxiety to be extinguished (Levis, 1980; Stampfl & Levis, 1967). Currently, the most widespread treatment utilizing exposure in the treatment of PTSD is prolonged exposure (PE; see Foa, Hembree, & Rothbaum, 2007) therapy, which is based on the emotional processing theory (Foa & Kozak, 1986), and posits that negative beliefs involving lack of safety result in avoidance behaviors that prevent the beliefs from being disconfirmed. Therefore, treatment consists of imaginal exposure to the event through repeated within-session descriptions of the trauma by the client, which are recorded. Between-session homework assignments involve listening to the recordings and daily *in vivo* exposure, in which the client is instructed to deliberately go to anxiety-provoking environments (e.g., a dark alley similar to the one where the woman was raped).

EMDR therapy offers an alternative treatment of traumatic memories that does not necessitate prolonged exposure to high-anxiety-producing stimuli or homework, yet desensitizes the traumatic event rapidly. Direct comparisons have reported more rapid declines of anxiety with EMDR processing (e.g., Rogers et al., 1999). Nine of 11 RCTs comparing forms of

exposure-based CBT have indicated that EMDR therapy is equivalent or superior on some measures, with five studies reporting positive effects in fewer sessions (see Chapter 12 for further discussion).

EMDR therapy may be considered an exposure method by some because the client is asked initially to maintain the traumatic event in consciousness for direct treatment effect. However, attention to the incident is not maintained, as in standard exposure therapies, and the amount of exposure needed in EMDR appears to be much less (e.g., 4.5 treatment hours; Ironson, Freund, Strauss, & Williams, 2002; Marcus, Marquis, Sakai, 1997, 2004; Rothbaum, 1997; Wilson, Becker, & Tinker, 1995, 1997) than the prolonged exposure required by DTE techniques for the extinction process to develop and for the client to show signs of decreased anxiety (see Rogers & Silver, 2002; Rogers et al., 1999). Additionally, research has indicated different underlying mechanisms of action in that the lengthy exposures used in trauma-focused CBT (TF-CBT) result in extinction, while short exposures such as those of EMDR therapy result in memory reconsolidation (Suzuki et al., 2004). As described by Craske, Herman, and Vansteenwegen (2006), " . . . recent work on extinction and reinstatement . . . suggests that extinction does not eliminate or replace previous associations, but rather results in new learning that competes with the old information" (p. 6). The differences between reconsolidation and extinction have important implications in regard to relapse potential and clinical applications (see Shapiro, 2014a) and are discussed in Chapter 12.

While PE utilizes extended imaginal and *in vivo* exposures to disconfirm the negative beliefs posited to underlie PTSD, other CBT treatments emphasize the use of a variety of techniques to directly restructure the beliefs. The most widespread of these cognitive therapies in the United States is cognitive processing therapy (Resick & Schnicke, 1992), which initially included an exposure-based written narrative of the account but has subsequently reported superior outcomes by dropping that element (Resick et al., 2008). The therapy includes discussions of the trauma and techniques such as the use of Socratic dialogue to directly address the negative beliefs. Other CBT therapies for PTSD such as cognitive therapy for PTSD (Ehlers & Clark, 2000), narrative exposure therapy (Schauer, Neuner, & Elbert, 2011), and brief eclectic psychotherapy (BEP) for PTSD (Gersons, Meewisse, & Nijdam, 2015) use a combination of cognitive therapy and exposure techniques. While the form of exposure may vary in type and duration, in all cases the event is discussed in detail and specific client–therapist interactions focus on changing the interpretation of the event.

As indicated previously, in the WHO (2013) practice guidelines, EMDR and trauma-focused CBT are the only two psychotherapies recommended for the treatment of PTSD across the lifespan. However, while similarities exist, distinct differences were described: "Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the

event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework" (p. 1). These procedural differences and the implications for clinical treatment are explored in detail in later chapters.

Integrative Approach

EMDR was initially developed as a therapy that would specifically help clients integrate new, desirable self-statements while allowing for rapidly desensitizing traumatic cues. In addition, a cognitive reassessment that includes redefining the event, finding meaning in it, and alleviating the inappropriate self-blame (Janoff-Bulman, 1985) was integrated as an important aspect of the EMDR treatment of trauma survivors. Furthermore, EMDR is structured to facilitate a rapid integration of the new information, coping skills, and behaviors offered by the clinician. Just as the cognitive-behavioral approach has come to include many diverse techniques, a number of them are inherent in EMDR's integrative procedures (Lazarus & Lazarus, 2002; Smyth & Poole, 2002; Young et al., 2002). Likewise, EMDR therapy also encompasses aspects of experiential (Bohart & Greenberg, 2002), psychodynamic (Solomon & Neborsky, 2002; Wachtel, 2002), feminist (Brown, 2002), somatic (van der Kolk, 2014), and a number of other major psychological orientations (Norcross & Shapiro, 2002; Shapiro, 2002a; Zabukovec, Lazrove, & Shapiro, 2000). However, as a distinct form of psychotherapy, the standardized procedures and protocols of EMDR therapy are unique, including the specific use of bilateral dual attention stimuli such as eye movements, taps, or tones. Furthermore, EMDR is guided by the AIP model, which differentiates it from other forms of therapy. As noted previously, the cognitive-behavioral paradigm views dysfunctional cognitions and behaviors as the sources of pathology and uses procedures to directly challenge and change them. The procedures of EMDR therapy are guided by the AIP tenet that the dysfunctional cognitions and behaviors are merely symptoms of the physiologically stored memory, which is addressed directly through processing procedures that include the use of bilateral stimuli.

Leading neurobiological researchers have posited theories to explain the effects of the bilateral dual attention stimuli (Andrade, Kavanaugh, & Baddeley, 1997; Stickgold, 2002; van der Kolk, 2002). Empirical investigations have indicated a direct effect on the working memory (e.g., Smeets, Dijs, Pervan, Engelhard, & van den Hout, 2012) and brain connectivity (e.g., Nieuwenhuis et al., 2013). Research has also explored the implications of a proposed orienting response and potential connections with rapid eye movement sleep (e.g., Kuiken, Chudleigh, & Racher, 2010). Concurrent with the use of other procedural elements, the bilateral dual attention stimulus appears to titrate disturbance, facilitate associative processing, and enhance memory retrieval. The research is reviewed in Chapter 12, along with suggestions for future investigations.

SUMMARY AND CONCLUSIONS

The origin of EMDR therapy, initially called EMD, was my observation of the apparent desensitizing effect of spontaneous repeated eye movements on unpleasant thoughts. The use of directed eye movements with 70 volunteers with nonpathological complaints proved effective in reducing disturbance. During these trials, the procedure was elaborated to maximize its effects for use on a clinical population. A controlled study of 22 subjects suffering from PTSD symptomatology, published in the *Journal of Traumatic Stress* (Shapiro, 1989a), indicated that the procedure was highly beneficial for desensitization, cognitive restructuring, and elimination of pronounced intrusions stemming from the traumatic event.

The change of name from EMD to EMDR occurred when it became apparent that the procedure entailed an information-processing mechanism rather than a simple desensitization treatment effect. The integrative AIP model underscores a methodology that stimulates the presumed self-healing mode of an inherent information-processing system. Early memories are considered to be the primary basis for most psychological disorders, and effects of EMDR therapy are viewed as rapidly changing the impact of these memories in order to alter the current clinical picture. A three-pronged approach is used to target the etiological event, current triggers, and templates for appropriate future action.

As an integrative psychotherapy, a variety of EMDR therapy's components are compatible with psychodynamic, cognitive, experiential, behavioral, and somatic orientations. However, EMDR therapy is widely recognized in both domestic and international practice guidelines as an effective form of treatment distinct from the other major modalities. It should be noted for both clinical and research purposes that EMDR therapy is a complex approach, with a variety of procedures and protocols that are deemed necessary for full effectiveness. Chapter 2 provides a more detailed explication of the model for clinical use.

CHAPTER 2

Adaptive Information Processing

The Model as a Working Hypothesis

As far as the laws of mathematics refer to reality,
they are not certain; as far as they are certain,
they do not refer to reality.

—Albert Einstein

As described in Chapter 1, EMDR therapy is based on my empirical observation of the effect of eye movements on emotional–cognitive processing. I developed the basic procedural steps through trial and error by observing clinical results. The rapid, observable effects allowed me to delineate various patterns of clinical response and naturally led me to formulate various theories in an attempt to explain them. Refining these theoretical principles allowed me to predict and test new applications of the procedures, which in turn shaped the ongoing development of the therapy. While we cannot be sure that the resultant theories represent what is going on physiologically, they are consistent with both observations and current research, and help to guide clinical decisions by the logical application of the primary principles. Additionally, for many, the model can be viewed as a paradigmatic shift in understanding the nature of therapeutic change.

In this chapter I describe "accelerated information processing," which helps to provide an explanation of how EMDR therapy works. First, I discuss how EMDR therapy fits into the Adaptive Information Processing model (changed from accelerated information processing model; Shapiro, 1995a). I then show how it can be used to gain access to and have an impact on material that is dysfunctionally stored in the brain. A transcript of an actual client session highlights some important aspects of this exposition. I also review the nature of psychopathology, a variety of clinical applications, and the integrated nature of the EMDR treatment approach.

Although this chapter presents in detail the model that guides EMDR therapy, it is important to understand that while this model was initially offered as a working hypothesis only and is subject to modification based on further laboratory and clinical observation, it has successfully predicted a wide range of treatment effects and has guided clinical practice worldwide over the past 25 years. Note that although the model applies to clinical practice, it utilizes the terminology of neurophysiological information processing introduced by Bower (1981) and Lang (1979). In addition, I introduce psychophysiological concepts by employing the term "neural networks." Although the term "memory networks" in this text refers to patterns of associated memories, the term "neural network" also refers to the neurobiological configuration of an individual memory. This use of the term subsumes the way "neural networks" is used by neurobiologists and extends it to an additional stratum of cognitive–emotional processing. It is particularly important to underscore that the efficacy of EMDR therapy is independent of the validity of the model being proposed. This is relevant because the physiology of the brain is not yet sufficiently understood to confirm the validity of this or any other psychotherapy model at that level. However, the model does not appear to contradict anything known to be true, is consonant with the current knowledge in cognitive neuroscience, is congruent with the observed treatment effects of EMDR therapy, and serves as a clinical road map for treating a wide range of pathologies. So far, the model has proved explanatory and highly predictive of therapeutic response in new areas of application.

INFORMATION PROCESSING

While EMDR therapy is a specific integrative psychotherapeutic approach, Adaptive Information Processing (Shapiro, 1993, 1995a, 2007) represents the general model that provides the theoretical framework and principles for treatment and an explanation of the basis of pathology and personality development.

The Adaptive Information Processing model is consistent with Freud's (1919/1955) and Pavlov's (1927) early understanding of what is now referred to as "information processing." Specifically, there appears to be a neurological balance in a distinct physiological system that allows information to be processed to an "adaptive resolution," which in this model is a resolution in which the connections to appropriate associations are made and the experience is integrated into a positive emotional and cognitive schema. Essentially, what is useful is learned and stored with the appropriate affect and is available for future use. For example, let us say something negative happens to us, such as a humiliation at work, and we are disturbed by it. We think about it, dream about it, and talk about it. After a while, we are no longer bothered by it, and the experience may be used appropriately

as information to guide our future actions. Thus, we learn something about ourselves and other people, we better understand past situations, and we are better able to handle similar situations in the future.

Psychological trauma is associated with numerous changes in the nervous system caused by cortisol release, spikes in adrenaline, fluctuations in neurotransmitters, and so forth, the result of which is a loss of neural homeostasis (Griffin, Charron, & Al-Daccak, 2014; Rodrigues, LeDoux, & Sapolsky, 2009; Weiss, 2007). Due to this imbalance, the information-processing system is unable to function optimally, and the information acquired at the time of the event, including images, sounds, affect, and physical sensations, is stored in its disturbing state. Stored in this distressing, excitatory, state-specific form, that original material can be triggered by a variety of internal and external stimuli and may be expressed in the form of nightmares, flashbacks, and intrusive thoughts—the so-called "positive" symptoms of PTSD.

The hypothesis is that the procedural elements of EMDR therapy, including the bilateral dual attention stimuli, trigger a physiological state that facilitates information processing. Various mechanisms by which this activation and facilitation of processing occur have been proposed, including the following:

1. Deconditioning caused by a relaxation response (Shapiro, 1989a, 1989b; Wilson, Silver, Covi, & Foster, 1996).
2. A shift in brain state, enhancing the activation and strengthening of weak associations (Stickgold, 2002).
3. Other factors involved in the client's dual focus of attention, as he simultaneously attends to the present stimuli and the past trauma.

Over the past decade, research has investigated various mechanisms of action. It is currently hypothesized that the bilateral stimulation during EMDR therapy processing sessions (1) tax working memory, (2) stimulate the orienting reflex and an associated parasympathetic response, and (3) elicit the same or similar processes that characterize rapid eye movement (REM) sleep. The RCTs and physiological studies regarding these mechanisms are discussed in Chapter 12. However, it should be underscored that these posited mechanisms of action are not mutually exclusive. Multiple mechanisms may be activated during the processing session to produce the accelerated treatment effects observed in EMDR therapy research and clinical practice. For instance, dual attention has been demonstrated to affect working memory capacity, resulting in a decrease in vividness of memory imagery and emotionality (e.g., Engelhardt, van den Hout, Janssen, & van der Beek, 2010), and bilateral stimulation has been shown to facilitate memory retrieval (Christman, Garvey, Propper, & Phaneuf, 2003), as well as the recognition of true information (Parker, Buckley, & Dagnall, 2009). All three of these factors are relevant to EMDR treatment effects and

outcomes, pointing to diverse neurophysiological mechanisms involving the information-processing system. Therefore, in EMDR therapy, when we ask the client to bring up a memory of the trauma, we may be establishing a link between consciousness and the site where the information is stored in the brain. In the context of the other procedural elements, the bilateral dual stimulation appears to activate the information-processing system and allows processing to take place (see Chapter 12 for additional discussion and research on mechanisms of action). With each set of stimulation, we move the disturbing information—at an accelerated rate—further along the appropriate neurophysiological pathways until it is adaptively resolved. For instance, resolution may come when the previously isolated disturbing information is brought into contact with currently held adaptive information (e.g., "It wasn't my fault my father raped me"). One of the main tenets of EMDR therapy is that activating the processing of the trauma memory will naturally move it toward the adaptive information it needs for resolution.

Inherent in the Adaptive Information Processing (AIP) model is the concept of psychological self-healing, a construct based on the body's healing response to physical injury. For instance, when you cut your hand, your body works to close and heal the wound. If something blocks the healing, such as a foreign object or repeated trauma, the wound will fester and cause pain. If the block is removed, healing will resume. A similar sequence of events seems to occur with mental processes; that is, the natural tendency of the brain's information-processing system is to move toward a state of mental health. However, if the system is blocked or becomes imbalanced by the impact of a trauma, maladaptive responses are observed. These responses may be triggered by present stimuli or perhaps by the attempt of the information-processing mechanism to resolve the material. For instance, the rape victim may automatically continue to recall images of the rape in a blocked attempt to reach resolution and complete processing (Horowitz, 1979). If the block is removed, processing resumes and takes the information toward a state of adaptive resolution and functional integration. This resolution is manifested by a change in the images, affect (i.e., emotions and associated physical responses), and cognitions the client associates with the event. Metaphorically, we can think of the processing mechanism as "digesting" or "metabolizing" the information so that it can be used in a healthy, life-enhancing manner.

The information-processing system is adaptive when it is activated: Abuse victims begin EMDR treatment with a negative self-concept in regard to the event and consistently end with a positive sense of self-worth. Moreover, the opposite does not occur; that is, EMDR processing reveals an accelerated progression toward health (positive emotions and higher self-regard), but not toward dysfunction (inappropriate blame and self-loathing). The notion of activating the adaptive information-processing

mechanism is central to EMDR treatment and has been critical in its application to a variety of pathologies.

Bilateral Dual Attention Stimulation

As noted earlier, there are other stimuli besides directed eye movements that can activate the information-processing system. For instance, alternating bilateral hand taps and auditory tones has also proven clinically effective (Shapiro, 1994b). Although research indicates that such stimuli are not as effective as the directed eye movements (e.g., van den Hout et al., 2011), the other forms of stimuli can be useful in a variety of clinical situations that will be discussed in later chapters. Specifically, information-processing may be activated when attention is elicited by or focused on the external cues (e.g., attending to tactile or auditory cues, or by the act of merely fixating on a stimulus). The simultaneous focus on the traumatic memory may cause the activated system to process the dysfunctionally stored material. Alternatively, if the eye movements themselves induce an altered brain state that modifies the behavior of the information-processing system, we might expect other rhythmical movements or forms of sustained or repeated stimulation to have a similar effect. In addition, it should be noted that while numerous randomized studies have reported that the eye movements are clinically superior to exposure alone (Lee & Cuijpers, 2013), studies have indicated that patterns of regional brain activation produced by attention alone show significant overlap with those produced by eye movements (Braga, Fu, Seemungal, Wise, & Leech, 2016; Corbetta et al., 1998; Corbetta, Patel, & Shulman, 2008). Possible approaches to testing these hypotheses are discussed in Chapter 12.

As previously mentioned, I am offering a theoretical model to interpret the clinical effect, not to prove the existence of specific mechanisms. For example, the REM hypothesis only attempts to explain the apparent role of the eye movements in the treatment effects; it does not preclude the possible usefulness of other stimuli, such as tactile or auditory cues. Even if directed saccadic or tracking eye movements do prove to stimulate a mechanism that also operates during REM sleep, this finding does not discount the potential effectiveness of other stimuli used in the waking state (see also Stickgold, 2002). Obviously, there may be other choices of stimuli, even though the body in a sleep state is incapable of generating auditory stimuli, hand taps, blinking lights, or other external fixating devices. As Stickgold proposes, the repetitive reorienting of attention may produce specific shifts in regional brain activation and neuromodulation similar to those produced during REM sleep.

Regardless of the exact mechanism that brings about EMDR therapy's effects, it is the activation of the information-processing system that provides the clinical focus for treatment. Therefore, although the terms "sets"

and "eye movements" are used throughout this text, they are meant to refer to sets of other effective stimuli as well.

MEMORY NETWORKS

The hypothesis about the brain's innate information-processing system leads us to the concept of memory networks. In very simple terms, a memory network represents an associated system of information. No one knows what memory networks actually look like, but we can picture them metaphorically as a series of channels where related memories, thoughts, images, emotions, and sensations are stored and linked to one another.

EMDR treatment is conceptualized as progressing through memory networks, a configuration that is illustrated in Figure 2.1. When conducting EMDR processing, we ask the client to focus on a target, that is, a specific memory or dream image; a person; an actual, fantasized, or projected event; or some aspect of experience, such as a body sensation or thought. In the AIP model, this target is called a "node," because it has a pivotal place among the physiologically associated material. For instance, if the client's response to her boss is the presenting complaint, the clinician might target an image of the boss's face, which would be considered a node because of the constellation of associated experiences around it. If the client reacts to the target with undue anger or anxiety, it is because of the associations linked to it. These associations may include certain experiences with the boss or with other authority figures, such as the client's father. Therefore, if the goal of therapy is for the client to react calmly to the target, it is necessary to "clean out" each channel by reprocessing the dysfunctionally stored

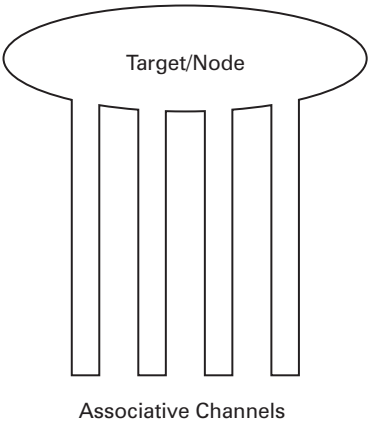


FIGURE 2.1. A graphic representation of the progression of EMDR treatment through the memory network.

material connected to that node. The reprocessing is done during each set of eye movements (or other stimuli), and we view each progressive stage of reprocessing as a plateau where images, thoughts, and emotions complete a shift in their progress toward greater therapeutic resolution. During this time, the underlying cause of the dysfunction may be spontaneously revealed.

A SAMPLE EMDR SESSION

To illustrate the concepts underlying EMDR therapy, let us look at the transcript of part of an actual treatment session. The client is a Vietnam War veteran who had already been treated for a number of combat-related traumatic experiences. The client had suffered moderate PTSD symptoms since the war, despite many years of therapy, including occasional inpatient treatment. In four previous EMDR therapy sessions he reprocessed his disturbing memories, and his intrusive thoughts subsided. The client's presenting complaint in this session is his negative reaction to an incompetent coworker. Although incompetence in a coworker is bound to be unpleasant for anyone, this client was reacting with such great anger and anxiety that he was incapable of working with the person. The client had been fighting his anger and frustration for weeks and finally asked for assistance because he could not escape working with his colleague on an ongoing project. The very thought of this coworker had become such a source of discomfort to the client that we used the coworker, rather than any specific interaction, as the target. As you will see, the clinician works with the client by using sets of eye movements to process the information causing his distress.

First, the therapist asks the client to visualize the incompetent coworker's face, the attendant negative belief, and to get in touch with the anxiety this generates. Then she asks him for a rating of any negative feelings he has, expressed in terms of the SUD (Subjective Units of Disturbance) scale, where 0 represents a neutral or calm feeling and 10 equals the most disturbance he can imagine. Next, the therapist asks the client to begin the set by visually following a rhythmical motion made by her fingers. (Specific instructions on how to do this are given in Chapter 3.) The clinician checks in with the client between sets to determine his condition and to ask if any new information has emerged. The clinician assesses the information revealed after each set to determine whether the client is processing the information and evolving to a more adaptive plateau.

At the end of each set, the therapist reinforces the client by saying, **"Good."** Then she instructs him to let go of what was last in mind and asks, **"What do you get now?"** The client then reports his most dominant thought, emotion (or intensity level), sensation, or image, so that the therapist can get a reading on the new information plateau. On the basis of what she learns, the clinician directs the client's attention either to the

new information or to the original target. Figure 2.2 shows the node (the incompetent coworker), with the associated channels of information that are revealed by the client's successive responses. The first designation in each column (e.g., major anxiety, comical) reflects the initial response of the client when the target was brought to mind; below each such designation are the associations that emerged after each subsequent set was initiated. Only one phase (desensitization) of the treatment session is illustrated.

Partial Transcript of the Sample Session

The client is Eric, age 39. He is a computer programmer.

THERAPIST: So let's go back to seeing the man you consider to be incompetent at work. Just look at him and see his face and feel how incompetent he is. From 0 to 10, how does it feel?

ERIC: 7.

[The client imagines the face of the coworker and gives an initial rating of 7 on the SUD scale.]

THERAPIST: Concentrate on the image and the feeling and follow my fingers with your eyes. (*Leads client in a set of eye movements.*) Good. Let it go and take a deep breath. What do you get now?

ERIC: I don't know. I guess it feels a little bit better. Before coming in today I worked through some of the things and at least on an intellectual level I realized . . . well, it's work and you know I'm going to be late on the schedule and people are going to be upset at it, but that's always going to be true. I mean in the computer business someone is always late. So I started making some connections with that.

[This is the first channel that opens up. The therapist decides to return to the original target.]

THERAPIST: Right. When you bring up his face now and get into the sense of his incompetence, from 0 to 10, where is it?

ERIC: Probably a 5.

THERAPIST: Notice that. (*Again the clinician leads the client in a set of eye movements.*) Good. Let it go and take a deep breath. What do you get now?

[As we will see, a new channel opens up because the client was brought back to the original target. This second channel indicates a chain of associated material linked by the concept of "personal acceptance."]

ERIC: One thing that comes up is, part of the reason that it's frustrating is that because of my boss's situation, he can't evaluate the other guy's ability. I guess it feels a little better in that other people can. I mean there are other people that see it and are frustrated by it. But I guess

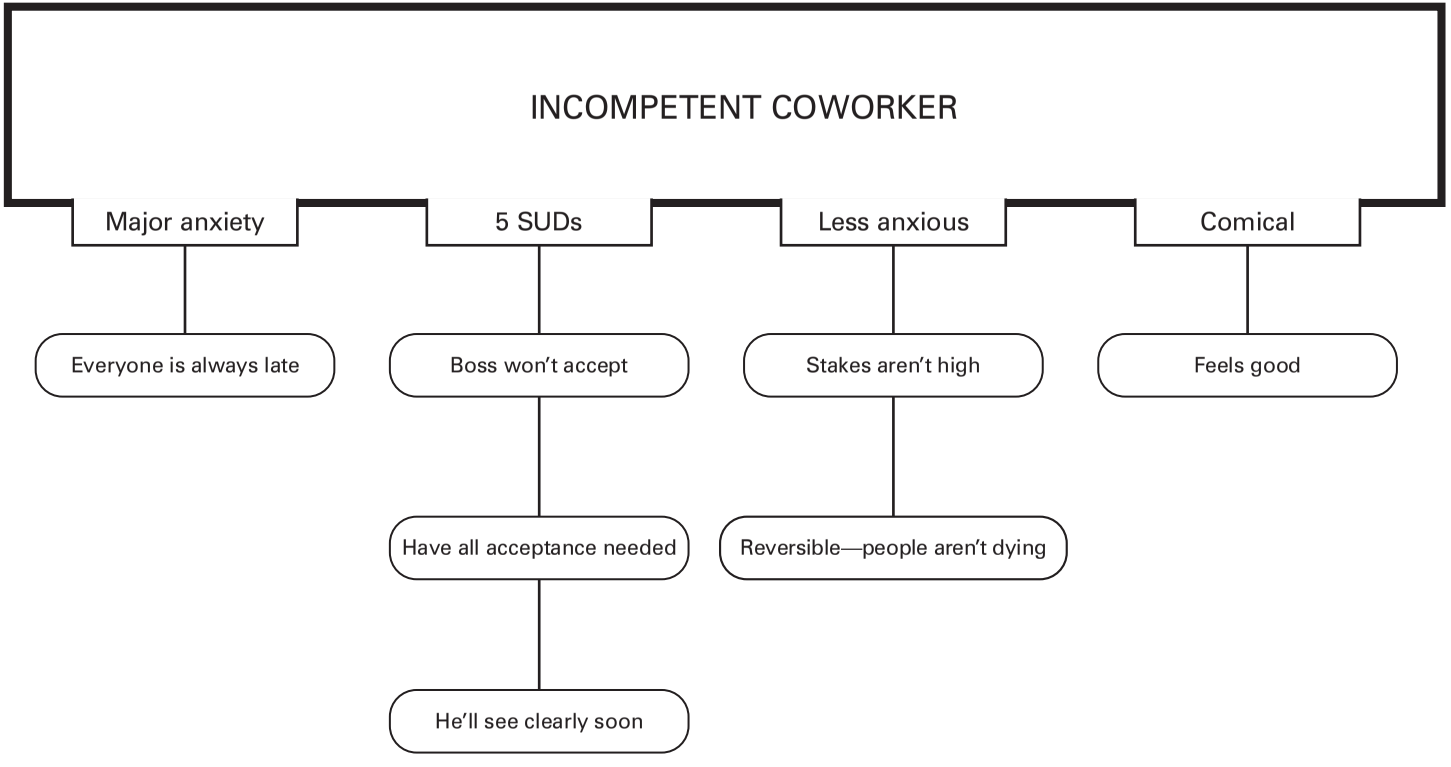


FIGURE 2.2. Diagram of a target (the incompetent coworker) and the channels of information that emerge with EMDR treatment, in the form of the client's responses and the sequential associations related to those responses.

it's like I need everybody to realize what's going on. And since my boss can't recognize it, and agree to it, I guess it gets back to me needing to be competent and having other people feel I'm competent.

THERAPIST: Think of all of that. (*Leads client in another set of eye movements.*) Good. Let it go and take a deep breath. What do you get now?

ERIC: Probably a 4 or a 3. Slowly but surely I'm starting to have periods where I realize I don't need other people's acceptance. I have a lot of people's acceptance and those are probably the ones that are important. It's difficult right now because my boss is one of them that I probably don't have, but that's his problem, not mine. (*Laughs.*)

[At this point a clinician using traditional therapy might be tempted to start a discussion focused on helping the client with his attitude. However, in EMDR therapy, this response is contraindicated. Rather, the clinician asks the client to hold in mind what he just said, then leads him in another set of eye movements to stimulate further processing. The client then provides another reading on what is happening for him. As we will see, this client has reached a new plateau and the information has evolved to a more adaptive form.]

THERAPIST: Okay. Think of that. (*Leads client in another set of eye movements.*) Good. Let it go and take a deep breath. What do you get now?

ERIC: I guess that I've got enough of his acceptance. I've got as much as I need. I mean, my boss needs me really badly right now, so certainly my job isn't in danger. So I've probably got as much as I need.

THERAPIST: Okay. Think of that. (*Leads client in another set of eye movements.*) Good. Let it go and take a deep breath. What do you get now?

ERIC: Ah . . . the thing that occurs to me is that probably in the next couple of months the pressure's going to let up on the project and by that time he'll be able to see.

THERAPIST: Okay. Notice that one. (*Leads client in another set of eye movements.*) Good. Let it go and take a deep breath. What do you get now?

ERIC: About the same.

[When the client indicates no change and is relatively comfortable, the clinician assumes he has "cleaned out" that second channel and brings him back to the original target.]

THERAPIST: Okay. Now what happens when you go back to the man's face that you feel is incompetent? What do you get now?

ERIC: It bothers me. I know I'm going to be frustrated by him in the future, but I think I'm going to be less likely to lose sight of what's going on.

[Note that although the client's level of disturbance has dropped, it is still bothersome. During the next set of eye movements the processing stimulates information stored associatively in a third channel. Here we discover

the impact of Vietnam combat material: If someone was incompetent in Vietnam, it meant people could die.]

THERAPIST: Just see him again and feel the incompetence. (*Leads client in another set of eye movements.*) Good. Let it go and take a deep breath. What do you get now?

ERIC: The thing that came to mind is, in this case the stakes aren't high. I mean, assuming I'm right and he is incompetent in this area and he gets in and screws everything up. So what? (*Laughs.*) I mean, we can turn it around.

THERAPIST: Really. Notice that one. (*Leads client in another set of eye movements.*) Good. Let it go and take a deep breath. What do you get now?

ERIC: Um, it's just nice to know . . . it's nice to think about the stakes and realize that it's just a bunch of computers and obviously the issue is people aren't dying because that you can't reverse.

THERAPIST: So if you bring up his picture again, what do you get?

ERIC: Um, it's sort of comical!

[Once again, since the previous two responses were the same and the client is relatively comfortable, the third channel is considered cleared and the original target is elicited. We see that the client's reaction to the incompetent coworker is now quite different. Only after the psychological pressures of the past Vietnam experience were released could the client react in a more relaxed manner in the present.]

THERAPIST: Yes.

ERIC: I mean he's a very bright guy. He's a very capable guy. It's just that when I look at the kinds of errors he makes, they're comical, and they're the same ones we all made when we first tried this stuff out. You know you found a problem, you solved a little bitty piece of the problem. There's this giant problem out there, but you went, "Yeah! Great, I solved it," because it was the only thing you could find. (*Laughs.*) And so you're so excited you found it, you pretended that was the whole thing. And other people are seeing it as well, and they've been handling it better than I have. I think they've always been at the chuckling level. You know, "Well what do you want him to do at the level he's at?" They just handle it better, but they all see it as well, and I think it's sort of cute that he thinks he can solve the world.

THERAPIST: Okay. Think of that. (*Leads client in another set of eye movements.*) Good. Let it go and take a deep breath. What do you get now?

ERIC: About the same.

THERAPIST: Great.

ERIC: Yeah, it feels good. It's nice to not be lost in the frustration and anger,

and that's where I was last week. I was losing it and I felt like there was nothing I could do about it. I tried to sort of detach myself but I couldn't.

Evaluation of the Sample Session

The transcript provides an excellent example of the precept "The past is present." The unprocessed memories of people dying in Vietnam 10 years previously, because of someone's incompetence, were feeding Eric's current reactions to his incompetent coworker. Processing revealed the internal associations, but more importantly, allowed the spontaneous emergence of adaptive information appropriate in the present situation. The final sense of understanding and self-efficacy shown by the client in the sample session is the hallmark of a successful EMDR processing session. However, this kind of unimpeded and uneventful information processing (i.e., processing without the need for additional clinical guidance) occurs with EMDR therapy only about half the time. For the remainder, the eye movements are insufficient and the progression ceases, requiring the clinician to intervene at a number of points or risk having the client retraumatized by the possibly highly charged, disturbing information. Alternative EMDR strategies to unblock information processing are especially important when using the procedures with highly disturbed clients (see Chapters 7 and 10).

Which associations the client might have cannot be completely predicted. For instance, if Eric had seen a friend die in combat because of someone's incompetence, he might have launched into an intense abreaction, or a reexperiencing, of the event. Clinicians, therefore, should be trained in EMDR procedures and observe a processing session involving highly charged material before attempting EMDR therapy with a client, and they should proceed with caution if they are not experienced at handling abreactive responses. Furthermore, clinicians must always use EMDR therapy in a clinically safe environment and with sufficient time for the client either to process an event fully or to return to a state of equilibrium. Again, there is no way of knowing if a channel contains dissociated material that will emerge full-blown once the processing is started. In other words, the client's level of disturbance can get much worse before it gets better, and the clinician must be fully prepared for this (see the discussion on history taking and cautions, covered in Chapter 4, and on the preparation phase, covered in Chapter 5, both of which are mandatory to lay the appropriate therapeutic groundwork).

DYSFUNCTIONAL TO FUNCTIONAL

Trained therapists consistently report that during EMDR processing their clients' negative images, affect, and cognitions become less vivid and less

valid, while positive images, affect, and cognitions become more vivid and more valid. A good metaphor for clinicians to apply here is that of a train traveling along its route. Initially, the information starts off in a dysfunctional form. When information processing is stimulated, it moves like a train down the tracks. During the accelerated processing that takes place with each set, the train travels one more stop along the line. At each "plateau," or stop, some dysfunctional information drops off and some adaptive (or less problematic) information is added, just as some passengers disembark and others get on a train at each stop. At the end of EMDR treatment, the target information is fully processed and the client reaches an adaptive resolution. Metaphorically speaking, the train has arrived at the end of the line.

Clinicians should remember that until processing is complete, the client's statements regarding the targeted material will not be fully functional. These verbalizations only manifest, or describe, the immediate plateau; they indicate the current state of the processed information. These interim nonadaptive statements may tempt the clinician to challenge the client verbally or to use cognitive restructuring. This would be a mistake, however, because it is equivalent to inviting the client to get off the train at an intermediate (and upsetting) stop. Because of EMDR therapy's emphasis on self-healing, any premature attempt by the therapist to intervene may slow or stop the client's information processing. In fact, when moving from one plateau of information to the next set, the clinician should direct the client (as much as possible) simply to think of the previous statement and should not attempt to repeat it. The client knows what he has just reported. Again, metaphorically, when we open the information-processing system, we allow the train to proceed down the line. The clinician's job is, whenever possible, to stay off the tracks.

DISPARATE NEURAL NETWORKS

To reiterate, the AIP model posits that the symptoms of PTSD are caused by disturbing information stored in memory in the brain. This information is stored in the same form in which it was initially experienced, because the information-processing system has, for some reason, been blocked. Even years later, the rape victim may still experience the fear, see the rapist's face, and feel his hands on her body, just as if the assault were happening all over again. In effect, the information is frozen in time, isolated in its own neural network, and stored in its originally disturbing state-specific form. Because the intensity of the affect has effectively locked the memory into a restricted associative network, the neural network in which the old information is stored is effectively isolated. No new learning can take place because subsequent therapeutic information cannot link associatively with it. Therefore, when thoughts of the incident arise, they are still connected to all the negative attributions of the original event. The results of years of

talk therapy, of reading self-help books, and of experiencing counterexamples are also stored, but they reside in their own neural network. It is in part the disparity between this therapeutic information and the dysfunctionally stored information that impels the client into the therapist's office for treatment and has him say, "I shouldn't be this way."

Although combat veterans, sexual molestation victims, and rape victims may know intellectually that they are not to blame for what happened to them, they often continue to struggle with the negative cognitions and disturbing affect. Again, this conflict appears to be due to the fact that the disparate information is stored in separate neural networks. The AIP model suggests that the moment of insight and integration comes when the two neural networks link up with each other. When the information-processing system is activated and maintained in dynamic form, the appropriate connections between the two networks can be made. Clinicians can observe a transmutation of information after each set as the target material links up with and is reshaped by the more positively oriented information. It is posited that the adaptively resolved memory is then restored in altered form through the process of memory reconsolidation (Suzuki et al., 2004; see Chapter 12). At the end of EMDR processing, the clinician asks the client to access the original target; after a successful session that memory will emerge spontaneously in a more positive form and will be integrated with appropriate affect and self-attribution.

APPLICATIONS OF EMDR THERAPY TO OTHER DISORDERS

The clinical applications of EMDR therapy are not limited to PTSD. As indicated by the AIP model, complaints not organically based or caused by inadequate information are rooted in insufficiently processed memories inappropriately stored in the brain. These unprocessed memories can include the impact of dysfunctional family of origin interactions, along with any other detrimental experiences and relationships throughout the person's lifetime. The memories are encoded with the emotions, beliefs, and physical sensations that occurred at the time of the event. When something happens in the present, it links into the existing memory network to be understood, and this connection is the basis of current reactions. Consequently, dysfunctional traits, behaviors, beliefs, affects, and body sensations are manifestations of the unprocessed memories. To treat these negative attributes with EMDR therapy, the physiologically stored memory that is the basis of the pathology is identified, accessed, and processed to resolution. In sum, according to the AIP model, inadequately or unprocessed experiences are the basis of pathology across the clinical spectrum, and processed experiences are the basis of mental health.

Consequently, the successful results of EMDR therapy with trauma victims have led to its application to a wide range of disorders. Essentially, the already stated principles of reprocessing apply. The AIP model predicts that most kinds of disturbing life experiences can be successfully treated, regardless of their origin.

A "big T" trauma (Criterion A event necessary to diagnose PTSD), such as rape, sexual molestation, or combat experience, clearly has an impact on its victims in terms of how they behave, think, and feel about themselves, and in their susceptibility to pronounced symptoms, such as nightmares, flashbacks, and intrusive thoughts. These victims will have self-attributions such as "I'm powerless," "I'm worthless," or "I'm not in control." Of course, clients who have not experienced such traumas may also have dominant negative self-attributions, such as "I'm worthless," "I'm powerless," or "I'm going to be abandoned." Many of these clients seem to have derived their negative self-statements from early childhood experiences. Therefore, when they are asked to rate on a 0- to 10-point scale how they feel about a representative event from their family of origin that helped give them these beliefs, they may report an 8, 9, or 10. Like "big T" trauma victims, they see the event, feel it, and are profoundly affected by it.

Such clients were not, of course, blown up in a minefield or molested by a parent. Nevertheless, a memory of something that was said or that happened to them is locked in their brain and seems to have an effect similar to that of a traumatic experience. In fact, by dictionary definition, any event that has had a lasting negative effect on the self or psyche is by its nature "traumatic." Consequently, these ubiquitous adverse life events have long been referred to in EMDR practice as "small t" traumas to keep in mind the nature of their impact (Shapiro, 1995a; for additional case applications, see Shapiro, 2012; Shapiro & Forrest, 1997/2016). A wide range of adverse life experiences can be the basis of pathology, because of their emotional impact. For instance, while being humiliated in grade school cannot be designated a "trauma" for the diagnosis of PTSD, on an emotional level, such an event can be considered the evolutionary equivalent of being cut out of the herd. The impact can be affectively devastating, with long-lasting effects.

Various studies in the last decade have supported this basic tenet of the AIP model in reporting that general adverse life events resulted in an equal or greater number of PTSD symptoms than major trauma (e.g., Gold, Marx, Soler-Baillo, & Sloan, 2005; Mol et al., 2005; Robinson & Larson, 2010). These life events included issues as ubiquitous as problems in relationships, at work, and at school. An indication of the pronounced dysfunction is the fact that the memory of the event still elicits similar negative self-attributions, affect, and physical sensations as existed on the day the memory was originally created. The therapeutic target is the disturbing

memory as it is currently stored, because the dysfunctional information has set the groundwork for the present pathology. While a wide variety of conditions are amenable to change, the specific diagnosis is less important than the appropriate targeting of the earlier experiences that are generating the client's dysfunctional symptoms, characteristics, and behaviors. For instance, body dysmorphic disorder and olfactory reference syndrome have been successfully treated through EMDR processing of the apparent etiological event (Brown et al., 1997; McGoldrick, Begum, & Brown, 2008). In most cases, the targeted initial event was no more than a perceived disparaging remark or humiliation (see Chapter 12 and Appendix D for a comprehensive review of clinical applications).

The AIP precept regarding the impact of trauma, and other adverse life events that do not meet the criteria of major trauma, has now been demonstrated by research. The first study to corroborate the posited effects of adverse childhood events on a wide range of disorders was an examination of over 17,000 Kaiser Permanente patients (Felitti et al., 1998). The research evaluated the prevalence of 10 categories of experiences and reported that the more kinds of adverse experiences in childhood, the greater the likelihood of developing mental health problems such as alcoholism, drug abuse, and depression, as well as physical ailments (e.g., heart, liver, and lung disease; cancer; skeletal fractures). Research has continued to support the negative effects of adverse childhood experiences, including:

1. Harsh physical punishment in childhood, not rising to the level of child abuse, is associated with mood disorders, anxiety disorders, substance abuse/dependence, and personality disorders as an adult (Afifi, Mota, Dasiewicz, MacMillan, & Sareen, 2012).
2. Verbal abuse by peers is associated with anxiety, depression, and drug use (Teicher, Samson, Sheu, Polcari, & McGreenery, 2010).
3. Adverse life experiences contribute to the development of depression (Heim et al., 2004).
4. The relationship of adverse childhood experiences to psychosis (Arseneault et al., 2011; Heins et al., 2011). In fact, according to some researchers (Read, Fosse, Moskowitz, & Perry, 2014, p. 73), "contrary to long-held beliefs among biologically oriented researchers and clinicians, the etiology of psychosis and schizophrenia are just as socially based [e.g., early-life adversity] as are nonpsychotic mental health problems, such as anxiety and depression."

In short, a wide range of research has indicated that adverse childhood experiences, including household dysfunction, peer problems, humiliations, and failures, can have profound and long-lasting effects. As posited in the AIP model, the cause is the unprocessed memories of these events that are physiologically stored with the cognitive, affective, and somatic elements that were originally experienced.

STATIC EXPERIENCE: AFFECT AND BELIEF STATEMENTS

The disturbing aspects of dysfunctionally stored memories are statically associated together, because the system cannot make new, appropriate connections. The information stored in the neurophysiological memory network may be manifested by all elements of the event: images, physical sensations, tastes and smells, sounds, affect, and cognitions such as assessment and belief statements. When the unresolved trauma is stimulated, the client not only sees what occurred but may also reexperience the affect and physical sensations that were felt at the time. Some researchers believe that maintenance of the disturbing elements, including strong physical sensations, is due to inappropriate storage in short-term memory rather than in the appropriate long-term memory (Horowitz, 1986, 2011) or to storage in episodic/implicit systems rather than in semantic systems (see Stickgold, 2002, 2008; van der Kolk, 1994, 2002, 2014). If so, successful EMDR processing includes a dynamic shifting of the information to functional storage in memory as it is metabolized and assimilated, which means that what is useful is learned and is made available, with appropriate affect, for future use.

Although the person's negative beliefs and self-attributions are transformed simultaneously with the other manifestations of the trauma, they are not given greater weight than sensory experiences. They are termed "meta-perceptions," because they are not sensory experience but, rather, are interpretive of the experience and entail language.

Language is not a necessary component of the original trauma, as seen, for example, in the negative effects of sexual and physical abuse on preverbal infants. For instance, many children are locked in closets and abused before they can speak, yet they clearly have symptoms of PTSD. Some cognitive therapists might say that a child placed in a room with a tiger would not fear the beast unless the child was old enough to know that a tiger is dangerous. However, it seems clear that if the tiger turned and roared at the child, no matter what the child's age, fear and possibly traumatization would result. This illustrates one of the genetically encoded responses in human beings, responses that have developed through evolution and do not require the stimulus of language. Thus, while a person's beliefs, stated via language, are clinically useful distillations of experience, it is the affect feeding them that is the pivotal element in the pathology.

The concept that past experiences lay the groundwork for present dysfunction is far from new, but let us examine it in the context of EMDR therapy, specifically, in terms of memory storage and the AIP model. Imagine that a little girl is walking beside her father and reaches up for his hand. At that moment the father deliberately or inadvertently swings his arm back and hits the child in the face. The child experiences intense negative affect, which might be verbalized as "I can't get what I want; there is something wrong with me." (This self-blame is almost predictable: Children typically

seem to take the blame for their parents' mistakes or flaws, a fact that is most painfully obvious in the case of sexual molestation victims who blame themselves for their abuse. This tendency may also be caused by evolutionary processes that encode the submission to authority as a necessary adjunct to survival.) The affect, perhaps intense feelings of worthlessness and powerlessness, and the images, sounds, and the pain of the blow are stored in the child's memory system. This experience becomes a touchstone, a primary self-defining event in her life; in the AIP model, it is called a node. Since memories are clearly stored associatively, the next event that represents a similar rejection is likely to link up with the node in the ongoing creation of a physiologically stored neural memory network that will be pivotal to the girl's definition of her self-worth. Subsequent experiences of rejection by mother, siblings, friends, and others may all link up with the node in channels of associated information. Even before language is adequately developed, all the different childhood experiences containing similar feelings of powerlessness, despair, and inadequacy are stored as information linking into a memory network organized around the node of the earlier touchstone experience. Positive experiences are not assimilated into the network, because the node is defined by the negative affect.

When there is sufficient language to formulate a self-concept, such as "I can't get what I want; there is something wrong with me," verbalization is linked associatively with the network by the affect engendered by the meaning of those words. In essence, once the affect-laden verbal conceptualization is established in the neural network, it can be viewed as generalizing to each of the subsequent experiences stored as information in the memory network. The process continues in adolescence, for instance, when the girl in our example experiences rejection by a teacher or a boyfriend. Thus, all subsequent related events may link to the same node point and take on the attributions of the initial experience. Therefore, the assessment associated with such an event is not limited to a function-specific statement (e.g., "I can't get what I want in this instance"), but is linked to the dysfunctional generalized statement, "I can't get what I want; there is something wrong with me."

What happens when the girl reaches adulthood and something happens that seems like—or even threatens to become—a rejection? This new information is assimilated into the memory network, and the concept "I can't get what I want; there is something wrong with me" and its affect generalize and become associated with it. Over time, the accumulated related events produce a self-fulfilling prophecy; thus, any hint or chance of rejection can trigger the neural network with its dominant cognition of "There is something wrong with me." This person's consequent behavior and attributions in the present are dysfunctional, because what motivates and fuels them is the intense affect, fear, pain, and powerlessness of that first experience, now compounded by all of the subsequent experiences. Thus, the pain of childhood continues to be triggered in the present, and

because of the associational nature of memory and behavior, the woman's current responses and assessments of herself and the world will be dysfunctional. When the woman enters a social or business situation and desires something, the neural network with the affect that is verbalized by "I can't get what I want; there is something wrong with me" will be stimulated, and the associated affect, level of disturbance, and self-denigrating belief will severely hamper her functional behavior in the present.

RESOLUTION

Resolution of disturbance is achieved through the stimulation of the client's inherent self-healing processes. As previously discussed, one of the primary principles of the AIP model is the notion of a dynamic drive toward mental health. The information-processing mechanism is physiologically designed to resolve psychological disturbances, just as the rest of the body is geared to heal a physical wound. According to our model, psychological dysfunction, with all its complex elements of lack of self-esteem and self-efficacy, is caused by the information stored in the brain. By means of EMDR therapy, this information is accessed, processed, and adaptively resolved. As explained earlier, asking the client to bring a picture of the original event to consciousness stimulates the physiologically stored information. The eye movements (or other stimuli) activate the information-processing mechanism, and with each set, new, adaptive, information is assimilated into the memory network, transforming the target material until it arrives at a healthy, functional state.

For example, during an EMDR processing session, a client who starts with a picture of her abusive father towering threateningly over her may spontaneously report seeing herself grow in size until she is eye-to-eye with him. As the old information evolves toward a therapeutic and healthful resolution with successive sets, the client may spontaneously state something like, "I'm fine; Dad really had a problem." This shifted assessment is an integral part of the new affect and sensory experience, an experience that will now dominate whenever the neural network is activated by either internal or external stimuli. In other words, as the information transmutes, the changing picture corresponds to shifts of affect and self-assessment, which become a part of the way the experience is now stored.

The client automatically behaves differently now, since the underlying belief is "I'm fine" rather than "There is something wrong with me." For most clients, successful EMDR treatment results in the new, positive cognition generalizing throughout the entire neural network. Therefore, any associated memories (e.g., of other threats by the abusive father of the woman in our example) that are accessed subsequent to treatment will result in the emergence of the positive cognition ("I'm fine") along with appropriate affect. The therapeutic resolution is revealed in all aspects of

the target (images, physical sensations, emotion, and cognitions) and in past and present associated events, as well as in an appropriate change in behavior.

FROZEN IN CHILDHOOD

Clinical observation of EMDR treatment sessions indicates that therapeutic results are often achieved through the progressive emergence of an adult perspective, particularly in cases where the client was previously locked into the emotional responses of a childhood trauma. Many childhood experiences are infused with a sense of powerlessness, lack of choice, lack of control, and inadequacy. Even the best of childhoods have moments, such as when parents go out for the evening, in which the child feels uncared for, abandoned, and powerless. The AIP model posits that even these normal experiences can be the physiologically stored causal events for many dysfunctions.

The language of the client often includes expressions of such childhood states as powerlessness, lack of choice, fear, and inadequacy. For example, the 50-year-old client who speaks long-distance to her mother and starts reacting with fear, frustration, and anxiety is not reacting to the present-day 75-year-old invalid on the telephone. Rather, the emotions of her childhood are experienced because of the stimulation of the neural network associated with her mother, a network based on earlier touchstone memories that include intense feelings of fear and lack of safety. Essentially, the client cannot react calmly to her mother until the earlier memories are appropriately processed and relegated to their proper place in the past.

As EMDR activates the information-processing system and maintains it in a dynamic state, the guilt and fear of the child's perspective can be progressively transmuted into the adult perspective of appropriate responsibility, safety, and confidence in one's ability to make choices. Perceptions, such as of one's lack of control, that were perfectly valid in childhood or during a rape or combat situation, are no longer true for the adult in the present.

It is important to understand the parallel between negative childhood experiences and the experience of the trauma victim. In both there are generally feelings of self-blame and inadequacy and a lack of control, safety, or choices. Presumably, a dysfunctional node is set in place in childhood (during developmental stages), when positive information is not assimilated into the neural network during the critical period immediately following a disturbing experience (e.g., the child may not receive comforting after an injury). The nature of preexisting nodes, as well as the intensity of subsequent stressors, may determine the formation of pronounced PTSD symptoms. In adult trauma victims, the presence of a preexisting dysfunctional node may explain why processing the chronic memories of the trauma

suffered in adulthood by means of EMDR therapy often results in the client's reporting the emergence of early childhood memories with similar affect. Adequate information reprocessing allows the client to recognize appropriate present conditions or circumstances on both emotional and cognitive levels. What we have seen in a vast number of EMDR therapy clients is their progressive evolution to a state of self-acceptance in which they have a sense of safety and control in the present.

"TIME-FREE" PSYCHOTHERAPY

Traditional psychotherapy has been time-bound in the sense that its effects occur only after a protracted period of time. Conventional therapy uses verbal (rather than physiologically based) procedures to shift information that is dysfunctionally locked in the brain (see also van der Kolk, 2002, 2014). In the AIP model the healing of psychological dysfunction is viewed as being comparatively "time-free," because rapid treatment effects can be observed when EMDR processing is initiated, regardless of the number of disturbing events and no matter how long ago they occurred.

As discussed earlier, EMDR treatments can target early childhood memories, later traumas, or current situations for positive therapeutic effect because the neural network has associative links to all similar events. As the client holds the target in consciousness, the dysfunctional information is stimulated. The information-processing system is activated through sets of bilateral dual attention stimuli, and the traumatic event is transmuted to an adaptive resolution with appropriate affect, self-attribution, and overall assessment. Since the information is linked associatively, many similar memories can be affected during the treatment session, and it is possible for the new positive affect and positive cognitions to generalize to all events clustered in the memory network.

Alternatively, since multiple-rape victims, sexual molestation victims, and combat veterans may have many traumatic events in their history, the clinician can cluster the client's memories into groups that have parallel cues and stimuli, such as memories of seeing comrades wounded in combat or memories of abusive acts by an older brother. The EMDR treatment then actively targets one event that represents the entire cluster, which often allows for a generalization effect throughout all the associated experiences.

The changes during EMDR treatment occur rapidly compared to conventional treatment presumably because (1) the memories can be targeted in clusters, (2) the dysfunctional state-dependent material is accessed directly, (3) focused protocols (which will be explained in later chapters) are employed, and (4) stimulation of the innate information-processing system apparently transforms the information *directly on a physiological level*.

The ability of EMDR treatment effects to be comparatively free from time restraints is analogous to the ability of individuals to dream through

extremely long sequences of events in just 45 minutes of REM sleep. Presumably, similar mechanisms in the dream state and the AIP state of EMDR therapy allow rapid physiological shifting through cognitive–emotive material (see also Stickgold, 2002). Although this processing effect may be found in many individuals following a dream about a minor disturbance, a conscious, active engagement appears necessary for many kinds of traumatic material to be similarly influenced. During EMDR treatment, the adaptive processing of memories is dynamically maintained; that is, EMDR procedures keep the information-processing mechanism active. This is in sharp contrast to the static recall of events typical of long-term verbal therapies.

In EMDR, the history taking, the directed processing procedures, and the treatment protocols all reflect a model that emphasizes a sharp therapeutic focus. As previously mentioned, the model incorporates the notion of self-healing and spontaneously generated recovery once the proper nodes are accessed and the information-processing system is activated (with the obvious exceptions of chemically or organically based disorders).

There is an analogy here to the medical treatment of disease: Just as the use of modern drugs made us revise our assumptions about the amount of time required to heal various physical ailments, so too does the use of EMDR therapy force us to examine our preconceived notions about the time required to heal psychological wounds.

According to the AIP model, the EMDR clinician catalyzes the appropriate biochemical balance necessary for processing. For instance, the altered brain state caused by focused attention and simultaneous eye movements (or alternative stimulation) may lead to specific activation of the limbic and cortical systems (Stickgold, 2002, 2008; also see Chapter 12). This interaction may underlie rapid treatment effects. However, full therapeutic treatment involves the use of clinical procedures and protocols that maximize the beneficial effect. Each client history, as discussed in Chapter 4, includes indicators of client readiness and demands unique treatment plans and levels of therapeutic support. EMDR clinicians have found that through use of the structured protocols, a few sessions can often clear up an area of dysfunction that may have appeared resistant to months of previous therapy.

The clinician's mind must be open to the fact that rapid, profound, and multidimensional change in a client can take place and can be maintained over time. For those clinicians trained in a long-term model such as psychoanalysis, this may be difficult to accept. However, let me stress that clinical observations of EMDR processing sessions have revealed that no pertinent stage of healing is skipped: Symbols become clear, insights occur, lessons are learned, and the various stages of emotional resolution are experienced, albeit in an accelerated fashion (see also Wachtel, 2002).

Regardless of the psychological modality used by the clinician, it is only logical that any therapeutic change must ultimately be based on a physiological shift of information stored in the brain (see Chapter 12 for

neurophysiological data regarding EMDR treatment). It might be helpful for clinicians to recognize the comparatively short distance involved in crossing a synapse. Even in long-term psychodynamic therapy, insight occurs during a single moment in time; in the AIP model, insight occurs when two neural networks connect.

TARGETS

The key to psychological change is the ability to facilitate appropriate information processing. This means making connections between healthier associations. Specific targets are used to gain access to the dysfunctional memory networks. On the basis of clinical observation, it appears that any manifestation of the stored information can be used as a target for EMDR processing. Thus, a dream, a memory, and current behavior are all useful foci inasmuch as they all stimulate the specific neural network containing the disturbing information. For instance, a combat veteran may have a recurring nightmare of being killed, a memory of being shot, or an anxiety reaction to loud noises, along with a pervasive belief about lack of control. All these elements can be combined in an appropriate treatment plan. Once the information-processing system is activated, the dysfunctional elements can be metabolized and the presenting complaint resolved through the progressive linking of the target with more adaptive material.

In addition, there are a number of indications of obstructed memory networks that may be targeted, including memory lapses, dissociations, and the fact that access is restricted to negative material.

Access Restricted to Negative Material

One indicator of an obstructed memory network is when the client is able to retrieve only negative memories even when other, positive, events have been experienced. For example, one client's presenting complaint was that she had felt for 2 years that a "black cloud" was hanging over her head. She had been very close to her father, who had died a terrible death in a nursing home while she had been powerless to do anything. Whenever she tried to think of her father, or whenever anything stimulated a memory of him, the only images that arose were of his suffering in the nursing home. EMDR processing was aimed at these images. Subsequently, to check on the effectiveness of the treatment, the client was told to think of her father and was asked, **"What do you get?"** She reported spontaneously seeing a picture of the two of them at a party. When she was then asked to blank out the picture and to think of her father again, the same type of result occurred. The positive images were linked to a feeling of peace, and the black cloud had vanished. Research has also indicated that positive recall is increased subsequent to EMDR treatment (Sprang, 2002).

According to the AIP model, the negative information is held dysfunctionally in an excitatory form and, as a consequence, is more likely to be stimulated than are other associations. Thus, although many kinds of information are stored in the associative memory network, access to all but the highly charged negative material is blocked. When the disturbing events have been processed, they resolve adaptively into a more neutral form, with cognitions that verbalize a more appropriate affect (in the preceding example, one such cognition would be "He is at peace now"). The positive memories can then emerge. As a result, any internal or external cue that would elicit information from the targeted memory network will no longer access only the dysfunctional information. For instance, if the client in our example is asked to think about her father or if she hears about someone else's father, she will no longer be limited to thoughts about the events at the nursing home. Once the disturbing memories are adequately processed, cues allow access to other, more positive, aspects of the neural network.

Memory Lapses

Victims of childhood sexual abuse often report being unable to retrieve many memories of the years during which the molestations occurred. It seems that the highly charged information about the abuse is blocking access to the rest of the childhood memory network. Once the trauma is processed, the client is able to remember many positive events, such as experiences with friends that occurred during that time. As the full memory network becomes available and happy memories become unblocked, the client's self-concept automatically changes. As a result of the increased range of the client's childhood memories and associations she is able to redefine herself as a person with positive abilities, a history, and a future.

Dissociation

Clients may present themselves as highly symptomatic but with no memory of a traumatic event that may have led to this condition. In these cases, the presenting symptoms appear to be a manifestation of dysfunctionally stored information. There is no presumption, however, as to the nature or factual accuracy of the touchstone event. Clinicians should take great care not to lead or interpret for the client (see the section "False Memory" in Chapter 11).

It should be recalled that dissociated material may be nothing more than information that is unavailable to awareness because it is stored in state-dependent form in an isolated neural network. As the information is processed, it can emerge into consciousness. However, an image is only one of many possible manifestations of dysfunctionally stored information, and the actual visual memory of an event may never be retrieved. Nevertheless, clinicians have reported that by targeting other aspects of the

stored memory such as sounds, smells, thoughts, feelings, sensations or the present symptoms (including the client's sense of danger), many of these clients retrieve visual images of the dissociated event. In fact, a variety of studies have reported that the eye movements enhance episodic memory retrieval (e.g., Christman et al., 2003; Nieuwenhuis et al., 2013). More importantly, however, the present symptoms may subside even if there is no image retrieval. EMDR therapy sessions have shown that effective processing can occur whether or not the information is released as an image into the client's conscious awareness. Metaphorically speaking, the video can be running (i.e., the information can be processing) whether or not the monitor is turned on.

Other forms of dissociation occur in clients who merge with the past experience during abreactions. The overwhelming sensations and emotional reactions experienced as the event is accessed are indicators that the information has been held in dysfunctional form. As the information is successfully processed, clients often exclaim, "Oh, I'm here," adding, "I'm not in Iraq" or "I'm not in my old house" or "I'm not in danger."

Likewise, a complete lack of appropriate affect, which can also be indicated by the client who uses terms such as "numb" or "blocked" when a traumatic event is accessed, indicates information that has been dysfunctionally stored. In these cases, clients can retrieve the affect, often at a high level of disturbance, during the initial phases of processing. *Any* inappropriate dissociative response, either an over- or underreaction to a traumatic event, is considered indicative of a blocked memory network and is therefore an appropriate target for EMDR processing.

INTEGRATED PSYCHOTHERAPY

As you can see from the previous discussions, many psychological modalities dovetail in EMDR therapy. As a clinical approach, EMDR paradigm opens up new therapeutic possibilities by supporting an integration of key treatment elements from the major psychological modalities.

In a typical 90-minute EMDR session, the clinician observes rapid changes in the client. Clinicians who use a psychodynamic approach are likely to notice free association, catharsis, abreaction, symbolism, and family-of-origin material. Behaviorists easily observe learning chains, generalization, conditioned responses, associative material, and more. The cognitive therapist finds the progressive shifting of cognitive structures and beliefs. The Gestalt therapist observes the removal of emotional static, which allows the client to differentiate more easily the figure and ground relationship. The Reichian observes the shifting of physical sensations linked to the dysfunctional material. What we find in EMDR therapy is an interweaving of much of what appears to be valid in traditional psychotherapy. Essentially, regardless of the terms used, what all psychological

modalities have in common is that information is stored physiologically in the brain. When healing is activated, the key elements of most psychological approaches are represented.

However, while the AIP model offers a unifying theory that can be seen as synthesizing all psychological modalities, the model opens up new territory by defining pathology as dysfunctionally stored information that can be properly assimilated through a dynamically activated processing system. Thus, the clinician utilizing EMDR therapy is offered a new role in helping to facilitate positive treatment effects.

Global diagnoses, such as personality disorder, often serve to chain the client to an immovable mountain. Use of the AIP model and EMDR therapy suggests that the clinician focus on the characteristics that generate the behaviors responsible for the diagnosis rather than attend primarily to a diagnostic label. Characteristics are viewed as having been produced by earlier experiences, including parental modeling, that are physiologically stored in the brain and as being susceptible to change through targeted processing. Thus, a vast range of adverse experiences in childhood, adolescence, and adulthood can be located on a spectrum of trauma and can become subject to EMDR-activated shifts toward self-healing and resolution.

Each clinician, regardless of orientation, is invited to observe EMDR processing effects and rediscover everything that is believed to be true of his or her modality. The clinician also is urged, however, to consider the proposed information-processing model rather than prematurely superimpose on EMDR therapy a previously derived theoretical approach.

The AIP model, refinements of the EMDR procedures, and treatment protocols have evolved in order to explain and maximize treatment effects. Therefore, clinicians are advised to use EMDR therapy (as described in later chapters) and observe its clinical results before attempting to define it (thereby circumscribing it) and make it conform to previously established modalities. This caution may help prevent EMDR therapy's benefits from being confined to the limits of what has so far been achieved. For instance, if EMDR therapy is defined simply as hypnosis, its usefulness will be limited to those effects already available to the hypnotist. If it is viewed solely as desensitization, essential dynamics and applications may be ignored by the therapist. Allowing EMDR therapy to define its own parameters on the basis of its effects means that the boundaries observed in other modalities may be surpassed (see also Norcross & Shapiro, 2002). Thus, for the fullest therapeutic effects it is crucial that the clinician observe the client's responses without preconceived limitations. In actual practice, EMDR therapy may perhaps best be described as a client-centered, interactive, interactional, intrapsychic, cognitive, behavioral, body-oriented therapy. Key elements of all these modalities are integrated to treat the client as a whole person.

SUMMARY AND CONCLUSIONS

The AIP model posits a series of interactions and effects involving the centrality of unprocessed memories in conceptualizing and treating a wide range of pathologies. The model is offered as a neurophysiological hypothesis, because current understanding of brain physiology is not yet sufficient to verify information-processing models underlying any form of psychotherapy. However, research has supported many of its tenets and predictions. Since this model is based on observed treatment effects, and has successfully guided EMDR therapy practice and research for the past 25 years, it can serve as a clinical road map that is both explanatory and predictive, even if it turns out that the neurophysiological details of the hypothesis are incorrect.

The AIP model states that there is an innate physiological system that is designed to transform disturbing information into an adaptive resolution and a psychologically healthy integration. A trauma or other adverse life experience may disturb the information-processing system, causing perceptions to be stored in state-dependent form and manifested by pronounced symptoms of PTSD and a wide range of other disorders. The blocked information-processing system is thought to be stimulated through a variety of possible physiological factors, including (1) deconditioning caused by a compelled relaxation response, (2) a shift in brain state enhancing the activation and strengthening of weak associations, or (3) some other function of a dual-focus information-processing mechanism (see Chapter 12 for a discussion of proposed mechanisms and review of research data). Alternative bilateral stimulation such as auditory and tactile stimuli have been found to have a clinical effect similar to that of the eye movements. As emphasized throughout this text, the stimuli are used within the context of focused and multifaceted procedures that are also designed to support and facilitate the processing. Essentially, the hypothesis states that the targeted information is metabolized and transmuted along associated memory channels through the progressive stages of self-healing. Transmutation is seen in all elements of the information—images, emotions, sensations, and beliefs. As the information moves from dysfunctional to functional form, the negative manifestations of the target dissipate and the positive ones become more vivid. In addition, there is a comparatively high incidence of emergence of previously dissociated material as disparate neural memory networks progressively associate with one another until an adaptive resolution is achieved.

Within AIP, most psychopathologies are assumed to be based on earlier life experiences that are in state-dependent storage. These adverse life events may be designated as "small t" traumas to remind clinicians of their impact. This designation underscores the notion that childhood events can have a lasting negative effect on the self and psyche and can be

conceptualized as encoding negative affects and sensations that spontaneously arise when triggered by present conditions. Therefore, a childhood humiliation can be stored dysfunctionally in ways that inhibit the adult's sense of self and optimal behavior. Clearly, although designated "small t" trauma to denote the ubiquitous nature of these types of experiences, the events did not feel "small" to the child. Indeed, childhood humiliations can be seen as the evolutionary equivalent of being cut out of the herd and may help explain why an emotional overload consequent to the triggering of a survival mechanism may result in dysfunctional storage. However, regardless of cause or length of time since the event, the associative nature of the memory network allows the generalization of positive treatment effects to modify present self-assessment and behavior. Whether the complaint is simple PTSD or a more complex diagnosis, the transmutation to an adaptive adult perspective may be accomplished comparatively rapidly by this focused, physiologically based approach, which appears to unblock the information-processing system and memory networks.

All of the salient elements of the primary psychological modalities, as well as the indicators of profound psychological change, will be apparent in the integrated EMDR therapy approach. All of the procedures are viewed as contributing to the positive treatment effects. However, clinicians are cautioned to remain flexible and to use the proposed model as a clinical road map to permit the possibility of an expansive psychological change that can be achieved with unusual rapidity. It is necessary, of course, for the clinician to have the appropriate education and qualifications, since EMDR is only as effective as the person using it and all of one's previous clinical training and skill will be called upon to achieve therapeutic success.

CHAPTER 3

Components of EMDR Therapy and Basic Treatment Effects

If you have built castles in the air, your work
need not be lost; that is where they should be.
Now put the foundations under them.
—Henry David Thoreau

In the first part of this chapter, I explore in detail the importance of a delineated target used as the focal point of EMDR processing and define the basic components. These include the image; the negative and positive cognitions; the emotions; the physical sensations; and the emotional and cognitive rating scales, the SUD (Subjective Units of Disturbance) and the VOC (Validity of Cognition) scales. I then describe the eye movements themselves, as well as alternative stimuli. Next, I review the eight phases of EMDR therapy: history taking and treatment planning, preparation, assessment, desensitization, installation, body scan, closure, and reevaluation. Finally, I discuss some clinical effects of targeting and typical client experiences during EMDR processing. Defining in this chapter all these aspects of treatment places the following chapters in the context of client–clinician interaction by giving specific instructions for their use. The procedures in these explanatory chapters are primarily illustrated by case examples of trauma treatment. However, these fundamental components apply to all EMDR therapy applications. Additional clinical populations are explored in Chapters 9 and 11.

BASIC COMPONENTS OF THE EMDR PROCESSING TARGETS

Effective EMDR processing depends on effective targeting. If the wrong targets (or the wrong components) are used, positive treatment effects are likely to be minimal. For the sexual abuse survivor, appropriate targets

include early childhood memories, recent events that trigger current disturbances, and imaginal events that incorporate appropriate future behaviors. When treating a relatively uncomplicated case, such as a victim of simple PTSD who has suffered a trauma such as a natural disaster, it may be necessary to target only the single memory of the event, although the present triggers and a positive template to address avoidance behavior should be assessed (see Chapter 8). However, if the event has taken place within the last few months, specific recent event protocols may need to be used (see Chapter 9). It is important for the clinician to be familiar with both the processing procedures and specific protocols delineated in this text.

Regardless of the number of clinical aspects that require treatment, each target must be individually circumscribed and fully processed. These targets are the building blocks of EMDR treatment and deserve careful clinical attention. A fully delineated target helps the client and the clinician to understand the trauma context and configuration (all the details that make up the trauma and response) and will result in more rapid processing. The most useful parameters for treatment are the picture, the negative and positive cognitions, the emotions and their level of disturbance, and the physical sensations. These aspects of the target must be clearly defined for initiating, continuing, and concluding EMDR processing. Let us take a close look at each of them.

The Image

The clinician should ask the client to think of the event, then to focus on one image that represents either the entire incident or the most upsetting part of it. Whether or not the image is distinct is of little consequence. Indeed, it is quite common for the client to have only a blurred image or fragmented view of the event. The goal is simply to establish a link between consciousness and where the information is stored in the brain.

The Negative Cognition

The client is next asked to identify a statement that expresses the underlying negative belief or maladaptive self-assessment that goes with the image. This statement is called the "negative cognition." While the term "cognition" has often been used to define all of the conscious representations of experience, in EMDR therapy we use it to signify a belief or assessment. Therefore, the cognition represents the client's current "interpretation" of the self, not merely a description. As an interpretation, the negative cognition answers the question, "What are my self-denigrating beliefs about myself in relation to the event?" Negative cognitions include statements such as "I am bad/worthless/unable to succeed." The rape victim who looks back at having been bound and gagged, and offers the statement "I was powerless" or "I was afraid" is *not* providing a negative cognition; she is

giving a statement of fact, a description. EMDR therapy cannot transform this rape victim's statement, because processing affects only inappropriate, dysfunctional material. An example of a negative cognition that is appropriate for the hypothetical rape victim might be "I *am* powerless." This statement indicates how she currently feels about herself when she recalls the rape. When the traumatic memory is stimulated, the dysfunctionally stored affect is felt and the negative cognition serves to convey its meaning. Because the statement "I am powerless" is inappropriate or dysfunctional (since there is no current danger or threat), EMDR can be used to reprocess it.

For sexual abuse survivors, some appropriate negative cognitions may include "I am damaged for life," "I am powerless," or "I don't deserve love and can't have it." Note the following characteristics of these negative cognitions: They are all "I-statements," they are expressed in the present tense, and they involve negative self-attributions because of the client's participation (though forced) in the traumatic event. These statements indicate pathology. Like the image, the negative cognitions are links to the dysfunctional material that is in need of processing.

The "negative cognition" is defined as the negative self-assessment that victims make in the present. When the client brings up the memory of a trauma that may have occurred many years ago, the clinician must ascertain how the level of disturbance is presently experienced. The client may continue to think inappropriately about himself in relation to the event (with feelings of self-blame, incapacity, powerlessness, or self-denigration), demonstrating that the memory has not been resolved. When the rape victim brings up the rape scene and states, "I am powerless," or "I am dirty," or "I am worthless," these are interpretations about the self made in the present. Because they represent inappropriate (objectively untrue) negative beliefs, they are prime targets for EMDR processing.

I want to emphasize that clinical observation indicates that EMDR therapy does not lead the client to falsify history. Thus, a negative cognition that is actually true will not be changed; that is, clinical observation consistently indicates that EMDR processing cannot be used to remove a true negative cognition or to instill a false one. This phenomenon was first noticed with an EMDR client who was a rape victim. Her presenting negative cognition was "I am guilty." During the treatment session, she reported that this cognition became progressively more, not less, valid. When questioned, the client revealed that she was thinking of the fact that she had lied to the police and prosecutor regarding the actual facts of the case; that is, she *was* guilty—of deception. A new negative cognition then had to be used for treatment.

Once again, a negative cognition is interpretive ("There is something wrong with me") rather than descriptive ("Mother did not love me"). If the latter statement were true, as in the case of a psychotic or sadistic mother, it could not (and obviously should not) be changed by EMDR processing:

An abusive parent cannot be turned into a nurturing parent. However, the resulting negative self-attribution ("There is something wrong with me") can be addressed and appropriately reprocessed in order to help shift the client's pathology. Although as a child the client may have blamed herself for her mother's lack of love, this was and remains inappropriate and constitutes the true target for the reprocessing. In fact, a common negative cognition, often used in work with victims of child abuse, is "I am not lovable."

Some clients have difficulty constructing a negative cognition. The clinician may offer such a client a list of alternative negative cognitions to help him understand the concept (see Appendix A). However, it is important that these suggestions be presented in an open and unpressured manner that leaves the choice—or construction of a more useful negative cognition—completely up to the client. It is vital that this cognition stem from the client's own experience and not be an artificial construct of the clinician.

If a client has difficulty putting a negative cognition into words, offer some examples that, in your clinical estimation, seem to be a good fit. As a rule of thumb, most negative cognitions seem to fall into three categories: (1) responsibility/defective ("I did or am something wrong"), (2) lack of safety, and (3) lack of control. Examples include the following:

"I'm worthless."
"There is something wrong with me."
"I'm a bad person."
"I'm dirty."
"I'm not lovable."
"I'm in danger."
"I'll be abandoned."
"I'm powerless."
"I'm out of control."
"I cannot succeed."

Identifying the negative cognition assists the client to recognize more fully its irrationality, establishes a baseline, and helps to stimulate dysfunctional information that requires reprocessing. A more extensive list of negative (and positive) cognitions is presented in Appendix A.

The Positive Cognition

Once the client and clinician have identified the negative cognition associated with the target, the next step in the EMDR session is for the client to identify the desired positive cognition and rate it on the 7-point VOC scale (Shapiro, 1989a), where 1 is "completely false" and 7 is "completely true." The VOC rating should be based on how true and how believable the positive cognition feels to the client, not on how true it is objectively. Even while remaining in emotional turmoil, the client is often aware that

he *should* believe something positive. Therefore, the clinician should ask the client to report his "gut-level" response. For instance, a rape victim may know that the rape was not her fault but still feel guilty. Therefore, she may initially give only a 4 on the VOC scale to the positive cognition "I'm a good person."

The purpose of identifying a desired positive cognition is to set a direction for treatment, to stimulate the appropriate alternative neural networks, and to offer the therapist and client a baseline (the VOC rating) from which to assess progress. Identifying a positive cognition before beginning the reprocessing also provides a statement that can be used for rapid installation (the installation phase immediately follows desensitization and will be described shortly) if a better one fails to emerge in the course of treatment.

Consistent reports of EMDR processing sessions show that if a client's positive cognition is inappropriate or impossible, it will disrupt the reprocessing. When disruption occurs, the client is generally trying to incorporate some form of wishful thinking. Unrealistic desired positive cognitions will not be incorporated into the client's system. One sign of this condition is an initial VOC rating of 1 ("completely false"), which usually indicates that the desired belief is impossible to achieve. An example of this is from the case of a client who had been raped by her employer. The client's desired cognition was "I can fight back." This seemed reasonable to her clinician, but the initial VOC rating she gave this statement did not increase during her processing session. Observing this, the clinician asked her, "What prevents it from being a 7?" The client replied, "He's 6 and a half feet tall and weighs 350 pounds." Unless the 5-feet-tall client had taken martial arts lessons, the statement "I can fight back" (which the client meant in a literal sense) was clearly untrue and was inappropriate as a positive cognition for effective EMDR processing.

When developing a positive cognition, instruct the client whenever possible to make an "I-statement" that incorporates an internal locus of control. Clients often offer initial statements that are beyond their control, such as "He will love me" or "They will give me what I want." Give clients appropriate examples to redirect them away from such statements, and point out the impossibility of ensuring the truth of statements like "My children will never get hurt." Appropriate positive cognitions—such as "I can handle the situation," "I can trust myself," or "I can act responsibly"—offer the client a redefinition of her own capacities. Clearly, there is more power to the statement "I am lovable" than to "He will love me." The client has no real control over other people's thoughts and actions. The goal should be that the client will be able to maintain a sense of self-worth and equilibrium regardless of external forces, instead of resorting to rationalizations or false hopes for the future.

Sometimes the only positive cognitions that can be reasonably presented are embodied in statements such as "It's over," "I did the best I could," or "I now have choices." This is particularly true in the case of

perpetrator guilt, where sometimes all that can reasonably be said is "It's in the past" or "I can learn from it." In these cases, an appropriate level of responsibility for past behavior is recognized and the emphasis is placed on present and future action. While clinical reports indicate that EMDR processing cannot obscure or falsify what is appropriate or true, lessons can be learned, the impact of events can be redirected, and the client can be liberated from the negative affect that prevents positive actions in the future.

Helping the client identify a positive cognition is an important step in recovery. The ability to define an alternative view of the trauma in reasonable language offers hope of escape from the pain of self-denigration. This activity is useful in any form of therapy. However, as the session progresses, the initial positive cognition identified by the client may be superseded by a better one. Indeed, in EMDR processing, it is common for a more beneficial cognition to emerge as the dysfunctional older material is processed. The clinician should take special care to note a preferable cognition and, when possible, to use the client's own words when stating it. For instance, a client may start with a positive cognition such as "I can succeed." During processing, he might not only realize that he has already succeeded at many tasks, but also that it is not necessary to define himself by his job. He may end with the cognition, "I am a worthwhile person." This second cognition has greater power than the first and should be incorporated into the installation phase of treatment, which focuses on and strengthens the positive cognition.

At times, the client will need assistance to formulate positive cognitions. If the client has difficulty putting a positive cognition into words, consider whether any of the following statements might apply to the client's case:

"I did the best I could."
"It's in the past."
"I learned from it."
"I'm in control."
"I'm lovable."
"I'm a good person."
"I now have choices."
"I can succeed."
"I can handle it."
"I'm safe now."

Avoid using the word "not" in the formulation of the positive cognition ("I'm not bad" or "I am not powerless"). The therapeutic intention is to assist clients in a positive redefinition of themselves. The new self-concept should be the most positive self-attribution possible. Using the word "not" fails to indicate a completely positive characteristic. Thus, the sentence "I am powerful" is more therapeutic than "I am not powerless." Likewise, "I am a good person" is more useful than "I am not a bad person." However,

there may be exceptions. For instance, an abuse survivor may initially benefit greatly from the positive cognition "I am not responsible for my mother's actions." Subsequent sessions can then focus on more personally enhancing self-statements.

After the dysfunctional older material has been processed, the positive cognition is intentionally linked or associated with the previously upsetting information during the next phase of treatment, known as "installation." In other words, we are incorporating the positive cognition into the memory network that holds the target material. In so doing, it becomes possible for this cognition to generalize through the network into all of the associated experiences. Furthermore, when the processed information is subsequently triggered, it will now emerge into consciousness with the positive cognition dominant. In addition, this linkage will allow all the information regarding positive outcomes to be associated with the previously traumatizing material. This linking of neural networks is viewed by the Adaptive Information Processing (AIP) model as a primary outcome of successful reprocessing.

The clinician should help the client verbalize a positive cognition that can generalize over the largest range of dysfunctional material and afford the greatest advantage to associated future activities. Often, briefer, less specific cognitions have a better chance for generalization. For example, if a client is reprocessing a memory of falling off a ladder, the negative cognition might be "I'm a failure," whereas an appropriate positive cognition would be "I can succeed." An inadequate positive cognition would be "I can succeed with ladders," because that statement would allow generalization only to incidents that include ladders. Another inadequate positive cognition arose in the case of a client who was reprocessing a memory of having slipped and fallen in public. She was dissuaded from using the statement "It can happen to anyone once," because such a statement, while compatible with the original event, would not support a positive self-assessment if she fell in public again. Whenever possible, self-empowerment for future events should be incorporated into the positive cognition.

The Emotions and Their Level of Disturbance

The client is asked to hold in mind the picture of the memory and the negative cognition, to name the emotion felt, and to give a rating based on the Subjective Units of Disturbance (SUD) scale (Wolpe, 1958) (0 = "no disturbance" to 10 = "highest possible disturbance") for how it feels now. The clinician should make sure the client is not reporting the level of distress he felt at the time of the event. The target for EMDR processing is dysfunctional information. While many things can happen that are originally upsetting, not all remain actively distressing. Some are spontaneously dealt with through natural information processing and are adaptively resolved. Only when a past event is still unresolved should it be targeted for

treatment. In most cases, unresolved material is indicated by a significant level of current emotional disturbance.

By having the client evaluate her levels of emotional disturbance using the SUD scale, the clinician can determine which memories should be targeted. When making a treatment plan for a client, the clinician can isolate the dominant negative belief, such as the cognition "I will be abandoned," and ask the client to scan earlier memories for any related events that rate 5 or higher on the SUD scale. These become excellent initial targets for processing.

The clinician should take care to determine which emotion the client is rating. EMDR therapy is used to process any emotional disturbance associated with the event, whether fear, anxiety, shame, guilt, anger, or sadness. However, it is useful to identify the client's starting point. Clients who become confused and report positive emotions on the SUD scale should be reminded that the scale is used to evaluate only disturbing emotions. Also, a variety of emotions can arise during processing, making it important to have the client name each emotion he is rating. Furthermore, a client using the SUD scale may report no change in the intensity of disturbance when, in fact, the emotion has changed qualitatively. For example, anger may have changed to grief, but the client may give the same SUD scale rating as before. The clinician needs to know which emotion is being rated in order to give the appropriate responses and support and to ensure that processing is occurring.

The Physical Sensations

Clinical experience indicates that the physical sensations generated when clients concentrate on a traumatic memory are useful focal points for treatment. These sensations may be associated with emotional tension, such as tight neck muscles or increased heart rate. Other physical sensations may be part of the sensory experience of the target trauma itself, such as the sensation of feeling the grip of the perpetrator's hand. Pronounced physical sensations are also associated with negative cognitions. Therefore, the EMDR treatment of a memory is not considered complete until all negative physical sensations generated by thoughts of the trauma have been appropriately reprocessed. By the end of the treatment, a mental scan of the body by the client should reveal no residual tension or atypical physical sensations.

ACTIVATING THE INFORMATION-PROCESSING SYSTEM

The client's inherent information-processing system can be activated by the EMDR procedures and the use of directed bilateral eye movements or by alternative forms of stimulation (e.g., tactile or auditory). As client preferences vary, the clinician should be familiar with all three.

Eye Movements

As we shall see, there are several different kinds of eye movements that can be used in EMDR therapy. The clinician's job is to make use of the kind that best fits the needs of the client. This includes ensuring client comfort in regard to the eye movements themselves. At no time should the clinician proceed if the client reports eye pain, dryness, or anxiety caused by the procedure itself. For example, some clients report strong associations between the clinician's moving hand and memories of having been hit in the face by a parent. In this instance, the clinician would want to use tactile or auditory stimuli or a light bar instead of hand-directed eye movements (see Chapter 9).

The clinician's objective is to generate eye movement from one side of the client's range of vision to the other. This full bilateral movement is done as rapidly as possible without discomfort. The clinician should use two or more fingers as a focal point. This technique allows the client to track the fingers without having to focus on a small object and without having the negative associations that might be elicited by a single moving index finger (e.g., memories of being reprimanded by an adult). The clinician may also use a pen, ruler, or any other object to direct the client's eye movement. However, two fingers serve very well and appear to be preferred by many clients as affording a more interpersonal experience.

Typically, the clinician holds two fingers upright, palm facing the client, approximately 12–14 inches from the client's face. The client is then asked, **"Is this comfortable?"** If the answer is no, the clinician should determine the placement and distance with which the client is most comfortable. The clinician then demonstrates the direction of the eye movements by slowly moving her fingers horizontally from the extreme right to the extreme left (or the reverse) of the client's visual field, a distance of at least 12 inches (see Figure 3.1). The clinician should evaluate the client's ability to track the moving fingers by starting slowly, then increasing the rate to obtain the

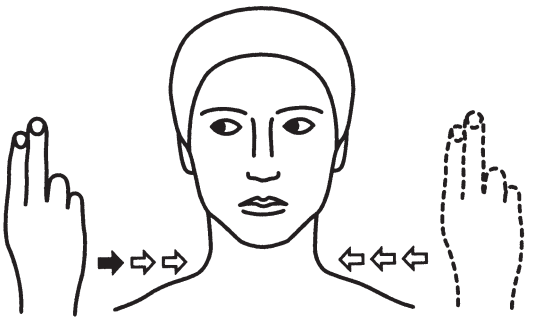


FIGURE 3.1. Horizontal hand movements used in performing EMDR.

maximum comfortably sustainable speed. Clinicians have reported more efficient processing with a fast speed (i.e., two back-and-forth movements per second), although some clients work best with a slower motion. During this testing phase, many clinicians ask the client to report any preferences regarding speed, distance, height, and so forth, before concentrating on emotionally disturbing material. After the dysfunctional material has been targeted, the clinician should listen to the feedback the client gives at the end of each set to assess the amount of processing that has taken place. If the dysfunctional material is shifting readily and the client is relatively comfortable, the speed at which the fingers are moving may be maintained. If either of these conditions is not met, however, the speed as well as the direction (to be discussed shortly) and the number of eye movements within the set may be adjusted.

During this preliminary phase the clinician may find that the client has difficulty in easily following the fingers. This inability can manifest itself as irregular eye movements ("bumpiness"), including stops and starts and darting. When this occurs, the clinician should tell the client, **"Push the fingers with your eyes."** This statement coaches the client to develop a sense of dynamic connection with the guiding fingers, an exercise that can give him a sense of movement control, thus resulting in smoother tracking.

The clinician can then test the effectiveness of a set of diagonal eye movements by moving her hand across the midline of the client's face from the lower right to upper left (or the opposite), that is, from chin level to contralateral brow level (see Figure 3.2). Once again, the clinician should evaluate the results regarding ease and speed of movement. If the client tracks more easily in one direction than another, this should be the dominant direction used. If the processing appears stuck (there is no reported change of information after successive sets of eye movements), the clinician should try a variation in the eye movements, starting with a change in direction. The duration of the set is also determined by client feedback. The first set consists of 24 bidirectional movements, where a right-to-left-to-right shift equals one movement. This set enables the clinician to assess client comfort, preferred speed, and ability to sustain the eye movements. During this set, the client may simply observe his own reactions or concentrate on the Safe/Calm Place exercise (using slow eye movements rather than the rapid ones used in processing), which will be described in Chapter 5. The same number of movements may be used in the first reprocessing set. After this initial reprocessing set, the clinician should ask, **"What do you get now?"** This question gives the client the opportunity to report what he is experiencing in terms of imagery, insights, emotions, and physical sensations. If the client shows any indication of increased therapeutic effects—if he feels better or if new information has emerged—the clinician can repeat the direction, speed, and duration of the set. However, the clinician should be willing to experiment to discover whether some variation would be more



FIGURE 3.2. Diagonal hand movements used in performing EMDR.

beneficial. Clinicians have reported that a 24-movement set is generally necessary for the average client to process cognitive material to a new level of adaptation. However, the response of the individual client is the final determinant. Some clients need 36 or more movements per set to process material. Highly emotional responses, which I cover in Chapter 7, generally demand a great many more eye movements in one set than does purely cognitive material (e.g., new insights that increase depth of understanding).

On the other hand, some clients are physically incapable of doing more than a few eye movements in a row because of an inherent weakness in their eye muscles. Other clients may be unable to follow the hand movements owing to a high level of anxiety. Still other clients may show an extreme tracking deficit or may find the tracking movements aversive; they may be treated with the two-handed approach (see Figure 3.3) or with auditory or tactile cues.

The two-handed approach entails having the therapist position her closed hands on opposite sides of the client's visual field at eye level, then alternately raising her index fingers. The clinician instructs the client to move her eyes from one raised finger to the other. This form of eye movement entails a pure orienting or attentional response that some clients find much easier to maintain than the rapid tracking movement in the original procedure, and it has often yielded the same therapeutic results. However, the technique does not provide the same flexibility of varying directions when, for example, processing gets stuck.

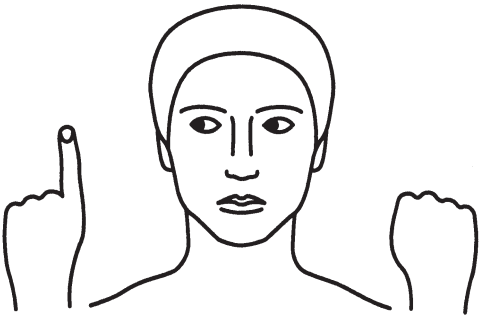


FIGURE 3.3. Two-handed version of performing EMDR.

Significantly, many clinicians have observed that a client may have greater difficulty in maintaining a smooth tracking motion during the earlier stages of processing. It is possible that as anxiety diminishes, the eye movements become more fluid and easier to maintain, which perhaps supports the concept of reciprocal inhibition (see Chapters 1 and 12) as a contributing factor in treatment effects. Consequently, when the clinician has been forced to begin with the two-handed orienting eye movement, it may be useful to switch to the one-handed tracking eye movements once a lower SUD level has been achieved.

Alternative Forms of Stimulation

For those clients who find the eye movements physically or psychologically uncomfortable, the alternative forms of stimulation (tactile and auditory) can be used and have proved effective. Tapping is done by having the client sit with his hands palm upward on his knees. The clinician then (with one or two fingers) rhythmically taps the client's palms, alternating right and left, at the same speed at which sets of eye movements would be conducted. Alternatively, the clinician can tap the client's knees. The client need not deliberately fixate each of these taps for the therapy to be effective; however, it has been clinically reported that spontaneous sets of rapid eye movements often occur during this procedure.

Auditory stimuli entail having the client keep her eyes open or closed (if necessary) while the clinician alternately snaps fingers next to each ear at a rate comparable to that used with sets of eye movements. However, this should only be used in isolated situations, when no other option is viable and the clinician is able to determine that the physical proximity required will not be experienced by the client as intrusive or possibly threatening. Clinicians also report positive results with the use of headsets for auditory stimulation and electronic devices for tactile stimulation. While these alternative forms of stimulation preclude the possibility of changing direction,

both speed and intensity may be altered. And, of course, they enable the clinician to use the EMDR approach with the blind and visually impaired or with those who simply prefer other modes of processing. However, they do not provide the high level of feedback about the client's attention and connection to the clinician that can be obtained by observing the eye movements. I should also mention that other possible eye movement sets guide the client's eyes in a vertical direction. The vertical movements are not used for processing, but they appear to have a calming effect and are particularly helpful in reducing extreme emotional agitation, dizziness, or nausea. They may also be useful at the end of a session.

THE EIGHT PHASES OF EMDR THERAPY

EMDR treatment consists of eight essential phases. The number of sessions devoted to each phase and the number of phases included in each session vary greatly from client to client (guidelines are discussed in later chapters). The first phase involves taking a client history and planning the treatment. This is followed by the preparation phase, in which the clinician introduces the client to EMDR procedures, explains EMDR theory, establishes expectations about treatment effects, and prepares the client for possible between-session disturbance. The third phase, assessment, includes determining the target and baseline response using the SUD and the VOC scales. The fourth phase, desensitization, addresses the client's disturbing emotions, and elicits insights and appropriate associations. The fifth phase, installation, focuses on enhancing the integration of cognitive reorganization. The sixth phase, which evaluates and addresses residual body sensations, is the body scan. Next comes closure, a phase that includes debriefing and is essential for maintaining client equilibrium between sessions. The eighth and final phase is reevaluation.

While each phase focuses on different aspects of treatment, it may be useful to remember that many of their effects—an increase in self-efficacy, desensitization of negative affect, elicitation of insight, shifting of body sensations, and a cognitive restructuring—occur simultaneously as the dysfunctional information is processed. These phases are discussed in detail in Chapters 4–8. What is presented here is an overview of the treatment.

Phase One: Client History and Treatment Planning

Effective treatment with EMDR therapy demands knowledge of both how and when to use it. The first phase of EMDR treatment therefore includes an evaluation of the client safety factors that determine client selection. A major criterion for the suitability of clients for EMDR treatment is their ability to deal with the high levels of disturbance potentially precipitated by

the processing of dysfunctional information. Evaluation therefore involves an assessment of personal stability and current life constraints. For example, a client might be facing major deadlines at work and would not want to be distracted by the ongoing processing of traumatic material; in this instance, the clinician might delay processing until such work pressures have eased. In addition, a client should be physically able to withstand intense emotion. The clinician must evaluate potential problems due to age or a preexisting respiratory or cardiac condition.

Once the client has been selected for EMDR processing, the clinician obtains the information needed to design a treatment plan. This part of the history-taking phase entails an evaluation of the entire clinical picture, including the client's dysfunctional behaviors, symptoms, and characteristics that need to be addressed. The clinician then determines the specific targets that will need to be reprocessed. These targets include the events that initially set the pathology in motion, the present triggers that stimulate the dysfunctional material, and the kinds of positive behaviors and attitudes needed for the future. EMDR therapy should be used to reprocess information only after the clinician has completed a full evaluation of the clinical picture and designed a detailed treatment plan.

Phase Two: Preparation

The preparation phase involves establishing a therapeutic alliance, explaining the EMDR process and its effects, addressing the client's concerns, and initiating relaxation and safety procedures. It is essential that the clinician clearly inform the client of the possibility for emotional disturbance during and after EMDR processing sessions. Only in this way will the client truly be in a position to give informed consent. Not only does this warning give clients the opportunity to make appropriate choices, but it also allows them to prepare their work and social schedules to accommodate any emotional upheaval. Before processing begins, clinicians should also practice with the client the guided visualization techniques described in Chapter 9. If the client is unable to completely eliminate moderate levels of disturbance with one of these techniques, the clinician should not continue EMDR processing until some affect regulation strategy is established. Relaxation techniques such as these may be necessary to help the clinician bring to a close an incomplete session and to assist the client in dealing with memories or unpleasant emotions that may emerge after the session. Adequate preparation is important to foster the rapid treatment effects and low dropout rates demonstrated by research (see Chapter 12). The effective use of affect-regulating techniques can give clients the confidence to deal with the high levels of disturbing material that may emerge during the session, whereas an inability to handle the disturbing feelings can increase the client's level of fear and make processing even more difficult. Clients can also benefit from audio recordings that include guided relaxation exercises

(e.g., "Letting Go of Stress" [Miller, 1994] or the "Light Stream technique" [EMDR Humanitarian Assistance Programs, 2001]). The goal is for clients to be proficient in these relaxation techniques and capable of using the recordings with confidence, so that they can deal with any between-session disturbance that may occur. For some clients with complex PTSD, it may be preferable to teach affect regulation techniques before taking the history (see Chapter 11).

The preparation phase also includes briefing the client on the theory of EMDR therapy and the procedures involved, offering some helpful metaphors to encourage successful processing, and telling the client what he can realistically expect in terms of treatment effects. These aspects, along with sample instructions, are covered in detail in Chapter 5.

During the preparation phase, the clinician should also explore with the client the possibility of secondary gain issues. What does the client have to give up or confront if the pathology is remediated? If there are concerns in this area, they must be addressed before any trauma reprocessing begins. Included in this precaution is the development of an action plan to handle specific situations that may arise, situations such as the client's need to find a new job or a new place to live. If the secondary gains are fed by feelings of low self-esteem or irrational fears, they should become the first target of processing. Until these fears are resolved, no other significant therapeutic effects can be expected or maintained.

Phase Three: Assessment

In the assessment phase the clinician identifies the components of the target and establishes a baseline response before processing begins. Once the memory has been identified, the client is asked to select the image that best represents that memory. Then he chooses a negative cognition that expresses a dysfunctional or maladaptive self-assessment related to his participation in the event. These negative beliefs are actually verbalizations of the disturbing affect and include statements such as "I am useless/worthless/unlovable/dirty/bad." The client then specifies a positive cognition that will later be used to replace the negative cognition during the installation phase (Phase Five). When possible, this statement should incorporate an internal locus of control (e.g., "I am worthwhile/lovable/a good person/in control" or "I can succeed"). The client assesses the validity of the positive cognition using the 7-point VOC scale.

At this point the image and negative cognition are combined to identify the emotion and the level of disturbance, the latter being measured by the 10-point SUD scale, described previously. The client is asked to pick a number that indicates the intensity of his emotions when the memory is currently accessed. As reprocessing commences, both the emotions and their intensity will probably change, with the disturbance potentially becoming temporarily worse.

Next, the client identifies the location of the physical sensations that are stimulated when he concentrates on the event.

Thus, the assessment stage offers a baseline response with respect to the target memory and the specific components necessary to complete processing.

Phase Four: Desensitization

In this phase the clinician and client begin the eye movement (or other bilateral stimulation) sets. The fourth phase focuses on the client's negative affect, as reflected in the SUD scale. This phase of treatment encompasses all responses, including new insights and associations, regardless of whether the client's distress level is increasing, decreasing, or stationary.

During the desensitization phase the clinician repeats the sets, with appropriate variations and changes of focus, if necessary, until the client's SUD level is reduced to 0 or 1 (or is otherwise "ecologically appropriate" to the individual given his present circumstances). A 0 or 1 SUD indicates that the primary dysfunction involving the targeted event has been cleared. However, reprocessing is still incomplete, and the information will need to be addressed further in the crucial remaining phases.

It should be emphasized here that in many cases the sets of eye movements (or alternative forms of stimulation) are not sufficient to complete processing. Clinical reports suggest that at least half the time the processing will stop and the clinician will have to employ various additional strategies and advanced EMDR procedures to restimulate it. These variations are covered in depth in Chapters 7 and 10.

Phase Five: Installation

The fifth phase of treatment is called the installation phase, because the focus is on accentuating and increasing the strength of the positive cognition that the client has identified as the replacement for the original negative cognition. For example, the client might begin with an image of her molestation and the negative cognition "I am powerless." During this fifth phase of treatment, the positive cognition "I am now in control" might be installed. The caliber of the treatment effects (i.e., how strongly the client believes the positive cognition) is then measured using the VOC scale.

The installation phase starts once the client's level of emotion about the target event has dropped to 0 (or is otherwise ecologically appropriate) on the SUD scale. At this point the clinician asks the client to hold the most appropriate positive cognition in mind, along with the target memory. Then the clinician continues the eye movement sets until the client's rating of the positive cognition reaches a level of 7 on the VOC scale. Keep in mind that the client should rate the cognition based on how she *feels* at a gut level.

The most appropriate positive cognition might be the one the client identified during the assessment phase, or it might be one that has emerged spontaneously during the successive sets. Even if a new positive cognition has not emerged, clinicians usually find that the client's VOC rating of the original positive cognition has increased by the end of the desensitization phase. The clinician should continue the sets (with the client simultaneously focusing on the positive cognition and the target event) in order to ensure the greatest possible strengthening of the cognition. While negative images, thoughts, and emotions generally become less vivid and less valid with each successive set, the positive images, thoughts, and emotions become more vivid and more valid. As long as the client's sense of validity, self-confidence, and certainty is increasing, the sets should be continued.

The VOC rating is extremely valuable in determining what further work must be done to complete the treatment session. For example, if a client reports a VOC rating of less than 7 after two sets, the clinician should question her to determine whether the current level of validity is appropriate for her. For instance, a client may say, "I can't give a 7 because I don't believe in extremes" or "I'll have to see my brother to know for sure that I can stand up to him." These are statements of innocuous or appropriate beliefs and indicate no pathology; consequently, the next phase of the treatment session may begin. However, the client may voice a negative belief such as "I don't deserve to be completely happy." Since this type of negative belief will block the complete installation of the positive cognition, it will have to serve as an additional target of EMDR processing. The ultimate goal is the installation of a strong and completely valid positive cognition that will raise the client's sense of self-efficacy and self-esteem.

Linking the positive cognition with the target memory strengthens the associative bond, so that if the memory of the original incident is triggered, its return to consciousness will now be accompanied by the new, strongly linked positive cognition, such as "It's over; I'm safe now." As the client concentrates on the positive cognition, it is infused into the target memory network, where it can generalize to associated material. As discussed earlier, the positive cognition is chosen on the basis of its ability to generalize and reshape the perspective of the greatest amount of dysfunctional material, as well as to empower the client for present and future occurrences. Metaphorically, the negative and positive cognitions give color to past and present incidents (as if the client were seeing through dark or rose-colored glasses) so that the positive cognition acts as a dye of a different hue that permeates the memory network.

Clearly, the installation and strengthening of the positive cognition is a crucial component of EMDR therapy. The very existence of negative cognitions is an indication that the traumatic event is a powerfully defining factor in the person's life, one that has not yet been adequately assimilated into an adaptive framework. Unresolved traumas are typified by negative perspectives on issues of self-control and empowerment, perspectives that may

be manifested in many forms throughout a person's life. Fully processed traumatic information, by contrast, is typified by access to a memory that incorporates an adaptive perspective, complete with positive cognition and appropriate affect. The installation phase of EMDR therapy focuses on the strength of the client's positive self-assessment, which appears pivotal for comprehensive positive therapeutic effect.

Phase Six: Body Scan

After the positive cognition has been fully installed, the client is asked to hold in mind both the target event and the positive cognition and to scan her body mentally from top to bottom. She is asked to identify any residual disturbance in the form of body sensation. These body sensations are then targeted for successive sets. In many cases the tension will simply resolve, but in some cases, additional dysfunctional information will be revealed. As mentioned previously, there appears to be a physical resonance to dysfunctional material, which may be related to the way it is stored physiologically. Identifying residual physical sensation and targeting it in this sixth phase of EMDR treatment can help to resolve any remaining unprocessed information. This is an important phase and can reveal areas of tension or resistance that were previously hidden.

Phase Seven: Closure

The client must be returned to a state of emotional equilibrium by the end of each session, whether or not the reprocessing is complete. (Techniques to close the session are reviewed in Chapter 9.) In addition, it is vital that the client be given the proper instructions at the end of each session; that is, the clinician must remind the client that the disturbing images, thoughts, or emotions that may arise between sessions are evidence of additional processing, which is a positive sign. The client is instructed to keep a log or journal of the negative thoughts, situations, dreams, and memories that may occur. This instruction allows the client to cognitively distance himself from emotional disturbance through the act of writing. Specifically, the client is told to "take a snapshot" of any disturbances so that they can be used as targets for the next session. The use of the log and the visualization techniques taught by the clinician or via a relaxation tape (explained in Chapters 5 and 9) are extremely important for maintaining client stability between sessions. As with any trauma treatment, unless the clinician appropriately debriefs his EMDR client, there is a danger of decompensation or, in an extreme case, suicide, which can occur when the client gives his disturbing emotions too much significance or views them as indications that he is permanently damaged. The clinician should provide the client with realistic expectations about the negative (and positive) responses that may surface both during and after treatment. This information increases the likelihood that the client will maintain a sense of equilibrium in the

face of possible disturbance engendered by the stimulation of the dysfunctional material. There may be a domino effect that stimulates other negative memories as the information processing continues. A further review of this material and a sample treatment is presented in Chapter 6.

Phase Eight: Reevaluation

Reevaluation, the eighth phase of treatment, should be implemented at the beginning of each new session. The clinician has the client reaccess previously processed targets and reviews the client's responses to determine whether treatment effects have been maintained. The clinician should ask how the client feels about the previously targeted material and should examine the log reports to see if there are any reverberations of the already processed information that need to be targeted or otherwise addressed. The clinician may decide to target new material but should do so only after the previously processed traumas have been completely integrated.

Integration is determined in terms of intrapsychic factors, as well as systems concerns. The reprocessed traumas may have resulted in new behaviors on the part of the client, requiring the clinician to address problems that arise in the family or social system. The information gleaned during the reevaluation phase guides the clinician through the various EMDR protocols and the full treatment plan. Successful treatment can only be determined after sufficient reevaluation of reprocessing and behavioral effects.

STANDARD THREE-PRONGED EMDR THERAPY PROTOCOL

While the standard EMDR procedures take place during each reprocessing session, the standard three-pronged EMDR therapy protocol guides the overall treatment of the client (see Chapter 8). Each reprocessing session must be directed at a particular target. The generic divisions of the targets are defined in the standard protocol as (1) the past experiences that have set the foundation for the pathology, (2) the present situations or triggers that currently stimulate the disturbance, and (3) the positive templates necessary for appropriate future action. All of the specialized EMDR protocols (e.g., those regarding phobias or somatic disorders) are interfaced with this standard format.

CHOOSING A TARGET

Choosing a target is straightforward when treating a single-event trauma victim. However, when treating a multiple-trauma victim, the clinician should cluster the traumatic incidents into groups of similar events, then

choose as the target a representative incident for each group. Reprocessing the representative incident usually results in a generalization, allowing the positive treatment effects to spread to all of the associated incidents. Asking clients to designate their 10 most disturbing memories of childhood allows them to sort through and consolidate their past experience into manageable targets. By assessing the SUD level of every event and arranging them in order of increasing disturbance, clinician and client can jointly decide which memory should be the initial target for the EMDR treatment. (See Chapter 11 for separate considerations in the treatment of complex PTSD).

The decision about whether to begin in the first session at the high end or the low end of the distress continuum depends on clinician preference and assessment of the client. Some clinicians feel that starting with an event that has a low rather than a high SUD level enables clients to experience the shifting and resolution of material with less distress; the consequent feeling of accomplishment, in turn, gives them confidence to work on more disturbing material. While this is a reasonable strategy, clinicians have found in many cases that a low-SUD scale target event changes rapidly into more distressing associations or remembered incidents, perhaps causing the client to be dismayed and to feel ill-prepared to continue treatment. This possibility underscores the importance of proper client preparation.

In my own practice, I prefer (if the client consents) to target the most upsetting childhood incidents first. My rationale is that by preparing the client for the worst eventuality and highest level of distress, there are no surprises later. In addition, clients often feel a sense of great accomplishment by the end of a session that focuses on a highly distressing target. Not only can they justly feel that they have confronted the worst, but they may discover that the worst is not as bad as they had anticipated. Moreover, they have resolved the most traumatic memory, which means subsequent sessions can only be easier. This reprocessing often results in a "generalization effect" (a general decrease in associated disturbance), reported as a great reduction of fear and anxiety in the ensuing week. However, targeting low SUD scale events, or events in chronological order, is also appropriate, depending on clinical assessment.

As noted earlier, some clients experience high levels of emotional disturbance between sessions, particularly if the reprocessing was incomplete and they have undergone many highly distressing related traumas. The initial target should therefore be assessed on the basis of client readiness and stability (see Chapter 4 and Appendices A and E). EMDR processing should not be initiated with clients who are unable to contain high levels of emotional disturbance or are not in an appropriate therapeutic relationship with the clinician (see Chapter 5).

In attempting to resolve a trauma, the clinician should target all of the following elements: (1) the memory of the actual event; (2) any flashbacks, since they might be different from the actual traumatic incident; (3) any nightmare images; and (4) any triggers, such as certain loud noises, that

bring back feelings of fear and confusion associated with the earlier trauma. "Triggers" are any stimuli that elicit the dysfunctional images, cognitions, emotions, or sensations, either as full flashbacks or as partial arousal of the dysfunctional material. Clinicians must treat each trigger separately; owing to second-order conditioning, each may have become independently disturbing because of the previous paired association. Therefore, for complete resolution of a trauma, each of the four elements should be targeted in turn.

Appropriate targets for the EMDR processing session include any manifestation of the dysfunctional information. For example, one important and often useful treatment focal point is a recurring nightmare. Clinical observation has shown that when a nightmare image is targeted, therapeutic effects are achieved even when the client is initially unsure of the dream's actual meaning. The symbolic overlay of the dream is often removed during EMDR processing to reveal the life experiences that were driving the discomfort. The AIP model proposes that the REM dream state is a period when unconscious material arises to be processed. Nightmare images appear to be correlated with the client's level of affect and cognitive assessment. When disturbance is too high, the REM state itself is disrupted, and the disquieting material remains unassimilated.

When the nightmare image is targeted during an EMDR processing session, it is treated as a direct link to the network in which the underlying traumatic material is stored. It is this link that makes the material available for therapeutic resolution. For instance, a female sexual abuse victim recounted a nightmare of being chased by a monster through a cave, with no understanding of the significance of the dream, but she nevertheless had overwhelming feelings of fear and danger. When the image was targeted during EMDR processing, the client reported seeing it spontaneously shift with successive sets to reveal her stepfather–perpetrator chasing her through her childhood home. This new image was then available for further processing. In other cases, the dream image may simply dissipate without obvious references or insights.

Regardless of the level of insight derived from the experience, once the dream image or recurrent nightmare scene is targeted and processed, the dream generally does not recur. Therefore, it can be useful to have clients report (as part of their logs) any disturbing dreams they may have had in order to use them as targets in subsequent sessions. Dreams that are not disturbing, or that were resolved before awakening (e.g., winning a fight), probably were successfully processed and are not targeted.

PATTERNS OF RESPONSE

Clinical observation indicates that approximately 50% of the time, clients experience a continual, progressive shift toward a resolution of the target event. The kinds of shifts reported by clients indicate that processing affects

all aspects of the traumatic memory and can progress in a variety of ways. At the end of each set, clients may report a change of the target memory or a shift to a different memory. Clients report that new memories appear momentarily during the set, that they emerge and remain during the entire set, or that they surface only as the set concludes. The client may report merely visual images of the event or may give a full-blown description, including thoughts, voices, smells, emotions, and body sensations. The client may experience these elements as merely a shadow of the original or in a full-force abreaction.

In order to explore the types of changes that indicate processing, it is useful to return to the concept that memory networks are associatively linked channels of information. A targeted memory may be one of a number of incidents stored in a particular channel. As the eye movements begin and the information starts processing through the channel, new memories can rise to consciousness. These new memories may appear to the client in flashes (as though the event were suddenly caught in a spotlight), they may appear as a collage of many events all at once, or they may come to consciousness as body sensations. No matter how the information subjectively emerges, as long as processing has continued, for the next set the client should simply be directed with the global statement, "Notice it." In other words, the clinician needs to address the targeted memory in whatever form it arises.

In working with clients in EMDR therapy over the years, some general patterns of association have become clear. The following sections show the kinds of client responses that may emerge when the information is processing. Clinicians should take careful note of these responses, since they indicate that the clinician can continue the procedures without needing to engage in any complex EMDR intervention (see Chapter 7); that is, as long as clients are making new associations, the sets may be continued.

The variety of possible associations to a given target is indicated in Figure 3.4. The first six types of associative channels entail the linkage of various discrete events that are bound by a common thread, whereas the seventh channel indicates shifts of information (e.g., image, insights) confined to the single targeted event.

After a set, a new event may arise that is linked associatively with the initial targeted event. There is no way of knowing before processing begins what the association will be. However, each type of association is linked by one of a variety of dominant threads. No particular pattern of association is considered preferable to another from a therapeutic standpoint, as each type of associative response achieves a resolution of the material that is unique to the individual client.

In the following paragraphs we will first review patterns that emerge when the client reports a variety of memories. Then we will turn to the kind of processing patterns observed when the client retains only one memory in consciousness throughout the treatment session.

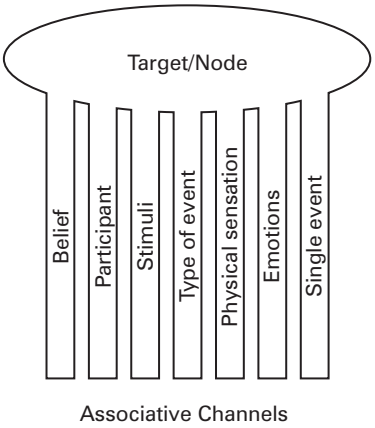


FIGURE 3.4. Target/node and possible types of associative channels.

Multimemory Associative Processing

The Belief Inherent in the Trauma

Emerging memories may be linked by the client's dominant belief inherent in the traumatic target event. For example, a memory of a car accident may be associated with the memory of a sexual assault, because they share the client's cognition "I am powerless." In turn, processing might reveal either of these incidents as the pivotal memory that causes the client extreme anxiety when feelings of powerlessness in the workplace are targeted. Clinicians can often recognize important dysfunctional beliefs by determining what these associated memories have in common. This discovery can be helpful in delineating a more thorough treatment plan, but clinicians should usually postpone discussion of the material with the client until after the eye movement part of the treatment session is concluded.

Remember, associations are always based on the client's experience. No memory will emerge that is not in some way associated with the target. However, the clinician should allow the client to come naturally to a realization of the meaning of the connection rather than superimposing it or pushing the client to identify it during the early phases of processing. Regardless of whether clients recognize the connections between their negative cognition and their memories, cognitive restructuring will take place during EMDR therapy's installation phase.

The Major Participant or Perpetrator

Targeted memories may be linked with new memories by the perpetrator they have in common. For example, a client's molestation by his father may become associated with a beating his father gave him and with his father's

abandonment of him on another occasion. Processing these associations will help the client resolve his "unfinished business" with his abusive parent. Often the abusive parent has set in motion the problems that a client has with authority, lack of self-esteem, and so on. Once the memories connected with a parent are processed, clients often spontaneously begin reacting to present situations differently (e.g., by asserting themselves in the workplace).

The Pronounced Stimuli

The emerging memories may be linked by the primary stimuli inherent in the events. For example, when processing the memory of an earthquake, a military veteran may suddenly recall a combat experience if the sounds of falling objects or loud rumbling dominated both events. Although it is often difficult to separate the emotion (e.g., fear) or cognition (e.g., "I am powerless") from the external trigger, there can be a train of associations primarily linked by a sensory cue. The cue is revealed as the connective link during processing, because there is a dysfunctional aspect to the client's reaction to the stimulus. That the reaction is dysfunctional is shown by the high level of emotion and the negative cognition it comprises.

The Specific Event

Emerging memories may be linked to the targeted memory by the nature of the event itself. For example, when a rape is targeted in a victim of multiple assaults, a sequence of memories of other rapes may emerge. Naturally, these memories carry the same negative cognition and emotion as the targeted rape, but the dominant thread is the rape itself. It is also possible for dissociated memories of childhood molestation to emerge when the primary target is some other form of sexual abuse. Be aware that a multiple-molestation or multiple-rape victim may feel overwhelmed when many memories of additional assaults emerge during a session. Take special care with these clients to foster feelings of safety, and reassure them that they can rest when they need to. Procedural steps on how to do this are covered in Chapter 5, and additional information on working with this population is presented in Chapter 11.

The Dominant Physical Sensations

Remember that the physical sensations experienced at the time of the event are stored in the brain and may constitute the dominant thread of the associative sequence. For example, one client had a physically abusive childhood: The mother used to tie the child's hands to a bed and beat her with a broomstick. As the client processed this memory, the dominant physical sensations she experienced were pressure around her hands and wrists. The

next memory to come to consciousness was of a molestation that included the physical sensation of her father forcing her hands around his penis. This memory was followed by one of a rapist holding her hands together during the attack. The final memory to emerge was of awakening after an operation and of being tied down to a gurney in a hospital room and screaming but without understanding why. These sequential memories revealed to the client that the reason for her terror in the hospital was the sense of violation and danger associated with the sensation of pressure around her wrists.

The Dominant Emotions

The emerging memories may be linked by the primary emotion inherent in the event. For example, processing a memory of a failed business venture that generates emotions of despair may be followed by a memory of abandonment by a parent, an event associated with the same emotion. While a cognition may be found that could appropriately link the two events, what is primary for the client is the overwhelming emotion; it is not necessary for the client to engage in a cognitive evaluation of the memories.

Once again, the clinician must be attuned to the amount of emotional distress the client is undergoing during processing. The client who is processing a chain of memories that are stimulating intense despair or the multiple-rape victim who is mentally sequencing through all of the rape experiences of her life may feel as if a locomotive is bearing down on her. As will be more fully explored in the following chapters, the clinician must immediately honor any indication by the client that she needs to stop. This response not only reinforces the client's ability to say no and maintain a sense of control, but it also demonstrates that the client is the final judge of when to rest during the intense processing. However, clinicians should note that when a rape victim, for example, says "Stop" during processing, she may be verbalizing what she said, or wanted to say, to the perpetrator, because these are the thoughts, experienced at the time of the event, that are now surfacing. When directed at the perpetrator, words such as "No" and "Stop" should be targeted with the sets. When spoken directly by the client to the clinician, they mean the sets should be terminated until the client is willing to proceed. In order to avoid confusion between the two, the client should be prepared and encouraged in advance to use a hand gesture that signals a desire to stop. When in doubt, the clinician should stop the set and ask the client.

Single-Memory Processing Effects

While processing is often indicated by a sequential emergence of new memories, as discussed in the previous section, the clinician should note that sometimes new memories surface only temporarily during the set, then shift back to the initial target memory. In other cases, no new memories emerge

consciously, and the target incident is the only one that is consistently maintained. In still other cases, the target may shift to another memory that remains in consciousness during most of the session. In all these instances (in which a single event continues to occur in consecutive sets) the clinician should assess the target for other indicators of successful processing.

One indicator of processing is when the client describes a change or shift in any of five distinct aspects of the memory: image, sounds, cognition, emotion, or physical sensations. Although all aspects of the incident are shifting simultaneously (e.g., a substantial shift in cognition correlates with a shift in physical sensations and emotion), the client may find that one aspect dominates his consciousness. He should be encouraged to verbalize whatever aspect stands out. When change is evident, the clinician should take care not to pull the client out of the process by asking about aspects that he has not spontaneously reported.

The following are the kinds of changes or shifts that the clinician can expect to see during EMDR processing.

Changes in Image

As already indicated, the image of the target event can change to an image of a different but associated event, or it can shift to a different aspect of the same event. However, the image can also change its content or appearance. In a content change, a leering face may change to a smiling one, a weapon may disappear, and so forth. The image can change in appearance by a shift in perspective or the expansion of a scene to include more details. For example, a client retrieved the memory of a meeting in which he had been humiliated, but all he could see initially was the look on the face of the colleague who insulted him. As processing continued, the scene expanded, as if blinders had been removed. In the broader scene, the client saw other people—with more positive and supportive expressions. It is interesting to note in this example that this more self-affirming information had always been stored in the client's brain. However, it was not previously available when the memory was accessed, presumably because the image of the coworker's face was associated with a particular level of the dominant affect (anxiety and humiliation). As dysfunctional information is processed, a greater access is afforded throughout the associational network. After treatment, the client in this example was able to retrieve not only the look on the face of the person who humiliated him but also other, more positive details, since anxiety was no longer dominant; when asked to retrieve the memory, he now spontaneously saw the larger scene.

Successful processing is also apparent when the client reports other shifts in the appearance of the image. The picture may become larger, smaller, or blurred; it may turn gray or move closer or farther away; or it can disappear completely. The exact nature of the change cannot be predicted. Clients who must give a detailed account of the incident to the

police or in court must be warned that after treatment a picture of the event may not be retrievable. Some clients become confused or disturbed when the picture begins to disappear. Often they say, "I must be doing something wrong; I can't get the picture back." Clinicians should reassure them that any change is natural as long as the processing continues, and that if they lose the picture, they should just think of the incident, regardless of what comes to mind.

Some clients may become disturbed when the picture begins to disappear, because they fear they will lose good memories or completely forget that the incident occurred. These clients should be reassured that the target event will not be forgotten and that good memories or emotions are never lost in EMDR treatment. They should be told that the dysfunctional information is being "digested" and converted to a more useful form, and that all that is being shifted is the way the information is stored in the brain, so that the upsetting picture and emotions will no longer dominate.

Any change in image reported by the client is indicative of information processing, and the subjective nature of the shift need not be questioned by the clinician. In other words, it makes no difference how large or small the picture has become or how blurry it appears. Clinicians will know processing has occurred if they detect any indicator of change. Even the statement "It looks different" is sufficient. Clinicians should avoid questioning the client about such changes. Attempts to get a detailed description of the content of the picture or the nature of an unspecified shift can interrupt and undermine the processing effects.

Changes in Sounds

The client may report that the voices of people in the target memory are becoming quieter or have completely disappeared. In one instance, a client reported that the target event included hearing her baby screaming; she reported after a few sets that the sound had disappeared completely. Likewise, the sound of gunfire and explosions may increase or decrease in volume as processing continues.

Clients commonly report shifts in the auditory component of target memories when processing interactions with perpetrators, parents, or others in a variety of social settings. When processing an uncomfortable confrontation at work, a client may report that the remembered dialogue has shifted, that he has spontaneously begun to use new, more assertive, language while his coworker is making more deferential statements. During the sets, clients often begin verbally asserting themselves with an abusive parent. The clinician should encourage the client to repeat these assertive statements, internally or out loud, until they are confidently and strongly felt. This verbalization has often resulted in major breakthroughs for clients who have been frozen in a child-like role with respect to their parents and other authority figures.

Clients report that the words spoken or thought at the time of the event may spontaneously arise, along with the image. Clients raised with English as a second language in the household may begin to speak in their native language when early memories are processed. If the client begins to speak in a foreign language, simply direct him as usual (**"Just think of that"**) and continue the sets. Although clients may speak in their childhood language, they can still understand directions in English.

Changes in Cognitions

The client's level of insight often increases from one set to another. As shown in the transcript in Chapter 2, in which the client had to deal with an incompetent coworker, the client's cognitions can become more therapeutically adaptive as the information is processed. However, until the information is completely processed, the cognitions will not be fully appropriate. Metaphorically, the train has not reached its destination until the last stop. Along the way, at pauses between sets, there will still be some dysfunctional material to be processed, and the clinician should resist the temptation to explore or probe a particular information plateau unless processing is stuck. As long as shifts are being reported, the clinician should simply direct the client to think of the cognition just verbalized during the previous set.

Occasionally, a client may give what is termed a "polar" response, which is a dramatic shift from a negative to a positive cognition at an early point in processing. This is interpreted in information-processing terms to be a shift in neural networks from a configuration of "no" to an associated configuration of "yes." In other words, a client may start with the cognition "There is something wrong with me" in relation to social situations and after a single set may start thinking, "I'm fine." When such an about-face occurs, the client is assumed to have reached the end of a channel. The clinician should then bring the client back to the original node (the target memory) and continue processing. There may or may not be additional dysfunctional channels.

Changes in Emotions

As the memory is processed, the associated emotions may lessen in intensity. However, the emotional level may also increase dramatically before the memory reaches an adaptive resolution. As long as the client is reporting a different level of emotion, either higher or lower, the information is assumed to be processing. When emotion is the dominant presenting element of the memory, clinicians can use the SUD scale to assess the degree of change.

While the SUD scale is helpful, remember that it may be an insufficient measure in some cases. Many clients report a shift in the type of emotion (e.g., from grief to anger), as well as shifts in its intensity. When the client

feels a different emotion, the SUD level may increase (anxiety at an SUD level of 3 can shift to sadness at an SUD level of 7), decrease, or remain the same. The clinician should be alert to any new emotion that arises during the session in order to meet the client's needs. For instance, the kind of verbal and nonverbal support that would be reassuring to a client experiencing extreme anger may be dramatically different from the support needed if the client begins to experience sorrow or despair.

Clients often report a progressive shift toward more ecologically appropriate emotions. This shift manifests itself as movement through different "layers" of emotion (e.g., from guilt to rage to sorrow to acceptance). However, each client reacts uniquely, and the emotions and sequence can vary. At times, there will not be any expression of a particular emotional state, and no specific emotion or level of expression should be demanded of the client. While some clients abreact with high emotional intensity, others process in a straightforward manner, with little overt display.

Changes in Physical Sensation

When a memory is being processed, most clients experience some manifestation of the information on a somatic level. The body sensations may be connected to emotions experienced during processing (e.g., a high pulse rate and tight stomach associated with fear). Alternatively, the body sensations may be those that were experienced during the original event (as in the example of the client who had been bound to a bed as a child and who felt pressure on her wrists while processing that memory). Finally, the body sensations may be a nonspecific physical resonance of the dysfunctional cognition (this is explained in Chapter 6).

Processing may be manifested somatically through a release of the physical sensations; that is, the client experiences them with decreasing intensity with each set. These changes may appear simply as a reduction in pulse rate or as what is termed a retracing of the experience itself. As an instance of the latter, a client whose mother punished him by burning his hand on the kitchen stove initially reexperienced the burning sensation as if it were occurring in the present, but with each set, he felt this sensation lessen in intensity. Remember, however, that while the client may feel only vague physical sensations of the experience at the start of the processing session, these sensations can suddenly increase in intensity at any time.

The physical sensations felt by the client are viewed in EMDR simply as a manifestation of the information being processed. Conceptually, since the physical sensations present during the trauma are also locked in the brain, the stimulation of the information can be experienced by the client in the part of the body where the sensations were originally felt (through the afferent–efferent nervous system). This stimulation, as with any other painful sensation, may seem to be in the part of the body that hurts, but the pain center is, of course, in the brain.

While explained conceptually here in terms of sensation stored in the neural network, the actual reexperiencing of the memory (as in an abreaction) can be frightening for both client and clinician in the absence of preparation. A client who experiences distress through the restimulation of the pain of physical assault should be comforted and reminded during the set that he is in no present danger. However, if the clinician is not comfortable with the possibility that the client might feel strong emotions and high levels of physical sensations, she should not use EMDR therapy. This caveat is especially important, since the client can certainly be traumatized further if the clinician shows fear or aversion to his reactions during processing.

Processing of information can also be indicated by shifts in the location of body sensations. For instance, a client may initially indicate tightness in the stomach, but with each set, the sensations may seem to move upward (to the chest, throat, or head). The clinician should merely direct the client to think of the new location, without attempting to ascertain what the sensation feels like or ascribing a meaning to it. A significant number of clients consistently report that a sensation feels as if it is located in the head. This experience should be treated by the clinician not as a metaphorical construct but as an actual physical sensation. Clinicians should direct clients to focus their attention wherever the sensation currently resides and not ask them about sensations reported in past sets. Additionally, if the client reports dizziness, pain, or nausea, or if no movement in the sensation is reported after two sets, the clinician should change the direction of the eye movement. This change will generally cause the physical sensations to shift in some manner.

While physical sensations during EMDR processing are considered an appropriate target for subsequent sets, the clinician must use common sense. Some physical sensations might actually be the result of problems in the present moment. A heart attack or stroke, after all, might conceivably occur during an EMDR session, just as it might happen during choir practice. Caution is always advised, particularly when working with older adult clients.

As noted earlier, when eye pain is reported, the eye movements should be stopped and alternative modes of stimulation used. At no time should eye movement be continued when the client reports eye pain. Alternative stimuli can easily be substituted.

DIFFERENTIAL EFFECTS

Keep in mind that the aforementioned changes are intended to convey a general idea of what can be expected. Because EMDR therapy is not a regimented approach, no two treatment sessions will be the same. Each client should be treated as a unique individual with needs that vary from moment to moment. Clinicians must be vigilant, so that they can alter the

procedures at any time to accommodate the needs of the client; they must refrain from viewing EMDR therapy as a race to achieve treatment effects. While the following chapters are offered to assist the clinical implementation of the EMDR therapy model, therapists must be sure to use all their rapport-building skills and clinical resources to support the client. The effectiveness of EMDR therapy depends as much on the quality of the journey as on the designated destination.

SUPERVISED PRACTICE

Instructors may wish to supervise students in exercises that allow them to practice eliciting and developing negative and positive cognitions in a variety of role-play situations. This is a difficult part of EMDR therapy for many clinicians. A list of generic cognitions is included in Appendix A to assist the clinician's (and the client's) learning process. It may also be useful to supervise students in the use of the various types of eye movements and alternative forms of stimulation. This is suggested before the clinician attempts to use the procedures in an actual reprocessing session with a client.

SUMMARY AND CONCLUSIONS

EMDR processing treatment effects are based on the ability to target and access dysfunctional material. The initially targeted manifestations of this material include the image, the negative cognition, and the physical sensations associated with the event. Baseline measures include an identification of the stimulated emotion, an SUD rating that indicates the intensity of the disturbance, and a VOC rating of how true the client believes the desired positive cognition to be. The client should be thoroughly prepared before this focused accessing of the stored material. Processing of the target material is initiated by having the client focus on the appropriate stimuli (eye movements, tactile, or auditory) while simultaneously concentrating on the aligned elements of the target (image, cognition, and physical sensation) in sequential doses. Processing takes place during successive stimulation sets, which alternate with feedback from the client to determine the next appropriate target.

The purpose of the entire eight-phase EMDR treatment is to facilitate accelerated information processing. The first phase determines whether the client is an appropriate candidate for EMDR processing and includes treatment planning. The second phase prepares the client for any disturbance that may arise during or between sessions and sets appropriate expectations. The third, or assessment, phase focuses on ascertaining a target and determining its components and measures. During the following three phases

the clinician conducts the stimulation sets. The fourth, or desensitization, phase focuses on the disturbance, which is judged by the client's reports of the spontaneously generated material and the SUD scale. When this is completed, the installation phase begins, a phase that concentrates on infusing and strengthening the positive cognition (as measured on the VOC scale). In the sixth phase, the remainder of the reprocessing is accomplished by targeting any material revealed by a body scan. The seventh phase is closure, which returns the client to emotional equilibrium and during which the client is reminded about the potential for between-session processing. During debriefing, the client is also asked to record any attendant disturbance in a log and to use a variety of relaxation techniques to maintain a relative state of calm. Appropriate client selection, thorough preparation, careful application of the procedures, and adequate debriefing are vital for client safety, because unexpected unresolved material can surface during or between EMDR processing sessions. The eighth and final phase, reevaluation, determines the quality of the treatment effects and guides the clinician through the extended protocols.

The application of EMDR therapy to the treatment of the traumatic memories responsible for pathological symptoms involves grouping the events, then targeting not only a significant representational memory for each cluster but also nightmare images, flashback scenes, and present triggers. In addition, positive templates for appropriate future action are also processed. The activation of the client's innate self-healing processing system should be done with minimal clinical intrusion. As the processing proceeds, clinical effects are judged by the client's reports of new memories that conform to patterns of associated memory networks linked by similar cues (e.g., beliefs, participants, or sensations). When a single memory is maintained during the entire session, clinical results are assessed by the quality of the changes in the image, the sounds, the cognitions, the emotions, and the physical sensations. While treatment is straightforward about half the time, the remaining cases demand more complex clinical involvement (see Chapters 7 and 10). However, clinical attention and focus are mandatory at all times because of the magnitude and variety of the treatment effects. Specific instructions to guide the treatment process are offered in the next chapters.

CHAPTER 4

Phase One

Client History

The curious paradox is that when I accept myself just as I am, then I can change.

—CARL ROGERS

In this chapter, we look at the first phase of EMDR therapy, which entails history taking—to determine whether a given client will benefit from EMDR processing—and treatment planning. Any form of trauma processing can be disturbing to the client both during and after sessions. The first section of this chapter offers an understanding of the nature and intensity of the disturbances that may arise. This should help the clinician to assess the client's readiness. It is imperative that the clinician make informed decisions regarding the client's ability to maintain a sense of stability and to perform certain therapeutic tasks in the face of high levels of emotion.

The next section, on client safety factors, delineates the areas of inquiry used to select clients for EMDR treatment. As indicated previously, this information should be supplemented with supervised practice. For those clients deemed appropriate for EMDR therapy, the clinician then takes a detailed history in order to outline a treatment plan and identify the specific information needed to address the presenting problems. To illustrate the clinician–client interaction, this chapter will conclude with a transcript of an actual history-taking session.

CLIENT READINESS

The clinician needs to obtain a careful, detailed client history to assess the suitability of a client for EMDR processing and to gauge the client's psychological needs during and after sessions. It is important to remember that each

session is different, and each client's needs and responses are unique. In order to make an informed decision, the therapist must be sensitive to the kinds of experiences clients have during the information processing that may occur both inside and outside the office once EMDR processing has been initiated.

Stimulating the information that constitutes the client's target memory brings its various components to consciousness. Dissociated information can readily surface, as can many of the emotions and physical sensations experienced at the time of the event. While it is unnecessary for the client to give a detailed description of the event, this resurfacing can be extremely distressful for the client. If properly handled by the clinician, the accelerated processing that EMDR activates will resolve this information far more rapidly than conventional therapies. However, the clinician must assess the client's readiness and ability to uncover and withstand the information in order to ascertain whether the client can be guided through the disturbance that may emerge if the memory is treated. If not, extended preparation is needed before processing begins.

An important characteristic of EMDR therapy is that the information processing may continue *after* the session, although at a slower rate. Therefore, the client may experience some discomfort between sessions as new memories are stimulated in or below consciousness. A helpful metaphor is that of a row of falling dominoes: As each memory is stimulated and processed, it may set off an associated memory. Moreover, as each memory is stimulated, it may release disturbing images and emotions. For treatment to be successful, the client must be able to handle whatever emotions—despair, helplessness, vulnerability, and so forth—are associated with the memory.

There is no way to predict exactly how a client will process a particular event. Responses can range from a mild emotional reaction to a full-blown abreaction. In EMDR therapy, we define "abreaction" simply as the reexperiencing of the stimulated memory at a high level of disturbance. Images, thoughts, emotions, and physical sensations may be brought to consciousness as the client processes the information. During an abreaction, the emotions and physical sensations are particularly strong, perhaps almost as strong as they were during the original event. EMDR processing does not, however, generate full flashbacks, since the client is coached to have a dual focus by maintaining an awareness of the disturbing past event while staying in the safety of the present. This is aided by the dual tasks of concentrating on the target and following the clinician's fingers.

Because of their great intensity the physical sensations may be frightening to the client. For instance, one client had been playing cowboys and Indians as a young child when her friends captured her, tied a rope around her neck, and hung her from a tree. Luckily, one of the mothers ran out and cut her down, with only moments to spare. As her EMDR processing began, the client began to emit choking sounds, turned a vivid color, and clearly was having great difficulty breathing. In this case, processing was successfully completed, but clinicians should keep in mind the possibility of such a violent client response when determining safety factors.

Even if the target memory appears minor, it can quickly shift to a highly charged memory. The hallmark of EMDR treatment is accelerated processing, with its potential for a rapid uncovering of previously unsuspected material, some of which may be extremely distressing. Therefore, client readiness should be carefully assessed.

CLIENT SAFETY FACTORS

The following factors are crucial in maintaining client safety and should be carefully assessed to determine which clients are ready for EMDR processing.

Level of Rapport

Clients should be able to feel comfortable with the possibility of experiencing a high level of vulnerability, a lack of control, and any physical sensations from the event that may be inherent in the target memory. This means that clients must be willing to tell their therapist the truth about what they are experiencing. While it is not necessary for them to reveal the details of their trauma, they must be willing to experience in the presence of the clinician whatever emotions emerge and to report accurately the nature and intensity of these emotions. Sometimes—because of insufficient trust, a high susceptibility to demand characteristics, or a desire to avoid further painful material—a client will inaccurately report a low level of distress and inappropriately or prematurely terminate the session. When this happens, the client is more likely to experience discomfort between sessions and may be forced to deal with abreaction-level material without the appropriate clinical support. Clients are reported to be at greater risk for suicidal ideation and suicide attempts when they feel greatly disturbed but withhold this information from the clinician. While this is true with any form of therapy, the potential for additional between-sessions disturbance during EMDR treatment underscores the need for a strong therapeutic alliance, specific truth-telling agreements, and a therapist who can convey a message of safety, flexibility, and unconditional regard.

Clients with severe abuse backgrounds should be given careful consideration before proceeding with treatment, because they generally have difficulty around issues of safety and trust. Until the client feels comfortable with the clinician in the common interactions of traditional therapy, EMDR processing should not be used.

Emotional Disturbance

Clients should be able to withstand the high levels of emotional disturbance that may arise during or between EMDR processing sessions. In order to help test this capacity before the traumatic material is specifically targeted,

it is strongly recommended that the clinician discover during the history-taking sessions whether the client can respond to self-control and relaxation techniques. The clinician should try a variety of these techniques with the client in the office and only proceed with EMDR processing if the client can successfully be guided to dissipate a moderate level of disturbance (see Chapter 9 for some examples).

When targeted material has been incompletely processed during any session, proper debriefing (as defined in Chapter 6) is imperative, and guided visualization, relaxation techniques, or hypnosis are used to help the client regain emotional balance. Because the clinician will not be able to predict the level of between-sessions disturbance, it is useful to train clients in these self-control techniques before undertaking EMDR processing. I also recommend the use of audio recordings that can be employed between sessions (e.g., "Letting Go of Stress"; Miller, 1994). Some of these relaxation techniques are described in Chapter 9 and can be used to bring closure to otherwise incomplete sessions. They should also be used by clients daily and to provide relief if spontaneous processing between sessions is causing emotional disturbance.

If the client is unable to use such self-control techniques, EMDR processing should not be attempted until sufficient preparation is completed. Clinical reports indicate that EMDR procedures can be used for resource enhancement to prepare more complex clients with affect dysregulation (Korn & Leeds, 2002). Known as "resource development and installation" (RDI; Leeds, 1998; Leeds & Shapiro, 2000), these procedures enhance access to a variety of positive affects in a manner similar to the Safe/Calm Place technique (see Chapter 9). When appropriate, clinicians should experiment with this and alternative methods until the client is able to reduce significant levels of disturbance. Inability to reduce disturbance can justifiably add to the client's fear when dysfunctional material is accessed, and can severely hamper positive treatment effects.

Stability

It is vital that the client be assessed for personal stability. As with most trauma therapy, suicidal ideation is not uncommon after EMDR treatment with certain clients, such as severely disturbed victims of multiple sexual molestations. Clinicians must appropriately debrief such clients (see Chapter 6), and the initial assessment should include the client's capacity to remember the debriefing instructions and ability to ask for assistance if needed.

The level of environmental stability is also significant. For example, clinicians should not attempt to reprocess unrelated traumas if clients are currently undergoing major life pressures (e.g., family/social crises or financial/career problems) and are unable to handle the additional disturbance engendered by reprocessing.

Of course, clinicians need to determine whether the earlier traumas are indeed unrelated to the client's present life conditions. Clients who are

constantly in a state of crisis may be driven by earlier adverse life experiences that need to be resolved before they can obtain relief from their present problems. It is important to determine which disturbing memories are directly responsible for present dysfunction, and therefore should be processed now with EMDR therapy, and which are incidental to the present crisis and can be set aside while current problems are addressed with appropriate plans of action.

Life Supports

Clients must have life supports, including friends and family members who can nurture them through any between-sessions disturbance. If clients are isolated or are primary caretakers without a supportive network of their own, clinicians should proceed with caution. Clinicians should determine whether their clients are able to sustain themselves psychologically or can be sufficiently comforted by them over the telephone if they need help.

General Physical Health

The client should be healthy enough to withstand the physical rigors of memory reprocessing. In the earlier example of the choking memory, the client was in her 30s when treated and strong enough to withstand possible physical consequences. However, had she been 70 years old, with a heart condition, I would have had serious concern about her ability to withstand the physical onslaught.

The potential effects of aroused emotion on women who are pregnant should also be taken into account. While, to date, there have been no reports of serious physical side effects, it is always better to use caution. When any physical problem, including a respiratory or cardiac condition, is part of the clinical picture, a physician should be consulted regarding the possible negative effects of high levels of emotional response.

Office Consultation versus Inpatient Treatment

Memories should be assessed to distinguish between those that may be targeted at the office and those that may require medical intervention or consultation, including the possibility of inpatient hospital support. During one reprocessing of a near-death experience, the client stopped breathing; fortunately, the clinician, a psychiatric nurse, had made provisions for resuscitation. In another case, a client was being seen in an inpatient setting by a psychiatrist. During the reprocessing of a memory of electrical torture, he began writhing and convulsing in bed, almost as if he were being shocked again. The psychiatrist was able to work with him to complete the processing, but clearly the experience would have been much more traumatic for both of them had it not occurred in a protected environment. Clinicians should always assess the need for appropriate restraint, medical

attention, or medication when treating clients with schizophrenia, near-death memories, or physical impairments, or when in doubt about suicidal tendencies, personal stability, or appropriate life supports. For active drug- and/or alcohol-addicted individuals, treatment needs depend on where the person is on the continuum of severity (see Chapter 11). Those who are severe/chronic alcoholics in need of detox, in dire physical health, or at risk for seizures (e.g., caused by abruptly stopping the use of large amounts of alcohol) should be in a higher level of care and under medical supervision. If there is any question of clients becoming a danger to themselves or others, inpatient work should be strongly considered.

Neurological Impairment

There have been no reports of client harm for those suffering from neurological impairment. However, since the AIP model posits certain underlying physiological processes, clinicians should be sensitive to any history of neurological abnormalities or organic brain damage. No contraindications for the use of EMDR have been reported with clients suffering from attention-deficit/hyperactivity disorder.

Clinicians have reported a tendency for less treatment generalization to occur with some clients who have organic brain damage and, consequently, a need to target a greater than usual number of memories to achieve full therapeutic effect. While EMDR processing has been used successfully with clients evincing a range of neurological complaints, caution should be observed when attempting treatment of this population; that is, there may be some form of brain damage that would cause either no response or extreme discomfort during EMDR processing sessions. A physician consultation should always be sought if the clinician suspects that a physical condition, including neurological impairment, might present a problem. Clinicians attempting EMDR processing with such individuals should also be thoroughly experienced with a wide range of EMDR treatment effects in order to recognize any abnormal response, in which case the session should be terminated.

Epilepsy

While a number of clients with epilepsy have been successfully treated with EMDR therapy, caution should be observed as a matter of course, as with any client who is neurologically impaired.

I have heard only three reports of clients experiencing seizures (all small) during EMDR processing sessions. In one instance, the memory being reprocessed was seizure related; the client regained consciousness within 5 minutes, washed her face, and went on with the session without further incident. (This was the only seizure suffered by the client in over a dozen sessions.) Another client suffered a small seizure during an EMDR

processing session but after concluding treatment was never troubled by seizures again. Both occurred with the use of eye movements. The third case involved the use of a lightbar for tracking purposes. Overall, clients with epilepsy should be informed of the possibility of a seizure during EMDR before treatment is begun, and it is suggested that therapist-directed tactile or audio stimulation be used.

Also noteworthy is the case of a client with epilepsy who had been successfully treated for PTSD and attempted the eye movements on her own whenever she had an "aura" or other sign of an oncoming seizure. She discovered that the eye movements enabled her to avoid the attacks.

Eye Problems

There has been a report of a client sustaining severe ocular damage that resulted in blindness because of eye movement treatment. This occurred at the hands of a clinician who was untrained in the use of EMDR. Apparently, even though the client reported consistent eye pain, the clinician, who had no knowledge of EMDR treatment effects, continued to administer the eye movement sets. *Under no circumstances should EMDR processing be continued if the client reports eye pain.* If this occurs, the clinician should use alternative forms of stimulation. The same is true for clients who are unable to maintain continued eye movement sets because of eye muscle weakness.

Clients who wear contact lenses should bring their lens cases to treatment sessions so that the lenses can be removed if any sign of dryness or irritation occurs. With many clients, it may be preferable to avoid using eye movements when they are wearing contacts.

Again, when eye movements cannot be used, the clinician can use alternative forms of tactile or auditory stimulation (as described in Chapter 3).

Drug and Alcohol Abuse

Clients with a substance abuse history should have in place appropriate supports, such as a 12-step program, Smart Recovery, Buddhist Recovery, or an equivalent, before initiating EMDR treatment. Outside support from others in a shared emotional struggle cannot be underestimated. Isolation and shame keep many individuals from being able to ask for or accept help. Clinicians have reported that while some clients easily abandon substance abuse or cravings during treatment, others have a greater desire to resume the activity, presumably because of the stimulation of disturbing psychological material. Whether the resumption of chemical abuse or other addictive behavior represents an attempt to medicate against the stressful material that is emerging or stimulation of the old desire is unclear. In any case, clinicians should take special care with this population by briefing clients about potential problems and by setting up safeguards against potential

resumption or exacerbation of abuse behaviors (see also Chapter 11). In addition, every attempt should also be made by clinicians to contract with addicted clients for rigorous honesty about their substance use or lapses to ensure their safety and build trust in the relationship. This level of honesty will contribute significantly to their recovery.

Legal Requirements

If a crime victim, witness, or police officer is being treated for a critical incident, it is essential to establish whether a legal deposition or any specific kind of trial testimony is, or may be, required of the individual. During EMDR processing, the image of the event may fade, blur, or completely disappear. Although the client does not forget what happened and will still be able to tell what occurred, she might not be able to provide a vivid, detailed description of the event. Conversely, the client may be able to give a more detailed description and may actually see the picture more clearly after EMDR treatment. However, there is no way of knowing beforehand how a client will process a particular event.

Consequently, informed consent should be used with all pertinent parties when legal proceedings are under way (or might be contemplated). Clinicians should explain that after EMDR processing, (1) the client may be unable to access a vivid picture of the event, and (2) the client may no longer recount the incident with extreme emotion (which may be a problem if a very emotional witness is needed on the stand).

Systems Control

As with any form of psychotherapy, EMDR treatment influences not only clients but also their families and friends. As the dysfunctional information is processed and new self-assessments are engendered, the client's behavior changes. As clients become open to new choices, they should be educated with skills training. For instance, they may need to be taught how to deal with problem people or new situations through instruction in assertiveness, dating skills, or career-related matters. Early in treatment, clinicians should arrange for appropriate peer support and training groups for the client. EMDR therapy clients can process material at a surprisingly fast rate, and they must be prepared to handle the resistance they may encounter from colleagues, family members, or friends. For example, if clients insist on remaining in a dangerous environment in which new assertiveness would be detrimental (which might be the case for a battered wife who is still living with her alcoholic husband), they should be briefed about potential problems and offered alternative strategies for self-expression.

Clients in dysfunctional social relationships (e.g., in which they might be taken advantage of if they appear to be in a vulnerable state) should be cautioned to avoid these relationships immediately after trauma processing.

For this reason, treating clients in penal institutions may be contraindicated in many instances because of the peer pressures inherent in the system.

Secondary Gains

Special care must be taken to assess the possible positive consequences, needs, or identity issues that are served by the presenting complaint. Clients may have organized their existence around their pathology, and this possibility must be addressed, at least cognitively, before any changes can be expected from EMDR treatment. Essentially, the clinician must identify what the client will need to confront or give up if treatment succeeds and determine whether the client has the stability and resources to handle the change.

A prime example of this problem can be found in certain veterans. Having suffered flashbacks, nightmares, and intrusive thoughts over many years, they are now offered EMDR treatment along with the claim, "We will take away your flashbacks, nightmares, intrusive thoughts—and your disability check." A veteran's fear (which he might reject on a conscious level) of becoming homeless because of loss of income is quite understandable. Unless this issue is addressed, his dysfunction is liable to remain unresolved. The clinician should address this concern (and others) by means of appropriate action plans before attempting to treat the trauma of clients who are receiving compensation or special caretaking because of their emotional disability.

Fear of loss of social identity may also be an issue. A number of veterans have said, "Who am I if I'm not a wounded veteran?" Combat veterans may be afraid of losing the sense of comradeship that goes along with being a suffering member of their treatment group. They may also be afraid that as their emotional pain lessens, they will stop honoring their dead. Exploring these concerns before starting to work on the trauma is highly recommended. The factors directly related to combat veterans are explored more fully in Chapter 11.

The fear of loss of identification with a peer group is also pertinent to some molestation victims. They may become afraid of healing, because they recognize that as their pain eases, they no longer feel as strong an affiliation with other survivors. Finally, those clients who have been in a treatment group for many years may have established their identity and social structure around treating their dysfunction; such individuals need to become affiliated with the group in a different way if treatment is to be successful.

Timing

The emotional responses of clients and the intensity of their between-sessions disturbance are highly variable. There is no way to predict accurately these

reactions before processing begins. It is important, therefore, to assess the client's (and the clinician's) current life situation in order to reduce potential problems. For example, if the client is scheduled to make an important presentation at work, EMDR trauma processing should not be initiated, because she may be too distracted or disturbed to function at peak effectiveness.

Furthermore, since there is no way of knowing how much residual dysfunctional material may remain at the end of a session or how much associated processing will continue spontaneously, care must be taken to prevent high levels of distress if the client lacks psychological support. If, for example, the client is about to take an out-of-town trip or if the clinician is scheduled for a 2-week vacation, the reprocessing of a major trauma should not be started.

Clinicians should explain to clients that EMDR memory processing may entail emotionally intense work and that no important appointments or long work hours ought to be scheduled immediately following a treatment session. The client's work schedule must be amenable to these postsession requirements. If this is not possible, trauma work is contraindicated.

Clinicians should provide adequate time during each session to process the presenting traumatic memory and conduct the required closure. It is recommended that the initial history taking be done in separate 50-minute (or longer) sessions and that subsequent EMDR processing of traumas be carried out in 90-minute sessions. Although long by conventional standards, even a 90-minute session may provide only adequate time for implementing Phases Three through Seven and sufficiently processing a particular trauma. At least a 90-minute session can allow the most distressing aspects of the memory to be adequately addressed. If a single trauma is rapidly treated, more than one memory may be addressed in that session.

As mentioned earlier, if the trauma is insufficiently processed, the client is likely to be left with a relatively high level of disturbance that may continue, or even increase, between sessions. Regardless of the length of the session, under no circumstances should a client leave the office during (or immediately after) an unresolved abreaction. Although a 50-minute client hour is not generally recommended, a randomized controlled study indicates that it can be successfully utilized by experienced EMDR clinicians with civilian populations (see Marcus, Marquis, & Sakai, 1997, 2004). Under these circumstances, EMDR processing should be done with the understanding that it may increase the likelihood of the client's remaining in a relatively high level of distress at the end of the session and during the processing that continues between sessions. Additional emphasis should be placed on self-monitoring distress and using affect-regulating techniques at the end of a session and between sessions. Maintaining the traditional 50-minute hour also generally more than doubles the number of sessions needed for full remediation of clients' complaints. Since some disorientation may occur immediately after treatment, the clinician should assess the

client's ability to leave the office and drive safely. Sufficient time must be left at the conclusion of the session to debrief clients and allow them, if necessary, to regain any loss of equilibrium. Even under the best of conditions, there is the possibility that a trauma will be insufficiently processed after a 90-minute session. Some traumas take a number of sessions to defuse. Always use caution if a client remains in distress, and assess what special needs he might have in returning to work or going home. The appointment time should be geared to the specific needs of the client. For instance, clients with a great deal of responsibility at work should be seen at the end of the day, or at the end of the week, rather than at the beginning, because they may feel unfit to return to a high-pressure situation. To accelerate treatment, if needed, processing sessions can also be scheduled on consecutive days.

Medication Needs

At times, a client may already be stabilized on prescribed medication or may be assessed as needing such medication to maintain emotional stability between sessions. So far, no medications appear to completely block EMDR processing, although the benzodiazepines have been reported to reduce treatment efficacy with some clients. A client who is on any medication for emotional distress should be carefully monitored, so that the drug can be reduced or discontinued at the appropriate time. Presumably, as the dysfunctional psychological material is processed, the attendant anxiety or depression is alleviated, thus reducing the need for medication to treat the problem.

Clinicians should process the presenting traumas again, after the client is no longer taking the medication. Clinicians have reported that if a client is asked to reaccess the treated memory after medication has been discontinued, it can return with approximately 50% of its original associated disturbance. For instance, an initial combat trauma that was given a rating of 10 on the SUD scale may decline to a posttreatment level of 0 while the client is on medication, but once medication has ceased, the memory may elicit a rating of 5. This regression reveals the presence of some residual dysfunction in state-dependent form, a problem that contrasts with the stable treatment effects typically found with nonmedicated patients. Therefore, the need for medication should be assessed carefully, with the understanding that its presence will likely increase the time required for successful treatment.

Dissociative Disorders

Using EMDR processing with dissociative disorders, especially dissociative identity disorder (DID; known prior to DSM-IV as multiple personality disorder, or MPD), is strongly discouraged without supervised training in

dissociative disorders and the appropriate EMDR protocols. In addition, the more advanced procedures of EMDR therapy (described in Chapter 10) are required because of the tendency of clients in this clinical population to have difficulty reprocessing the traumatic memory completely (see the EMDR Dissociative Disorders Task Force guidelines in Appendix E). While the dissociative disorders constitute a separate section in DSM-5, EMDR specialists regard DID as a complex form of PTSD (Spiegel, 1993) in which the victimization was so great that, for survival, the global memory was compartmentalized to hold different aspects of the pain and disturbance and becomes divided into more dissociative personality states. Thus, the personality states can be conceptualized as neural network configurations that serve as memory compartments (Braun, 1988; Lanius & Bergmann, 2014). When EMDR therapy (or other treatments; e.g., hypnotic abreaction) has successfully resolved the traumatic material, the need for the compartmentalization lessens, amnestic barriers between the personality states dissolve, "co-consciousness" increases, and integration can occur. However, it is vital that a phase-oriented treatment be used (International Society for the Study of Trauma and Dissociation, 2011), allowing time for sufficient preparation and stabilization prior to trauma processing (Chu, Dell, van der Hart, & Cardeña, 2011; Ross, 1997; van der Hart, Nijenhuis, & Steele, 2006).

Clinicians report that a comparatively rapid spontaneous integration of personality states is observed when EMDR therapy is properly utilized with dissociative disorders (see Chapter 11). However, clients are at great risk if the pathology is misdiagnosed or if treatment is attempted by a clinician who lacks appropriate training in severe dissociative disorders. If a client with a dissociative disorder is treated without the appropriate safeguards, the targeting of traumatic memories may result in the client having difficulty reprocessing a high level of affect and somatic sensations. Furthermore, although the material may appear to come to a successful conclusion during a session, its activation may cause a high level of disturbance by "affect bridging" (in the rest of the memory system), an effect that can result in the need for hospitalization or emergency care between sessions. In addition, there have been reports of a significant number of incidents of DID personality states spontaneously emerging with the initiation of EMDR processing, a phenomenon that may be due to the active stimulation of the associated neural networks.

Because many clinicians are not educated in the treatment of dissociative disorders and greatly underestimate their prevalence, the appropriate safeguards must be stressed (see Ross, 2015). A common characteristic of clients with DID is a history of many previous diagnoses, because they are not easily identified. Therefore, the clinician intending to initiate EMDR should first administer the Dissociative Experiences Scale–II (DES-II; Carlson & Putnam, 1992) and do a thorough clinical assessment with every client. When the DES score is above 30, the application of a structured

diagnostic interview for the dissociative disorders, such as the Structural Clinical Interview for DSM-IV Dissociative Disorders (SCID-D; Steinberg, 1994), is indicated (see also Appendix E).

A brief summary will be given here of several of the primary indicators of DID. Note that while most clinicians associate DID with memory lapses, clients may be unaware of their amnesia and fill in memory gaps, without knowing that dissociative episodes have occurred (Putnam, 1989).

Within a standard mental status exam, the following clinical signs should suggest to the interviewer that the client may have a dissociative disorder: (1) intractable, unexplained somatic symptoms, (2) sleep problems, (3) flashbacks, (4) derealization and depersonalization, (5) Schneiderian symptoms (e.g., voices, unexplainable feelings), (6) memory lapses, (7) multiple psychiatric hospitalizations, and (8) multiple diagnoses with little treatment progress (see also Ross, 2015; Van der Hart et al., 2006). Although dissociative disorders have been underdiagnosed, care must also be taken not to overdiagnose (Draijer & Boon, 1999). The EMDR Dissociative Disorders Task Force's recommended guidelines in Appendix E offers further diagnostic assistance. When in doubt, the clinician is strongly advised to refer the client to an expert in dissociative disorders for a thorough evaluation.

TREATMENT PLANNING

As in any form of psychotherapy, the purpose of history-taking sessions is to identify the complete clinical picture before attempting to treat the client. While the initial stage of history taking in EMDR therapy determines the suitability of the client for trauma processing, the second stage identifies the potential targets with as much specificity as possible. A useful metaphor is to imagine the presenting pathology to be a board screwed down on top of the client. The clinician's job is to remove the board in order to give the client room to grow. Rather than hammering away at the board, it is more appropriate to attempt to identify the screws that need to be targeted. Thus, in a manner of speaking, EMDR serves as a power tool to remove these screws more rapidly.

Even if two clients enter therapy with the identical complaint, their treatment needs may vary greatly. Clinicians must determine which problems should be remediated by education, problem solving, or stress management techniques, and which are based on dysfunctional information that needs processing. While EMDR may be used to increase the assimilation of new skills, any existing dysfunctional patterns should generally be addressed first.

For instance, if a client requests help because of an abusive marriage, the history-taking process will need to ascertain the primary focus of the EMDR intervention. If the client's husband recently became abusive

following a car accident, the appropriate treatment plan clearly will differ from the one needed if the client has had a long history of abusive relationships that include a domineering father. While, in the first example, the client may require the reprocessing of the abusive events that have just occurred in the marriage, the existence of a normal relationship before the husband was injured in a way that caused a personality change allows the clinician to concentrate on present factors, stimuli, and problem solving.

In the second example, the client's history of abusive relationships indicates characterological elements that need to be specifically addressed. This observation is not new in the area of psychotherapy in general. However, in this case, the EMDR treatment plan is based on, among other things, a conclusion from the clinical observation of thousands of reprocessing sessions, namely, that earlier abuse experiences are often directly responsible for dysfunctional relationships in the present. The association between present dysfunction and earlier incidents (explored in Chapter 2 in the context of the AIP model) has been supported by research and is consistently demonstrated by client reports during EMDR processing sessions that attempt to target the present situations. In order to treat clients with current dysfunctional relationships who have a history of early or serial abuse, their pervasive characteristics (including predispositions and behaviors associated with negative beliefs) must be identified. Along with the abuses that have occurred in the current relationship, the earlier touchstone events (i.e., early, pivotal self-defining incidents) generally have to be targeted and reprocessed before substantial and pervasive present psychological and behavioral changes can be expected.

While some single-event PTSD victims may be treated with EMDR by merely targeting the traumatic memory, most clients need more comprehensive treatment. This treatment should entail sequential targeting of the early, critical touchstone experiences, the present situations that stimulate the dysfunction, and alternative behaviors that can be used in the future to meet the goals of therapy. The clinician should attempt to delineate the presenting complaint and its antecedents with as much specificity as possible. While the following list is not exhaustive, it provides the clinician with some basic guidelines (see also Appendix A). To inform their treatment planning, clinicians should take care to ascertain the following:

1. *Symptoms*. What are the prevalent dysfunctional behaviors, emotions, and negative cognitions? What are the specific symptoms, such as flashbacks, intrusive thoughts, panic attacks, and reckless behaviors? What are the current triggers and their frequency, timing, locations, and other characteristics?

Let us use as an example the case of the client who was currently involved in a marriage that was the most recent in a series of abusive relationships. The clinician determined that the primary pathology was defined by the client's feelings of shame and powerlessness, along with the

cognition "I am worthless," all of which were contributing to her continuing attraction to abusive partners and to her inability to assert herself. History taking revealed that feelings of panic and memories of childhood beatings occurred when the client's husband acted coldly, when her boss became angry, when she had to assert herself with a storekeeper, and so forth.

2. *Duration*. How long has the pathology been apparent? How has it changed over time? What alterations have occurred in the factors contributing to the pathology?

In our sample case, the client's pathology had existed since childhood, but the panic attacks had increased in number and intensity in recent years. Since having a baby, the client felt more vulnerable and out of control.

3. *Initial cause*. What was the original occurrence or most disturbing primary event, modeling, lesson, and so forth, that represents the genesis of the dysfunction? What were the circumstances—including interactional, social, or family systems factors—at the time of the first event? A useful question is, **"When was the first time you can remember feeling this way?"**

In our sample case, the client was the youngest of three children. She was beaten by her father for minor infractions and was bullied by her siblings. The first panic attack she was able to recall occurred when she ran to her mother for assistance and was pushed aside. Her mother believed her siblings' story and yelled at her, "Wait until your father gets home."

4. *Additional past occurrences*. What other incidents have been instrumental in influencing or reinforcing the pathology? What other significant variables exist? Who are the major participants? What categories of participants, maladaptive responses, negative cognitions, and so on, are apparent? How could the events be clustered or grouped to maximize the generalization of treatment effects? Clients can be asked to identify their 10 most disturbing memories. They can be encouraged to scan their life with an attitude of exploratory interest, with the therapist as a reinforcing partner in the examination. Briefly describing the 10 or so memories will generally help to define the types of negative cognitions and experiences that have to be addressed. This is generally a good time to identify an equal number of positive memories that can be used to identify people and experiences as potential resources. If the client cannot identify positive memories and/or becomes distressed, it is an indication that additional stabilization may be needed (see Chapter 11 section on Complex PTSD). The client in our sample case was negatively influenced by multiple abuses and beatings throughout her childhood; by her dyslexia, which resulted in humiliations at school; by a date rape, which occurred during her adolescence; and by her experiences with a series of abusive boyfriends. It was possible to cluster the different kinds of abuse and humiliation. "Clusters" are composed of events that are similar in a variety of aspects, such as verbal assaults by

the same person, or times of being abandoned by the same parent. Parents, siblings, three teachers, and the abusive boyfriends were targeted as the major perpetrators, and the following negative cognitions were identified: "I am worthless," "I am dirty," "I am not in control," and "I cannot succeed." Such cognitions surfaced at work, in social relationships, and when the client was involved with authority figures. In other cases, clusters may comprise similar incidents such as fire fights experienced by military personnel. Targeting the most disturbing of these instances often results in a generalization of positive processing effects to the other experiences in the cluster.

5. *Other complaints*. What other difficulties are encountered? What other dysfunctions may be masked by the primary presentation? Evaluate personal and relational domains.

In the sample case, work-related difficulties and inadequate parenting by the client (of her daughter) had to be addressed.

6. *Present constraints*. How is the client currently affected? What dysfunctional emotions or behaviors are elicited? What actions is the client unable to take? What systems issues (such as dysfunctional family or social structure) need to be addressed?

The client in our example was unhappy in her home and work environment and had pervasive feelings of failure and low self-worth. She could not assert herself, leave her present situation, or offer appropriate support to her daughter. Furthermore, it was clear that neither her parents nor her husband would welcome the behaviors that would result from an increase in her self-esteem.

7. *Desired state*. How would the client prefer to be acting, appearing, feeling, and believing? What, specifically, is preventing this? What are the potential consequences of successful treatment? What positive experiences exist in the client's history?

Although the client in our example wanted to be more assertive and to have an increased sense of self-worth, she was constantly bombarded by memories of earlier abuse and by the negative emotions triggered by her husband and her boss. While some of her feelings were appropriate to present situations, their intensity was compounded by childhood events; thus, her feelings often overwhelmed her to the point of inaction. The potential consequences of successful treatment included the client's concluding that she might need to divorce her husband and find a higher paying job to support herself and her child. Understandably, the prospect of standing up for herself triggered the negative cognition "I cannot succeed." Of course, any existing secondary gain issues would have to be addressed first.

Overall, in planning treatment, the clinician is attempting to discover parallels between the client's past and present, in order to identify patterns of responses. Having delineated the present stimuli, dysfunctional

cognitions, emotions, and behaviors, the clinician must isolate specific targets, which can range from a client's earliest memories to the latest disturbing experience. Treatment plans entail consolidating resources, then targeting (1) the early memories that set the groundwork for the dysfunction, (2) present triggers that stimulate the material, and (3) desired future responses (the standard protocol is discussed in Chapters 3 and 8, while considerations for treatment of complex PTSD are presented in Chapter 11).

HISTORY-TAKING TRANSCRIPT

The following transcript includes sections of a history-taking session that involved treatment planning. The client is a sexual abuse victim who is in therapy to alleviate the sequelae of the molestation. The annotations indicate the therapist's purpose in asking particular questions and the answers the therapist intends to pursue in future sessions.

THERAPIST: What brings you here?

CLIENT: I've had nightmares and sleep disturbance for really as long as I can remember. I don't really remember not having it, and I attribute that to sexual abuse by my uncle when I was around 5 years old. I think it's a combination of that and my dad being what I call emotionally incestuous. He never touched me or anything like that but made really inappropriate sexual comments, stuff like that. And my mother, during my childhood, always ran a lot of rage. You ever watch these training films for child abuse? And you know when the parent who's about to hit the kid starts escalating? It was that level of escalation, short of hitting, on a daily basis. So it's like the triple whammy. It's all that altogether. I did a lot of therapy, I've done a lot of meditation, and I've done really tons of stuff. You know, 5 years ago, I woke up terrified six nights a week, and I would say now it's more like a sleep disturbance. And I have really bad nightmares when I get stressed.

[The therapist identifies the primary complaint as a sleep disturbance. Primary targets will include the client's father, mother, and uncle.]

THERAPIST: How often?

[Therapist attempts to establish the frequency as a baseline.]

CLIENT: I was trying to think, because I figured you would ask me that. It depends on my stress level. Maybe a few times a month.

THERAPIST: How many? Four, three?

CLIENT: Around that.

THERAPIST: OK. To what do you attribute the partial resolution, so that 5 years ago it was six nights a week and now it's only three times a month?

CLIENT: I think it's a combination of everything I've done. I do a lot of meditation, draw, writing, therapy, and I think there was a sense 5 years ago of the trauma being unconscious and therefore being more powerful. And I think at this point I am, well, maybe I am more powerful. I am more conscious of how the trauma affects me and how it affects my relationships with other people, so I think that's what's brought down the charge.

THERAPIST: What brought about more consciousness?

CLIENT: It was repressed for 15 years, from 5 to 20. I was on vacation, and [describes event that occurred]. In the wake of that I remembered; the memory came back. And even for a couple of years into my own therapy, I wasn't real sure it had happened, because when you're 5 it's like a dream, you know. And after a couple of years I told my parents and found out that he's sexually abused most of the women in my family.

[In this interchange the therapist explores parameters and limitations of memory recall and attempts to determine whether conditions warrant a formal report.]

THERAPIST: Tell me a bit about what you remember as far as the molestation.

[Therapist identifies one of the primary targets.]

CLIENT: The memories are very dreamlike. What I remember is a birthday party and him like climbing on top of me on all fours with my pants down. I was in a car accident about 4 months ago, and I've been getting a lot of body work done, particularly around this area of my buttocks and hips. During a couple of sessions I had more memories of being held down and inserting something in my buttocks. I don't think it was a penis. It was like a finger or an object, or something like that.

THERAPIST: Okay. Any other memories?

CLIENT: No.

THERAPIST: So the one memory then, at the birthday party with him climbing on you, holding you down, and inserting something.

CLIENT: It was two separate memories. The birthday party was one, and then being held down and putting something in me was like another one. It's like two separate fragments.

THERAPIST: Okay. Do you have any idea where that took place?

[Therapist checks for clarity.]

CLIENT: My house, the first one. I remember that really clearly. My house where I grew up.

THERAPIST: So the birthday party occurred in your house? And the other memory?

CLIENT: I don't know.

THERAPIST: Okay. How old was he?

CLIENT: Probably in his thirties.

THERAPIST: And you were five? Okay. So we are looking at someone now in his sixties, around there?

[Therapist defines parameters regarding present safety for future work.]

CLIENT: Yes.

THERAPIST: Okay. When you say that you believe the nightmares stem from that, could you be a little bit more specific?

CLIENT: Well, it's always men attacking me sexually.

THERAPIST: Okay. So are they the same dream, the same men?

[Therapist attempts to define targets of dream imagery.]

CLIENT: No, different, but with the same theme.

THERAPIST: Do you have vivid recollections of them?

[Therapist seeks to identify targets for processing.]

CLIENT: The most recent one that I had was actually not my uncle but my father. And the dream—this was a really bad one—he was masturbating and using me as a fantasy to jack off. I was screaming in the dream for him not to do that.

THERAPIST: Okay.

CLIENT: It's usually being threatened, waking up and someone's in the room who's going to hurt me, someone breaking into the apartment.

THERAPIST: Okay.

CLIENT: One I had as a kid that was particularly terrifying is a bunch of men coming in the door with guns threatening me. One was my dad. My dad worked where the garage was and that he had an evil double who was masquerading as him. And that was terrifying to me as a kid.

THERAPIST: Okay. Besides the nightmares that go on, how else do you feel you might be affected now?

[Therapist elicits other complaints.]

CLIENT: Well, I have this real hypervigilance. You know, it's really hard to calm down. I have a lot of trouble in my relationships with men.

THERAPIST: In what way?

CLIENT: All ways. I've recently realized that I tend to choose men who are kind of sociopathic, like my dad. Very charismatic, very charming, very attractive, who really don't bond. They have an affair with somebody else, they lie to me about it. Usually men who are very angry and hostile and emotionally abusive, I would say.

THERAPIST: Are you in a relationship with one right now?

CLIENT: No! (*Laughs.*)

THERAPIST: When was the last one?

[Therapist searches for a relationship that can be used as a target.]

CLIENT: I had a breakup around 6 months ago. It was an 8-month relationship and it was very serious, and it was all that I just described. He said he had fallen in love with someone else, and he was very cruel. That was really devastating for me, and I am really just over it now.

THERAPIST: Okay. What about the relationship with your father now?

CLIENT: Boy, it's difficult, because with my uncle, I can more or less cut him off. My dad was the person in my family who nurtured me, probably more than anybody else. It's always been really hard for me to individuate from my dad, and—how can I say it?—there is still a lot of warmth and nurturing. A few years ago I just really set a limit on his sexual comments and told him I couldn't spend time with him if he did that, and he stopped.

[Present relationship with father will be targeted.]

THERAPIST: You said that the men reminded you of your father in terms of being sociopathic. How did that manifest for you? What about your dad specifically?

CLIENT: Well, after 25 years, he left my mother, leaving a note and running off to Europe with his girlfriend, and never really seemed to find anything wrong with that. Interestingly enough, my mom got into therapy a couple of years before that and started to change. Started to really come into her own and drop the rage. My relationship with my mother is healthier than it's ever been. We process stuff and we work through stuff. She's still my mother; she still drives me crazy but it's a working relationship that I have with her.

THERAPIST: Okay. What memory do you have of your father that would represent your feeling of disturbance about him?

CLIENT: One of the first things that pops into my head was walking out the door to go to a party and my dad looked at me and he said, "You have too much makeup on," and I had no makeup on. There was a sense of him saying, "Don't grow up, don't be a woman, don't be sexual, don't be with somebody else."

[This memory will be targeted.]

THERAPIST: Okay.

CLIENT: I really hadn't thought of that in about 15 years.

THERAPIST: Okay. What about in relation to your mom?

CLIENT: The memory is of me, literally on my knees, with her screaming at me and me saying, "What do you want me to do?" and she couldn't answer.

[This memory will be targeted.]

THERAPIST: Okay. What other relationships or memories do you have that come up that reinforce the feeling of your not being good enough or your being powerless?

[Issues of self-worth and control will be targeted and used for negative and positive cognitions.]

CLIENT: Does it have to be family? Can it be anybody in my life?

THERAPIST: Kind of the top 10 on the hit parade.

[In this case, the therapeutic issues appear clear; in other cases, the therapist might ask for the 10 most disturbing memories, without suggesting a specific cognitive theme.]

CLIENT: One is a man who I slept with a few years ago. We were about to have sex, and he told me in bed that I just didn't turn him on. That devastated me. I don't know that it would devastate me as much now, but at the time it really did.

[This memory will be targeted.]

THERAPIST: You were how old?

CLIENT: Twenty-three maybe. It's during the last year and a half that I'm really getting to the core of some of this stuff.

THERAPIST: What else has reinforced it?

CLIENT: The breakup with this man 6 months ago, and it's not like any particular instance but of him really treating me like I was yesterday's garbage.

THERAPIST: Is there any memory there that would represent it?

CLIENT: Of me saying, "You've deceived me," and he said, "Yeah, you'd like to think that." And there was just so much hostility in his voice.

[This may be targeted depending on the level of disturbance at a later stage of treatment.]

THERAPIST: Okay. Are there more ways that's been reinforced?

CLIENT: Yes. There's another belief I have, too. Making an appointment to come here brought up all kinds of stuff, like what would it be like to lose my nightmares? You know, I identify with my nightmares. I identify with my trauma and my mood, and one belief I have is that I am damaged for life. And that on some level, my choice of profession, you know, and my relationships with men—all that revolves around my wound and trauma.

THERAPIST: And what would happen if you weren't damaged for life?

[Therapist investigates secondary gains and goals. "I'm damaged for life" will also be targeted as a negative cognition.]

CLIENT: You know, I have glimpses of that. I guess a glimpse that I have is being more—I know it's very general—just being more joyful. Feeling

like I deserve love and the good things that I have in my life already. Being able to have more good things. Like a stable, healthy relationship.

[These statements will be used therapeutically and transformed into positive cognitions.]

THERAPIST: Are there any specific memories that you have where you feel you were taught that you didn't deserve love and you didn't deserve good things?

[These will be targeted negative cognitions.]

CLIENT: Yeah. The big thing that I got from my mom is I had to be beautiful. So I remember . . . if I was looking at this today . . . see this little thing on my pants here? That would be an hour's rage. That if I didn't look perfect, if I wasn't beautiful, if I was fat, she just raged at me as a kid for gaining 5 pounds. And I was a thin kid. I don't understand why I don't have an eating disorder. All the other women in my family do.

[Mother's reaction will be targeted.]

THERAPIST: What's the best realization that you feel you've gotten out of all the years of therapy that you had?

CLIENT: It's just realizing that there is a reason I don't have good relationships with men. It never made sense to me. I'm a nice person. Why am I having bad relationships? I have wonderful friendships. How I'm really repeating these patterns that have to do with my uncle, have to do with my mom, have to do with my father, and really watching how I do that. Pulling myself out when it looks like that's going to start happening. I've been dating a lot, and I kind of stumbled a couple of times. I dated one guy who was like that pattern, and it cycled very quickly. It was just a few weeks or something.

THERAPIST: You've mentioned feelings or thoughts regarding not being good enough or being powerless, or being damaged for life. The feeling about having to be perfect—is that still there for you?

[Therapist summarizes client's negative cognitions and seeks more information.]

CLIENT: It's better. It's still there.

THERAPIST: What memory do you have that's connected with that specifically? Is that raging at the 5 pounds?

CLIENT: Yeah.

THERAPIST: Okay. Any other beliefs that you could say have run you, like the need to be perfect but not being good enough, needing to be beautiful? Anything else?

CLIENT: That really the only thing that is important about me is how I look.

THERAPIST: And what memory goes along with that?

[Therapist elicits a memory in order to target the negative cognition.]

CLIENT: Everything. Well, it's recent memories, actually. My mom came out for a visit, and it was her constant attention to what I was eating. She took me shopping, and she concentrated her comments on what a nice figure I had, more than anything else. Are you looking for like one specific thing, like how?

THERAPIST: Yes, let's say that there were a lot of messages that you had in childhood and beyond that were saying who you were or what you were being judged by was your appearance. If you cluster them, if you were going to say, "Okay, there were a lot," would you say you got that message more from your mother or more from your father?

CLIENT: Both.

THERAPIST: From both. Okay.

CLIENT: More from my mom, like, "You have to be beautiful." But you see with my dad it was more subtle. With my dad I had to kind of be the wife to get nurturing from him. I had to be kind of sexualized to get nurturing from my dad, and I had to be beautiful to get any strokes from my mom.

THERAPIST: Okay. So what memories do you have in regards to the need to be sexualized to get nurturing?

CLIENT: I remember the both of them just standing there and saying, "Oh, you are just so beautiful." I was 10 years old or something like that. I've looked at pictures of when I was 10 years old, and I was not beautiful. I was really gawky and . . . but, you know, that's what it was for them. And as an adolescent my dad going on and on, on the phone, about how sexy I was. And how people, men in particular, were probably nice to me because I was pretty. I probably got out of that traffic ticket because I was pretty.

[The memories of the parents' reactions will be used as targets.]

THERAPIST: In regards to the dreams, what was the last dream?

CLIENT: The last dream was the masturbation dream with my dad.

THERAPIST: And before that?

CLIENT: It was another one with my dad. Actually, the last couple have been a little more empowered, terrifying. I was dating somebody, and he was unavailable. I was supposed to spend the night with him and he was unavailable, and I wound up in the same room with my dad to sleep. There was a double bed, and there were flowers there or something. The other part of the dream I remember is telling him I think I wanted to sleep in my own bed.

THERAPIST: Okay. You said that the dreams come up more when you are stressed. What is it that gets you stressed?

[Therapist attempts to identify present stimuli.]

CLIENT: I was dating somebody, and it started to break up during the last month. We both realized that it wasn't going to go anywhere, and I started getting the dreams then. If I see anything on TV that has to do with someone being traumatized, that brings it out.

THERAPIST: Any kind of trauma in particular?

CLIENT: Sexual trauma.

THERAPIST: Okay. Anything else?

CLIENT: I think that's pretty much it.

THERAPIST: Breaking up a relationship or sexual trauma on TV?

CLIENT: Yeah.

THERAPIST: How would you describe your job right now?

[Therapist examines alternative complaints and systems issues.]

CLIENT: My job. Well, I'm working. I work at [a large office], and I like it.

THERAPIST: Okay. Anything else?

CLIENT: Not that I can think of.

THERAPIST: If we proceed with the EMDR work, how will you know that we are done? What's going to make you decide that you are finished?

[The goals the client states may constitute behavioral measures for later assessment.]

CLIENT: To be able to sleep deeply and peacefully and to really break up that concept that I'm damaged for life and that I don't deserve love and I can't have it. To be in a healthy relationship.

THERAPIST: Anything else?

CLIENT: More joy in life.

THERAPIST: Anything else?

CLIENT: No.

THERAPIST: When you say, "I don't deserve love and I can't have it," when did that come up for you?

[Therapist searches for a target for the negative cognition.]

CLIENT: I don't think there are times when it flares in particular. Probably when I'm very stressed out and I am working a lot and not getting enough back. Certainly during this last breakup.

THERAPIST: Is there anything else about the men that you choose besides the fact that they give the signs of not being able to bond?

[Therapist explores additional problems.]

CLIENT: I pay too much attention to looks. I mean, if they are good-looking, I'll go out with them. I ignore the rest. Another thing, too, is that I always know right at the beginning that it is a mistake. My intuition

is really good; that's really intact. It's following it that has been a challenge for me.

THERAPIST: Give me a run-through.

CLIENT: With this last relationship, I remember telling a friend, "You know, I'm getting together with this guy, but I know he's trouble. I'm not going to get involved with him." And I end up in an 8-month relationship. Not only did I think it, I said it out loud to another person. I mean, what could be clearer?

THERAPIST: So what happened between that statement and the time you went out with him?

CLIENT: He came on like gangbusters. He was really seductive, and the sex was really good. And I just did what I do; I just gave up my power. I just really go along with this to get this nurturing.

THERAPIST: What does "give up your power" mean?

CLIENT: It means I don't act on what my perceptions are. It's like the inside and the outside lose any kind of congruency. It's like I have the perception and then I ignore it, and I go along with the other person's plan, the other person's agenda.

THERAPIST: What about abilities to set boundaries in terms of saying, "No, I'd prefer not to" or "I want to do that instead" or asserting a desire to do something? How are you at that in relationships?

[Therapist searches for behaviors to be targeted.]

CLIENT: Sometimes I'll wind up having sex with a man when I know it doesn't feel right. I'll just push through the sense that it doesn't feel right.

[Therapist identifies this as a behavior to be targeted.]

THERAPIST: What do you gain by that?

CLIENT: Nothing. But it's following an old pattern; it's what's most familiar. Just ignoring, you know. I mean growing up surrounded by these abusive people, what could I do but to ignore my perceptions? It was too painful, and I couldn't do anything about it, anyway.

THERAPIST: What else other than having sex even when it doesn't feel good?

CLIENT: I'm really caretaking, and sometimes I'll just give and give and give, rather than saying, "It's your problem; you deal with it."

[Therapist identifies this behavior as a potential target if it is still problematic at a later stage of therapy.]

THERAPIST: How about self-nurturing?

[Therapist is checking for overt signs of self-destructiveness or instability.]

CLIENT: I do a lot of that. I've had this back injury, but I really like to exercise a lot and hike and take lots of hot baths.

This transcript indicates that the client is suffering from sleep disturbances and low self-esteem. The associated negative cognitions reveal feelings of worthlessness and lack of control. The client's negative self-assessments appear to be the result of possible early molestation, as well as dysfunctional parent–child relationships. These difficulties have been partly responsible for a series of self-destructive and abusive relationships in adulthood.

Incidents directly relating to the client's lack of self-worth will be reprocessed during the initial phase of therapy. These include the earlier childhood incidents involving her mother and father, as well as a number of more recent interactions that reinforced her feelings of being worthless and damaged. Specific nightmares directly related to feelings of fear and equivocal emotions relating to men in her life will also be targeted.

A similar therapeutic assessment, conducted on the basis of a history taken at a depth equivalent to that revealed by the foregoing transcript, would be needed if the client had presented an eating disorder or substance abuse issue that needed to be directly addressed, because specific EMDR protocols are used for these conditions.

In addition to identifying adverse life experiences, it is important for clinicians to identify positive experiences the client has had in order to facilitate processing and preparation. Positive role models and counterexamples assist in opening blocked processing (Chapter 10) and provide clinicians with an indication of the full clinical history. Clients who are unable to identify positive experiences and significant others generally need a longer preparation time and a greater dependence on the therapeutic relationship. A wide variety of aids can be used to augment the basic history-taking process, including the Multimodal Life History Inventory (Lazarus & Lazarus, 1991), functional analyses (Smyth & Poole, 2002), the genogram (Friedman, Rohrbaugh, & Krakauer, 1988; McGoldrick, Gerson, & Petry, 2008), the Inventory of Altered Self-Capacities (Briere, 1996), the Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998) Questionnaire (see Appendix A) and schema questionnaires (Young & Brown, 1994). All negative response patterns in the present are investigated and tracked back to earlier targets for processing by asking: **"When have you felt this way in the past? What is the earliest experience you can remember when you felt this way?"** If nothing comes to mind, the "Floatback" technique (Young, Zangwill, & Behary, 2002) can be used. Ask the client to recall the recent disturbing experience, identify the negative cognition, and notice the associated physical sensations. Then instruct him: **"Now hold the image and negative belief in mind, and notice the sensations in your body, and just let your mind float back to an earlier time and tell me the first scene that comes to mind where you felt this way before."** If no childhood experiences emerge, the Affect Scan technique (Shapiro, 1995b) can be used: **"As you bring up the recent disturbing experience of _____, notice the emotions you're having right now and notice what you're feeling in your body. Now let your mind**

scan back to an earlier time when you may have felt this way before and just notice what comes to mind." Any memories that emerge with either of these techniques are noted for potential targeting.

Once the history taking is complete, secondary gains have been addressed, and appropriate stabilization has been achieved, the processing can begin according to the client's symptom picture (see also Chapters 8 and 11). However, due to the generalization effect, not every memory will need separate processing. In most instances, (1) no memories before age 4 or 5 should be selected for initial processing; (2) childhood events should generally be addressed before adolescent or adult memories, because they are feeder memories to those that follow; (3) memory fragments, especially those with primarily somatosensory storage, should be left until after all the remembered/contained memories are completed; (4) it appears that fewer than two dozen memories will generally need to be addressed to eliminate most of the obvious current dysfunction; and (5) the rest of the past events and the second (present) and third (future) prongs of the protocol should be completed (see Chapter 8) for comprehensive and stable treatment.

Generally, therapy should not be considered complete until all disturbing memories, triggers, and deficits have been assessed for appropriate processing. EMDR therapy can be used specifically to address the symptom profile, but clinicians are urged to remain cognizant of the entire clinical picture and comprehensively address the full client history (see Chapter 8). Clients may offer only a partial description of their symptoms or traumata because of a lack of clarity regarding the possibilities that exist for a high-functioning individual. As previously noted, personality characteristics are rooted in earlier memories that have left the client in "child" perspectives and affect states. Therefore, many dysfunctional characteristics are ego-syntonic to the client who lacks the appropriate adult development and perspective. Processing all of the dysfunctional memories may therefore serve a useful function and need not take years, because of the ability to cluster and the generalizing of treatment effect. Nevertheless, although positive affects and behaviors automatically arise subsequent to memory processing, to optimize effects, processing should include the introduction of new, positive social and relationship behaviors. Therefore, any shortcoming of education and experience should be assessed for future remediation.

SUPERVISED PRACTICE

Instructors may wish to supervise students in practice history-taking exercises and review the consequent treatment plans. Appropriate client selection is such a vital part of treatment and client safety that instructors are encouraged to test students' knowledge of the indicators for caution and exclusion. The client checklists in Appendix A may be helpful for this purpose.

SUMMARY AND CONCLUSIONS

EMDR therapy is a highly interactive approach that demands clinician sensitivity and flexibility. It is essential that client selection be conducted properly because of the nature of the unresolved, dissociated material that may spontaneously emerge during treatment and the intensity of the emotional experience that may be generated. Therefore, clinicians should use EMDR processing only with clients who have sufficient stability and appropriate life conditions to handle possible abreactive responses and the distressing affects that may arise between therapeutic sessions.

Client safety requires that the clinician assess such therapeutic factors as the clinical relationship; life conditions, including legal and relationship needs; issues of stabilization, including hospitalization and medication needs; dual diagnoses; physical constraints; and the client's ability to utilize the relaxation procedures. Adequate screening for dissociative disorders must also be done before attempting EMDR (see Appendix E).

In general clinical practice, EMDR processing should not be implemented in the absence of an adequate client history, a clinical relationship that includes rapport and client comfort, adequate client resources, and a treatment plan. The treatment plan should identify specific targets, including aspects of secondary gain, which should be sequentially addressed. For most clients, it is useful to identify the 10 most disturbing memories from childhood, and assess the full range of adverse life experiences that may be contributing to less than optimal functioning. Essentially, the clinician should ascertain across the entire clinical picture the past memories that set the pathology in motion, the present people and situations that stimulate the dysfunction, and the components necessary for an adaptive, positive template for appropriate future action. Unless the symptoms, contributing factors, and baseline of dysfunction are adequately assessed, clinical effectiveness will be limited. The EMDR approach is not one-session therapy, and the clinician should have a clear picture of the client's problem areas and the sequence in which they should be targeted. A variety of clinical aids are included in Appendix A to assist in the history taking, treatment planning, and client selection.

CHAPTER 5

Phases Two and Three

Preparation and Assessment

It does not matter how slowly you go
as long as you do not stop.
—CONFUCIUS

After taking a thorough client history and completing treatment planning, the clinician needs to set the stage for the reprocessing. Client preparation involves establishing a safe therapeutic relationship, explaining in detail the process and its effects, and addressing the client's concerns and potential emotional needs. Assessment determines the components of the target memory and the baseline measures of the client's reactions to the process.

This chapter supplements the information about the individual components of EMDR therapy already described in Chapter 3 and explores how to work with these components. For both phases covered in this chapter, we begin with a discussion of the clinical perspective and the type of information clinicians have found useful to communicate to clients. Next, sample wording is suggested for some specific instructions the clinician will give the client. I then review possible client reactions and alternative clinical strategies to assist with client comfort.

PHASE TWO: PREPARATION

The preparation phase sets the therapeutic framework and appropriate level of expectation for the client. Preparing the client to handle the disturbance that may arise in EMDR processing is crucial. Before starting the preparation phase, clinicians must lay the proper groundwork (as defined

in Chapter 4); that is, they must take an appropriate client history, determine that the client is suitable for EMDR processing, prepare a treatment plan, and formulate an action plan to address any secondary gain issues that might prevent treatment effects.

Having done this, the clinician must complete certain steps before beginning to use the bilateral stimuli on any disturbing material. As discussed in Chapter 1, avoidance behavior is considered both part of the pathology and one of the reasons it is maintained. The steps discussed in the following sections allow the client to access the traumatic material for processing and set a therapeutic framework that will promote the interrupted exposure employed during desensitization and complete reprocessing.

Adopting a Clinical Stance

Since EMDR therapy is highly interactive and client-centered, it demands flexibility on the part of the clinician. Throughout all the interactions and use of procedures the clinician must be finely attuned to the needs and particular characteristics of the client and prepared to adjust and change direction, if necessary.

The clinician's attitude should be one of respect and accommodation regarding the client's need for safety and reassurance. The clinician's job is to facilitate the client's self-healing process. Any nonspecific aids to this end (including ways to facilitate therapeutic bonding and communicate unconditional support and regard) will increase therapeutic effectiveness. As with any treatment modality, the procedures used in EMDR therapy should interface with clinical skills, not substitute for them.

Forming a Bond with the Client

The clinician must establish a relationship with the client that includes a firm therapeutic alliance, a recognition of common goals, and an understanding of the need for honest communication. Unless the client and clinician have established a sufficient level of trust, EMDR processing should not be initiated. Clients must feel that they will be protected during processing and that, ultimately, they are in control. This can be done only if an atmosphere of safety and confidence is established during the initial sessions. Attaining this level of rapport may take many months with some clients; for others, it will be a matter of one or two sessions. Regardless of how long bonding takes, EMDR processing should not be attempted without it, or the client may break off treatment during an abreaction, refuse to continue, and perhaps terminate therapy altogether.

The clinician should make sure the client understands the importance, during and between sessions, of the "truth-telling" agreements. If the client falsely informs the clinician that the emotional disturbance is reduced

(in order to "do it right," to please the therapist, or perhaps to end the treatment), there is a good chance that between-sessions disturbance will increase, and the client may be at risk without the proper support. Because of the desire of many clients to please the therapist, it is important to convey to the client that the clinician desires an accurate report, regardless of its nature, even if the client wishes to stop. The clinician should say something like the following:

> **"All you need to do is tell me the truth about what you are experiencing so I can make the proper choices. Just give me accurate feedback about what is happening. Also, you are the one in control. If you need to stop, just let me know. Just tell me what is happening for you."**

Explaining the Theory

The clinician should provide clients with a general understanding of EMDR theory in language they can understand. For most clients, a brief description, such as the following statement, will be sufficient: **"When a trauma occurs, it appears to get locked in the brain."** In addition, clients should be informed that this "locked information" often gets triggered by a variety of reminders and is responsible for their frequent feelings of helplessness, hopelessness, fear, and so forth.

Clients seem to respond well to this description, because their own experience is often one of feeling that something is locked inside them. For instance, client language often conveys feelings of being "stuck" or "imprisoned." Offering clients this explanation also helps remove the sense of shame and guilt they often feel at having been unable to shake their symptoms. Placing the blame on the brain's storage, rather than on the client, is often a liberating step in its own right.

The clinician should tell the client that the eye movements appear to allow the information to be unlocked and processed, perhaps in a way similar to what occurs during REM sleep, and that using the eye movements while awake permits the negative information to be discharged from the nervous system in a more focused way. Clinicians might use an explanation such as the following:

> **"Often, when something traumatic happens, it seems to get locked in the brain with the original picture, sounds, thoughts, feelings, and so on. Since the experience is locked there, it continues to be triggered whenever a reminder comes up. It can be the basis for a lot of discomfort and sometimes a lot of negative emotions, such as fear and helplessness, that we can't seem to control. These are really the emotions connected with the old experience that are being triggered.**
>
> **"The eye movements we use in EMDR seem to unlock the system and allow your brain to process the experience. That may be**

what is happening in REM, or rapid eye movement, sleep, when our most intense dreaming takes place: The eye movements appear to be involved during the processing of unconscious material.

"The important thing to remember is that it is your own brain that will be doing the healing and that you are the one in control."

Testing the Eye Movements

It is useful for clinicians to test the client's ability to make the eye movements before targeting any disturbing material. Using finger movements according to the guidelines in Chapter 3, clinicians should ask clients to follow the movements and to give feedback on how comfortable this is to do. The clinician can experiment to find the most comfortable distance from the client's eyes at which to hold his fingers and can then determine whether the client is able to execute eye movements in various directions. The direction the client finds easiest is often the most successful during the processing phase.

Clinicians should also experiment with different speeds of eye movement in each direction. Most clients seem to prefer a rapid rate, and it appears to produce the most significant treatment effects (see Chapter 12). Clinicians should make notes if they observe any difficulties during these exercises or if clients report any problems, including headaches, with any particular direction (this direction should be avoided during actual processing). If the client is unable to follow the clinician's fingers in a tracking motion, the clinician should experiment with the two-handed approach and with tactile or auditory stimulation (described in Chapter 3).

This is a good time to tell the client that if she needs to stop during processing, she can hold up her hand as a signal, or turn her head. This gives the client a greater sense of control, and is an important element for client comfort and safety. If a client gives either of these signals, the clinician should stop immediately, find out what the difficulty is, and meet the client's needs before resuming. Ignoring the client's signal will be antitherapeutic and can cause a permanent breach of trust.

This testing phase provides the opportunity to experiment with the eye movements, assess any difficulties, and determine the preferred signaling method. The clinician might, for example, give the following instructions:

"Let's just experiment with the kinds of eye movements we use. If you find them uncomfortable, just hold your hand up like this [*demonstrate*] **or turn your head away to let me know. Remember, I just need accurate feedback about what you are experiencing.**

"As I hold my fingers up [*demonstrate*]**, just focus on them. Is this a comfortable distance?** [*adjust for client comfort*] **Good, now just follow my fingers with your eyes."**

Creating a Safe/Calm Place

In Chapter 4, the clinician was instructed to use a number of relaxation techniques with prospective EMDR therapy clients during the history-taking phase and plan to initiate processing only with those clients who responded favorably. Some of the many self-control techniques are explained in Chapter 9. However, I describe in this section one exercise that can be particularly helpful to reassure the client that he can quickly recover his emotional stability during any disturbance. The exercise is especially useful for a client who cannot relax because he feels a need to remain vigilant, a need that may have been conditioned during episodes of sexual abuse or in combat. Participants with PTSD in a study of EMDR (Wilson et al., 1995) reported that this exercise was particularly helpful for them; we now suggest that some variation (with a relevant positive affect) be used with everyone. It also serves to set up an initial positive association with the use of the eye movements.

The eight-step "Safe/Calm Place" exercise was initially recommended by Neal Daniels (personal communication, 1991) based on his work with combat veterans. It is a variation of one of the guided visualizations included on the stress reduction recording "Letting Go of Stress" (Miller, 1994), which can also be used as a resource. The client should be urged to practice the Safe/Calm Place exercise daily before EMDR processing begins. Such practice can increase the effectiveness of the exercise as a self-control technique.

The objective is for the client to create a safe place in her imagination before processing. This emotional oasis can be used for a temporary rest during processing, as an aid to closing down the disturbance in order to end the session, and as a way to deal with disturbing material that may arise between sessions. The clinician should allow the client complete leeway in identifying a personal refuge and should carefully assess the client's reaction to it. Some clients try to use an image that is popularly associated with feelings of peace but is just the opposite for them, because it is associated with a traumatic event. For example, a client may try to imagine a beautiful beach and ignore the anxiety generated by the memory of being assaulted near the ocean as a child. Obviously, in this case, the client should find another safe place.

The eight-step exercise is as follows (see Chapter 9 for suggested wording of instructions):

Step 1: *Image*. The clinician and client identify an image of a safe place that the client can easily evoke and that creates a personal feeling of peace and safety. For those clients who are unable to feel safe because of the nature of their trauma (e.g., sexual abuse or combat), it is best to identify and focus on a place that allows them to feel calm. If neither of these states are accessible, then identify another positive feeling state (e.g., secure, peaceful, restful, enjoyable).

Step 2: *Emotions and sensations*. The clinician asks the client to focus on the image, feel the emotions, and identify the location of the pleasing physical sensations.

Step 3: *Enhancement*. The clinician may use soothing tones to enhance the imagery and affect. He should take care to convey a sense of safety and security for the client, who is asked to report when she feels the emotions.

Step 4: *Eye movements*. The positive response is further expanded by including a series of eye movements. Rapid bilateral stimulation (BLS) paired with the development of the Safe/Calm Place can occasionally be activating and bring up negative associations. Instead, use slow BLS, or omit BLS and proceed through the following procedural steps.

The clinician should say, **"Bring up the image of a place that feels peaceful and safe [or calm]. Concentrate on where you feel the pleasant sensations in your body and allow yourself to enjoy them. Now concentrate on those sensations and follow my fingers with your eyes."** Sets are kept slow and short, four to eight movements apiece. At the end of the set, the clinician asks the client, **"How do you feel now?"** If the client feels better, the clinician should continue the sets as long as the positive feelings increase. If the client's positive emotions have not increased, the clinician should try tactile stimulation or repeat with no stimulation until the client reports improvement. If feelings come up that are negative, identify another calm or safe experience to target.

Step 5: *Cue word*. The client is then asked to identify a single word that fits the picture (e.g., "relax," "beach," "mountain," "trees") and to rehearse it mentally as pleasant sensations and a sense of emotional security are noticed and enhanced by the clinician's directions. This procedure is repeated four to six times if the positive affect strengthens, along with additional eye movements.

Step 6: *Self-cueing*. The client is then instructed to repeat the procedure on her own, bringing up the image and the word and experiencing the positive feelings (both emotions and physical sensations), without any eye movements. When the client has successfully repeated the exercise independently, the clinician points out how the client can use it to relax during times of stress.

Step 7: *Cueing with disturbance*. To emphasize the preceding point, the clinician asks the client to bring up a minor annoyance and notice the accompanying negative feelings. The clinician then guides the client through the exercise until the negative feelings dissipate.

Step 8: *Self-cueing with disturbance*. The clinician asks the client to bring up a disturbing thought once again and to follow the exercise, this time without the clinician's assistance, to its relaxing conclusion.

Once this exercise has been completed, the clinician should instruct the client to practice it at home every day by calling up the positive feelings and the associated word and image while she uses a relaxation CD or performs some other relaxation exercise (e.g., those reviewed in Chapter 9). Clients can then use the technique for simple relaxation and stress reduction. Finally, before any EMDR processing session, the clinician should say to the client, **"Remember, this safe place is always available to you. Just let me know if you need to return to it at any time."** The clinician should occasionally use the eye movements to reinforce the safe place. This also maintains a positive association with the eye movements themselves. Sometimes clients, especially in complex cases, need access to other positive affects in order to engage in processing. In that case, situations of "courage" or "strength" or any other needed affect can be substituted in this exercise. See Chapter 9 for an additional resource-building protocol.

Describing the Model

The clinician should remind the client that just as positive feelings are available to him, so too are negative feelings of old memories stored in his brain. When the client brings up the safe place, he experiences the pleasant feelings; when he brings up the old memories, he will experience the disturbing feelings.

It may be useful to explain to clients that the brain has stored the disturbing event in a memory network in a way that isolates it and prevents it from connecting with more useful, adaptive information, and that when EMDR processing begins, the appropriate connections are made. In addition, in order to explain how other disturbing material from the past can emerge unexpectedly and how resolution can take place, the clinician can sketch a diagram that shows how memory networks can link up, for example, a diagram similar to that in Figure 5.1, then give an explanation such as the following:

> **"Disturbing events can be stored in the brain in an isolated memory network. This prevents learning from taking place. The old material**



FIGURE 5.1. Separate target and adaptive networks.

just keeps getting triggered over and over again. In another part of your brain, in a separate network, is most of the information you need to resolve it. It's just prevented from linking up to the old stuff. Once we start processing with EMDR, the two networks can link up. New information can come to mind and resolve the old problems."

The clinician then indicates, in a diagram similar to Figure 5.2, how the two networks are linked.

Clients should also be told that when this disturbing material is unlocked and allowed to process, the reservoir of negative emotions is drained along with it. This explanation often gives the client the courage to persist through the intense emotions that may arise during treatment. The client should be told that regardless of how disturbing the emotions might be as they come up, **"nothing negative is being put in."** Instead, it is being let out. The client may be able to see that rather than "dying a thousand deaths" every day, she can be liberated by one processing experience. The client needs to know that the unpleasant sensations that may arise during treatment are simply a sign of the old material leaving the brain.

It may be helpful to use the analogy of driving through a dimly lit tunnel. If the driver wishes to speed through the tunnel, then he must keep his foot on the accelerator. If he takes his foot off the accelerator, the car will slow down and merely coast. In EMDR processing, the eye movements (or other stimuli) appear to be like the accelerator. If the set is allowed to continue, the processing can be accelerated and the unpleasant sensations or emotions can be passed through rapidly. If the eye movements are stopped prematurely, however, the unpleasant sensations will be experienced longer. (Although the other forms of stimulation can be used in these circumstances as well, I prefer the eye movements, when possible, in order to monitor the client's dual awareness, which is maintained by following the moving fingers.) Of course, clients should be reassured that if they wish to stop for a moment, all they need to do is give the signal.

The clinician's description of the EMDR treatment model should include the reassurance that although unpleasant sensations and emotions may arise during EMDR treatment, they are caused merely by the processing of the old memories and present no current danger. It is useful in

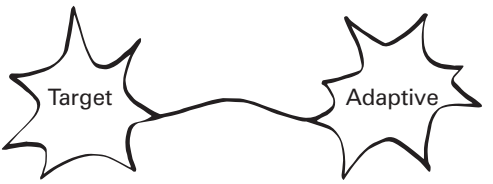


FIGURE 5.2. Connected target and adaptive networks.

allaying the client's apprehension to say something like, **"Just because you feel fear does not mean there is a real tiger in the room."** The clinician must give this guidance in a manner that is nurturing and reassuring and in no way dismissive. The level of fear and vulnerability that may surface for the client can be extremely high, and this experience should not be minimized or trivialized. However, clinicians need to bolster their clients' ability to withstand, as well as observe, their emotions without attempting to block or escape them. To warn the client that avoidance is counterproductive, the clinician might say the following:

> **"Although unpleasant pictures, sensations, or emotions may come up as we do the eye movements, you can stop the process whenever you want simply by raising your hand like this** [*demonstrates the action*]**. It is best to allow the eye movements to continue as long as possible, but if things feel too rough, we can stop and you can rest. The idea is that if you want to drive through a dark tunnel quickly, you keep your foot on the accelerator. If you take your foot off, your car slows down and coasts. So, to get through unpleasant emotions, keeping the eyes moving will get us through more quickly.**
>
> **"As we do the sets of eye movements, try to remember that we are only processing old stuff. It may feel real, but it's just the old memories locked in the brain. Just because you feel fear, does not mean there is a real tiger in the room. The idea is to let the brain become unlocked, and let the information process through."**

Setting Expectations

It is useful to assure the client that nothing will be imposed upon her during treatment, that the memories will be processed as a function of her own self-healing capacity, and that she will remain in control and can rest at any time simply by using the stop signal. It cannot be too heavily stressed that if the client raises her hand to "stop," the clinician should stop immediately. Because most trauma victims feel they are personally inadequate and have no control in their lives, the client's fears and negative self-assessments are likely to be reinforced if the clinician persists after being told to stop. Regardless of the clinician's intention, such a breach of trust can undermine treatment benefits. Regardless of the level of support being provided, the clinician cannot possibly know the amount of pain being experienced by the client at any given moment in the treatment. Therefore, it is crucial that the client have the power to take a break on command.

The initial description of what can be expected in the treatment phase provides reassurance for the client. The emphasis should be on safety and joint participation. It is often useful to state to the client that while emotions and recalled experiences may arise, they should be seen as merely transient, that it is as if the client is on a train and the experiences are

merely the scenery passing by. This explanation helps promote a sense of safety in that it connotes movement away from the pain and suggests that, regardless of how real the experience may seem, there is no real danger since the client is protected (i.e., she is inside the train). Also implicit in this metaphor is the notion that even as the scenery is noticed through the train's window, it is already passing by.

The intent is to impress upon clients the idea that they should observe the experience rather than give significance to it. The objective is to allow the experience to process, permitting sensations and emotions to flow through consciousness without being afraid of the fear, which can cause a retraumatization. In essence, the client should be told, **"Just let whatever happens, happen."**

The clinician should tell the client that while she is asked to start by concentrating on an image, she will probably find it impossible to maintain this image. The idea is simply to begin by focusing on the designated target, then to allow the processing to occur during the eye movements. The clinician should remember that the dominant belief system of the client may emerge. For example, the client who has always viewed herself as a failure can make statements such as the following: "I must be doing something wrong; my eyes aren't moving" or "I can't keep the picture" or "I'm thinking of something else." The client should be reassured that she is doing the exercise correctly.

The clinician should tell the client that the set of stimulation will continue for a while and that she will then be asked for feedback; that is, she should then describe whatever new or relevant information has emerged. However, as with all EMDR instructions, the clinician should avoid placing demands on the client about her performance, expected treatment results, or the amount of time the processing should take. As much as possible, the client should be placed in a state of mind in which she is willing to allow the processing to take its own course, rather than attempting to make anything specific happen. If the client tries to force anything to occur, the processing is likely to stop. To return to our metaphor, it is as if we are letting the train lay down its own track as it goes along. Both clinician and client must try to stay out of the way as much as possible. The clinician might, for example, say the following to the client:

> **"As we process the information and digest the old events, pictures, sensations, or emotions may arise, but your job is just to notice them, just to let them happen. Imagine that you are on a train and the scenery is passing by. Just notice the scenery without trying to grab hold of it or make it significant. Remember, if you need to take a rest, just hold up your hand.**
>
> **"We will start by asking you to focus on a target. Then I will ask you to follow my fingers with your eyes. After we do that for a while, we will stop and talk about anything that comes up. You can't keep**

a picture steady while the eye movements are going on, so don't try. When we talk, you just need to give me feedback on what is happening. Sometimes things will change and sometimes they won't. I may ask if something else comes up; sometimes it will and sometimes it won't. There are no 'supposed to's' in this process. So just tell me what is happening, without judging whether it should be happening or not. Just let whatever happens, happen. Any questions?"

Addressing Client Fears

Whenever giving instructions, the clinician should be sensitive to nonverbal signals of confusion from the client and should answer questions as they arise. Case examples should be given when necessary to illustrate certain points. For instance, to explain how old memories impinge on daily life, the client may be told about the woman who felt terror every time her employer got angry, because her father used to look at her in the same way before beating her.

It is important that the client understand the instructions, because the clinician will use the same analogies during processing to reassure or calm the client when disturbing material comes up; that is, it is easier to remind a disturbed client to treat the material as "scenery passing by" than to try to introduce the metaphor for the first time while the client is strongly reexperiencing a memory. Please note that the sample instructions included here are only suggested; adjust the language and illustrations to the needs of the individual client.

All of the client's questions and doubts should be addressed, including fears of going crazy, of not being able to handle the treatment experience, or of "not making it back." The clinician should assure the client that although these fears are normal, these kinds of negative effects have never been observed with EMDR therapy. Sometimes the client may want to talk to someone else who has had EMDR treatment, read an article about it, or otherwise obtain corroboration (see Appendix F for clinician resources) before continuing treatment. Books written for laypeople that describe the EMDR treatment of various complaints can also be helpful to allay fears and demystify the process (e.g., Shapiro, 2012; Shapiro & Forrest, 1997/2016). EMDR should not be implemented until the client is ready.

If the client declares an unwillingness to proceed with processing in general or with any particular memory, that wish must be respected. If the clinician resorts to high-level demand characteristics to impose treatment, for instance, intimating that EMDR therapy is the only way to heal and that the client "should" engage in the treatment, negative results are likely to occur. The client may remain anxious during the entire session, break off treatment during an abreaction, or dissociate in order to escape the ordeal. If EMDR processing is not agreed to by the client and viewed as an enterprise of joint participation, treatment should not proceed.

Sometimes a client is unwilling to concentrate on a particular memory because of shame or guilt. The clinician should reassure the client that because the processing is happening internally, he need not divulge the details of the memory; merely reporting the fact that he is withholding something is sufficient.

This reassurance has been particularly helpful to rape victims who are humiliated by their experiences, molestation victims who have been threatened and warned not to tell, and combat veterans who are wracked with guilt. With all such clients, processing can proceed satisfactorily, even in the absence of specific details. Often, however, once the material is sufficiently resolved, the client may reveal more about a specific event. These revelations should not be discouraged, since it will be therapeutic for some clients to receive a response of unconditional support from the clinician. However, for other clients, such additional revelations are unnecessary for resolution, and they should not be prodded to divulge details.

The ability to process traumatic memories without the client providing a clear picture of the event can also be helpful to the clinician. Some clinicians have been vicariously traumatized (McCann & Pearlman, 1990) by vivid client imagery. When a clinician has been bombarded by highly detailed accounts of traumatic episodes, self-administered eye movements, Butterfly Hug, or the recorded Light Stream technique (see directions in Chapter 9) can be used to minimize the negative effects. Self-administered eye movements are contraindicated for personal therapy but may be very useful for rapid reduction of minor stress. This is explained in Chapter 9.

PHASE THREE: ASSESSMENT

During the assessment phase, the clinician determines the components of the target memory and establishes baseline measures for the client's reactions to the process.

Once the client has identified the memory to be treated, the clinician asks the client, **"What happens when you think of the incident?"** or **"When you think of the incident, what do you get?"** The client's response provides a baseline on how her brain is currently encoding the information. By the end of the treatment, the same questions should elicit a very different response.

The client is invited to reveal whatever she desires and to state any relevant parts of the memory. However, this aspect of the treatment session need not be emphasized; as discussed earlier, successful EMDR treatment does not require that the clinician be aware of all the details of the memory. Remember, the client should not be pressured to reveal more details than she can comfortably handle. The clinician may need to explain to the client that although other therapies she may have undergone required her to reveal all the explicit details, this is not necessary for EMDR and that

instead of most of the session being used to discuss what occurred, the time is spent in processing the disturbing information. Therapeutic processing starts at an accelerated rate with the beginning of the eye movements and is done by the client's internal information-processing system rather than because of interaction with or interpretation by the clinician. The client must feel comfortable and safe in the presence of the clinician in order to experience or reveal anything she feels is important. On no account should the therapist make the client feel that her revelations are unwelcome or distasteful.

Selecting the Picture

After the client has described any relevant elements of the traumatic incident, the clinician should ask him to designate a single image as the initial focus for treatment. While the image does not have to be vivid, it allows primary access to the memory network by representing a single event rather than an abstract thought (e.g., the general idea of molestation or military combat). While the client often cannot maintain the image after the eye movements begin, it provides the initial link to the neurologically stored information.

Specifically, the clinician asks the client, **"What picture best represents the experience to you?"** If there are many choices or if the client becomes confused, the clinician assists by asking, **"What picture represents the worst part of the experience as you think about it now?"** When a picture is unavailable, the clinician merely invites the client to **"think of the incident."**

Remember, the image is only one manifestation of the disturbing information regarding the event that has been dysfunctionally stored. Although the image may be initially dissociated, indistinct, or blurry, or may become dissipated and unavailable after subsequent processing, merely thinking of the incident causes the client's access to and stimulation of the targeted information. In addition, some clients do not think or remember events in terms of imagery. This assessment phase delineates the most dominant manifestations of the incident (whether they be images, physical sensations, emotions, etc.) as the access points to the targeted information. When simply asked to think of the incident, the client stimulates his own subjective connections.

Identifying the Negative Cognition

The next step is to identify the negative cognition, that is, the negative self-statement associated with the event. Although the event may have occurred in the distant past, its evocation is likely to cause feelings of dysfunction and distress that feed the client's negative self-beliefs. The client is asked to isolate the present self-limiting or self-denigrating belief about herself or

her participation in the event. In other words, when the stored information is stimulated, a variety of emotions emerge that color the client's present perceptions, and these emotions should be verbalized in the negative cognition.

The client may have difficulty stating her negative cognition. She may be embarrassed, anxious, or unclear about what is meant by belief. It may help to explain to the client that these self-limiting assessments are irrational, and that there is likely to be a split between what the client knows to be true and what she feels. Explaining that emotional responses arise independently of logic, and that mature awareness is often necessary to reduce the client's embarrassment so that she can state her negative self-belief. At times, it helps if the clinician tells the client, **"State what you think of yourself in your worst moments, even if you know it isn't true."** However, for most clients, a simple understanding of the concept of irrational negative beliefs is all that is necessary.

Specifically, the clinician asks the client, **"What words go best with the picture that express your negative belief about yourself now?"** (In some cultures it is preferable to say: **"How do you define yourself?"** or **"What adjectives do you give yourself?"**) When the client cannot specify a negative self-statement, the clinician should offer a list of suggestions, such as "I'm worthless/powerless/not lovable," "I should have done something," "I will be abandoned," or "I can never succeed." It is important for the clinician to use verbal and nonverbal cues that give the client complete permission to choose or reject these suggestions. The clinician might also write out a list of negative cognitions (reviewed in Chapter 3 and Appendix A) and hand it to the client as a set of alternatives. If these strategies are not successful, the clinician can ask, after inviting the client to hold the memory in mind, **"What thoughts do you have about yourself?"** The clinician can then assist the client to formulate an appropriate negative cognition.

When the thoughts, emotions, or situation appear to be too confusing or complex, it is appropriate to continue without the negative cognition. However, if at all possible, one should be specified. The assessment phase itself, along with a simple negative self-statement that the client perceives to be even slightly irrational, can greatly assist the therapeutic process. In addition, pinpointing the appropriate negative cognition seems to allow that stratum of dysfunctional material to be more fully accessed for subsequent reprocessing.

The clinician should make sure that the negative cognition is self-referential, is stated in the present tense, and is a belief rather than a description of circumstances. For instance, "I am powerless" is a good negative cognition; "I was not in control" is not, because it is merely an accurate description of the event as it occurred. The clinician should explain to the client that because EMDR processing cannot modify anything that is factually true, it will not work to use a statement such as "I

was powerless," which is a truthful description of a past condition and cannot be changed.

In addition to formulating a statement in the present tense, the clinician must take care to avoid simple statements of emotion. For example, while a statement such as "I am afraid" aptly describes the emotion currently felt, it is not therapeutically useful for EMDR processing. The therapeutic goal is to identify a self-denigrating or self-limiting statement that is inaccurate by consensually derived standards of reality in the present. The appropriate negative cognition would therefore be "I am powerless" or, at least, "I am in danger" (if the primary problem is fear), which is an irrational cognition, since the traumatic event actually occurred long ago.

If there is a valid present reason for fear—if the rapist is still stalking the victim, for example—EMDR processing will not shift the information verbalized by the statement, because it is not dysfunctional. And since clinical reports indicate that processing will not eliminate any healthy responses (e.g., arousal necessary as an impetus to correct action), an alternative target will have to be found. In the case of real danger, the client and clinician will have to work through the appropriate real-life possibilities, then attempt to reduce the excessive fear by focusing on a negative cognition such as "I am powerless." This excessive fear needs to be reduced, because it may paralyze the client and prevent appropriate action. In one case, after processing excessive fear about a man who had raped her, a client decided to move to a new town because she could not get police protection. Later, it became clear how appropriate this solution was: The rapist was arrested only after he murdered his next victim.

The clinician should take care not to accept cognitions that merely verbalize sad or unfortunate childhood experiences. Remember, accurate descriptions, regardless of the nature of the tragedy, will not be changed by EMDR processing. The clinician should adapt a statement such as "Father didn't love me," "I didn't stand a chance," or "It was unfair" into an appropriate negative cognition by asking questions such as **"How does that make you feel about yourself?"** Typically, this will elicit appropriate negative cognitions in the form of denigrating self-statements such as "There is something wrong with me" or "I am not lovable." For a negative cognition to be most effective, it should be stated in the client's own words and be accompanied by the significant associated affect. Even if the clinician is capable of formulating a more elegant statement, he should allow the client to use words and expressions that are familiar to her and that elicit feelings that are congruent with the statement.

As with the positive cognition, the negative cognition should represent a general statement about the self rather than about the specifics of the event. For example, the client will be able to process more material about a childhood experience if she uses the general negative cognition "I am a failure" rather than the more specific "I fail in baseball games."

Developing a Positive Cognition

Once the negative cognition is identified, the positive cognition should be developed. The positive cognition is a verbalization of the "desired state" (a self-belief that is a distillation of the positive affect) and is generally a 180-degree shift from the negative cognition. It is an empowering self-assessment incorporating the same theme or personal issue as the negative cognition. This self-assessment should be put in positive terms that indicate how the client would prefer to think about himself currently, even though the disturbing event did happen.

Specifically, the clinician asks the client, **"When you bring up that picture (or experience), what would you prefer to believe about yourself instead?"** (In some cultures, it is preferable to say, **"How would you like to define yourself?"** or **"What adjectives would you want to give yourself?"**) When possible, the positive cognition should include a self-referencing internal locus of control, thereby reinforcing the client's ability to enhance and incorporate a new feeling of self-worth and to make effective choices, all of which are aspects of the optimal EMDR treatment outcome. The positive cognition makes possible a generalization of the positive self-assessment throughout the neural network, which, through principles of association, will presumably influence not only the client's perceptions of past events but his current assessments and expectations for the future.

The positive cognition should be the most powerful statement the client can conceive, even though it may be hard for him to believe at the present time. In order to greatly increase the possibilities for high self-esteem, it is important that the word "not" generally be avoided in the positive cognition. For example, statements such as "I will not fail" or "I am not incompetent" do not offer the client a sufficiently positive evaluation, nor do they stimulate and directly link to the appropriate positive information stored in the client's brain as strongly as do statements such as "I can succeed" and "I am competent." When possible, the positive cognition should incorporate a new self-assessment with implications for a positive future.

Exceptions to this guideline may be made when the overriding feeling of fear in regard to a traumatic incident is the primary manifestation of the dysfunction. In this case, an appropriate positive cognition might simply place the incident firmly in the past, since the constant intrusions and current state of fear are the most troublesome aspects of the event. A useful generic positive cognition in this case might be "It's over; I'm safe now." In addition, as reviewed in Chapter 3, perpetrator guilt may be dealt with by statements such as "I did the best I could," "I learned from it," and "I can now make other choices."

Once again, it is vital that clinicians determine the appropriateness of the client's positive cognition. Whenever possible, the clinician should ensure that the positive cognition is a valid self-assessment or belief regarding the targeted memory. Statements indicating wishful thinking or an

attempt to rewrite history, such as "I can trust everyone" or "It never happened" will disrupt treatment effects. Any attempt to utilize an untrue positive cognition will stop the processing. Clinical reports have consistently indicated that EMDR processing does not allow the client to incorporate into his belief system anything that is inappropriate or invalid. Because of this, clinicians should view with suspicion any positive cognition that uses words such as "always" and "never." For example, statements such as "I will always succeed" and "I will never fail" are inappropriate.

The clinician may have optimal positive cognitions in mind only to have them rejected by the client as too unrealistic given her present psychological condition. The clinician should be sensitive enough to accept a statement that seems right to the client and most closely approximates a positive therapeutic direction. One client who was a victim of sexual molestation by her father wanted to use "I was an abused child" as her positive cognition, because she felt that it diametrically opposed her negative cognition of "I am a whore." While the first statement was obviously descriptive and not currently applicable or overtly empowering, it was clearly the first step toward relieving the client's guilt about having participated in the molestation. Likewise, a client may at first only be able to accept a positive cognition of "I can learn to trust myself" before fully adopting the stance, "I can trust my own judgment." Remember that once EMDR processing is initiated, a more suitable positive cognition may emerge or may be suggested by the clinician, depending on client readiness. It is crucial, however, for the client to feel that she is in control of the situation; imposing negative or positive cognitions on her, regardless of how eloquent they are, is likely to have a detrimental effect.

Rating the Validity of Cognition

Once the client has developed the positive cognition, the VOC level for that cognition is ascertained to provide a baseline and ensure that the positive cognition is actually possible (and not a product of wishful thinking). The clinician asks the client, **"When you think of the memory, how true do the words [*repeat the positive cognition*] feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?"**

Sometimes it is necessary to explain further: **"Remember, sometimes we know something with our head, but it feels differently in our gut. In this case, what is the gut-level feeling of the truth of [repeat the positive cognition], from 1 (completely false) to 7 (completely true)?"**

If the client reports that the desired cognition is no more than a 1, the clinician should assess the statement for flaws in logic, applicability, or ecological appropriateness (validity within the client's present environment). While some EMDR clients successfully assimilate positive cognitions that are initially assessed at a 1 or 2, such a low rating is often an indication of unsuitability.

As discussed earlier, the assessment phase has many positive therapeutic effects built into it. However, if the client begins to abreact during this phase, the clinician should not force the assessment to continue but should instead initiate reprocessing. This is why the clinician should provide the relevant instructions, theory, and metaphors to the client before the assessment phase begins. We expect that the client will get progressively more stimulated as the assessment phase proceeds. The EMDR assessment components (and the order in which they are used) are specifically designed to access the dysfunctional information. Once this is done, the client's level of distress increases accordingly, and the clinician should be prepared to engage the client in the actual reprocessing to help alleviate the disturbance. Therefore, while discomfort can arise even when identifying the cognitions, the clinician should remain cognizant that when measurements are taken of emotions and physical sensations, the order of the measurements is designed to stimulate the target material as well. Once activation is accomplished, the sets of stimulation should be started immediately after a final reminder to the client about the EMDR processing and expectations.

Naming the Emotion

In order to complete the assessment of baseline measures and stimulate the dysfunctional material, the client is next asked to bring up the image of the event and hold it in mind, along with the negative cognition. Specifically, the clinician says, **"When you think of the memory and the words** [*repeat the negative cognition*]**, what emotions do you feel now?"**

This convergence of the image and negative cognition will generally stimulate the dysfunctional material to a greater intensity than either of the two alone. Clients are asked to name the specific emotion or emotions that arise; this prevents confusion in case they subsequently describe the reprocessing experience by primarily using the SUD scale (i.e., by simply reporting a number after each set). Such a response might lead the clinician to conclude that nothing has changed, when actually the emotion might have shifted from guilt to rage to sorrow. The clinician should also keep in mind that the SUD rating can rise dramatically when new layers of emotion emerge.

Estimating the Subjective Units of Disturbance

After the client has named the emotion he is feeling, the SUD rating should be determined. Specifically, the clinician should ask, **"On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it feel now?"**

If there are a number of different emotions felt, the SUD rating is given only on the total disturbance, not on each separate emotion. Getting this rating gives a baseline reading not only to the clinician but also to the client.

Even if the client's traumatic memory is not fully processed in one session, the SUD level at the end of the session will generally have decreased. This can give the client a sense of accomplishment, which is one of the goals of every therapy session.

Identifying Body Sensations

Next, the clinician asks the client, **"Where do you feel it [the disturbance] in your body?"** Clinical experience with EMDR has shown that the responses of the body to a trauma are often an important aspect of treatment. This question assumes that there is, typically, physical resonance to dysfunctional material. Although it asks the client to determine where that body sensation is located, it is not necessary to ask for a description of the sensation. In fact, doing so will actually stall the procedure by including irrelevant details.

A client who has difficulty assessing the location of the body sensations should be coached (instructions will be provided shortly). One of the benefits to the client of identifying the location of the body sensations is that it provides the client with an alternative to the reliance on verbalization inherent in most traditional therapies; that is, focusing on the body sensation stimulated during successive sets frees the client from the need to concentrate on painful thoughts or gory pictures.

Identifying the location of body sensations during successive sets is often necessary in order to assess the effects of EMDR processing, and it also lays the groundwork for the next phase of the treatment. However, the clinician should be aware that many clients may need sensation awareness training because they have learned to separate themselves psychologically from their bodies, either as a result of continuing disturbance or in the belief that their needs will not be fulfilled.

Clinicians can assist some clients in locating body sensations by referring to their SUD score: **"You reported an 8 on the SUD scale. Where do you feel the 8 in your body?"** If the client is still unable to respond, the clinician should gently offer additional help, such as the following simple, nonintrusive instruction:

> **"Close your eyes and notice how your body feels. Now I will ask you to think of something, and when I do, just notice what changes in your body. Okay, notice your body. Now, think of (or bring up the picture of) the memory. Tell me what changes. Now add the words [***the clinician states the negative cognition***]. Tell me what changes."**

Most clients will be able to notice the tightening of a muscle or an increase in heart rate or breathing. No matter how small a change the client notices, this body sensation should be targeted. This, in turn, will often increase the client's awareness of other sensations.

The clinician should also stay alert to any response by the client that denies body awareness while simultaneously revealing a physical sensation. For instance, when a client says, "I feel numb," "I feel blocked," or "I feel separated," this indicates a specific set of sensations that have taken on a particular emotional connotation mistakenly indicating a lack of feeling. In response to such verbalization, the clinician should ask the client to locate the sensations (**"Where do you feel blocked?"**), then focus attention on them.

A few clients will be unable to identify a body location despite coaching, and the clinician will have to adjust subsequent instructions accordingly by asking the client to concentrate on the other components of the target. One of the therapeutic goals, however, will be to enable the client to gain greater access to physical sensations and emotions. Frequently, this aim can be more easily achieved during reprocessing or after a number of the more formidable memories have been treated.

IMPORTANCE OF THE COMPONENTS

At this point the client should be sufficiently prepared and the clinician should have enough baseline information to commence with EMDR processing. The next four phases of treatment (desensitization, installation, body scan, and closure) are described in Chapter 6. Before continuing, however, remember that the clinician must pay careful attention to all components of the EMDR therapy procedures, since each component contributes to therapeutic effects. There are a number of reasons for this multifocus approach, including the following:

1. The use of negative and positive cognitions is a necessary element for the most effective case formulation. In addition, identifying and verbalizing the negative cognition gives the client an opportunity to begin to observe the irrationality of his present beliefs, while the positive cognition offers him an alternative that serves as a light at the end of the tunnel. This factor may inspire the client with courage and commitment to treatment born of the belief that an alternative is indeed possible.

2. The use of the SUD and VOC scales provide the client with quantitative data for a progress report, even in an uncompleted session. The sense of accomplishment on the part of the client—and the sense of accountability on the part of the clinician—allows for the progressive evaluation of new blocks and goals.

3. The use of the physical sensations as a focal point for processing allows clients who are inhibited because of the negative content of their thoughts to concentrate on a factor that offers no negative personal connotations. Furthermore, it allows clients who have a tendency to become

bogged down because of overanalysis to focus on a factor that eliminates their need to buffer negative affect.

4. Identifying the components of the trauma (image, cognition, emotions, sensations, and so on), the sequential bringing to mind and blanking out of the traumatic imagery, the use of metaphors and hand signals—all are geared to convince the client that she is larger than the pathology and can effectively remain an observer of its previously overwhelming effects. This stance offers the client a greater ability to achieve the sense of understanding, accomplishment, and control that is an essential outcome of any successful therapeutic intervention. In addition, the sequential, small doses of exposure while the client maintains a sense of control can aid the deconditioning process.

5. The eye movements themselves allow a titration of the negative affect of the target memory, while simultaneously giving the client a task he can accomplish effectively and, consequently, a sense of self-efficacy. Research has indicated that the eye movements cause a reduction of emotional distress and image vividness and an increase in recognition of true information (see Chapter 12). Although other stimuli are also effective, the paired movement of the clinician's hand and the client's eyes may also establish a sense of teamwork that can offer support during times of high disturbance. In addition, the use of eye movements gives the clinician a good indication of client attention to the task, which may be an important benefit when treatment is carried out with highly traumatized clients who might otherwise dissociate into the material and stare fixedly into space. The clinical attention to monitoring and maintaining the client's dual attention may be responsible for the comparative ease with which clients handle EMDR processing, as opposed to the intensity of hypnotically induced abreactions. Clinical comparisons of the two states have indicated that EMDR processing is much less disturbing to the client. Additionally, meta-analyses of randomized controlled trials of EMDR therapy reveal lower dropout rates compared to those reported with exposure-based therapies (e.g., Bradley, Greene, Russ, Dutra, & Westen, 2005; Swift & Greenberg, 2014; see Chapter 12).

The full assessment phase should be used, particularly in the early stages of therapy, to ensure that all the accessible dysfunctional material is processed in a controlled and contained manner. As previously mentioned, in some instances it may be necessary to drop the negative cognition because the issue is too diffuse or disruptive (confusing, difficult, or distressing) to the client's process. However, this is the exception and should be done judiciously. By focusing on one memory, with all the component parts delineated, straightforward accessing and processing are generally able to take place. Although the dysfunctional neural network may be accessible through any single component or any combination of these components,

attempting to process in this way at the early stages can be detrimental to treatment effects. For instance, concentrating on only a disturbing physical sensation can cause the client to move indiscriminately through a variety of disturbing memories without the appropriate cognitive framework or historical distance necessary to facilitate the appropriate clinical interventions described in later chapters. At the latter stages of therapy, after most of the dysfunctional memories have been resolved, this type of single-component accessing can at times be beneficial. However, clinicians are cautioned to utilize all the components when possible, as it appears to result in the most effective and efficient processing effects.

SUPERVISED PRACTICE

Instructors may wish to supervise exercises involving the preparation and assessment phases. Specific attention should be given to using the eye movements with the Safe/Calm place exercise and developing the negative and positive cognitions. Checklists and a procedural outline are provided in Appendices A and C.

SUMMARY AND CONCLUSIONS

The second and third phases of EMDR treatment are vital to the overall methodology. The clinical preparation for EMDR processing includes the establishment of rapport and adequate bonding to give clients a sense of safety and foster their ability to tell the clinician accurately and with sufficient information what they are experiencing once processing starts. The preparation phase also provides the client with information about treatment effects. After explaining EMDR theory to clients and setting their expectations (using instructions and metaphors in terms they can understand), clinicians should carefully address all client concerns. The Safe/Calm Place exercise is an important element of the preparation phase that increases the likelihood of successful processing. For more complex cases, additional affect regulation protocols are described in Chapter 9.

In Phase Three, the clinician should ascertain baseline measures of the client's current state (image, cognitions, emotions, somatic responses, SUD and VOC scales) before beginning accelerated processing. The specific instructions given here to elicit baseline measures and access the target material for processing are suggestions only. Clinicians should have sufficient understanding of all aspects of EMDR treatment to enhance the instructions and metaphors if a client needs more assistance in following the directions.

Clinicians should notice that most of this chapter is devoted to preparing the client. This is an essential phase of EMDR treatment, because it

sets up therapeutic conditions conducive to feelings of client safety, which encourage exposure to the memory instead of the avoidance that can maintain or exacerbate the negative effects of the initial trauma.

The assessment phase includes accessing the memory, which stimulates the information stored at the time of the trauma. Clinicians must remain cognizant that client distress may therefore increase during this phase. The stimulation and initial processing have already begun, even before the eye movements are used on the disturbing material. Once again, EMDR therapy is not limited to eye movements but includes a variety of components, all of which interact to increase treatment efficacy.

The ultimate goal of therapy is to increase the client's sense of self-esteem and self-efficacy. This can best be accomplished if the clinician enhances these abilities at every phase of treatment. The client should always feel empowered and in control of the treatment session. EMDR therapy is a client-centered approach in which the clinician acts as a facilitator of the client's self-healing process.

The next four phases of EMDR treatment, including the accelerated processing of the target memory and closure, are covered in detail in Chapter 6.

CHAPTER 6

Phases Four to Seven

Desensitization, Installation, Body Scan, and Closure

The great thing in this world is not so much where we are but in which direction we are moving.
—OLIVER WENDELL HOLMES

This chapter examines the desensitization, installation, body scan, and closure phases of EMDR therapy. The first three phases entail the accelerated reprocessing of the target event (memory or current trigger); the closure phase describes procedures and information that should be used to debrief clients at the end of every session. For each phase, the conceptual material (which should be augmented by the pertinent information in Chapter 3) and the clinical intention is reviewed, along with suggested wording for client instructions (see also Appendix A).

The desensitization, installation, and body scan phases all involve accelerated processing of information. This chapter begins with a description of the interactions that are applicable to all three phases. Following this, instructions for each individual phase, along with pertinent process information, are presented.

This chapter offers some general guidelines for effective processing. Clinical strategies for restimulating the system if processing appears blocked are covered in the next chapter, and advanced methods for more disturbed clients are covered in Chapter 10. The material covered in this chapter should first be reviewed in a practice session using a low-level disturbance before more distressing material is targeted.

ACCELERATED REPROCESSING OF THE MEMORY

After the clinician has carefully prepared the client and assessed the baseline information about the target, the stage is set for the accelerated reprocessing. As soon as the final step in the assessment phase is complete (identifying the location of the body sensation connected to the traumatic event), the clinician should review with the client how EMDR processing works and stress the importance of not purposely discarding any information. The latter point is particularly necessary with clients who are working on an identified adult trauma. These clients may find that a childhood memory emerges during processing but ignore it as not being part of the problem. However, this early memory may be the root cause of the client's high level of distress and should therefore be the focal point of the next set. It is critical to remind the client to notice whatever comes up during processing and to report it. Because time has elapsed since the explanation of the treatment was initially given to the client in the preparation phase, some additional reminders may be in order. The clinician should be alert to any signs of confusion or hesitation in the client. A reminder may be worded as follows:

> **"Now remember, it is your own brain that is doing the healing and you are the one in control. I will ask you to mentally focus on the target and to follow my fingers with your eyes. Just let whatever happens, happen, and we will talk at the end of the set. Just tell me what comes up, and don't discard anything as unimportant. Any new information that comes to mind is connected in some way. If you want to stop, just raise your hand."**

The clinician should then ask the client to keep the image in mind, along with the negative cognition and an awareness of the body sensation. For example, the clinician might say, **"Bring up the picture and the words** *[clinician repeats the negative cognition]* **and notice where you feel it in your body. Now, follow my fingers with your eyes."** Metaphorically, this is the equivalent of directing three laser beams at the dysfunctionally stored material. Simultaneously holding all three elements in mind usually intensifies the level of response. This is done only to establish an initial link to the dysfunctional memory; as soon as the eye movements begin, new images, thoughts, and feelings emerge. For instance, after the first set, the negative cognition is generally not used again during processing (exceptions are discussed in Chapter 7). Similarly, the client should not try to hold on to the image with which she started. Its purpose is merely to serve as an initial focal point for entering the memory network.

Immediately after the material is accessed, the clinician initiates the sets of stimulation. The first set should include around 24 cycles and, if using eye movements, should be done horizontally (a set of 24 movements has been found clinically to produce a marked processing effect in many

clients). The initial set is used to determine whether the horizontal direction is effective for the client (see Chapter 3 for a complete discussion of the number, direction, and speed of the eye movements). Clinicians should gently reinforce the client's effort during the set by softly saying, **"Good."** This often reassures clients who are not sure they are doing it right.

At the end of the set, the clinician says a version of, **"Let it go or blank it out, and take a deep breath."** While doing this, clients are not coached to close their eyes, because this could contribute to dissociation or trance-like states. This refocusing period serves to interrupt the intensity of focus and concentration, and gives the client permission to rest, reorient, and prepare to verbalize the new information plateau. Being able to set the disturbance temporarily aside also tacitly teaches the client that she is larger than the pathology and can be in control of her own experience. Alternating eye movements and instructions also provides the client with small doses of exposure to the target in manageable segments that foster dual awareness and enables the clinician to assess progress.

In order to increase a sense of bonding, the clinician might want to inhale and exhale along with the client at the end of the set, after the instruction to take a deep breath. Such nonspecific adjuncts to treatment play an important role in the positive therapeutic effects derived from any method. It is important to maintain a sense of bonding and teamwork throughout the session.

When the client appears ready, the clinician reestablishes contact by asking, **"What do you get now?"** This allows the client to reveal the most salient information now emerging as a result of the accelerated processing. If the client is at a loss, the clinician asks, **"What came up for you?"** This allows the clinician to get a readout from the client on any aspects of the event that have shifted and on the current state of the targeted material. The client will generally reveal new information, images, emotions, or dominant sensations. The clinician can then judge whether any reprocessing has taken place. If the client says he gets nothing, the clinician should direct him to think of the incident again by asking, **"When you think of the incident, what do you get?"**

The intention here is to be as nondemanding as possible regarding any aspect of the event so that the client can easily state what is most salient, and so that processing can continue between sets. For some clients, the focus will be a change in the image; for others, it is a new insight or shift in perspective; and for still others, it is a marked shift in body sensations. For that reason, the clinician should not say **"What do you see?"** or **"What are you feeling?"** when trying to prompt a response.

The interval between sets is extremely important for many clients, because it provides the opportunity to put words to an internal experience and allows them to understand the changes more readily. The accelerated processing can occur so rapidly during the sets that the client is unable to understand it fully until she can verbalize it. Regardless of what the client

says, the clinician should listen with compassion and unconditional support.

Since reprocessing will manifest itself differently in each individual, the general statement **"What do you get now?"** allows clients to report whatever appears dominant regarding a change in thought, feeling, image, emotion, body sensation, new incident, and so forth. If a significant change in any of the information is indicated, the same direction of eye movement should be used for the next set. If there is no change, a different direction of eye movement should be tried. As noted earlier, if the processing still fails to occur or if information that has started to change seems to get stuck and does not move after two or three different directions have been attempted, the clinician needs to consult the more proactive procedures covered in Chapter 7 before proceeding.

An apparent lack of treatment effect may also mean the client is simply not amenable to processing in the office. However, even if there has been little or no obvious processing, a closure and debriefing should be done, as explained later in this chapter.

For most clients, some type of change will occur. Regardless of the kind of experience reported, any change in material generally indicates that processing is continuing. As long as this is so, the clinician should refrain from making interpretive remarks. The clinician can confirm the client's experience by such nonverbal means as smiles or nods, or by comments such as **"Good"** or **"Uh-huh."** Rather than attempting cognitive restructuring or going off on a tangential explication of issues that will become irrelevant once the problem is resolved, the clinician can achieve the most effective treatment by asking the client to concentrate on the new material for a new set. The intention in EMDR treatment is to stimulate the dysfunctional material, activate the processing mechanism, and allow information to flow along its natural course to adaptive resolution. To best accomplish this, the client must be allowed to remain within the experience, that is, in touch with the sensory manifestations of the information.

Active listening—with the clinician stating, **"What I hear you say is . . ."** and then repeating or paraphrasing the client's words—should *not* be used during EMDR processing. Although this technique is used widely in other forms of psychotherapy, in which therapeutic gains rely largely on verbal reassessments, it is antithetical to EMDR treatment effects. When the clinician repeats the client's words, even a slight shift in intonation can change the meaning. The client is forced to step out of his experience sufficiently to interpret the clinician's words, compare the clinician's statement to what he is feeling, then verbalize the comparison. This form of cognitive interpretation, which takes the client out of the emotional and sensory experience, can interrupt the processing. The clinician should not attempt to repeat or summarize, even if the client has spoken for 5 minutes after the set; the client is aware of his own key points and does not need them repeated. Asking the client to keep his attention on what he just said (or,

if the client is confused, on the last thing he said) is preferable to the clinician's trying to paraphrase or reiterate the client's words.

Another approach that can hinder rapid EMDR treatment is a clinician-imposed attempt to explore the meaning of any symbols, memories, thoughts, feelings, and so on, that arise for the client during the sets. Clients continually report new insights and understandings that evolve naturally as the processing continues. For instance, when a new memory emerges, it is assumed that there is an associative link to the earlier material. Therefore, rather than asking the client **"What do you think that means?"** or **"Why do you think that came up?"** the clinician should merely direct the client to pay attention to the new memory during the next set. Clients generally volunteer pertinent cognitive interpretations, or these can be discussed after the processing is completed. The clinician's attempts to interpret each plateau can have a detrimental effect on treatment by distracting the client from the stimulated experience and replacing it with a cognitive digression. Keep in mind that therapist interpretation is the hallmark of many forms of traditional therapy, all of which have had only limited success in the treatment of trauma. In EMDR therapy, a new cognition should be the manifestation of a new plateau of processed information, not a clinician-imposed construct.

When the client has revealed a shift in any part of the information, her attention should again be focused with the instruction **"Think of that"** or **"Notice that"** or **"Go with that,"** and a new set should be initiated. At this point the clinician should use the client's nonverbal cues (e.g., widening or narrowing of the eyes, changes in pupil size or mouth tension) to determine the length of the new set. The intention is to bring the client to a new plateau of processing with every set. The clinician should stay alert to the client's responses to ascertain any new awareness or any lessening of suffering. Keep in mind that the new information will register on the client's face before she is cognitively aware of it. Therefore, to enable the client to get an internal grasp of it, the clinician should continue the set for a few seconds after noticing the new facial expression. These cues are best demonstrated in a practice session.

If pronounced emotion is evident, the clinician should continue the set until it is apparent that new plateaus of information have been reached. The clinician's attention to nonverbal cues in the client's attempt to reach a more therapeutic plateau is particularly important for abreactive responses, which are dealt with more fully in the next chapter. If the shifts in information are primarily cognitive rather than emotive, the clinician should experiment to determine whether the client responds better with sets of 36 or 48 movements. (For some clients, a set of less than 24 movements appears to give better results.) However, the clinician should not concentrate on counting the movements but should simply get a sense of the set's approximate length; the clinician's attention should be on the facial expressions and other body cues of the client.

While an SUD level should not be requested after each set, a good guideline is that the equivalent of a change at least one SUD (on the 11-point scale) should be evident in the client's responses after each set. Remember, however, that increases in distress can also indicate processing; that is, new emotions or new associations may temporarily increase the disturbance as the processing proceeds. Appropriately administering the sets in response to the client's nonverbal cues can often be crucial in achieving therapeutic effect. Therefore, I strongly recommend that the reader engage in practice, and be instructed and supervised by a trained and experienced EMDR clinician before proceeding with a client. The following sections augment this instruction.

Clinical reports have supported the need to alter the characteristics of the eye movement sets for best therapeutic results. Therefore, if the client reports headache, dizziness, or nausea, he should be asked to concentrate only on the disturbing body sensation while the direction of the set is changed. This procedure often allows the physical sensations to dissipate. Employing vertical eye movement to help eliminate the sensations can also be useful. The direction of the eye movement should also be changed if no shift in information is manifested. It has been observed clinically that some clients only process if eye movement sets are done in a certain direction, whereas others either process equally with all directions or process only if the direction is changed at different times during the treatment. Likewise, the length and speed of the set must be changed to accommodate individual differences. The same appears true of auditory and tactile stimuli.

Clinical reports have consistently shown this need for alteration, and possible explanations are explored in Chapter 12. Changing the direction, length, and speed of the set may cause different kinds of effects for different clients. When using EMDR therapy, perhaps 50% of the time the proper application of the eye movements alone causes a consistent reprocessing of the dysfunctional information to an adaptive resolution. When the information does not shift after repeated changes of the sets, other alterations (discussed in the following chapters) must be made.

PHASE FOUR: DESENSITIZATION

For purposes of standardization, the fourth phase, which concentrates on reducing the client's disturbance (when possible) to 0 on the SUDS, is called the "desensitization phase." However, while this term is used to designate one phase of the EMDR procedures, it should not be viewed too narrowly. Rather, desensitization, or removal of disturbance, is actually a by-product of the reprocessing, as are the positive restructuring of the cognition, elicitation of insights, and so forth. Manifestations of positive change on emotional, somatic, and cognitive levels continue throughout the treatment.

For desensitization to occur, it is necessary to process the dysfunctional material that is stored in all of the channels associated with the target event. When an event is reprocessed, a variety of channels of association may be revealed in consciousness. Each initial target is considered a physiological node to which other past experiences are linked. It is assumed that the disturbance inherent in any target node is fueled by the various channels of association.

Processing of the information in these channels can be evinced through the observed shifting of the manifestations of the information (image, affect, thoughts, sounds, sensations, or beliefs) while the client remains focused on the target memory. For some clients, the shifts can occur through awareness of other linked events or through a progression of insights. For many clients, treatment sessions include a variety of these different forms of association. The clinician should be sure to give the proper reassurances, when necessary, for client comfort but, at the same time, should try to allow the processing to continue without undue interference.

The clinician should keep in mind as a clinical heuristic the notion of a target node with ancillary channels (see Figure 6.1, previously presented as Figure 2.1). Each new awareness of a shift is a sign of a domino effect of progressive processing through the channel. The sets should be applied to each new sign of progressive awareness until all the channels are "cleaned out."

As each channel is accessed, there emerges a set of lawfully linked associations. (These associations were explored in Chapter 2.) For instance, some channels will include shifting representations of the target incident while others entail a change in the focus of awareness among different incidents that are linked by the dominant emotions. Still others will take the form of a shift in beliefs while others manifest new insights linked with

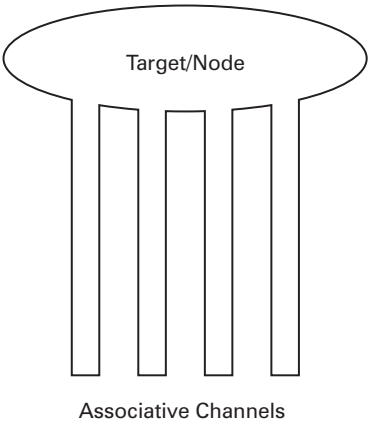


FIGURE 6.1. A graphic representation of the progression of EMDR treatment through the memory network.

other memories that serve as either examples or counterexamples. In the last instance, a client may begin to accept the fact that she was not responsible for being abandoned by her mother and may remember scenes of happiness with her parents or other family members; these memories may be interspersed with others that incorporate the theme of abandonment.

Between each set the clinician should listen carefully to the client in order to identify the next focus for processing. Depending on the client's response, the clinician directs attention to the latest statement, to some alternative aspect of the experience, or to a new target.

The following examples illustrate dysfunctional information in associated channels that needs to be addressed. In all cases, once the chain of association is exhausted, the client should be asked to return to the original target for additional sets. The client is *not* asked, "Think of the original picture," since that may no longer exist or be relevant to the current plateau of processing. Rather, the appropriate target is accessed by asking, **"Think of the original incident."** This question will bring up the appropriate target as it is currently stored in the brain, and additional sets will reveal if new channels need to be processed. When all channels are treated, the installation phase (described later in this chapter) can begin.

Associative Processing

Clients report their experiences in terms of changing imagery, sounds, sensations, emotions, tastes, or smells. If tastes or smells emerge, they should be targeted for successive sets. If these sets cause them to fade without leading to another association, the original target should be reaccessed.

Imagery

Most often, clients describe processing in terms of changing images. Regardless of whether these are new memories or alterations of a single event, the emerging material should become the focus of concentration for a new set. Again, the clinician should not encourage any particular way of reporting (e.g., by asking, **"What do you see?"**), because the client may be most attentive to new thoughts or other sensory stimuli. The following are generally observed client patterns involving shifts in imagery and the appropriate clinical response.

NEW MEMORY

When the client reports that a new memory has come to consciousness during the previous set, that memory becomes the focus in the next set. If several memories are reported, the client should be instructed to concentrate on the one she finds most disturbing. If all the memories are reported to be at the same level of disturbance, then the focus should be directed to the last one to appear.

Some clients offer a seemingly endless stream of associated distinct memories. If accessing the information becomes overwhelming to the client or leads him to become exhausted due to the intensity over an extended period, it may be useful to limit the amount of information being accessed during processing by asking him to return to the original memory after each shift. This is a situation not uncommon with combat veterans. (Further research is needed to determine whether a generalization effect occurs in such cases.)

In all cases, the clinician should note for subsequent targeting any transient memory reported during processing that appears particularly relevant or disturbing. Such memories may surface briefly and vanish in one set. However, retargeting generally should not occur until after the presenting memory has been completely processed. (This subsequent targeting is covered more fully in Chapter 8.) When possible, the client should be allowed to take the lead by targeting the content of her progressive consciousness as the information changes within each channel. However, it is important to return to the original target for further processing after a line of association has ended.

IMAGE CHANGES

At times, clients report a shift in the presenting image (even though the incident remains the same) or an image without any specific incident attached, such as a person's face. If a negative image emerges (e.g., mother scowling), it should be targeted with the next set. If a neutral or positive image emerges (e.g., mother sitting in the living room or mother smiling happily), a set or two may be added to see whether it will be strengthened, but the original image should be readdressed as soon as possible, especially if it has occurred early in the session. If this situation occurs later in the processing session, the sets should be continued on the positive image until the strengthening ceases. If the client states that two images have emerged, one negative and one positive (such as mother scowling and mother smiling), the negative one should be targeted. This guideline is based on the assumption that positive associations will take care of themselves, whereas negative ones must be processed. In order to ensure the lowest level of disturbance for the client (e.g., if the treatment is not completed within a single session), as many of the negative associations as possible should be processed. Once again, the dysfunctional channels must be "cleaned out" before the positive associations can be permanently strengthened.

INCIDENT UNFOLDS

When a trauma occurs, it becomes locked in the brain in its originally disturbing form; clients often state that the information feels "stuck" or always present. This is evident in many clients, who, when asked to bring the memory of an incident to mind, find that the most disturbing part of

the incident is the only one available. For instance, when a woman who had been in a boating accident was asked to think of the incident, what emerged was the scene of going under for the third time. Understandably, this was the most terrifying moment of the entire event, one that defined her subsequent stress reactions. However, since the woman was currently sitting in the clinician's office, she clearly was not in danger of drowning. Metaphorically, it as if the entire incident is being played on a DVD that has been put on "pause." When the scene is targeted for processing and the sets begin, it is not unusual for the incident to start unfolding, frame by frame, as if the DVD had returned to "play." For example, the aforementioned client reported seeing someone jump in the water and remembered being grabbed and rescued, resting in the boat, being taken to shore, and so on. Very often, the incident will even continue to include the client's subsequent experience (e.g., in the hospital) and any disturbing family reactions. The client should focus on each scene in separate sets, until resolution is achieved.

The actual aftermath of the initially identified traumatic event can often be as disturbing as the trauma itself. For example, some rape victims have reported feeling grossly violated by hospital attendants and police during the subsequent investigation. When the targeted incident has not spontaneously moved to this portion of the event, it may be appropriate for the clinician to elicit these channels, particularly if these aspects were reported to be troubling during the initial history-taking session.

APPEARANCE CHANGES

Some clients focus on a profoundly disturbing aspect of an event that is represented by a single image. These images are often reported as intrusive thoughts, flashback scenes, or recurrent nightmares. During reprocessing, the appearance of the image itself may change. As long as changes in appearance are being reported (e.g., getting darker, brighter, bigger, or smaller; or being seen from a different angle), the sets should be repeated with the changed image as their focus. Even if the picture is described as "blurry," the client should be asked simply to concentrate on it.

At times, the client will report that the image disappears, although some disturbance remains. When this occurs, the client should be told, **"Just think of the incident"** (and concentrate on the physical sensations). This allows the information about the event to be stimulated, so that reprocessing can be completed. It is important that the clinician continue the sets until the disturbance is resolved and not assume that the disappearance of the image signifies therapeutic success.

The client may have to be reassured that he can retain an accurate memory of the event or of an individual even though a particular image has disappeared during reprocessing. This is especially important for the client who is grieving for a loved one, in which case he should be reassured that other images will still be available once reprocessing is complete. In fact,

research has indicated that positive recall of the deceased is increased subsequent to EMDR processing (Sprang, 2001). The clinician should remember, however, that since the disappearance of the pivotal image is a common occurrence, the legal ramifications must be carefully evaluated before EMDR processing is initiated. (This topic is covered in Chapter 4).

Sounds and Thoughts

The clinician should be sensitive to any evidence that the target information is being processed. While many clients report shifts in images, the auditory and cognitive changes are no less significant. Thus, the focus can change with a sequence of new thoughts; thoughts that were experienced at the time of the event can emerge, or insights can unfold without visual references. As long as the thoughts occur spontaneously and progressively, the client is simply encouraged to note them for use in subsequent sets. Once again, after an auditory or cognitive channel of association has been successfully processed, the client should be invited to reaccess the original target.

NEGATIVE STATEMENTS

When a new negative statement or idea emerges, the clinician should ask the client where she feels it in her body. This should be done before a new set is begun. This can reduce the emphasis on the self-denigrating aspects of the statement. Generally, a new thought will emerge, and the sequence of question (**"Where do you feel it in your body?"**) and set should be repeated.

The clinician should look for a progressive lessening of the negative associations. If the same negative thoughts persist, the client may be stuck (see Chapter 7) or "looping," and the clinician may need to use the proactive version of EMDR processing procedures, called the "cognitive interweave" (see Chapter 10). Generally, looping is said to be occurring when the same negative statements and a high level of disturbance are generated and recycled over three consecutive sets, and none of the suggested alternatives discussed in the next chapter have worked. New clinicians should disengage with such a client, then resume with the proactive procedures of EMDR processing, but only after they have had sufficient practice and supervision.

MISMATCHES

A mismatch occurs when the client deliberately tries to bring something to consciousness that is inconsistent with the current level of affect. We assume processing can take place when the eye movements are done in concert with a conscious focus on the aligned components of the dysfunctional material (image, thought, physical sensation). After the clinician has coached the client to formulate a negative cognition that verbalizes the level of affect associated with a target event and has asked the client to maintain awareness of the physical sensations that are associated with the target,

all these elements (image, cognition, sensation) are held in consciousness. They can be thought of as the equivalent of three laser beams directed at the physiologically stored dysfunctional material. If, while experiencing a high level of distress because of a trauma-induced sense of powerlessness, the client attempts to comfort himself by adding an affirmation, such as "I am powerful," the mismatch between the affect and the affirmation will generally cause processing to cease.

If the client unexpectedly reports after a set that she is thinking of something pleasant, the clinician should determine whether the client is deliberately attempting to evoke a sense of relief by the addition of a less distressing thought by asking, **"Are you doing or saying anything deliberately?"** If this is the case, the client should be invited to drop the mismatched statement and, once again, be instructed as follows: **"Just let it happen, without judging or trying to force anything to happen."**

Please note, however, that positive statements can spontaneously arise in direct response to the negative cognition, and these should not be discouraged. For instance, without any deliberate attempt on the part of the client, the words "I am fine" can emerge in response to the negative cognition "I am terrible." At times, the two statements alternate spontaneously throughout a set. However, this alternation does not cause processing to cease. It is only problematic when the client consciously attempts to orchestrate processing by inserting a positive statement prematurely. When in doubt, the clinician should inquire whether the client is doing it deliberately.

POSITIVE THOUGHTS

If a new positive thought emerges early in the treatment, the clinician should instruct the client to concentrate on it when another set is initiated. However, unless a significant change then occurs, the client should be directed to return to the original target. If the positive thought is strengthened, additional sets should be administered. It is especially important to focus on and strengthen new positive thoughts that are particularly adaptive for the client before returning to the target. When both negative and positive thoughts emerge simultaneously, the client should be directed to concentrate on the negative one. Once again, the negative statement is associated with more dysfunctional material that must be metabolized, whereas the positive thought is connected to appropriate material that is progressing spontaneously toward integration. All the negative associations should be reprocessed before concentrating on a full integration. Therefore, if positive thoughts emerge during the later stages of processing, particularly during the installation phase, the sets should be continued.

INSIGHTS

If insights become progressively more adaptive, the client is requested to maintain awareness of his latest thoughts during the next set. Regardless

of what the client says, the clinician should merely say, **"Think of that,"** and not attempt to repeat or explicate it. Allowing processing to progress unimpeded can be extremely difficult for many clinicians, especially when the client's statements appear to have flaws in logic or to reveal imperfect understanding. However, it is important for the clinician to remember that the processing entails a transmutation of the dysfunctional material and a gradual linkup with appropriate, useful, self-enhancing information. Each statement is a verbalization of the specific plateau of information and stage of processing. Until the end of the EMDR processing, each statement will be less than fully adaptive but will set the stage for the next plateau.

If we remember the metaphor of a train progressing to each new stop, it becomes clear that the client's view cannot be completely functional until the "last stop" of fully adaptive information is reached. Challenging the client or attempting to explicate his statements is equivalent to asking him to get off the train. In EMDR therapy, the clinician attempts to stimulate the dysfunctional material and process it in an accelerated manner with additional sets. The clinician should intentionally intervene only if processing becomes blocked. (The appropriate timing and interventions for blocked processing are discussed in Chapter 7.) Even if a client has just given a lengthy discourse on the newly revealed information, the simple instruction **"Think of it,"** along with the appropriate nonverbal indicators of support, allows him to concentrate on the most pertinent element of what was just reported. If the client asks for instructions, the clinician should advise him to hold in mind the last pertinent point made.

Sensation and Affect

Clients often report processing effects in terms of emerging and changing physical sensations or emotions. EMDR processing may release into the client's conscious awareness not only the physical sensations associated with a variety of emotions but also the physical sensations stored at the time of the traumatic event. For example, the rape victim may feel the hands of the rapist, and the accident victim may feel the crash of the car. Special care must be taken when a client experiences painful affect or physical sensations associated with trauma. Instructions for working with clients in abreactions that include high levels of disturbance are reviewed in the next chapter. However, regardless of the level of disturbance, as long as the material is shifting, the usual processing instructions apply.

NEW EMOTIONS

When an incident is processed, a variety of emotions may sequentially emerge. Whenever the client mentions a new emotion, the clinician should ask, **"Where do you feel it in your body?"** and then begin another set. Specific emotions, or a combination of several emotions, may arise and

be dispelled within a single set, or they may remain for the entire session. Because these emotions can be intense, it is important to remind the client that they are manifestations of old material: For instance, just because one is experiencing fear does not mean there is actual danger. The clinician should not be surprised if a low level of one emotion transmutes into a high level of another. For instance, sorrow rated as 3 on the SUDS can easily turn into a level of anger rated 8 on that scale. The new emotion should be targeted without reference to the previous one. For instance, the question "Are you also feeling sad?" may only delay processing.

It is preferable that the accelerated processing of emotions be done in the office, but at times, the client will continue to experience the emotion in "real time," or a variety of emotions will spontaneously emerge sometime after the session. The client should be given adequate debriefing (discussed later in this chapter) about EMDR processing, regardless of its apparent effect. This is important because even when an incident appears to be completely processed, new emotions may emerge. For instance, after the successful reprocessing of an incest memory, a client returned the following week in intense grief and reported, "I have been grieving for the death of my father. I never mourned him before."

When a client describes feeling numb or dissociated, the clinician should first ask him to locate the feeling in his body, then continue the sets. The clinician should be verbally supportive and reassure the client during the sets by reminding him of the therapeutic process. This can be a very frightening time for the client. Saying things like **"That's it; just remember it's the old stuff,"** can be very helpful.

Remember, however, that the client should be appropriately screened for dissociative disorder before starting EMDR processing. If this has been adequately done, feelings of dissociation are viewed as the next layer of emotion that needs to be processed. Feelings of dissociation in clients with PTSD are not uncommon, because many clients dissociate at the time of the trauma. However, the clinician should make sure that she has not pushed the client too far, that is, into trying to dissociate to escape the perceived ordeal of the EMDR processing session itself. When in doubt, stop and ask the client how he feels about continuing the session before proceeding.

SHIFTING SENSATIONS

If the body sensations shift, the client should be directed to focus on the new location during additional sets. Although it is tempting, the clinician should not request an appraisal or description of the sensation, because this does not provide useful information. In addition, if the sensation shifts, the clinician should refrain from asking about the status of a sensation previously reported (e.g., **"Do you still feel it in your stomach?"**). The body scan will take care of all remnants of physical sensation at the end of the session.

To facilitate processing, the clinician should in general ask the client as few questions as possible.

Assessment

Each line of association should be assessed to ascertain whether there appears to be a progression, a sequential processing, that is therapeutically relevant. The dominant tendency is for the client to report new or shifting information that is progressively less disturbing. However, even if disturbance increases, reprocessing can be occurring because another aspect of the memory is being experienced as it is metabolized.

Clinicians can assume a channel has been cleared out when the client has become progressively less disturbed, when the associations appear to have reached a reasonable stopping point, and when nothing new or significant emerges after two sets of eye movements in different directions. The clinician should be sensitive to the fact that a new image or statement coming to the client's consciousness may simply be at the same plateau of information as the previous image or statement. For example, if a client begins to access positive feelings about her mother and reports scenes of different parties or luncheons they attended together, these released memories, though pleasant, are not indicative of a new plateau.

As the sets of therapeutically enhanced associations cease, the client should be asked to retarget the original incident: **"Think of the incident. What do you get?"** Then a new set is initiated, even if the response appears positive or clients believe there is nothing left to process. Often, the new set will open up an otherwise unexpected channel. Any new channels should be processed according to the preceding guidelines. At the end of each channel the clinician should ask the client to return to the original target.

If after retargeting the original incident and completing a set on it no new associations are given and no new emotions, sensations, or images are revealed, the clinician should recheck the client's SUD level. If the client reports a zero, the target is considered desensitized and the installation phase can begin. Once again, however, the distinction between these phases is somewhat arbitrary, because the entire EMDR treatment is considered a reprocessing, and the desensitization and enhancement of positive responses are considered simultaneous by-products.

While it is necessary to process all channels of revealed dysfunctional information before the installation phase begins, the clinician should remain conscious of time. Arriving at the end of any given channel will leave the client feeling less disturbed, but retargeting the original information may open another channel with yet more disturbing material. Therefore, if there are only a few minutes left in the session, a new channel should not be opened. The clinician may wish to go directly to the closure phase if there is insufficient time to finish the processing. The idea is to leave the client at the end of each session feeling empowered and possessing a sense of accomplishment.

If the client reports a low SUDS level (but more than zero) that does not shift with changes of direction in two eye movement sets, an additional assessment is made. The clinician asks, **"What emotion are you feeling?"** At times, clients may have become confused and give an SUD level to report a feeling of calm or well-being. If so, they should be reminded to assess only disturbing emotions. If, however, the client reports low-grade negative emotions, the clinician should ask, **"What prevents it from being a zero?"**

A response revealing a blocking belief such as "If I'm too happy, I'll be sorry" needs to be addressed by a full EMDR treatment on a corresponding memory. If the client's response appears ecologically appropriate, that is, appropriate to the situation (e.g., "I'm feeling sadness because my uncle died"), the installation phase may then be carried out.

The clinician should be careful not to accept prematurely a client's statement that seems to limit further progress. For instance, if a client is working on a public speaking phobia, it might be tempting to leave him with a low grade of anxiety, especially if the client states, "I guess I'll always be a little anxious in order to do a good job." This kind of statement may be merely a belief that is consistent with that plateau of processing. Unfortunately, some clinicians may accept this kind of statement and truncate the treatment because it parallels their own belief system; however, some people can indeed make wonderful speeches while feeling anticipation and excitement, rather than anxiety, as the source of arousal. Therefore, the clinician should acknowledge the client's statement and do at least two additional sets of different eye movements before accepting the limitation as an accurate statement. Stopping the sets prematurely may leave important unexplored areas or unwarranted levels of disturbance. Limitations should be accepted only if they appear reasonable and if two additional sets prove unproductive. SUD levels higher than a 0 should be carefully examined to determine their ecological appropriateness before proceeding to the installation phase.

PHASE FIVE: INSTALLATION

After initial reprocessing has been achieved—with the accessed target emerging at no greater than an SUD rating of 0 or 1 (unless otherwise ecologically appropriate; e.g., "I'm sorry he died")—the installation phase begins. Installation concentrates primarily on the full integration of a positive self-assessment with the targeted information. This phase is used to enhance the positive cognition and to link it specifically with the original target issue or event. Since all of the information should have shifted during reprocessing, the positive cognition is checked for both applicability and current validity. The clinician asks the client to evaluate the positive cognition she chose during the assessment phase; that is, the clinician says, **"How does** *[clinician repeats the positive cognition]* **sound?"**

By this point in the session the client should have progressed dramatically in the way she feels about the original event. Because of a variety of new insights, she may have far surpassed her own expectations and may now view the event in a much more positive light than originally imagined. In other words, the positive cognition she desired at the start of treatment may not be positive enough now. For instance, feelings of failure and guilt in response to an early tragedy might have led a client initially to choose the cognition "I learned from it." At the end of treatment, however, the client may come to realize that she in fact did very well at the time of the event, and the more appropriate positive cognition may now be "I am a worthwhile person."

After the clinician repeats the original desired cognition, the client should be encouraged to accept or change it or to substitute a better one. It may be useful for the clinician to say, **"Do the words** *[clinician repeats the positive cognition]* **still fit, or is there another positive statement that feels better?"** The clinician should also note whether a more therapeutic or enhanced positive cognition has emerged during processing. If it appears more potentially empowering, the clinician should offer the new positive cognition to the client in a tone that easily permits its rejection.

It is crucial that the client choose the positive cognition that is most meaningful for her. However, it is the clinician's job to assist in the therapeutic process. Just as the clinician's expertise in case formulation is needed to help frame the initial negative and positive cognition, so too is that expertise necessary to help the clinician create a new positive cognition that sums up the processing experience and is particularly useful and acceptable to the client. When offering a potential positive cognition that was not initially voiced by the client, the clinician should be careful to frame it as a tentative suggestion only. No demand characteristics should be used, since the primary goal is the client's sense of self-efficacy. If the client accepts the suggestion, the installation can proceed after checking her VOC rating on the new cognition.

If the client accepts the original positive cognition, the clinician should ask for a VOC rating to see whether it has improved: **"As you think of the incident, how do the words feel, from 1 (completely false) to 7 (completely true)?"** If the VOC has not increased, the positive cognition should be reexamined. That is, with the information now processed, the client's increased sense of self-efficacy should be reflected in a strengthening of the cognition. If it is not, there is a good chance that the proposed positive cognition is inappropriate, and a substitute will need to be found.

After the VOC is checked, the chosen positive cognition is explicitly linked with the previously traumatic event. By instructing the client to **"think of the event,"** either the original image or the current manifestation will emerge. The instruction is a general one, because the original image may have disappeared or been replaced by one that is now more pertinent.

The client is then asked to hold the image in mind (if there is no image, the client is asked to **"just think of it"**) while mentally repeating the positive cognition. That is, the clinician says, **"Think of the event, and hold it together with the words** *[clinician repeats the positive cognition]*," and then leads the client in a new set. Afterward, the clinician checks the VOC again, and the sets are repeated, with the event and the positive cognition linked, until the VOC reaches 7, or "completely true." Once the client rates the positive cognition as a 7, the sets are repeated until the cognition's validity and sense of appropriateness have reached maximum. The increase in validity may continue well past the arbitrary level of 7 on the VOC scale, since the client is often initially unaware of how positive and right a cognition can actually feel. It is often useful to coach the client in determining whether the statement feels "stronger" or "more solid." The guideline for the installation phase is that if the information continues to move further along the information-processing track, the sets should be repeated. The greater the client's sense of validity of the positive cognition, the greater the potential for improved self-esteem and a generalized self-enhancement.

If, with repeated application of different directions of eye movements, the client reports that the VOC level does not rise, the clinician should investigate whether other associations are emerging that need to be addressed. If the VOC does not progress above a 5 or 6, the client is asked, **"What prevents it from being a 7?"** The client will generally be able to report the blocking belief, which might be as benign as "I'll have to go through it to be certain it can be true" or as dysfunctional as "I don't deserve to be healthy." When an innocuous, nonproblematic statement is made, the clinician should proceed to the next phase, the body scan. When a dysfunctional blocking belief is revealed and does not remit with successive sets, the clinician will need to target it with a full EMDR treatment on the associated memory that is driving the negative self-assessment.

Typically, until the early memories that cause the blocking dysfunction are reprocessed, a completely successful treatment of the original target trauma cannot be attained. (The clinician identifies the target by asking, **"When is the first time you remember feeling this way?"** The Floatback and Affect Scan techniques reviewed in Chapter 4 can also be used. Once the early blocking memory is reprocessed with desensitization, installation, and body scan, the clinician should reevaluate the original target memory and complete the installation. Generally, however, because of time limitations, the clinician should wait until the following session to inaugurate treatment on the early blocking memory. When this is the case, the clinician should move to the closure phase (skipping the body scan) and administer an especially careful debriefing. Any uncompleted session is liable to increase the level of between-sessions disturbance, and no treatment is considered successful without completing the body scan.

PHASE SIX: BODY SCAN

The AIP model that guides EMDR practice posits that the dysfunctional material may have a discernible physical resonance (i.e., physical sensations that correspond to cognitive processes) that can itself be targeted. Therefore, the sixth phase of treatment, which concludes the accelerated reprocessing, concentrates primarily on body tension and the other physical sensations.

Once the positive cognition reaches a 7 on the VOC scale (or 6, if ecologically appropriate) and does not increase in strength with additional sets, the client is asked to hold both the image and the cognition in mind while mentally scanning his entire body to identify any lingering feelings of tension or tightness or any unusual sensation. The clinician might, for example, say the following:

> **"Close your eyes and keep in mind the original memory and the positive cognition. Then bring your attention to the different parts of your body, starting with your head and working downward. Any place you find any tension, tightness, or unusual sensation, tell me."**

If the client reports any unusual physical sensations, they are targeted with further sets. These sensations may disappear uneventfully with a few successive sets. On the other hand, focusing on body sensations at this point can open other channels of information that must be processed. These can include anger or grief that the pathology has existed for such a long time. The body scan can also highlight major areas of resistance stemming from the client's fears of who he will be or what he must confront if he lets go of his pathology. In addition, the body scan may reveal other associated networks containing dysfunctional material.

The importance of the body scan in the complete reprocessing of the targeted event and associated material cannot be overemphasized. Its importance is clearly illustrated in a case of a woman who was being treated for performance anxiety, and who had successfully reprocessed a memory of having frozen during a presentation. When asked to do a body scan, she reported a strange sensation at the small of her back, which she rationalized as having been caused by sitting so long during the session. When the sensation in her back was targeted with successive sets, however, the client suddenly exclaimed at the image that arose of being molested by her uncle, who held her down on the bed with his hand at the small of her back. Although this association was anticipated neither by the clinician nor the client, it supports the hypothesis that material stimulated by EMDR processing is lawfully associated. In other words, dysfunctional material associated with the presenting complaint of performance anxiety (i.e., the client's memory of freezing during a presentation) could logically be linked

to a molestation during which she would have felt anxiety and distress at having to "perform." While previously unrevealed, this kind of antecedent is often revealed to be the cause of a seemingly innocuous presenting complaint. The clinician should not automatically assume traumatic material is at the root of a presenting complaint but should be prepared for the possibility that it will emerge spontaneously. This underscores the need for the proper therapeutic alliance and for flexibility in clinical considerations, such as the scheduling of extra time for processing sessions.

The body scan phase of treatment is completed when the client, holding in mind the target event and the positive cognition, can mentally scan the body and find no residual tension or other negative sensations. If a positive or comfortable sensation is reported, sets can be done to strengthen it.

PHASE SEVEN: CLOSURE

While the clinician should be scrupulous in attempting to clear the channels of dysfunctional information, sufficient time to do so must be allotted. Although a 90-minute session is sufficient to process most distressing material involving a single memory, this may not always be the case. Therefore, the clinician should always reserve time to close the session with proper instructions, leaving the client in a positive frame of mind and able to return home safely.

The clinician should never allow the client to leave the office in a high level of disturbance or in the middle of an abreaction. Therefore, if only a few minutes of the session are left, a new channel should *not* be targeted and a body scan should *not* be done. A client may be feeling fairly calm after the successful reprocessing of a single channel and may have reached therapeutic insight regarding one chain of associations. The client may also feel a sense of well-being at reaching a VOC level of 7 regarding a new positive attribution. However, targeting a new channel or the tension revealed in a body scan can set off a new chain of associations that will require more than a few minutes to process. Therefore, the clinician should always use good judgment regarding the time requirements necessary to enable the client to leave the office in a stable state.

Visualization

If, at the end of the allotted time for the session, the client is evincing any signs of disturbance or is abreacting, the clinician should utilize hypnosis or a guided visualization to return him to a state of comfort. Clinicians who are unfamiliar with guided imagery techniques should learn them before using EMDR processing. The Safe/Calm Place exercise described in Chapter 5 may be used with most EMDR clients, since clinicians have

consistently reported positive effects from it. Additional self-control and closure procedures (including audio recordings) are reviewed in Chapter 9 for this purpose.

As noted before, clinicians should use a relaxation process, such as the Safe/Calm Place exercise, with the client in an early session, before processing begins, a precaution that can give the client confidence about his ability to stop the accelerated processing and bring the disturbance under control. It is easier to use a previously successful relaxation method with a client during the closure phase than to experiment with new ones.

Safety Assessment

After using guided imagery, the clinician should assess the client for any dissociation that would prevent her from returning to the here and now or hamper her ability to negotiate the streets or drive a car. It may sometimes be necessary for a client to remain in the waiting room for some period of time until the clinician determines there is no potential for danger.

While most clients can be assisted in closing down the incomplete processing of a targeted event to a level that will be manageable until the next session, in a small number of cases it will be necessary either to see the client later in the day to complete the reprocessing or to schedule an appointment for later in the week.

While a week is generally recommended between sessions in most instances, in order to give the client a chance to integrate the material that has been processed and to identify new targets, some clients need to be seen more often. This is the case if many new disturbing memories are emerging or if the client is in great distress because of an incomplete session. It is important to assess the client's potential for high-level disturbance and to schedule a telephone appointment to check on his progress, if necessary. For some clients with complex PTSD, it may be useful to schedule multiple appointments early in treatment, after preparation, since processing itself contributes to greater stabilization. Processing the dysfunctional memories means that they will no longer be triggered in everyday life and buffeted by the high-intensity disturbing affects that were stored at the time of the traumatic event (see Chapter 11). Since homework is not needed in EMDR therapy, treatment can take place on consecutive days within the affect-regulating presence of the therapist. The clinician should keep in mind the cautions and guidelines covered in earlier chapters and rely on her own assessment of the client and level of disturbance; there is no substitute for the clinical judgment of a licensed clinician.

Debriefing and Log

It is important to debrief each client at the end of each session. However, it is especially important to provide a thorough, detailed debriefing if the

material has not been fully processed, for there is greater likelihood in this case that the client will continue the processing between sessions at a higher level of disturbance. In order to lessen the client's disturbance, the clinician should tell her that the target will be reaccessed at the next session.

It is important to remind the client at the end of each session to keep a log of any memories, dreams, thoughts, and situations that are in any way disturbing. By keeping such a journal, the client will be able to report to the clinician any obvious targets that should be treated. In addition, the clinician may be able to use the journal entries to identify any dysfunctional patterns of behavior and triggers that should be targeted (see Chapter 8). It can be helpful to instruct the client in the use of a TICES log by drawing six columns on a piece of blank paper (see Appendix A). Place a T on the top of the second column to stand for "trigger," an I on the top of the third column for "image," a C for "cognition," an E for "emotion," and an S for "sensation." The final column is for the SUD level. Then explain to her, **"If anything disturbing arises, you should simply jot down the information briefly in the columns. Just enough to remind you what happened. And then use a relaxation procedure, like the Safe [or Calm] Place."** This process assists the client in containing any distress. By asking the client to cognitively assess the situation and delineate the components, she is shifted from a purely emotional response and begins to see the reactions as a predictable occurrence, which will be attended to at the next session. The log functions as a container for the emotional disturbance, which she then further dissipates by using the self-control technique.

The client should be told that her awareness of any experiences she finds disturbing is an excellent step and will assist in defining targets for future sessions. In terms of any memories or dreams that might arise, it is useful to explain that it is important for her not to proceed too rapidly and that further disturbance is part of the processing. While this is actually the case, this statement also incorporates a paradoxical intervention (Fisch, Weakland, & Segal, 1982) that helps the client to accept any disturbance as part of the healing process. Thus, the client can be happy if no disturbance arises or if some arises. The client's ability to simply "let whatever happens, happen" is an important aspect of the between-sessions condition. If the debriefing is not properly done, the client may feel fine after a session and assume that she is finished. However, if disturbance then arises between sessions, she may view herself as "damaged goods." Unless appropriate debriefings are given to ensure realistic expectations, clients who have low self-esteem to begin with see this as another sign of their failure, and suicidal ideation can arise.

It is vital that the client understand that, regardless of the nature of the disturbance, it simply represents the continuation of the EMDR processing effect. Sometimes images and memories may emerge, and other times only disturbing emotions. Regardless of the nature of the distress, the client should just jot it down—without making it significant—then use

a relaxation exercise. If the client has any questions, she should call the clinician. A proper debriefing will result in fewer emergency calls (possibly fewer than the clinician has previously experienced). A properly prepared client can observe, rather than succumb to, the distress.

Another reason for requesting that the client keep a log is that it gives her another way to distance herself from the between-session disturbances. By observing her own distress, the client is again tacitly taught that she is larger than the pathology. She is asked to "take a snapshot" of the disturbance by jotting down a short description of what triggered it and of any specific thoughts, emotions, physical sensations, or images that came to mind at the time. This gives her the opportunity to observe her own patterns and responses. In addition, instead of using statements such as "I was afraid," the client is asked simply to identify the components of the fear. This begins to teach her that emotions such as fear, shame, and anger are actually primarily physical sensations that can be described and be changed. This educational process is further implemented by asking the client to use a relaxation audio recording or Safe/Calm Place exercise after writing the information into her log.

It is not necessary for the client to write a great deal in the log; what is needed is only enough information to allow her to bring the circumstances of the disturbance to mind for discussion and possible targeting during the next session (see Appendix A). The log can include dreams, past events, present situations, or fears of the future. In order to balance the ledger, it is useful to ask the client to note anything pleasant that arises as well. Positive insights are also useful for treatment planning and direction.

Although the clinician may have a list of the client's traumas derived from the history-taking sessions, no new traumatic memories should be targeted until the major reverberations from the old ones have died down. In other words, if the client experiences a number of nightmares obviously linked to the event just processed, the clinician should target them during the next session. If a number of associated images emerge or if the client reports a new perspective on the original target that needs further attention, the clinician should help the client process this before a new trauma is treated. It is important to leave the client in a state of psychological equilibrium. If ramifications of the original target are still disturbing, these should be addressed before processing new trauma material that may cause additional distress. However, if another disturbing memory has just arisen or is now being fixated, it should be addressed as part of the processing effect. The log should be the immediate indicator of the target for the next session.

During the initial stages of EMDR therapy the emphasis is on treating the most dysfunctional memories, which have set the groundwork for the pathology. Along with the history taking, the log reveals the most pertinent targets, including disturbing memories, dreams, associated incidents, and triggers. Further uses of the log are reviewed in Chapter 8, which covers the reevaluation phase, the eighth and final phase of treatment. Chapter 8

guides the clinician through the extended application of the EMDR therapy three-pronged standard protocol (i.e., past–present–future) and discusses its appropriate placement in an overall treatment plan.

Some clients show little or no change from reprocessing in the treatment setting. Nevertheless, the clinician should give the client the appropriate debriefing and the instructions for keeping a log, even if no obvious reprocessing has been accomplished. It is not unusual for a client to be comparatively resistant to in-session treatment but to process the material later. This unexpected processing can be highly disturbing to unprepared clients, and clinicians should take care to ensure their safety regardless of the amount of change observed during the session.

In additional to the self-use of the affect-regulation techniques, clients should be encouraged to use a stress-control recording daily as an aid to relaxation and an additional tool to deal with any disturbing thoughts or emotions that might arise. A guided visualization or relaxation exercise can be a stronger aid for most clients than attempts at unassisted cognitive or behavioral modification. If commercial recordings are not available or acceptable, the clinician can record one of the closure techniques in Chapter 9 for the client's home use.

Naturally, the client must be told to be prepared for any shift in emotions or, conversely, no change at all. The clinician should attempt to instill in the client a sense of acceptance and objectivity (**"Just let it happen and merely observe"**), so that changes are neither sought nor forced between sessions. For many clients, the time between sessions is a period of additional insights; for others, it may be a time of chaotic feelings and emotions. While the clinician may hope for signs of successful processing by way of new insights or behaviors, if the client is given false or undue expectations, any therapeutic benefit is likely to be undermined.

The general tone used for this part of the debriefing is summed up in the following example of what the clinician might say to the client:

> **"Things may come up or they may not. If they do, great. Write them down, and they can be a target for next time. If you get any new memories, dreams, or situations that disturb you, just take a good snapshot. It isn't necessary to give a lot of detail. Just put down enough to remind you in a TICES log so we can target it next time. The same thing goes for any positive dreams or situations. If negative feelings do come up, try not to make them significant. Remember, it's still just the old stuff. Just write it down for next time. Then use the recording or Safe [or Calm] Place exercise to let as much of the disturbance go as possible. Even if nothing comes up, make sure to use the recording every day and give me a call if you need to."**

While this concludes an individual EMDR processing session, EMDR treatment is not complete without attention to the reevaluation phase discussed

in Chapter 8 and the implementation of the three-pronged protocol (see Chapter 8). EMDR is not a one-session therapy, and the clinician should treat a client only when arrangements have been made for appropriate follow-up and assessment of potential needs. Even if the client appears to have successfully reprocessed a single-event trauma (along with the attendant triggers and potential future challenges) that was the stated reason for seeking therapy, another session should be scheduled for the following week. Without a follow-up appointment, the client will be more apt to feel like a failure if new aspects of the memory or triggers arise that need to be treated; she may feel too discouraged to seek further assistance. Therefore, the clinician should frame the next appointment as an integral part of treatment. Most clients can readily accept the need to complete EMDR therapy's eight phases and three-pronged protocol if the clinician compares it to the need to finish a prescribed bottle of antibiotics.

SUPERVISED PRACTICE

Before clients are treated, clinicians are advised to work with a trained EMDR therapy instructor in supervised small groups to practice the information covered to this point by targeting old memories whose level of disturbance is expressed as a 5 on the SUD scale. Once the clinician is comfortable treating this level of disturbance, he should practice using the following chapters as a guide for treating more disturbing memories, for instance, those that are rated as a 7 or higher on the SUD scale. Once treatment has begun, more disturbing memories have a tendency to start processing and to then become stuck or to produce an abreaction response. Of course, the clinician should remember that targets that seem quite innocuous at first can rapidly shift into more disturbing material and he should therefore ensure that the appropriate clinical safeguards are taken.

SUMMARY AND CONCLUSIONS

The phases of accelerated reprocessing are the desensitization, installation, and body scan phases. Although these designations offer useful divisions, a lessening of disturbance, a restructuring of positive attributions, the elicitation of insights, and a decrease in body tension are part of the whole reprocessing effect.

During the desensitization phase, the clinician gives attention to "cleaning out" the channels of dysfunctional information associated with the target. Clinicians are guided during this phase by the client's reports, which should indicate changes on emotional, cognitive, and somatic levels. At the end of this phase, the client generally should be able to concentrate on the target event with an SUD score of only 0 or 1.

The installation phase links the most adaptive positive cognition to the original target and aims for a validity rating of 6 or 7 (or more, if it continues to strengthen) on the VOC scale. It is important that the clinician's assessment of the level of validity of the cognition take into consideration the client's current life circumstances, that is, that it be ecologically appropriate. Any blocking beliefs revealed during this phase need to be addressed, with a separate treatment directed at the memories that laid the groundwork for the dysfunction.

The body scan asks the client to assess mentally the presence of any residual physical sensations, while the target event and the positive cognition are held in consciousness. The sensations will be processed with additional sets, which may reveal other channels of dysfunctional information, including fears, anger, sadness, or resistance to change. A completed treatment includes a body scan that reveals no tension or other disturbing sensations.

At the end of the session the clinician should make an adequate assessment of the client's safety, including his ability to leave the office and to handle any emotional disturbance that may subsequently arise. It is essential that adequate debriefing take place regarding the use of a log, affect-regulation techniques, and relaxation recording, all of which allow the client to observe, rather than be caught up in, any new material that emerges, both within and between sessions. If clients become too overwhelmed or lose their sense of being ultimately in control of the process, they may terminate treatment prematurely. In addition to the Safe/Calm Place exercise described in Chapter 5, appropriate affect-regulation and closure exercises are described in Chapter 9. The final phase of treatment, the reevaluation phase, places the individual reprocessing session in the context of the overall treatment plan (the reevaluation phase and three-pronged protocol are covered in Chapter 8).

Clinicians new to EMDR therapy should use the material in this book in a supervised practicum with a trained EMDR instructor. Initial use should be on circumscribed old memories rated at no higher than a 5 on the SUD scale. Events of higher disturbance than this often need a greater amount of clinical intervention (see Chapter 7) and should not be attempted until clinicians are comfortable with the basic components of EMDR processing. Various clinical aids, including a list of negative and positive cognitions, are found in Appendix A. Treatment transcripts are in Appendix B. For information on authorized EMDR therapy training and the availability of training consultants, consult Appendix F. Many facets of EMDR processing, including cues for the appropriate timing of successive sets, can only be conveyed in person; the better qualified the instructor, the better prepared the clinician will be.

CHAPTER 7

Working with Abreaction and Blocks

Our work is to keep our hearts open in hell.
—STEPHEN LEVINE

This chapter presents strategies for reprocessing sessions with especially challenging clients. As these approaches are incorporated into phases four through six, I have placed this chapter here, rather than proceeding with our exploration of the final phase of EMDR therapy—reevaluation.

As discussed in Chapter 6, some EMDR clients report a consistent reprocessing effect while focusing on a single picture, whereas others report a variety of other associations stemming from the original target. At the end of each set, the clinician must guide the client by instructing her either to maintain awareness of the emerging material or to shift her attention to something different. In addition, the clinician may need to help the client determine what aspect of the target to focus on during the next set or help her formulate a new target.

The choices the clinician will be called on to make are decided moment by moment as the effects of each set are observed. Approximately 50% of the time, the alignment of the standard components (image, cognition, body sensation), together with the eye movements, allows full processing to take place within one to three sessions. In the remainder of cases, a number of alternative procedural strategies are necessary for therapeutic effectiveness (described here and in Chapter 10).

The challenges to which this chapter is devoted include clients who are abreacting with a high level of disturbance and situations in which the processing stops prematurely. Each EMDR therapy session is unique in the kinds of subjective experiences displayed by the client. However, clinical

observations over thousands of treatment sessions indicate that certain generalizations can be made regarding successful therapeutic interventions.

We begin with a discussion of procedural strategies that are useful during abreactive responses. As defined previously, an "abreaction" is the reexperiencing of stimulated material at a high level of disturbance. The section on abreaction covers a number of important clinical considerations and the decision points necessary for adequate processing. The second half of the chapter includes instructions for dealing with clients whose processing has stopped despite successive sets of multidirectioned eye movements.

Clients with high levels of disturbance should not be treated until the clinician is familiar with the strategies described in this chapter. More advanced methods are covered in Chapter 10, but these should not be attempted until the clinician has adequate practice and is comfortable with the material presented here. Suggestions for appropriate practice sessions are offered at the end of the chapter.

ABREACTION

An abreaction is considered a normal, potential part of the integrative emotional and cognitive processing of any given target. Clinicians should not view abreaction as either mandatory or unnecessary but should accept it, if present, as an integral part of the client's subjective response during the processing of the dysfunctional information.

The clinician should remember (and should remind the client in appropriate language) that the targeted memories are considered to be information "packages" or "files" that are stored in the brain with the original perceptions and are held intact in state-specific form. When memories are stimulated, the client may notice both the sensory experiences that he originally perceived and the thoughts that occurred at the time of the event. In addition, the physical sensations and emotions that are part of the information about the targeted incident may also be stimulated. Clients may experience these with an intensity that can range anywhere from a duplication of the original experience to a mere shadow of it.

The focus of the EMDR processing session is on targeting and accessing the stored dysfunctional information. Because the information is stimulated, the original unmetabolized perceptions are brought to some degree of consciousness. When these are experienced at a high level of disturbance, an abreaction is said to have occurred. However, since we make no assumptions about the level of intensity necessary for sufficiently processing a targeted memory, the client should not be encouraged to force an abreaction or to suppress one. The clinician's ongoing message to clients should simply be **"Let whatever happens, happen."** Attempting to force the client to conform to any clinical standard will be detrimental to full therapeutic efficacy.

It is important to note the specific way "abreaction" is defined in EMDR therapy, because the term has different meanings for different clinicians. While an abreaction during EMDR processing includes a high level of disturbance, it does not include the element of dissociation usually seen in hypnotic abreactions. When properly used, EMDR processing does not bring on full flashbacks, because the client is coached to have a dual focus, namely, an awareness of the past and a feeling of safety in the present. In addition, unlike hypnosis, the EMDR abreaction does not continue moment by moment in a "real-time" reliving of the event. (Even in cases of induced time distortion, the hypnosis client generally goes through each instant of the event sequentially). However, the consensus of clinicians trained in both clinical hypnosis and EMDR therapy is that the EMDR abreaction moves four to five times more rapidly than in hypnosis, with the client appearing to jump from one key element of the event to another. Since the processing appears accelerated in EMDR, these sessions can resolve traumas comparatively quickly.

Clinicians must take great care during the abreaction to maintain the client's sense of safety. The clinician must also be comfortable with displays of intense emotion. Any fear or distaste the clinician might have for the client's response is likely to be communicated by tone of voice and nonverbal signals. The client's need for unconditional regard and support is evident throughout EMDR work, but it is especially important during times of abreactions.

It is essential for the clinician to remember that stimulating target memories allows the emotions that were locked in at the time of the event to surface. For example, while the client may be 40 years old at the time of treatment, the emotions felt may well be those of a child. Thus, the helpless terror of a 4-year-old during a molestation or physical assault may be reexperienced in all its original intensity. A client who has tried to deny, wall off, or suppress these powerful emotions for 35 years must be made to feel that it is safe to experience them in the clinician's presence. This is especially important, since feelings of self-denigration and self-blame, which are often inherent in the earlier experience, may be stimulated during EMDR processing. It is the clinician's job to help the client to process old material without fear of rejection or negative judgments.

Any clinician who finds strong emotional responses distasteful should not practice EMDR therapy, regardless of how innocuous the clinical presentation may seem. The cause of many apparently straightforward present disturbances may be one or more quite traumatic earlier life events. Therefore, regardless of the clinician's expectation, targeting the present dysfunction may cause the client to shift spontaneously to an earlier memory at full abreactive intensity. If the clinician has not prepared her for this, the client may try to suppress her emotional response, which may cause retraumatization.

Guidelines for Facilitating Abreaction

The guidelines in this section can help clinicians facilitate client progress through an abreaction. Whereas some of these will be familiar to clinicians already skilled in abreactive work with other methods, others are specific to EMDR processing. For clinical balance and client comfort, it is useful to keep in mind the following 14 points:

1. *EMDR processing is not causing the client's distress; it is simply releasing it.* The targeted event has been the source of continuous dysfunction in the client's life. It is the root of the presenting complaint, and the negative emotions inherent within the experience have been triggered repeatedly (either consciously or below the conscious threshold) since the event occurred. An abreaction during EMDR processing is a sign that the dysfunctional material is being metabolized.

2. *An abreaction has a beginning, a middle, and an end.* Clinical observations have indicated that EMDR allows processing of abreactions to occur at an accelerated rate, indeed, much more rapidly than hypnotically induced abreactions. While the client may be experiencing high levels of disturbance, the abreaction will certainly not last as long as the original experience; the client's distress should begin to subside dramatically within the first 10–20 minutes (and less with the use of the cognitive interweave described in Chapter 10). In most instances, the traumatic memory will be substantially processed within a 90-minute session.

3. *In most instances, the abreaction is occurring as the information is being processed.* Therefore, as the abreaction is successfully completed, the source of the dysfunction is simultaneously resolved. While the clinician may have seen clients become extremely disturbed during conventional therapies when discussing a childhood trauma or recent assault, those emotions were signs of the triggered disturbance and indicated the dysfunction; in contrast, an abreaction induced by EMDR processing is a sign of the transformation of the disturbing material and should therefore be viewed as a sign of emerging health. This is not to say that one abreactive session will necessarily resolve the entire trauma. But if the information is processing, that extreme level of distress will generally not reemerge in subsequent sessions.

4. *The clinician should maintain a position of detached compassion in relation to the client.* If the clinician becomes immersed in the disturbing emotions or horror of the traumatic event, she may overlook important decision points and interventions. The client relies on the clinician to provide emotional stability and a sense of safety during the abreaction. On the other hand, the client also needs compassion; he will not be well served if the clinician shows cold indifference to his evinced level of suffering.

Finding the balance necessary for optimal clinical support in the face of pronounced distress may be difficult for clinicians who are used to more cognitive interventions. It may be useful for these clinicians to recall a time when they offered support to a family member who was in pain. In order to help, they had to be understanding and compassionate while simultaneously using sound judgment. Some clinicians versed in hypnosis or guided imagery prepare themselves for intense sessions by visualizing the client surrounded by a "healing light" and themselves surrounded by a protective "golden bubble." For other clinicians, remembering the preceding three points of this list can help maintain a balanced detachment.

5. *To increase the client's sense of safety, follow the "golden rule" of "Do unto others. . . ."* The clinician should ask himself what kind of support he would want if he were suddenly flooded with the emotions and physical sensations of childhood terror. The answer will probably reveal the importance of something that conveys an atmosphere of nurturing and trust and makes him feel that it is safe to proceed. Based on this assumption, the client should be continually reassured that the clinician is calm, caring, unsurprised by the content of the abreaction, supportive of its manifestation (regardless of how intensely expressed), and responsible for the safety of the situation. This stance allows the client simply to notice the material as it arises in consciousness and to "let whatever happens, happen."

In order to create and maintain this atmosphere, the clinician should reassure the client during each set in a tone of voice that is both soothing and supportive. Using expressions such as **"That's it," "You're doing fine,"** and **"Good"**; encouraging the client to **"just notice"**; and reminding her during sets that what she is experiencing is "just the scenery" can give the client the courage and reassurance that EMDR processing is progressing as expected.

Because clients can observe the clinician's reactions with their peripheral vision, the clinician should maintain an expression of calm, sympathetic support throughout the processing. As mentioned previously, any nonverbal indication of fear, disgust, or displeasure on the part of the clinician can be detrimental to the client's sense of safety and may severely limit her ability to complete processing.

6. *Before treatment, clients should be reminded that they are safe in the present.* To allay fears of experiencing the traumatic event, it is important for clients to remember that any disturbance they are experiencing is being caused by the "old stuff" and that they are no longer in danger. Clinicians should remind them that different aspects of the targeted event can be observed and controlled in the same way that a recording can be seen and controlled on a TV screen as the DVD operates: It is as if the client is the one who holds the controls of the DVD player, for when he signals the clinician by holding up his hand or turning his head away, the clinician will halt the eye movements and the "movie" will stop. The intention is to allow the client to feel the experience fully while still maintaining a sense of control.

It is also helpful for clients to remember the metaphor of the train ride, in which the client is the passenger and the "old stuff" is the scenery. Even though the client may experience emotions and physical sensations, as well as images, it is helpful to think of this as just the scenery passing by. The client should remember that even as he notices this scenery, the train has already safely passed.

Another useful metaphor, mentioned previously, likens EMDR processing to driving a car through a tunnel. To get through the tunnel quickly, the client needs to keep his foot on the accelerator. The accelerator in EMDR treatment is the eye movement (or other form of stimulation), which seems to speed up the processing of the information. If he takes his foot off the accelerator, the car will slow down and it will take longer to get through the tunnel. Therefore, to get through the discomfort, the client should keep his eyes moving as much as possible.

It is important to inform clients that even if they begin to cry, it is useful to keep their eyes open and continue the eye movements, so that processing can go on. If they cannot keep their eyes open, the other forms of stimulation can be substituted. However, it is mandatory that clients be told that they can stop the processing at any time by using hand or head signals. As usual, clinicians should honor those signals immediately.

7. *It is vital that the clinician read the client's nonverbal cues to determine whether the disturbing information has reached a new plateau and the set can be ended*. Ideally, the goal of each set is to move the client from one plateau of information to a new plateau with greater therapeutic validity. Clinicians can observe the achievement of a new plateau when the client reveals (nonverbally) either a new insight or a dramatic decrease in the level of suffering. The nonverbal indicators may be changes in eye movement, facial tension, body posture, breathing rate, or facial color. Changes of this sort should be pointed out to clinicians during practice sessions supervised by an experienced EMDR instructor.

Although nonverbal cues are good indicators of new plateaus, the clinician should not stop the set immediately. New plateaus appear to manifest themselves physically before clients are able to make the conscious/cognitive connection. Therefore, the clinician should continue the set for 5–10 seconds after noticing the change in facial expression, in order to allow the information to become integrated. Figuratively speaking, the clinician should allow the client time to climb up and onto the new plateau. Keep in mind, however, that the climb may be too long and arduous to complete during any one set.

8. *Clients' nonverbal cues should also be used to ascertain whether the set should be ended before a new plateau is achieved*. While the transmutation of information appears to occur at an accelerated rate during the stimulation sets, clinical observation has indicated that the amount of time between sets is of great importance. The following are reasons for

breaking the stimulation into sets, rather than administering one continuous sequence:

a. To provide an opportunity for client feedback, that is, to assess whether processing has occurred.
b. To enable the client to integrate the new information on a verbal/conscious level.
c. To allow the client to experience any new revelations shared with and reaffirmed by the clinician.
d. To reorient the client to the sense of present time and consequent safety.
e. To provide the client with a rest so she can endure the physical stimulation of an abreactive response.
f. To reinforce the notion that the client is larger than and in control of the abreaction through his ability to enter and exit the disturbance at will.
g. To allow the client to reassure herself of the clinician's ongoing encouragement.
h. To allow the clinician to judge the need for additional clinical interventions.

The length of the rest period after a set is determined by the needs of the individual client, although this will probably differ from one set to another. The clinician should never reengage the eye movements if the client still needs reassurance and stabilizing. It is also important to remember that processing continues during the rest period, albeit at a slower rate. For this reason, clinicians should watch the client carefully to ascertain whether an abreaction is starting again; if so, the sets should be resumed.

9. *The clinician should reinforce the client's dual focus of attention.* Clinicians should remind clients to remain aware of the information being processed internally, while they simultaneously attend to any stimuli presented by the clinician. In this way, clients can allow the information from the past to be accessed and stimulated while remaining conscious of their current safety (and the current task). On a physiological level, this dual focus of attention appears to elicit an orienting response and to tax working memory, both of which decrease distress (see Chapter 12). On a conscious level, the dual awareness allows the client to maintain a sense of the present, along with a connection to the resources of the therapist. This can increase the client's ability to withstand the emotional turmoil of the abreaction.

In addition to providing verbal reassurances, the clinician can enhance the client's connection to present time by purposely changing the direction and speed of the eye movements. For clients to be able to follow the eye movements during an abreaction, the clinician may have to make slower movements or cover a shorter range. When a client is crying or showing

other signs of high emotional disturbance, the clinician may need to alter the eye movements to make it easier for the client to follow the external focal point. Many clients cannot maintain the full bilateral eye movement during strong disturbance and may falter if the clinician attempts to speed up the movements. Take special care not to instill a sense of failure in clients because of their inability to attain the usual speed or range of motion.

In addition, if eye movements become too predictable, the client may anticipate them and perform them mechanically while directing his full attention to the dysfunctional material. This is detrimental to processing and should be avoided by altering the speed of the eye movements during the set. Thus, by following the clinician's lead in slowing down and then speeding up his eye movements, the client is forced to remain conscious of the present environment. Changing the direction of the eye movement randomly from one set to the next (but not within an individual set) can also have this effect. Of course, the clinician should be sure to use only directions of movements that facilitate change for a given client. Remember that some clients will not process at all with certain directions of eye movements. It is important for the client to try to process the maximum amount of information possible during each set while maintaining a state of psychological equilibrium in order to feel encouraged to continue.

10. *During the abreaction, clinicians should treat a sense of dissociation as they would any other layer of emotion that presents itself to be metabolized.* Many clients dissociated at the time of the original trauma and report seeing the event as if they were "up on the ceiling." When this happens during EMDR processing, the clinician should be able to discern the true nature of the apparent dissociation as one of the following possibilities: (a) the old feeling of dissociation that arises from the target memory and that will be metabolized by the sets, (b) a new dissociation that is being triggered because the client has been pushed too far, or (c) a dissociation that is the product of an undiagnosed dissociative disorder.

The latter two antitherapeutic dissociative possibilities were discussed in Chapters 4 through 6, and pains should have been taken to avoid them. If they still occur, the clinician must stop the reprocessing immediately and take corrective action. If, however, the problem is the old dissociation, the clinician should ask the client to notice the relevant physical sensations and sense of dissociation and should assist her to stay in the present as processing continues. This can be achieved by (a) saying things like **"Stay with me"** or **"You're safe now"**; (b) using cadence sounds, such as **"Yes, yes,"** in unison with finger movements to facilitate forceful eye movement; (c) asking the client to pound on the arms of the chair in unison with the eye movement; or (d) asking the client to relate what is occurring in the memory being processed while doing the eye movements.

11. *The clinician can try to decrease the client's disturbance by inviting him to engage in certain visual manipulations of the target memory.*

Emotional distancing strategies that clinicians may use include asking the client to (a) change the memory into a still photo, (b) change the memory into a black-and-white video, (c) imagine the child victim holding the hand of his adult self, (d) place a protective glass wall between the self and the event, and (e) place a protective glass wall between the self and the perpetrator, who is placed at a great distance. As the processing continues in this last case, the perpetrator is slowly brought toward the victim, with the glass remaining in place (Wolpe & Abrams, 1991).

However, for several reasons, clinicians should stay alert to the need for additional strategies: First, not all clients are capable of the visual control necessary to make these adjustments; second, visual control can be lost during a set, allowing the level of disturbance to rise again; third, if visual manipulation is used, it will eventually be necessary to return to the original image in order to reprocess any information that may remain in state-dependent form. The purpose of the visual manipulation is to find a vantage point from which the client can observe the memory with a lower level of disturbance. Also inherent in the client's ability to manipulate the memory is the notion that the client is larger than the disturbance and is actually in control. Remember, however, that visual manipulation is used as a transition device. Ultimately, the target information must be fully processed. This situation is covered more thoroughly in the next section of this chapter, which deals with blocked processing.

12. *To ensure the greatest possible emotional stability, the clinician should encourage clients to make whatever personal arrangements are necessary for the session or afterward.* For instance, many clients choose to (a) have a loved one pick them up after the session or (b) bring with them a special object—such as a book, stuffed animal, or talisman—to give them a greater sense of safety. Pets are not appropriate, however, since they may be disruptive to the processing, particularly if they sense the client's disturbance. It is also not usually helpful to have other people present during the processing session, because of the possibility of distraction, therapeutic splitting, or nonsupportive dynamics.

In order to reassure the client during disturbing processing, it is appropriate for the clinician to leave one hand available for the client to grasp if an additional sense of connection or stability is needed. However, it is strongly advised that the clinician not move to take the client's hand or touch him in any way during an abreaction, since such acts may feed into the sense of violation caused by the perpetrator or the trauma itself. Remaining available to a client's expressed desires is quite different from intruding, which can lead to retraumatization.

13. *Clinicians should change to auditory stimuli or hand taps, if appropriate.* In some instances, the client is unable to maintain processing with her eyes open due to fear because of an association of hand movement to prior abuse, or because of uncontrollable sobbing. When the client's eyes cannot track, the clinician should attempt to use either rhythmical tones

or tactile stimuli. Great care should be taken when using these alternative stimuli during an abreaction, because they make it harder to notice whether the client is dissociating. One advantage of the eye movements is that the clinician is able to see when the client is beginning to associate too fully with the internal material, because the eyes stop tracking. However, for some clients, the tactile stimulation appears to titrate the intensity of response and thereby enable processing to continue when the disturbance is too high for adequate eye-movement tracking. The importance of nonverbal cues is critical in this case, and the clinician must decide whether processing is continuing from set to set.

14. *When the client is not processing information, despite the use of eye movements, tactile stimuli, or auditory stimuli, the clinician should use strategies designed to deal with "blocking."* A common form of blocking during abreactions is "looping." In this situation, instead of steadily progressing from one plateau to another (or indicating no change), the client is cycling around on the same plateau of information. Looping reveals itself when clients evidence a high level of abreactive distress and report that the same emotions, sensations, images, and so forth, are recurring in successive sets. Sometimes there is a slight decrease of distress, followed by an immediate return to the same round of negative thoughts and emotions. Clinicians should use the various strategies offered in the next section to restimulate processing during blocking. Clients who are looping generally need the strategies covered in Chapter 10.

If Abreaction Persists

If the clinician has tried all of the foregoing suggestions and those covered in the following section on blocked responses during an abreaction and has met with failure, the clinician new to EMDR therapy should use the Safe/Calm Place exercise (see Chapter 5) or one of the closure procedures described in Chapter 9 to disengage. The more proactive version of EMDR therapy, which is needed to continue processing, is given in Chapter 10. However, remember that this book is to be used initially as a textbook, with practice sessions supervised by a trained EMDR instructor. The more proactive version of EMDR processing should be attempted only after the clinician has become practiced and adept in the EMDR variations reviewed in this chapter.

STRATEGIES FOR BLOCKED PROCESSING

The strategies offered in the rest of this chapter can assist the clinician to restimulate processing that has become stuck. Those listed in the next section, entitled "Primary Target," maintain the client's concentration on manifestations of the original target. The suggestions given in the section entitled

"Ancillary Targets" focus on contributing factors that may be causing the block. These factors should be explored, because continued client distress may indicate the need to reprocess different material before returning to the original target; they should be used if the strategies in the earlier section have been unsuccessful in activating processing. However, the clinician should stay alert to the possibility that alternative strategies from both these sections may be necessary for a given session.

Primary Target

This section offers variations in procedures that the clinician may use to direct a shift in client focus regarding the immediate target when the reprocessing effect appears to have ceased. The clinician should assume that processing has stopped when the information has not reached the appropriate desensitization level but is unchanged after two consecutive sets.

As will be explained shortly, the first two technical variations are a change in the eye movements themselves and a concentration on only the body sensations. If these variations prove ineffective, additional strategies are required. The underlying principle is to "jump-start" the brain by asking the client to deliberately shift consciousness in a way that typically occurs spontaneously when processing is successful. These suggestions are the product of many hours of clinical observation, but the list is not exhaustive. After developing expertise with EMDR therapy, clinicians should feel free to add new variations from their own clinical experience.

Keep in mind that the more proactive version of EMDR processing procedures will be necessary for some clients, particularly those who dissociate. This version, described in Chapter 10, should be used only after the clinician has worked with the basic version of EMDR therapy for at least 8 weeks (or approximately 30 sessions), following appropriately supervised practice. Before using the proactive version of EMDR effectively, the clinician will need enough practice to become comfortable implementing the information in Chapters 4–9 and enough experience to obtain a general sense of the client response baseline. Clinicians not meeting these criteria should terminate the session with appropriate closure if a blocked client does not resume processing after trying all of the variations in this chapter and should switch to other forms of treatment until they have had supervised practice in using the proactive version.

The following variations are listed in the order of their utility. In all cases of blocked processing, the change in eye movement and attention to body sensation should be tried first.

Altering the Eye Movement

If the client's response remains the same after two eye movement sets, the clinician should change the direction, length, speed, or height of the eye

movements, gradually moving up and down in a horizontal plane. Combinations of changes may prove to have the greatest success.

Focusing on Body Sensation

Body sensations may be a manifestation of the affect or physical sensations experienced at the time of the event. Some of the most useful strategies for restarting processing involve attending to various aspects of sensation, as explained in the following paragraphs.

ALL SENSATION

Clinicians should ask clients to drop the image and the thoughts and to focus primarily on their bodies, and should direct them to concentrate on the attendant physical sensations while the eye movement sets are systematically altered.

THE PRIMARY SENSATION

If processing does not resume and the client reports many body sensations, she should be directed during the next set to concentrate on the most pronounced sensation, again without image or cognition.

UNSPOKEN WORDS

Certain kinds of body tension can indicate the need to voice unspoken words, that is, the cries or statements the client held back during the trauma or in childhood during abuse. When clients appear to be experiencing emotions of anger or betrayal (or physical sensations congruent with these states), the clinician should ask them to say whatever they want out loud or to themselves. This is particularly useful if the client reports tension in the jaw or throat, since cries for help or of anger are often choked back for fear of reprisal. Once the client is prompted to verbalize these unspoken words and focus on them in the next sets, processing can resume at the former accelerated rate.

The clinician must be careful to maintain a supportive and encouraging demeanor, regardless of the client's words. When intense pockets of rage are tapped, clients may visualize or describe horrendous atrocities toward the perpetrator. Clinicians should assure clients that these feelings are natural and that it is much better to let them out than to keep them bottled up. It is essentially the powerlessness of childhood rage (or the frustration of adult rage) that has finally been tapped. The clinician should communicate that the client's verbalization carries no moral stigma and will do no damage. Therefore, regardless of what the client says to the (imagined) perpetrator (e.g., "I'll cut you up"), the clinician should act as a cheering

squad for the verbalization itself. By continuing the sets, the anger and fear that suppressed the no longer unspoken words can be resolved. Obviously, the clinician needs to debrief the client before the end of the session about his present feelings and proposed actions. It is vital that the clinician discourage the client from attempting a confrontation with the perpetrator if the old material has not finished processing.

There are many options for clients to speak these unspoken words out loud or to themselves either during or between sets. If the client verbalizes between sets, her statements should be mentally rehearsed during the next set. They should be repeated with successive sets until they are said firmly and without fear. While it is preferable for the clinician to hear such statements himself to judge their timbre and volume for a sense of resolution, the client may be too inhibited to make a statement out loud. If so, she should be asked to verbalize internally during the set and to use the hand signal that indicates the desire to stop when she is finished. The clinician should extend the set until the hand signal is given. The client should then be asked how she feels, and her response should tell the clinician whether repeated verbalization and more sets are needed. In addition, clinicians can assist clients to state their declarations strongly by asking them first to mouth, then whisper, and then vocalize the statements in a progressively louder voice with each successive set.

This powerful intervention can greatly enhance the clinical treatment. By this means, the abuse victim is often able for the first time to make a declaration of independence from a parent or perpetrator. It is important, however, that the client's statements evolve from the helpless fear of childhood into an adult perspective that includes the appropriate placing of responsibility (i.e., on the perpetrator) and an understanding of present safety. The statements and the sets should continue until the client feels both justification and conviction, without fear or self-blame.

USING MOVEMENT

As noted earlier, physical sensations may be a manifestation of affect or simply the sensations experienced at the time of the target event. For instance, during experiences involving fear or anger, the client may have inhibited certain body reactions, such as striking out at someone. Therefore, when the client feels tension in any area of the body, indicating, for example, that it was suppressed during the original experience, he should be encouraged to act out the associated movement, such as striking out.

One client whose processing was blocked reported great feelings of anger at her father for humiliating her at her prom, and as she talked of it, her hands and arms became very tense. Because it was clear that her hands were curling into fists, she was urged to punch out if she felt so inclined. The sets were repeated as she punched out in front of her and processing resumed.

This manifestation of physical sensation is similar to the unspoken words phenomenon. With both, the principle is to allow the stored information to be adequately processed, which includes a stimulation of the suppressed emotions, statements, and physical actions. Allowing these to be vented during the sets appears to increase the rate of processing. However, clients should feel safe enough within the therapeutic alliance to express anything that emerges, because trying to suppress the material can cause retraumatization. The only restriction is the client's agreement not to injure himself or the therapist during reprocessing. This strategy has proved successful, even with the most explosive veterans in Veterans Affairs Medical Centers.

PRESSING THE LOCATION

When processing appears stuck and the primary manifestation is a body sensation that will not shift and there are no attendant thoughts or images, it can be useful to have the client physically press her fingers into the location of the sensation. Increased pressure often causes the emergence of an image or thought about an associated memory, which should then be targeted (Martinez, 1991). The clinician can achieve the same results with many clients by simply asking them to close their eyes and fix their entire attention on the location of the sensation. Whatever image or thought appears should then be targeted. If nothing emerges, it may be useful to return to the original target for processing.

Scanning

Once again, if processing stops, the clinician should specifically instruct the client to change the focal point of the next set. Successful processing will often involve a variety of elements spontaneously coming to consciousness. When blocked material must be artificially stimulated, clients are asked to do deliberately what has been spontaneously generated by other clients. It is presumed that in this way the neurophysiological connections will be made that allow information processing to resume.

VISUAL CUES

The clinician should ask the client to scan the incident for something that is currently more upsetting than the original target. For instance, when a rape victim is first asked to focus on the most upsetting part of the memory, she might concentrate on seeing the moment of vaginal penetration. In successful reprocessing, other aspects and events during the rape might spontaneously emerge. However, if the reprocessing effect ceases after the initial scene is targeted and only some of its emotional disturbance has eased after successive sets, the clinician should ask the victim to review the entire rape

in her mind to see whether she notices another aspect of the event that is particularly disturbing now. At this point, the client might report more distress about the attempt at oral penetration. Once identified, this scene is brought into focus for a set. Quite often, this allows reprocessing to continue and the emotional distress to decrease. The clinician may need to invite the client to shift her visual focus to another part of the memory several times before desensitization is complete. Before installation, the dominant manifestation of the event should be elicited and checked for complete processing by asking the client to return to the original target.

SOUND EFFECTS

If reprocessing stops, clients should be invited to search for a sound effect that may be particularly disturbing. Take, for instance, the case of the veteran who awakened to find that his men had released a prisoner so that they could shoot him in the back as he ran into the jungle. During reprocessing, the client's SUD level dropped to 5 but seemed stuck there. When he was asked to scan his memory for a sound effect, he noticed that the sound of the M-16 gunfire seemed to increase his anxiety dramatically. When the clinician asked him to focus on the sound of the rifle alone during the next set, the client's SUD level dropped further. The successful intervention having led to the end of a channel, the client was asked, as per the usual procedures, to return to the original target for further processing.

DIALOGUE

Another aspect of the memory that may not have emerged spontaneously and that may have to be sought is the dialogue that occurred during the event. When clients who are targeting a memory of physical abuse are invited to scan for what was said, they often find that it is the verbal abuse that is now significant. By focusing on the perpetrator's words and their own physical reactions, clients can reactivate the processing during subsequent sets.

Alterations

When strategies in which the client concentrates directly on the perceived memory are unsuccessful, the clinician may ask her to alter her focus of attention or the target itself. For instance, having the client imagine the event or its associated aspects in a different way (see the following paragraphs) during the sets may restimulate processing. Clinicians have not reported problems for clients when the target memory is retrieved after treatment is completed. Clients still know what actually happened, regardless of the alterations they made (whether deliberately or spontaneously)

during processing. However, as always, the clinician should eventually ask the client to return to the original target for final reprocessing.

APPEARANCE OF IMAGE

Attempting to alter the image itself can allow processing to resume. Some clients in EMDR treatment can successfully restimulate processing by making the image brighter, smaller, or more distant, or by changing it to black and white. Once again, this involves asking the client to do something deliberately that happens spontaneously during EMDR for others. The clinical caution is that clients must have good visualization control to implement this alteration, and that the original manifestation of the memory, without the superimposed distortion, should be retargeted to effect full reprocessing. Often the image distortion will shift spontaneously back to its original form during subsequent sets. Whether it is retrieved spontaneously or deliberately, the original image usually generates much less disturbance once the altered image is sufficiently desensitized.

NO ACTION

Another strategy of visual alteration is to ask the client to visualize the perpetrator (or other person causing distress) but not his actions. This usually reduces the disturbance and allows processing to resume.

Even when successful processing has been achieved, focusing on the perpetrator but not his actions produces a more complete generalization, particularly with children (see Chapter 11). Perhaps because there are comparatively few associated experiences in the neural network of a child, asking children to imagine the perpetrator the way he was usually dressed, without focusing on any particular action, produces a rapid generalization effect. This is especially true if the most salient memories have already been processed. For instance, a 5-year-old abuse victim revealed only three traumatic events, all of which were successfully reprocessed. However, she had many more memories, since the abuse had occurred over many months. Because the perpetrator habitually wore a red gown and mask when violating her, the child was asked to envision him simply standing in that attire. She did so while approximately seven eye movement sets were administered. After a single treatment, her presenting complaints of bed-wetting and nightmares ceased.

HIERARCHY

Another visual alteration is the creation and use of a treatment hierarchy, a procedure that achieved psychological repute by its use in systematic desensitization (Wolpe, 1991). Essentially, clients are asked to make the target

event less disturbing by imagining an alteration of it in terms of time or distance (e.g., **"Imagine the spider two blocks away rather than on your arm"**).

Thus, an abuse victim can imagine a glass wall between himself and the perpetrator, or the perpetrator can be made to appear more distant and only gradually brought back to the original location. While initial processing can be successful with these manipulations, be sure to return eventually to the original target, so that it can be completely processed without distortion.

REDIRECTING TO IMAGE

When different events have emerged during processing in a channel, one specific event may appear to cause a high level of disturbance. In subsequent sets, the client may start concentrating on thoughts or feelings about that specific event. Processing continues until the client's feelings or thoughts reach a state of mild disturbance and then will not shift any further. When this occurs, redirect the client's attention to the image of the last significantly disturbing event that emerged. This can reintensify the experience, and processing can resume.

REDIRECTING TO NEGATIVE COGNITION

As indicated in the previous example, an incident may appear initially disturbing but may then become less upsetting as subsequent tangential thoughts emerge. If processing appears stuck, it may be useful to reintroduce the original negative cognition in conjunction with the image of the last disturbing event. This can restimulate the dysfunctional material and allow it to continue processing.

ADDING A POSITIVE STATEMENT

When the processing becomes stuck at a low level of disturbance, the clinician may invite the client to add the statement "It's over" during a set. This often gives the client a greater sense of safety and allows processing to resume. In addition, the clinician can invite the client to introduce the positive cognition during the set. This may prompt spontaneous insights about secondary gain issues, or it may bring up fears about adopting the positive cognition, which must be addressed. In other instances, the SUD level will automatically drop, without bringing up additional cognitive material. The positive cognition should be used only with material that is stuck at a low level of disturbance. An attempt to introduce it prematurely, when there is a high level of disturbance, can backfire, leaving the client feeling worse and believing that the positive cognition is not true and probably never will be. Clinical observation indicates that under usual circumstances, EMDR

therapy does not allow a false statement to be considered true; in this case, however, the processing itself is stuck and the dominant feelings will generate beliefs on that plateau.

CHECKING THE POSITIVE COGNITION

Because clinical reports have indicated that EMDR therapy does not appear to allow the assimilation of untrue, unrealistic, or ecologically inappropriate material, the clinician should reassess the appropriateness of the positive cognition if a client is not processing appropriately during the installation phase. This reassessment is mandatory if the client begins to become agitated during the sets that focus on the positive cognition. Another reason for increased agitation at this point in processing may be the stimulation of a blocking belief. The investigation of this factor is covered later in this chapter in the section entitled "Ancillary Targets."

Return to Target

If the associations appear to stop in a given channel, the clinician should direct the client to return to the target for additional sets. In addition, the final stages of reprocessing include a return to the target with sets performed to (1) ascertain whether there are additional channels of dysfunctional information, (2) inaugurate the installation phase, and (3) complete the session with the body scan.

Since all proposed interventions are exploratory, the clinician should take care to offer each as a possibility rather than as a surefire solution. An open-minded clinical stance is mandatory, because each client processes as a unique individual. There is no guarantee that any particular suggestion will be acceptable or appropriate. In addition, when properly employed, EMDR processing will not allow anything to be incorporated into the client's schema that is contradictory or inappropriate to that client's ecologically appropriate beliefs. If this is tried, the client will either become more anxious or openly reject the material. It is crucial that there not be a conflict between the client's inner perceptions of truth and the demand characteristics of the clinician.

Ancillary Targets

The strategies discussed in this section require an even higher level of clinical acumen and experience in identifying the appropriate target. As noted earlier, EMDR therapy can only interface with clinical skills, not substitute for them. When a client has not been able to resume processing by shifting focus regarding the target event, there is the possibility that other factors are contributing to the disturbance. As described below, the clinician must identify the problem areas and deal with them by offering the proper

reassurances and, when necessary, reprocessing the residual blocks. Sometimes returning to the original target will have to be postponed to another session; other times, only a few moments are needed before returning to it. In either situation, the client should be reassured that redefining the focus of an EMDR session is part of the overall clinical strategy, just as a long-distance runner would make adjustments for new terrain along a course. The clinician may need to do a closure exercise with clients to be able to discuss any problems that arise and to arrange an action plan.

Feeder Memories

"Feeder memories" are untapped earlier memories that contribute to the current dysfunction and block processing of it. Let us start our discussion of feeder memories by reviewing some background material. The initial history-taking session is used to identify long-standing patterns of client dysfunction and the original events that set them in motion. The suggested EMDR protocol for most presenting complaints (as described in earlier chapters, and explained in detail in Chapter 8) has three prongs: (1) targeting the original material; (2) targeting the present stimuli that elicit the current dysfunction; and (3) incorporating a positive template to initiate the accelerated learning of healthy new behaviors for appropriate future action. I arrived at this protocol when I experimented in 1987 with first targeting clients' current dysfunction. I discovered that most people spontaneously remembered earlier experiences during the sets and that those who stayed fixated on the present situation often became more anxious, and their processing remained stuck.

Applying the underlying principle that processing can be unblocked by having the client do something deliberately that has already emerged spontaneously during successful processing, I asked those first EMDR clients to scan for an earlier memory that incorporated the negative cognition. Once such a memory was identified and successfully treated, I found that the current dysfunction was much less disturbing and much more amenable to processing than before. Asking the client to find an earlier memory by means of the negative cognition is an important strategy to unblock processing. It should be one of the first options considered by the clinician when it is necessary to process a client's memories from adulthood (see the Floatback technique in Appendix A).

The client may have no idea that an earlier dysfunction is related to his current experience. In these cases, if the negative reaction to present stimuli is targeted first, the client's disturbance may actually increase, and none of the variations previously suggested in this chapter will reduce it. Here's an example:

A client desired an EMDR processing session to allow her to feel calmer at work, where she had been experiencing great distress whenever her boss got angry with her. After first confirming that her distress was

inappropriate (she was not in danger of being fired), the clinician targeted her situation at work. The client reported high levels of anxiety, along with an annoying but unidentifiable sensation in her foot. Despite a targeting of various sensations and the use of several strategies for blocked processing, the client's high level of disturbance remained unchanged. Finally, the clinician asked her to focus on the negative cognition "I am in danger" while scanning her childhood to identify another occasion when anger meant danger. After a few moments, she reported a vivid memory of her father angrily throwing her against the refrigerator door. When this memory was targeted, processing began in earnest (the sensation in her foot, where her father had injured her, first increased and then disappeared). Once processing of this memory was completed, the client was asked to bring up the original target, and she found the present situation with her boss less disturbing and was able to process it more easily. In summary, while processing itself generally reveals the feeder memory spontaneously, sometimes the clinician has to identify and specifically target it in order to allow processing to proceed.

While many clinicians will undoubtedly suspect that a client's inappropriate reaction to anger as an adult originated in childhood, at times the genesis of the dysfunction may not be so obvious. The theoretical assumption of EMDR treatment is that any current dysfunctional reaction (with the exception of organically or chemically based pathologies) is always the result of a previous experience, although, of course, not necessarily one from childhood. Obviously, a recent traumatic event (e.g., a natural disaster or car accident) that appears to be the primary complaint should be immediately targeted. However, feeder memories may block processing. While clinicians with a strict behavioral orientation may continue to apply EMDR exclusively to current dysfunctions (and with excellent initial results in many cases), it remains important to scan for a feeder memory when reprocessing appears blocked.

The negative effects of feeder memories can also be seen when a seemingly successful reprocessing of a current situation once again appears disturbing when subsequently retargeted. Because it can be very disturbing and disheartening to have to scan for a feeder memory when processing is blocked or to reprocess a memory that seemed to have been successfully treated, the clinician is encouraged to use the standard EMDR protocols and initially treat the earlier memories whenever possible. However, the problem of feeder memories may also arise during the second prong of the protocol (targeting the present stimuli) when early events that differ from those targeted in the first prong of the protocol prove to be the unexpected source of disturbance.

Clients should be allowed to take the lead in ascertaining the earliest memory. One client wanted to use EMDR processing to target his anxiety about an anticipated inspection visit by a government agency. The first step the clinician took was to determine whether the anxiety was based on

consensual reality, since, as noted earlier, EMDR therapy will not remove any emotions that are either appropriate to the situation or an impetus to appropriate action. In other words, if the client was anxious because he was ill-prepared, his justifiable disturbance would not have been amenable to change with EMDR processing. After determining that the client was fully prepared for the inspection, the clinician began treatment with the negative cognition "I am a failure." This cognition was chosen because the client's anxiety was obviously linked to anticipation of being found inadequate by the inspectors. The client reported a continued feeling of disturbance, which he rated as 8 on the SUD scale, regardless of the number of EMDR procedural variations used. The clinician then asked him to identify a memory from childhood that had taught him the lesson "I will fail." The client stated that nothing from childhood came to mind, but that he did remember a relevant incident in graduate school. After this incident and the negative cognition were targeted in one set, the client remarked, "Oh, there was that time in first grade." Processing that memory led to the client's recognition that he had not failed after all in the childhood incident (he discovered that he had passed the test when the exam papers were returned) and that he had actually been rewarded for the success. When the upcoming inspection visit was retargeted, the client's SUD level was greatly reduced and the remaining distress was easily reprocessed.

As exemplified in these cases, the clinician should instruct clients to locate the earliest available memory to which the negative cognition applies. Scanning childhood memories while thinking of the negative cognition and attending to the physical sensations often reveals the original material needed for effective processing, or the Floatback technique can be used (see Appendix A). Clinical skill is necessary, however, because the original negative cognition designated by the client may not actually be the one linked to the earlier memory. For instance, the original negative cognition of the office worker who was unduly upset by her boss's anger might have been chosen to focus on her situation as an adult and been verbalized as "I can't succeed." It would then be the clinician's task to formulate the link between the client's feeling of fear and a possible childhood message or focus only on the sensation.

Another way to access feeder memories is to focus on the dominant emotion and physical sensation, to verbalize it, then to scan for an earlier memory. For example, while the presenting complaint of a client who had a fear of flying was being reprocessed by targeting an actual plane trip, the client's emotion changed and processing ceased. Her new emotion and the associated sensations were quite strong, which were verbalized by the words "I feel inadequate." She was then asked to close her eyes, focus on the physical sensations and the words, and scan for a time in her childhood when she felt strongly that way. She remembered a time when her mother lamented that she had been born. After reprocessing this memory, her fear of flying, which was associated with a number of contributory control

issues, was largely resolved. Alternatively, the Affect Scan technique can be used without the need for verbalization or cognitive assessment (see Appendix A).

When working with blocks due to undiscovered feeder memories, clinicians should be willing to explore a variety of possibilities. Fortunately, EMDR processing effects are so rapid that false avenues are quickly revealed. Keep in mind that feeder memories are an extremely important element in the successful processing of adult targets, whether these are memories or present situations.

Blocking Beliefs

When processing of the initial target is unsuccessful, the clinician should look for negative beliefs that are blocking progress. As indicated in Chapter 6, this can be done by asking the client, **"What prevents your SUD score from being a zero?"** (if the client is in the desensitization phase) or **"What prevents your VOC score from being a 7?"** (if the client is in the installation phase). Often, clients can identify another negative cognition that should be targeted and are able, after scanning, to designate the appropriate early memory associated with it. Until that identified negative cognition (the "blocking belief") is targeted and reprocessed, progress on the initial target will be halted.

A case in point is a veteran who was in treatment for PTSD symptoms. He reported panic attacks three to four times a week, flashbacks every time a plane went overhead, high levels of general anxiety, and relationship avoidance. After assessing the case, the clinician suggested the positive cognition "I can be comfortably in control"; the clinician felt that the client's need for control was high inasmuch as his panic emerged whenever he felt it slipping. The client accepted the positive cognition. Then the negative cognition "I am out of control" was introduced. When the clinician asked the client to target an event that represented this cognition, he described the time his wife had him committed to a mental hospital after the war, a memory that he rated as 10 on the SUD scale (and was able to process down to 0). However, when the clinician asked him to designate a VOC score for the suggested positive cognition, the client responded, "I am not worthy of being comfortably in control." This statement is considered a blocking belief, because it prevents the continued processing and resolution of the control issue. Therefore, the clinician asked the client to identify the memory that represented his feelings of lack of worth. The veteran spoke then of a failed sexual encounter with a woman he cared for deeply. That memory was processed from 8 to 0 on the SUD scale without incident. However, before the VOC score could be ascertained, the client spontaneously remarked, "I should probably talk to her about it, but I'll probably fail the way I have with everything else." This was also identified as a negative cognition blocking further resolution, and the client was asked

to identify the pivotal memory related to feeling like a failure. The client then revealed a tragic story of being falsely accused of dereliction of duty and causing the death of some soldiers while he was actually performing a heroic act. That memory, with its attendant negative cognition "I'm a failure," was successfully processed, allowing the positive cognition "I can be comfortably in control" to rise to a 7 on the VOC scale. The client's PTSD symptoms subsequently declined, and within 3 months he was successfully employed and involved in an intimate relationship.

Blocking beliefs may not always be verbalized by clients as clearly as in this case. When processing has ceased, despite a number of variations, the client should be asked to close her eyes, think of the situation, and verbalize any thoughts that emerge. The clinician should carefully assess the client's stream of consciousness for negative self-attributions that are inherent in her musings. Exploring possible interpretations and applicable negative cognitions with the client can often reveal a blocking belief, which can then be addressed. When the memory representing the blocking belief has been successfully reprocessed, the client should reaccess the initial target memory for completion. This should proceed smoothly if the blocks have been sufficiently processed.

Fears

Processing of targeted information also can be blocked by the client's fear of the outcome or of the process itself. First and foremost, the clinician must be sure that the client (1) feels safe and supported in the therapeutic relationship and (2) is not altering or inhibiting the emotional or cognitive processing effects.

Fear of the clinical outcome is most likely related to secondary gain issues, such as who or what the client will be forced to confront if therapy is successful. As explained in Chapter 4, all secondary gain issues must be addressed before pronounced therapeutic effects can be achieved. Fear of the process itself can be most easily recognized when the client mentions some element of EMDR or the therapeutic relationship that is problematic for him. For instance, a client may voice a concern about discovering the cause of his disturbance, or about the possibility that his level of distress will alienate the therapist. Regardless of the cause of the block, it must be explored and the client's fears allayed before EMDR processing resumes. Once the fear is cognitively debriefed, any remnants of the fear itself can be targeted (with the client's permission).

In addition to the client's statements, other indicators of fears that are blocking processing include the following: (1) pronounced tension independent of processed material, such as when a client is upset by the sight of the clinician's moving fingers; (2) consistent stopping during the middle of eye movement sets; (3) difficulty performing the eye movements themselves;

and (4) reluctance to engage in EMDR processing even though previous experiences and clinical outcomes with it have been positive.

The clinician should explicitly explore any of these hesitancies, when present, by specifically questioning the client about the factors causing the problem or preventing a resolution. Any of the indicators just mentioned may be caused by a variety of factors; therefore, the clinician should be exploratory, never adamant. Naturally, the clinician must take care to reassure clients that they are not the problem, that there are simply other conditions that have to be met for therapeutic progress. It may be useful to convey to the client that, in one sense, all fears are normal, because there are understandable reasons for them; the clinical aim is to identify and reprocess those fears that are no longer useful.

Clinicians should be alert to both verbal and nonverbal indicators of fear. Remember that all fears need to be debriefed and the client calmed before processing on the original target can be resumed. During processing, the client may state any of a number of fears, some of which are discussed in the following paragraphs.

FEAR OF GOING CRAZY

If the feelings that arise during an EMDR processing session are extremely intense and confusing, the client may become afraid of being permanently overwhelmed. Clients should be reassured that the emotions they feel during processing are part of their old experiences, which are being metabolized, and that there are no reported cases of EMDR clients going crazy because of the processing. Clients should be reminded of the metaphor of the train ride, of their prerogative to signal the clinician to stop, and of their ability to return to a safe place. They should be encouraged merely to notice the sensations and emotions rather than to judge or fear them. Clients should be reminded that abreactive responses can be passed through most rapidly if the eye movements are continued, just as one can drive through a tunnel most rapidly by keeping the foot firmly on the accelerator. Once the client feels reassured and gives permission to continue, the clinician should target any residual fear with successive sets until it declines. Then clinician and client should return to the original target.

FEAR OF LOSING THE GOOD MEMORIES

The rapid change in an image during EMDR processing can sometimes alarm clients. Some respond by saying, "I must be doing something wrong; I can't get the image." Others fear that they will lose all memories of the person or situation associated with the target. For instance, a client being treated for excessive grief over the loss of a loved one may target a tragic circumstance or his loved one in intense suffering. When targeted, these

images may become dimmer or more blurry, and the client may fear that if processing is continued, his ability to recall his loved one will be lost.

The client should be assured that there have been no reported cases of EMDR clients losing their memories of good experiences or of people for whom they care. In fact, clinical observation and research (Sprang, 2001) indicates that when negative images are processed, positive ones become even more accessible. In addition, the negative event will be remembered even if no image is present, since memory involves more than imagery and is based on a variety of sensory and cognitive factors. EMDR processing does not cause amnesia. However, an image may fade, just as distant memories do. EMDR processing simply allows the memory to take its place in the past.

The client can be further reassured by asking him to remember another, more positive, incident involving the loved one and to note that this memory has not changed. Once the client is convinced, processing can resume.

FEAR OF CHANGE

The fear of change can be the most difficult of all to address clinically, because secondary gain issues must be ascertained and reprocessed before the original targets can be reengaged. The clinical difficulty lies in the fact that secondary gain issues may entail a variety of possible, indeed probable, aspects of the expected therapeutic process or outcome, including fears of

- Success
- Failure
- The unknown
- Loss of control
- Loss of identity
- Who or what will need to be confronted if therapy is successful
- Letting go of therapy or the therapist
- Betrayal of parental injunctions
- Disloyalty to parents by becoming unlike them

The major therapeutic difficulty these fears pose is the fact that they may be grounded in old dysfunctional material that should be processed with EMDR but that spread an insidious web that makes the client reluctant to cooperate in the attainment of the therapeutic goal.

The clinician must attempt to identify the dysfunctional beliefs behind the fear of change. Then client and clinician should cognitively explore the areas of resistance. Clinicians should ask clients questions such as **"What would happen if you were successful?"** and employ cognitive restructuring, metaphor, and so forth, to debrief them. The clinician should then arrange a hierarchy of negative beliefs that block the client's ability to change; for example, the first fear to be listed might be fear of separation from the

therapist, the second one might be fear of failure, and so on. Those fears that can be dealt with by an action plan are addressed first. (For instance, a fear of separating from the therapist can be reasonably handled by appropriate agreements regarding continued therapeutic support.) After identifying the pivotal memories that have contributed to the other negative beliefs, the clinician should seek the client's permission to process them. The importance of identifying these aspects and defusing them in order to attain treatment effects cannot be overemphasized.

It is often clients who have been engaged in long-term traditional therapy who are the most susceptible to fear of change. One such client, who had been involved in psychodynamic therapy for 25 years, terminated her first EMDR processing session, which targeted a memory of a parental abuse, by saying, "I can feel it leaving me, and I don't want it to go. I feel there might be a lot more to learn." Such clients often can be recognized by pronounced noncompliance with homework assignments, oververbalization of experiences, and attempts to rigidly control the therapeutic process. Unless their fear of therapeutic change is addressed successfully, the clinical outcome may be negligible.

Clinicians should not assume that long-term or noncooperative clients are the only ones with fears of change. They should always be alert to the possible emergence of these fears during the successful processing of any client. It is not uncommon for fear of change to emerge at some point after several major traumatic events have been successfully addressed. Once the most troubling material has been dealt with, the client becomes more aware of the actual environmental factors currently present in his life. Fears of change may emerge as he tries to adjust his behaviors to his new sense of awareness or as he becomes aware of the need to integrate his new sense of self into an apparently dysfunctional family, workplace, or social system. The client may specifically identify these fears in his log report, or the fears may emerge during subsequent processing of new targets. In addition, it is quite possible that any client may report the fear of change as a negative cognition during the installation phase of any session.

If the client reports that the fear of change has emerged during a session, it is possible not only to debrief the fear cognitively but also to target the fear itself by asking, **"Where do you feel it in your body?"** At times, the fear will dissipate without the need to target the original material associated with it. If the client spontaneously remembers the origin of the fear, the memory should, of course, be processed before returning to the initial target. If the fear itself becomes weakened without the original material emerging, the processing can be completed, but the target should be checked the following week for an increase in disturbance. If the therapeutic effect has not been maintained, the fear of change may not have been adequately processed. In this case, the negative cognition associated with the fear should be explored, the present situation analyzed to identify and deal with any appropriate concerns, and the origin of the dysfunction

targeted. In all cases, the clinician should view and treat the fear of change and any secondary gain issues as part of the pathology. Remember, however, that some fears are reality based, such as a PTSD-disabled veteran's fear of losing his disability check. These fears must be addressed with an action plan, because clinical reports indicate that EMDR processing will not eliminate anything that is actually true.

Wellsprings of Disturbance

The wellspring phenomenon indicates the presence of a large number of blocked emotions that may be resistant to full processing during standard EMDR treatment. This condition may occur in a variety of individuals who ordinarily would be loath to seek clinical help. These clients may be induced to seek therapy by significant others, but they have no real desire of their own to "get in touch with" their feelings. Included in this group are those who have been forced into therapy by a spouse in order to "save the marriage." An example is the husband who described during an intake interview a terrible legal situation in which his ex-wife was causing continuous disruption and financial difficulties, but who nevertheless assigned the situation an SUD rating of only 3. The clinical picture indicated that the husband could not consciously connect with any higher level of disturbance because of early experiences that gave him the message that he was not allowed to feel, that his feelings would be disregarded, and that it was in some way unmanly to have feelings. To experience disturbance consciously at an SUD level of 7 or 8, which would have been appropriate to the situation and more congruent with his testiness and irritable actions at home, this man would require something on the level of a bomb attack during combat.

If sufficient clinical rapport and permission can be established with such clients, the first targets should be the early memories associated with the negative beliefs that block their ability to feel emotions. For some clients, no clear earlier memories of this sort will be identified. In these cases, it can be useful for the clinician to investigate further by asking, **"What's good about avoiding strong emotions?"** or **"What's the benefit you may get from not feeling . . . ?"** This line of questioning can often lead to childhood experiences that cause the client to shut down. When these are sufficiently processed, the current experiences will be easier to assimilate.

If permission to treat the full clinical picture is not forthcoming and the client insists on dealing only with present circumstances, the clinician can use EMDR processing to obtain some behavioral shifts and to lessen general tension; however, the SUD level may remain unchanged during the session. The theoretical assumption is that the negative earlier experiences are causing the suppression of a high level of disturbance, and that these dysfunctional emotions act as a wellspring that continues to feed the present pathology. When the current situations are targeted, the emotions will

surface to the maximum level permitted consciously before the client shuts down (which such clients are likely to rate as 2 or 3 on the SUD scale), and the processing will be experienced only at this tolerable range.

The wellspring phenomenon can be recognized clinically when there is a change in the client's insight, imagery, and body sensations, but a continued low level of disturbance is reported. For some clients, no processing effects at all will be evidenced and other treatments should be inaugurated. When the client is unable to engage fully in processing, it is useful to teach EMDR stabilization procedures to assist in affect regulation until a stronger therapeutic alliance is established. At that point, the client may be more open to processing the past events that are the foundation of the dysfunction. Clients with this kind of history can be very difficult to work with, and even if full clinical permission is given and early memories are accessed, there may be a need for the proactive EMDR processing strategies discussed in Chapter 10.

SUPERVISED PRACTICE

The strategies presented in this chapter can best be practiced by working in small-group exercises with an intact trauma at a level of disturbance between 7 and 8 on the SUD scale. Before clinicians try working with clients in the isolation of their office, they should be supervised by qualified EMDR instructors through at least three practica experiences with high-level disturbance.

Clinicians should become thoroughly familiar with the information and protocols covered in Chapters 8 and 9, and should be comfortable with the standard procedures and strategies. Generally, clinicians should work with EMDR therapy for approximately 30 sessions before attempting the more advanced material in Chapter 10.

SUMMARY AND CONCLUSIONS

Strategic variations of EMDR are needed for the successful processing of especially challenging cases. These can include abreactions and situations in which processing has become stuck.

In EMDR, "abreaction" is defined as a state in which stimulated material is experienced at a high level of disturbance. Because abreaction is a natural part of processing and integration for some individuals, clinicians using EMDR therapy must be comfortable with potentially high levels of emotion in their clients. To assure clients that it is safe to have these experiences during a session, clinicians should follow a "golden rule" philosophy, while keeping clients in a dual focus of attention, that is, the awareness of being safe in the present time while they simultaneously direct their

attention to the dysfunctional material. The clinician should note clients' nonverbal signals to ascertain their achievement of information plateaus and to guide successive sets. Processing should continue during periods of dissociation as long as appropriate screening and clinical cautions have been observed. However, variations on standard practice may be needed for abreactive work.

While simple treatment effects may be observed with a minimum of clinical intrusion in about 50% of cases, the clinician's more active assistance will be required in the remainder. When progressive treatment effects are absent for two successive sets, clinicians should first change the direction, length, and speed of the sets. If these attempts are unsuccessful, they should try to open blocked processing by changing the client's focus. This is done by evaluating and redirecting the client's attention to the preparatory material or to the target.

If the client becomes stuck, the clinician asks her to do deliberately what has occurred spontaneously in other clients. This is an open-ended list of possibilities, since clinicians can creatively add more strategies based on their own client observations.

When changing the client's focus of attention to another aspect of the target or to a different memory does not cause processing to resume, the clinician should look at ancillary factors that may be causing the block, such as feeder memories, blocking beliefs, or a need to maintain secondary gains. Clinicians should first target the earlier contributors to present dysfunction, or processing may be derailed because of feeder memories (see Appendix A).

It is important to remember that EMDR therapy does not function in the absence of clinical skills; rather, it dovetails with them. Inexperienced clinicians should make sure they receive adequate supervision and have consultants available to assist in case formulation and EMDR strategies. Clinicians should combine the material in this chapter and Chapter 8 to guide them in their next practicum on a target rated a 7 or 8 on the SUD scale. It should be understood, however, that the more proactive version of EMDR processing (described in Chapter 10) is necessary for certain clients.

CHAPTER 8

Phase Eight

Reevaluation and Use of the EMDR Therapy Standard Three-Pronged Protocol

We do not err because truth is difficult to see.
It is visible at a glance. We err because this is
more comfortable.

—Alexsandr Solzhenitsyn

The reevaluation phase is vital to EMDR therapy. During this phase, which should open each session after the first, the clinician assesses how well the previously targeted material has been resolved and determines whether the client requires any new processing. New targeting may be required for several reasons. First, the rapid treatment effects can have immediate repercussions intrapsychically and interactionally. Behavior change resulting from the alleviation of suffering can have unforeseen ramifications for some clients within their family system or social environment. As a result, additional targets may arise. Second, other targets, those that remained hidden because of the overwhelming nature of the original complaint, may have been uncovered. To help the client work through the various levels of dysfunction, the clinician should follow the general three-pronged EMDR protocol, targeting past and current issues, and preparing the client for alternative, more adaptive ways of dealing with whatever future issues may arise both personally and relationally. In general clinical practice, each EMDR therapy session should be integrated into a comprehensive treatment plan. The reevaluation phase is essential, because every human being is a complex individual incorporated within a complex social system. Any profound treatment effect can have significant impact on the person's associated intrapsychic factors and behaviors. These, in turn, have an impact on the individuals with whom the client interacts, necessitating attention to interpersonal systems issues.

The number of reevaluations varies from one client to another. A client with a single trauma may require only one to three reprocessing sessions to address the event, current triggers and anticipated future difficulties, followed by a revaluation phase of one or two follow-up sessions to review the treatment outcome and the log. For multiple-event and long-term trauma survivors, a comprehensive reevaluation may involve targeting, reaccessing, and review over many months. Each subsequent reevaluation of the previous sessions' work guides the clinician through the three prongs of the standard EMDR protocol. The final reevaluation generally concludes with an extensive follow-up period.

The standard three-pronged EMDR therapy protocol targets areas of dysfunction from both the past and present, then focuses on adaptive alternatives for the future. For example, a survivor of childhood physical abuse may first need to reprocess many early memories. In addition, the people and situations in his life that currently stimulate feelings of intimidation and fear must be targeted. Finally, new ways of socially interacting and standing up for himself are also targeted. The EMDR treatment may take many months, as will the follow-up reevaluation needed to ensure the client's social integration. In all cases, comprehensive EMDR therapy involves a full evaluation of the complete clinical picture, including personal, relational, and societal functioning.

As noted previously, even when working with a single-event trauma, responsible EMDR treatment includes adequate history taking and follow-up, in addition to the reprocessing session(s). Clients should not be treated in a single session, because reprocessed material causes new internal and external interactions. The reevaluation phase requires the clinician to pay close attention to how well the processed information has become integrated within the client and how well the client has become integrated within a healthy social system. The clinician selects subsequent targets based on these findings.

This chapter explores the standard three-pronged EMDR therapy protocol and the reevaluations that guide the clinical treatment for most trauma victims. It also provides the basic framework for the treatment of clients with a wide range of complaints (see also Chapters 9 and 11). It delineates the sequence of targets for reprocessing and assessment and should be fully implemented before concluding therapy. Clients with more extensive complaints are treated with additional protocols, which are covered in Chapter 9.

PHASE EIGHT: REEVALUATION

The term "reevaluation" reflects the need for the precise clinical attention and follow-up that frame any EMDR therapy session targeting disturbing material. The clinician actively integrates the targeting sessions within an

overall treatment plan. Regardless of how simple or complicated a case may be, adequate clinical attention must be paid to four factors, which are addressed in the following questions:

1. Has the individual target been resolved?
2. Has associated material been activated that must be addressed?
3. Have all the necessary targets been reprocessed to allow the client to feel at peace with the past, empowered in the present, and able to make more desirable choices for the future?
4. Has an adequate assimilation been made within a healthy social system?

In the following pages these four factors will be discussed as they are reflected in the standard three-pronged EMDR therapy protocol. I first provide an overview of the protocol, then a detailed description of the various aspects of treatment. However, a prerequisite for processing is sufficient preparation of the client. As noted in Chapter 2, no trauma processing should be attempted until sufficient stabilization is achieved (see also Chapter 11).

THE STANDARD THREE-PRONGED EMDR THERAPY PROTOCOL

Success with EMDR therapy requires the careful use of all three prongs of the standard EMDR protocol. These three stages call for the clinician to assess the appropriate targets and needs in relation to the client's past, present, and future and to proceed when the client is appropriately prepared. Regardless of how the childhood material is ordered for targeting, all three prongs of the protocol should be completed. Once the past events related to a particular area of dysfunction have been processed, each associated current trigger and disturbing situation is addressed through processing and incorporating a positive future template. For instance, some traumas may be contributing to difficulties at work, while others are related to intimacy issues. This chapter focuses on the treatment of trauma victims. The use of the three-pronged protocol employing a symptom-focused approach applicable to all clients should also be integrated into this treatment and is reviewed in Chapter 9.

Working on the Past

The first prong of the EMDR protocol focuses on the question, "What earlier events have set the groundwork for the presenting dysfunction?" In Phase One, the clinician takes a client history and delineates the pathological condition. Treatment (Phases Two through Seven) prepares/stabilizes

the client and targets and reprocesses the memories of the adverse life events that, within the AIP framework, are considered the cause of the client's symptoms. For a single-trauma victim, the cause will be self-evident. For debilitated clients with complex PTSD, see Chapter 11. For the multiple trauma victim with sufficient affect regulation, the clinician should determine during the history-taking sessions the 10 most disturbing memories. These are often from childhood, and the Adverse Childhood Experience Questionnaire (see Appendix A) is strongly recommended as part of the assessment process. The responses to it can be used for specific target development. The most disturbing memories may have similar or different themes and content, and may involve the same or different perpetrators. Regardless, each should be identified, assessed for SUD level, organized, if appropriate, into groups with similar themes, and evaluated for processing in terms of the client's complaints. In general, the memories that are contributing to the client's most pronounced dysfunction should be processed first. These are often revealed through the use of the Floatback technique. If they are all basically similar, the memories that are the most disturbing to the client should generally be targeted first. Often, they are revealed as important nodes with associations to several pertinent areas of dysfunction. A chronological approach to targeting these events can also be useful for processing and can be more efficient, because it decreases the possibility of blocked processing of the targeted dysfunction due to a feeder memory. However, before proceeding in this manner, determine whether the client would be better served by starting with a less disturbing event. It can give some clients a needed feeling of accomplishment and self-mastery to successfully process first a childhood memory with an SUD level of about 5. However, it is important to have prepared the client appropriately and carefully monitor the associations as they may move into something more disturbing. It may also become apparent through the associations that additional, newly revealed memories need to be specifically targeted. Once the client has successfully completed the initial target and feels comfortable with the process, targeting can proceed with the more disturbing ones. It may also be helpful to use a collaborative approach by asking the client whether she prefers to start with the earliest memory or the most disturbing one. It is possible that as the memories with the highest level of disturbance are reprocessed, the treatment effects will generalize and the others will become less troublesome. Even if this is the case, however, the other memories should be targeted to clear out any dysfunction that may remain. However, regardless of target ordering, all dysfunctional memories should be adequately processed and reevaluated as described later.

In addition, the other disturbing memories identified during the comprehensive history taking should be divided into clusters of similar events. One representative event from each cluster should be identified and reprocessed. This often allows a generalization effect to reduce disturbance in all of the associated memories. Clustering events into similar occurrences

(as described in Chapter 3) can help to leverage clinical time. It also allows both client and clinician to determine patterns of responses and negative cognitions that may have a continued detrimental effect in present time. Once a cluster is reprocessed, the associated triggers should be evaluated for immediate targeting and future templates incorporated (see below). When possible, all significant adverse life experiences should be assessed and processed for the most comprehensive effects across the clinical picture.

As treatment progresses, other events not previously identified may surface that need to be targeted. A clinical rule of thumb is that all negative associative material for one distinct traumatic target should be processed before moving on to another. The reevaluation phase that begins each subsequent EMDR session determines the appropriate target.

The aim of the first prong of the EMDR therapy protocol is to reprocess the dysfunctional residue from the past, so that the client can be freed to live in the present. Any inappropriate fears or behaviors are considered products of the past that need to be targeted. The clinician should assess clinical outcomes for each target and recycle through treated material to make sure that all dysfunction has been reprocessed and that the treatment effects are being maintained.

Single-Target Outcome

The clinician should reevaluate the successful reprocessing of any memory both at the beginning of the session following the one in which the reprocessing took place and once again, later in therapy. If continuing the incomplete processing from the previous session, the client is asked to bring up the memory, identify the worst part, the SUD level, emotions, and the location of body sensations. The negative and positive cognitions are not necessary, since they were previously obtained.

The memory is then retargeted, with bilateral stimulation initially focusing on the image and sensations. After the full EMDR processing procedures, including the installation and body scan, have been implemented, the clinician can assume that the target memory has reached adaptive resolution. Therefore, in the following session, the clinician should ask the client to reaccess the memory to see how disturbing it is. Based on the results, the clinician will do one of the following: continue reprocessing that target, move to another target, begin another prong of the protocol, or enter the final follow-up period necessary to conclude EMDR therapy.

After asking the client to think of the previously targeted event, the clinician should ask him to judge once again the quality of the memory that comes up and the level of disturbance evoked (using the SUD scale). Because the client is asked to retrieve the memory as a whole, successful reprocessing generally results in the emergence of a picture indicative of a resolution. If this picture is still highlighted by disturbing elements or vividly fixated on the most horrific moment of the adverse event, more

reprocessing is necessary. In addition, if the SUD rating indicates a level of emotional disturbance that is inappropriate to the circumstances, the memory should be retargeted. A number of new emotions that demand clinical attention may emerge.

It is also useful to ascertain the VOC level of the positive cognition to determine whether the client has any unresolved doubts about it. In addition, the clinician might ask the client to think about the event and to voice any thoughts that come up about it. This can indicate whether additional cognitive distortions need to be addressed. A variety of new perspectives may prove to be problematic and require further attention.

In general, returning to the targeted memory after a period of disengagement is a good test of the treatment effects. Therefore, if there is time during the initial reprocessing session, the client should be asked to retarget the memory immediately after the debriefing (as described in Chapter 6). Not only is the debriefing an essential part of client care, but it also helps the client disengage from the disturbing material. Asking the client to reaccess the memory allows a restimulation of the neural network to ascertain how the material is now being stored. Since this may indicate the need for further reprocessing, the clinician should attempt reaccessing only if there is sufficient time in the session to resolve whatever might come up.

Regardless of the outcome, the memory should also be reevaluated at the next session to determine whether it has other elements that need resolution. A certain amount of real time is needed to check for the full integration of the processed information within the client. It is also vital to retarget the memory if the client was on medication at the time it was originally processed. Clinical observations have indicated that there may be a need to reprocess the memory again to deal with any information still held in state-dependent form. For example, there may be aspects of a client's memory that only emerge when she is feeling anxious. If this client first processed the memory while on antianxiety medication, it may be necessary to reprocess the same memory later, when she is no longer taking the medication. Medications factor into the client's perceived physiological and emotional state at the time the issue was initially processed. It is presumed then, that in the absence of antianxiety medication, the client will be able to report anxiety that still exists around a target.

Another useful measure of clinical outcome is the Impact of Event Scale—Revised (Weiss & Marmar, 1997; see also EMDR Research Foundation Toolkit, 2015). While this measure was designed for research purposes, it is very useful in clinical practice. The victim of a single-event trauma may be asked to fill out the questionnaire during the history-taking session. This is helpful for establishing a good baseline of client responses regarding intrusion or avoidance symptoms. The week after the targeting session, the client should complete the questionnaire again. The new score may indicate the extent of resolution or point to other, associated material to be resolved.

For instance, a client who had been molested by her grandfather was troubled by intrusive thoughts and nightmares of the event. The Impact of Event Scale revealed a high score on all intrusion and avoidance symptoms. The client's memories of her grandfather were targeted during two EMDR reprocessing sessions, and the client reported feeling a sense of peace and forgave her grandfather for his "ignorance." However, the following session revealed that she rated the Impact of Event Scale item related to intrusive thoughts at a moderate level, although the rest of the items were low or at zero. When questioned, the client revealed that she had been thinking about her grandmother, who had not believed she was molested. The client's memory of her grandmother's disbelief was subsequently targeted, and the issue was resolved.

Recycling through Multiple Targets

After the initially identified targets and emerging associated memories have been reprocessed, the clinician should recycle through the material to make sure that the treatment effects have been maintained. This reevaluation for each cluster of events related to a dysfunctional pattern in the present, described in detail shortly, is necessary before moving on to the second prong of the protocol.

It is also useful to repeat the reassessment of the pivotal memories sometime before termination of therapy. Keep in mind that the information will continue processing between sessions and that new avenues of perception or emotions that should be addressed may be revealed. However, in the course of ongoing therapy, material unrelated to the previous targets may have appeared more disturbing, and these newly opened avenues of the original target may have been overlooked. Retargeting such material can determine whether any necessary processing or exploration is still incomplete and is a safeguard for thorough clinical treatment.

After the pronounced complaints appear to have been resolved and before therapy is terminated, the clinician should ask the client to reaccess a number of the targets. The purpose is to recycle through the earlier material and current issues that the client came to therapy to resolve, in order to identify and reprocess any troubling material that may remain. This will help prevent the client from uncovering disturbing material on his own later. While the client may have attained all the clinical goals identified during the initial history-taking session, retargeting will help to ensure maintenance of the treatment effects.

Specifically, the clinician should reevaluate the previous work with the client and access, assess, and appropriately reprocess (if necessary) the kinds of memories discussed in the following paragraphs. In all cases, the client's body reactivity to the memory should be assessed. It is an important indicator of possible residual dysfunction.

PRIMARY EVENTS

The "primary events" are those that have greatest significance to the client or that have been identified as representing certain crucial areas of dysfunction. The clinician should retarget them to assess the magnitude and constancy of the treatment effects and to determine whether other significant aspects of the memory appear to be unresolved.

PAST EVENTS

The clinician should ask the client to hold the most important negative cognitions in mind and ascertain whether any other memories are still disturbing. Any memory that emerges should be examined for significant differences of content or context from the memories already treated that may give the negative cognition a new meaning. For instance, the client may have started with the negative cognition, "I'm different," which was reprocessed for incidents involving social discomfort. However, she may have a memory involving herself acting insensitively that is still disturbing and that gives the cognition a different meaning, namely, "I'm a terrible person." Whether or not differences in the meaning of the cognition emerge, the memory should be appropriately reprocessed as long as disturbance is evinced.

PROGRESSIONS

While processing an identified target, the client may disclose another memory that comes momentarily to consciousness during or between sets. Additional sets may cause yet another memory to emerge or the initially targeted one to resurface. The clinician should, of course, follow the client's emerging consciousness and reprocess appropriately. However, the clinician should note any memories that emerge in passing that appear particularly salient to the clinical picture. Memories that appear fleetingly in relation to one issue may be central to another dysfunctional cognition or configuration. The clinician should use professional judgment in identifying and returning to these memories at an appropriate juncture in the therapy.

CLUSTERS

During the initial history-taking session, the clinician will have developed a series of clusters by appropriately grouping similar incidents. He will then ask the client to choose for reprocessing one incident that represents a particular cluster. Clinical reports have verified that generalization usually occurs, causing a reprocessing effect throughout the entire cluster of incidents. The clinician should verify this by asking the client to scan through the incidents in each separate cluster to identify any other memories that

have not been resolved. Let us say, for instance, that a sexual abuse victim has identified a cluster of incidents around being raped by her brother. Although the client may have been assaulted many times by her brother, a convenient cluster might be the times she was raped in the basement while hearing other family members walking around in the house above her. When returning to this cluster of incidents for reassessment, the client may discover that one incident remains unresolved because an additional humiliation (being watched by her brother's friend) was involved with the rape. In other words, incidents that contain additional factors (or significant variants) may require individual targeting for complete resolution.

PARTICIPANTS

The significant people in the client's life (e.g., family members, friends, teachers) should be identified and individually targeted to determine whether any disturbing memories or issues regarding them remain. This is particularly important in childhood abuse, a situation in which all family members should be targeted in order to identify any contributing elements to continuing issues of low self-esteem, lack of feelings of self-efficacy, and so forth. While only one member of the family may have sexually abused the client, the state of traumatization might lead to a heightened vulnerability to any deliberate or unintentional critical messages from others. When an individual family member is targeted and the client responds with a significant amount of disturbance, that person should be targeted to access any key memories that have remained dysfunctionally stored. Concentrating on the image of the individual, along with the physical response, without a particular action, is an acceptable target in the later, not early, part of this stage of therapy.

Working on the past is the first prong of the standard EMDR protocol. When a reevaluation of the past events related to an area of dysfunction indicates that they have been sufficiently resolved, the clinician should change the emphasis to present stimuli. This is the second prong of the standard protocol.

Working on the Present

The second prong of the EMDR protocol focuses on the question, "What present stimuli continue to elicit the disturbing dysfunctional material?" This stage targets the current people, conditions, and situations that evoke pathological or disturbing reactions and behaviors. Human behavior is not random; patterns of reaction and behavior established in the past are frequently triggered in the present. Good history taking delineates the current dysfunction and establishes a baseline of inappropriate responses. However, the initial history-taking sessions must be continually supplemented

by ongoing assessment and clinical observation, because processing primary traumata during the initial prong of the protocol is often the only way underlying problems can be fully seen. Often, resolution of obvious symptoms (e.g., intrusive thoughts) that have preoccupied the client will allow the clinician to make a more thorough evaluation of current life conditions.

Once early events have been processed, the clinician should reevaluate the client's current responses and check them against the information gleaned during the history taking. The common pattern seen in EMDR is that fears and anxieties will have greatly decreased as a result of trauma reprocessing. Not only will associated early memories be less troublesome, but there is also often a generalization to present-day situations. For example, a molestation victim may find that after targeting the memories of early assaults, he is no longer afraid to be alone at night, and an accident victim may find that she is no longer afraid to drive. These changes occur automatically, that is, without directly targeting the present-day situations.

It is important to check for the client's current reactions. Although some stimuli are automatically affected, others will have to be specifically reprocessed. Any present condition or interaction that causes disturbance should be individually targeted and reprocessed using the full assessment, desensitization, installation, and body scan phases. In most instances, this is comparatively easy, because the earlier source of dysfunction has already been treated. However, the clinician should be prepared for the emergence of other memories that may be unexpected sources of disturbance, particularly if dysfunctional physical reactions, such as a clenched jaw in present social situations, are targeted. Isolated sensations should be targeted directly only if they are still problematic after the remembered childhood events have been thoroughly processed. In addition, if the disturbance about the present-day situation does not diminish, the clinician may need to search for feeder memories. This can be done by use of either the Floatback or Affect Scan techniques. With the Floatback technique, the client is asked to hold in mind the current disturbing situation and identify the negative cognition that describes her feelings about it. For example, bringing to mind a recent difficulty at work, the client identifies the negative cognition "I'm inadequate." She is then instructed to **"Notice the image that comes to mind, the negative thoughts you're having about yourself along with any emotions and sensations, and let your mind float back to an earlier time in your life when you may have felt this way before and just notice what comes to mind."** If the client has difficultly putting words to negative thoughts or feelings, or if the earliest memory that can be identified is one from her teenage years or later, it can be useful to search using the Affect Scan. The clinician instructs the client to **"Hold the experience in mind, notice the emotions you're having right now and notice what you're feeling in your body. Now let your mind scan back to an earlier time when you may have felt this way before and just notice what comes to mind."** In either case, the memory is targeted for processing to resolution (see also Appendix A).

It is important to check treatment effects by recycling through any present-day situations that were targeted. The clinician should ask the client to reaccess any present stimuli that were previously identified as disturbing, then make the appropriate reevaluation. She should also ask the client to scan his current family, social, and work environment for any undue disturbance. The clinician should address any necessary client education (e.g., on assertiveness), then have the client reprocess the stimuli. Using probes of real-life situations, then targeting the attendant sensations, can allow an assessment of ecological appropriateness or underlying dysfunction. After each current trigger is processed, a positive template for appropriate future action should be incorporated (as described later in this chapter).

Using the Log to Report Systems Issues

It is important for clients to keep a log after each EMDR session in order for the clinician to ascertain what else needs to be targeted (see Appendix A). Asking a client to reaccess a particular target allows the clinician to determine how well the client has integrated the material within herself. The log enables the clinician to see how well the client's new pattern of reaction has been integrated with her current environment. This reevaluation gives the clinician the opportunity to review the quality of the client's internal and behavioral responses within her social system. If, for whatever reason, the client has not kept a log, the clinician should inquire about any changes in symptoms, patterns of behavior/reactions, new behaviors, "surprises," feedback from people around her, dreams, and anything that is out of the ordinary.

Since human beings are not machines, one would not anticipate that successful EMDR therapy clients would now be totally unresponsive to the traumatic events that led to their dysfunction or to current unpleasant circumstances. Certain levels of disturbing emotions may be viewed as appropriate responses to current situations.

Remember that EMDR processing will not remove any disturbance experienced by the client that is fitting or that serves as an incentive to appropriate action. For example, a client may be living or working in a situation that would be considered unpleasant, unjust, or unfair by any standard of consensus reality. When the client's log reports a high level of disturbance, the clinician must assess the entire situation in order to judge the appropriateness of the client's response to it. Even if the client's situation is untenable, the clinician should help him determine the most appropriate action he can take within the system, and should ensure that he can do so without the accompanying sense of self-denigration and worthlessness he may have felt during past experiences of victimization. Thus, log reports are vital to evaluate the client's current responses to the actual situation.

The clinician must explore the consensus reality of the client's situation, along with any real-world conflicts, to determine how the client's

current responses should be addressed. They might be dealt with by means of reprocessing, education, family therapy, or self-control techniques to help the client accept the unchangeable—and sometimes unfair—facts of daily life. Indeed, an important aspect of mental health is the ability to stop focusing on the "unfairness" of something and accept the simple fact that "it is." For each previously disturbing situation, after processing and needed education/modeling, a positive template for appropriate future action should be incorporated (described later). The log provides important information for assessing the client's needs.

The client's present condition can be most fully explored if she uses the log to report on any disturbances. Accurate log reports are necessary for comprehensive EMDR treatment, because they can also reveal patterns of responses that need to be addressed by identifying other core dysfunctional memories, before directly targeting the present disturbing condition. At this point in therapy, if earlier related memories are not discernable or disturbing, the present situation and physical sensations are directly targeted.

At times the clinician will notice that the disturbances recorded in the log reveal troublesome negative cognitions. However, occasionally these negative cognitions may seem justified to the client because of his earlier life experiences. In these cases, the clinician must be attuned to the necessity for cognitive investigation and appropriate education. The clinician should sensitively explore with the client the possibility that even if the dysfunctional beliefs were appropriate previously, society may have changed so as to make them obsolete now. Since the client has been locked in the life experiences and messages from his past, there has been little opportunity for the evolution of his social consciousness.

This scenario may apply especially to issues of relationships and gender identity. For instance, a female client may need to learn that holding a powerful position in business is compatible with femininity, and a male client may need to learn that experiencing emotions and taking care of the children are not threats to his masculinity. This also applies to a variety of issues that may arise for individuals who do not conform to the dominant cisgender paradigm. Also, systems issues may need to be addressed, so that the client can cope with any peer pressure from old dysfunctional relationships.

Often, the clinician may need to explain the basics of systems dynamics to the client, showing her how her newfound sense of self-efficacy or new attitudes may not be welcomed by the people in her life. For instance, the client will discover that not everyone is emotionally stable, responsible, compassionate, tolerant, fair, or trustworthy. She may need to learn that, as an adult, she has choices about relationships and work that were not previously available to her, choices that include simply withdrawing from an unpleasant and unchangeable situation. The clinician must make the appropriate evaluation to determine whether the client needs to do specific work on new behaviors so that such choices can be made.

Working on the Future

Once the contributing dysfunctional events of the past have been identified and reprocessed, and the present disturbance has been targeted and processed, the clinician should focus on the client's ability to make new choices in the future. This is done by identifying and processing anticipatory fears, as well as targeting a positive "future template" that incorporates behaviors appropriate for the future. This third prong of the EMDR therapy protocol includes adequate education, modeling, and imagining in conjunction with EMDR targeting to allow the client to respond differently in the future. The clinician should help the client assimilate new information and provide her with experiences to help ensure future successes. The third prong of the EMDR standard protocol is a vital aspect of treatment.

Significant People

When the client has reprocessed memories about a significant person, the clinician should ask him to imagine encountering that person in the future. The client's reaction should be assessed to determine whether additional processing is needed. For instance, a client who has processed memories of childhood molestations by a brother should be asked to imagine seeing him at a future family gathering. This is particularly important if such a future encounter is likely to occur. If the client describes feeling fear, the consensus reality of the situation should be explored. For instance, if the brother is violent or likely to attempt a verbal or physical assault, the client's reactions may be appropriate. However, if the client reports the brother as passive or repentant, there is good reason to assume that the client's fear is the result of unresolved material, which should be targeted. If the fear is inappropriate, the clinician should reevaluate the clusters of events involving the brother for any unresolved issues. Any remaining dysfunctional memories should be accessed and reprocessed. Other fears the client has about asserting herself or setting boundaries in general may need to be explored and appropriately targeted. Whether the fears are warranted or not, the clinician should discuss with the client appropriate adaptive behaviors and help her assimilate the information through the use of a future template (as described later in this chapter).

Significant Situations

As noted earlier, it is important for the client to imagine himself in significant situations in the future to determine whether he has any other areas of disturbance that have gone undetected. Inappropriate anticipatory fear or physical disturbance is generally driven by earlier unresolved dysfunctional memories. It may be useful to have the client imagine a videotape of

how situations from his current life would evolve one or more years into the future. Any disturbance can be assessed for the appropriate clinical interventions, including education about successful interpersonal strategies, modeling of appropriate behaviors, or reprocessing of dysfunctional memories. As mentioned earlier, it is also useful to ask clients to imagine specific situations or encounters with significant people who have been disturbing in the past. This can allow the clinician to pinpoint and address areas of difficulty.

Incorporating a Future Template

The evolution of a healthy self-image is dependent on the interaction between intrapsychic responses and external reinforcement. The clinician must therefore take care to monitor both factors in order to see whether specific therapeutic interventions are indicated. These include targeting inappropriate responses for subsequent treatment or specifically addressing systemic issues.

The concept of successful integration is inherent in each aspect of EMDR treatment. During each session, the clinician should attempt to identify the positive cognition that, when installed, not only best serves to shift the client's perspective on past events but also empowers him most fully in present situations and possible future ones. Once installed, the positive cognition appears to generalize to the associated memories and to positively orient the cognitive processes in regard to subsequent associations. It appears that a client's beliefs about his individual worth, efficacy, and relation to others are verbalizations of his sense of personal identity. Thus, we expect to see adequately processed targeted material integrated within an overall positive schema and a sense of self that spans past, present, and future.

While the installation phase is a part of EMDR processing, the overall EMDR treatment protocol calls for specific targeting of (1) early memories that have set the groundwork for the present dysfunction, (2) present stimuli that elicit the dysfunctional material, and (3) a positive template to guide appropriate future action. Whereas EMDR processing that concentrates on the client's responses to present stimuli includes the installation of a positive cognition to allow a different perspective, the treatment is not complete until there is a specific incorporation of an alternative behavioral response pattern. Such patterns represent what we refer to as a "future template."

In effect, the incorporation of a positive template for appropriate future action is an expansion of the installation phase. The clinician and client explore how the client would most like to be perceiving, feeling, acting, and believing from now on. It is important for the clinician to monitor the client's projections into the future, because they may incorporate

inappropriate goals or fears of failure due to lack of experience or poor early modeling.

For example, even after all the memories of a molestation victim have been reprocessed, she is not necessarily ready to start dating. The clinician may have to provide education about assertiveness, social customs, sexual safety, and so on, before this prong of the protocol can be completed. The clinician should address (either in the therapy session or through referral to a self-help group) the deficits in the client's early life experiences and the information that should have been integrated during the appropriate developmental stages. Furthermore, the clinician should reevaluate the client's successful integration of any treatment effects through the log reports.

The molestation or abuse victim is often unable to learn about appropriate social interactions because of the feelings of low self-esteem, fear, and isolation that were part of his early upbringing. In addition, many of his social skills are likely to be missing because of inappropriate parenting and lack of good modeling. It becomes the job of the clinician to help such clients learn aspects of social and family interaction that were not acquired in childhood. This is an important phase of treatment, because it helps the client to become actively integrated within the social fabric.

The incorporation of a future template is an aspect of EMDR therapy that includes visualization work similar to the kind done by some Olympic athletes during training (see also Foster & Lendl, 1995, 1996). Imagining positive outcomes seems to assist the learning process. In the case of a molestation victim, the clinician can review dating and assertiveness skills, then ask the client to try them out in a role play and in her imagination. Essentially, once the client has received the appropriate education, she is asked to imagine the optimal behavioral responses, along with an enhancing positive cognition. The clinician then leads her in successive sets of stimulation to assist her in assimilating the information and incorporating it into a positive template for future action.

Initially, a victim of molestation or other abuse may find just the prospect of holding someone's hand disturbing. In this case, she should be assisted in imagining the whole sequence of meeting someone, dating, and progressing through evolving sexual experiences. The clinician should ask her to imagine a given situation, then help her process the resulting disturbance. Next, she is asked to visualize the images again, while feeling positively. This is supported with additional sets. The incorporation of these positive future templates allows the client to achieve some sense of comfort and experience with new situations in the safety of the office. After the entire imagined dating sequence, from an initial meeting to a sexual experience, has been targeted, the client should be encouraged to begin social exploration. Once she has done this, there is a greater likelihood of actual positive experiences, because these internalized positive templates will be triggered by future external cues in the real world. Obviously, the

clinician will need feedback about these real-world experiences to determine whether a client needs additional assistance.

The same type of sequencing should be done with the abuse victim who decides to look for a better job. First, the clinician or a job counselor should educate him about job hunting. Then, a series of future templates should be incorporated, involving the necessary steps for him to take and the personal encounters he is likely to have when job hunting. Of course, the client should continue to keep a log to identify for reprocessing any difficulties he encounters in real-life situations. Once again, processing imagined encounters to incorporate a positive template for the future will generally result in fewer disturbances in the real world. It is much better for the client if the primary areas of disturbance are identified and dealt with in the clinician's office rather than encountered for the first time when he is on his own.

Remember that the positive cognition is installed (during the sessions that target memory work) only after the dysfunctional material has been reprocessed. Likewise, the incorporation of a detailed positive future template should not generally be attempted until both the earlier memories that caused the dysfunctional reactions and the present stimuli are successfully reprocessed. Since new and more adaptive positive cognitions are possible once the memories are processed, more adaptive actions can be envisioned by the client. The clinician should use EMDR processing to metabolize the dysfunctional material that drives the maladaptive behavior and to assist the client in imagining more life-enhancing responses and in formulating appropriate behaviors in her mind. Sets can then be used to integrate the imagined future responses before clients are invited to actualize them in real life.

The sequence for incorporating the positive future template employs bilateral stimulation to process any disturbance that arises while the client:

1. Imagines a scene of acting effectively in the future. This focus generally infuses an initial sense of well-being.
2. Runs a movie from start to finish of acting effectively in the future. This generally reveals any additional concerns or blocks.
3. Runs a movie from start to finish of acting effectively in the future in the face of challenges. This enhances resilience and expands the client's capacity to respond adaptively.

Overall, this third and last prong of the standard EMDR protocol allows the clinician to monitor the client's responses in the office in order to help her work through any internal resistance or obvious problems she is likely to encounter, before she tries out her new actions in the real world. Using the sets with the imagined actions and behaviors inaugurates the processing of a condition that can be described as "What would happen if I am successful?" The clinician must be attuned to any sense of fear or

resistance the client may feel as the positive future template is processed. These can be explored to see whether they include any false expectations or cognitive distortions. Once the appropriate cognitive explanation has taken place, any residual tension can be reprocessed.

Specifically, clients are asked to notice any negative feelings, beliefs, or disturbing sensations that arise when the positive future template is imagined.

For example, once a trigger has been successfully processed and adequate education has been offered, the clinician instructs the client: **"I'd like you to imagine yourself coping effectively with a similar situation in the future. With the new positive belief [_____] and a feeling of [_____]** *(e.g., calm, confidence*), **imagine stepping into this scene. Notice how you're handling the situation and what you're thinking, feeling, and experiencing in your body."** After a sufficient pause, the clinician asks, **"What are you noticing?"**

If there are any blocks, anxieties, or fears, these are then targeted directly by the sets. If a negative belief emerges, it is advisable to take the following steps before attempting to further incorporate the positive future template: (1) explore its meaning and appropriateness; (2) isolate any pertinent early memories that may be driving it; and (3) direct treatment to the applicable representational memory, including the installation of an appropriate positive cognition. In many cases, however, a simple discussion of the situation, along with appropriate information and modeling, may be all that is necessary to dispel the client's negative feelings.

If there are no apparent blocks and the client can visualize the future scene with confidence and clarity, ask him to focus on the image and positive belief associated with the scene, and introduce several sets of bilateral stimulation until the future template is sufficiently strengthened (to VOC score of 7 or ecologically appropriate rating). Next, ask the client to move from imagining this one scene or snapshot to imagining a movie, along with the positive cognition, from start to finish, in which he copes effectively in the future. As before, inquire regarding any difficulties and process as needed. Then add bilateral stimulation as the positive movie is run again to strengthen the feelings of confidence and process any disturbance that may arise. Finally, ask the client to run a movie of coping effectively in the face of specific challenges. Make some suggestions of possible difficulties in order to help inoculate him for future problems. If the client hits any blocks, address these as before, until he can play the movie from start to finish with a sense of confidence and satisfaction. In any case, in the final step, the client should experience the assimilation of the positive future template with a feeling of well-being and self-efficacy. (See client transcripts in Appendix B.)

Naturally, it is necessary to reevaluate treatment effects through the log reports and behavioral monitoring.

CONCLUDING THERAPY

Follow-Up

The final aspect of reevaluation involves decisions about concluding the therapy. The client should reduce her therapy sessions while continuing to keep her log for follow-up. After the log reports suggest that weekly sessions are unwarranted, the clinician may schedule an appointment for 2 weeks later, then 1 month, and then 3 months. During this time, the log is vital to identify any previously undisclosed patterns that need attention. It also assists the client in remaining more self-aware, which can encourage her to continue using the stress control recordings and techniques for ongoing psychological maintenance.

Extensive follow-up is especially important for clients with long-term abuse histories, for the negative beliefs resulting from the abuse are likely to lead to circumstances in adult life that constantly reinforce feelings of worthlessness and powerlessness. For instance, it is likely that the client's job performance will be mediocre and that she will anticipate failure and disapproval. These potential problems need to be targeted and addressed.

If the client has been successfully treated with EMDR therapy, the early memories of abuse will have been sufficiently metabolized to permit a cognition such as "I'm fine. Mom and Dad really had a problem. I can succeed." The present stimuli can then be reprocessed so that negative reactions in social and work situations can now be replaced by appropriate responses that encourage a new sense of empowerment. A positive future template for a variety of social situations can be incorporated to make up for any educational or developmental deficits (in assertiveness, boundary setting, etc.) due to inappropriate modeling and the self-denigration caused by the negative beliefs inherent in the abuse background.

In addition to the incorporation of specific positive future templates, automatic changes in the client can occur with EMDR processing. Thus, one of the anticipated consequences of appropriate reprocessing is a ripple effect; that is, adaptive behaviors spontaneously arise owing to the new sense of identity that emerges when the negative messages of the client's early memories are transformed. Therefore, clinicians can expect that the job performance of abuse clients will begin to improve and that this improvement will result in even greater job success.

The clinician should remember that any new client actions will be met with new external responses, which in turn stimulate other neural networks in the client that also contain positive or negative beliefs. One hopes, of course, that the client will begin to receive positive reinforcement for her new actions, but in the course of receiving compliments, promotions, or commendations the client may experience fear or anxiety. This may be caused by the activation of a neural network that contains a dysfunctional belief, such as "If I am too successful, I will be abandoned." Such a belief may have been incorporated from the observation of a real-life situation,

book, or movie. Regardless of its genesis, this belief was not previously examined, because the client had never before achieved sufficient positive results (and the consequent praise) to activate it. Nevertheless, negative emotions stimulated by situations that would normally be expected to evoke satisfaction should alert the clinician to the need for processing.

It is crucial that the client understand the clinician's need to continue monitoring in order to reevaluate her reactions and determine whether clinical intervention is needed. The memories that set the node points for the negative beliefs should be identified and processed, and the appropriate positive cognition installed.

Terminating Therapy

Whereas the client's log can highlight disturbing feelings indicative of dysfunction, it may also reveal disturbances that are merely the result of the vicissitudes of life. When the log begins to report minor and random arousal as the primary complaint, the client should consider whether therapy is still a necessity for emotional healing or simply an option for personal growth (which can be an independent, lifelong adventure). With some clients, it is important to discuss appropriate current goals and expectations.

In many cases, the client must learn the limitations inherent in being human, regardless of how well-adjusted or "self-actualized" he is. For example, many victims of PTSD believe that if their symptoms were successfully handled, they would never be unhappy again. While it would be unfair to prematurely short-circuit their personal goals, clients may need to be cautioned that life entails a series of shocks to the nervous system that trigger both appropriate and inappropriate reactions, depending on a number of factors, including chemical and hormonal balance, fatigue level, and convergence of stimuli. Instead of beating themselves up when anger, hurt, or fear arises, it would be more useful for them to determine whether the arousal is an appropriate impetus for action and, if so, to take the necessary steps to address the disturbing situation and any residual body tension.

Some clients need to be debriefed about the difference between "cannot" and "prefer not." For instance, a client who had been unable to fly in an airplane since childhood successfully reprocessed his fears in a few EMDR processing sessions. At that point, situations that previously would have induced a panic reaction were retargeted. When it was time to incorporate a positive future template, the client remarked that it was difficult to tell the difference between what he felt and what normal people might reasonably feel. For example, he had to be reassured that most people would not enjoy sitting in the middle seat of an airplane and that his dislike of it was perfectly normal. He learned that this kind of preference should not and need not be expected to change. The important thing was to recognize that if he had to, he could sit in the middle seat.

Once areas of dysfunction have been reprocessed and the client is experiencing success and joy in the present, has the necessary education to make new choices in the future, and the log reveals no new problem areas as therapy is tapered off, it is time to terminate the therapeutic process. It is nonetheless important for the client to feel that the door is always open if the need arises. She should be informed that if another area of concern arises or if she observes patterns of dysfunctional responses that do not respond to self-help techniques, then additional therapy is always available. The appropriate level of expectation is vital in order to continue therapeutic gains.

In one instance, a client who had been successfully treated 6 years earlier for a severe case of PTSD caused by combat reentered therapy. The initial dysfunction had not returned, he had started a successful and lucrative job, and he was now happily married. However, his current presenting complaint was a series of molestation memories and attendant disturbance that had recently arisen. In his earlier therapy, there had been no signs of sexual dysfunction or other indications of an abuse history, but the client had recently seen his mother in a particular body position at a motel and had begun to remember scenes of a childhood molestation involving his father and another woman. Conversations with his brother seemed to confirm his suspicions, which were accompanied by more molestation images. The client's disturbance now became extreme, because the emerging scenes entailed a lot of blood and seemed to indicate that a murder had been committed in his presence. These scenes were appropriately targeted and reprocessed in three EMDR sessions. During the reprocessing, the image became more distinct and appeared to involve not a murder but a woman menstruating. While a molestation did seem to be involved, the disturbance was handled without difficulty and the client was again discharged after a reminder that the therapist's door would always be open.

This case exemplifies several operational principles for the clinician:

1. *Do not assume that every possible unconscious dysfunction has been resolved within a given number of EMDR sessions.* Clients may arrive at a state of health and equilibrium appropriate for their current stage of life and personal development without having unearthed every possible source of disturbance. While clinicians have reported that EMDR processing seems to release dissociated material more often than other modalities, the successful targeting of all disturbance necessary to remediate the presenting problems does not mean that other issues will not arise in the future.

2. *It is necessary to communicate to clients that other material may arise, and that this is not evidence of failure on their part but, rather, a natural unfolding process.* It may be helpful to speak metaphorically, to say, for example, **"Targeting any new material that surfaces is like peeling an artichoke."** (I prefer "artichoke" to "onion" because at the center of an

artichoke is a heart.) This gives clients the sense that their essential health is always stable and intact within them, and the message that the unfolding of a new target simply offers them the opportunity to acquire additional refinement and information. The client should be instructed that other issues may naturally arise as she more fully integrates changes and new life experiences. Providing this information allows new material to be dealt with at the appropriate level of client readiness, which appears to accelerate the overall treatment outcome.

3. *It is necessary to instill in clients a sense of self-empowerment and confidence in their ability to exercise posttherapy self-monitoring.* The client should be asked to consider that an important aspect of continued mental health for any individual is the ability to identify a feeling of self-satisfaction and joy as a baseline response and to remain as alert as possible to the arousal of any states of internal suffering. Identifying the source of the disturbance allows the client to decide what kind of intervention is needed. Before clinical assistance is deemed appropriate, the client should attempt a variety of personal interventions. In many instances, the solution to the disturbance may be as simple as taking appropriate action or using guided imagery, meditation, or self-hypnosis. In addition, the self-administered eye movement and tactile procedures (presented in Chapter 9) may be used by clients at this stage of therapy.

SUPERVISED PRACTICE

Clinicians should use the information in Chapters 5, 6, and 7 during supervised practice before implementing the information in this chapter and the protocols given in Chapter 9. The more advanced material offered in Chapter 10 should not be used by clinicians until they have become comfortable at this level of practice and have acquired the appropriate baseline of experience. This should take from 6 to 8 weeks. As mentioned earlier, during this practice period, some clients may be found to "loop" (maintain the same level of disturbance) even when the alternatives described in these chapters are used. For this group, the more proactive version of EMDR procedures described in Chapter 10 is needed. Therefore, clinicians-in-training who are dealing with this kind of client should use the closure exercises offered in Chapter 9 and refrain from reinaugurating treatment until they have been adequately supervised on the more advanced material.

SUMMARY AND CONCLUSIONS

Phase eight of EMDR therapy is called the "reevaluation phase." During this phase, determinations are made regarding clients' assimilation of the reprocessed information and their integration into a healthy social

structure. The reevaluation phase takes place at the beginning of each session subsequent to reprocessing, when the clinician has the client reaccess the earlier targeted material and reviews the log. This phase guides the clinician through a three-pronged protocol that targets the past events that laid the groundwork for the dysfunction, and the present conditions that evoke the disturbance, and installs a positive template for the future that helps incorporate appropriate actions. The reevaluation of previous work indicates what prong of the protocol should be used or when therapy should be concluded. Appropriate follow-ups are a crucial aspect of EMDR therapy.

Treatment effects are reevaluated by assessing the quality of the image that represents the targeted event, the SUD level, the cognitions, the VOC level, the log, and the client's reaction to projections of the future. Before the client completes therapy, the material covered in the history-taking and subsequent reprocessing sessions should be reevaluated. All pertinent memories, present stimuli, and future anticipated events should be targeted. A positive template for appropriate future action should be created to incorporate new adaptive behaviors and to process any cognitive distortions. It is possible that the clinician will need to educate the client about new behaviors or attitudes to address deficits caused by inappropriate parenting and life experiences. See Appendix A for additional clinical aids and Appendix B for client transcripts.

Focused reeducation is particularly important for clients who have histories of prolonged abuse or neglect. Although the standard processing of earlier memories allows most clients to reach an adult perspective, more severe cases have developmental deficits that should be separately addressed. To implement the three-pronged protocol for this population, give special care to an adequate preparation that strengthens positive affects and resources (see Chapters 5 and 11). For these complex cases, after appropriate processing of relevant memories and stimuli, the positive future templates are used to encourage the development of the intrapsychic structures and developmental plateaus evident in a healthy, happy adult.

For all cases, reevaluation of the clinical work includes the client's reports regarding real-life occurrences. The log is necessary to ascertain potential targets and is crucial for full clinical effectiveness. Disturbances should be evaluated for appropriateness to the circumstances, underlying dysfunction, new distortions, or systems issues that may need to be addressed. The clinician should coach the client about realistic expectations, self-care techniques, and the availability of future clinical intervention, if the latter becomes necessary. The final reevaluation may include extensive follow-ups before deciding that it is appropriate to conclude therapy.

While the present chapter has dealt with the treatment of trauma victims, Chapter 9 includes the use of the three-pronged protocol employing a symptom-focused approach applicable to all clients.

CHAPTER 9

Standardized Protocols and Procedures for Special Situations

You can outdistance that which is running after you, but you cannot outdistance that which is running inside you.

—AFRICAN PROVERB

EMDR therapy is applied to various clinical problems by means of the generic three-pronged protocol, as well as a variety of specialized protocols and procedures used to augment treatment for specific complaints. So far, we have explored the basic principles of EMDR clinical work, the standard procedures, and the standard three-pronged protocol used for most clients. The three-pronged protocol, described in detail in Chapter 8, directs comprehensive attention to all dysfunctional material manifested by the client's responses to past occurrences, present stimuli, and future projections. This generic protocol, which has been explored previously in detail for the treatment of PTSD, has been successfully applied to the treatment of a wide variety of clinical complaints (see Chapter 12). It is considered an essential element of EMDR therapy treatment across the clinical spectrum and is reviewed again later. The specialized protocols and procedures described in this chapter are recommended in order to expand, not replace, the three-pronged protocol.

This chapter provides an outline to review the standard procedures, and then describes additional protocols and procedures. Any of these protocols and procedures may be applicable to an individual client (e.g., a trauma survivor may need treatment that combines the protocols for specific traumas, phobias, and illness, a treatment that is positioned appropriately within the

standard three-pronged protocol described in Chapter 8). In addition, this chapter provides instructions about affect regulation techniques, including self-use of bilateral stimulation (BLS).

The additional protocols demonstrate how to apply EMDR therapy to various clinical problems and provide the guidelines needed to serve most clients. (For comprehensive case descriptions, see Shapiro, 2012; Shapiro & Forrest, 1997/2016; for research, see Chapter 12). Information on the use of these protocols with selected, and perhaps more highly disturbed, clinical populations is covered in Chapter 11. However, the clinician should first use these additional protocols with the circumscribed targets of more intact clients during the 6- to 8-week practice period.

The following outline is a reminder of the basic procedural steps of EMDR therapy. The selection of targets is based on the client's feedback and the three prongs defined in the standard protocol.

THE STANDARD PROCEDURES

The EMDR therapy approach involves eight phases and a three-pronged protocol, both of which are considered essential for effective treatment. Identifying the processing targets needed to address specific diagnoses appropriately, as well as the comprehensive clinical picture, requires a carefully defined treatment plan and suitable therapeutic framework. See Appendix A for clinical aids that help to identify targets and develop effective treatment plans. In addition, see Appendix C for a fidelity checklist that can be used by researchers and supervisors, and for self-monitoring by clinicians.

After taking a client history, formulating a treatment plan, and preparing the client, the clinician may begin the assessment of an individual target, identify the appropriate components, and proceed with processing by completing the procedures described in detail in the preceding chapters (see also Appendices A and C). These standard procedures involve attention to the following steps:

1. *Client History Phase*. Evaluation involves an assessment of the personal stability and current life constraints that are needed to design a treatment plan. Based on an evaluation of the entire clinical picture, including the client's dysfunctional behaviors, symptoms, characteristics, and relationships, the treatment plan determines the specific targets that must be addressed. The targets include comprehensive attention to the following:
    a. Past events that set the groundwork for current dysfunction
    b. Current situations that stimulate disturbance
    c. Skills and behaviors needed for adaptive future functioning

2. *Preparation Phase.* Ensures client engagement, motivation, and stability during processing.
   a. Establishes a therapeutic alliance
   b. Explains EMDR theory, treatment, and its anticipated effects
   c. Addresses the client's concerns
   d. Teaches relaxation and safety procedures to achieve affect regulation during and between sessions
3. *Assessment Phase.* Identifies the following components of the target and establishes a baseline response before processing begins:
   a. Image: Have the client access an image that represents the entire event, generally depicting the most disturbing part of the incident. If none is available, the client simply thinks of the incident.
   b. Negative cognition: Develop the negative self-statement that conveys an underlying limiting self-belief or assessment. In most cases, it should begin with "I am" and incorporate words that go with the image.
   c. Positive cognition: Create a desirable positive self-statement that, when possible, incorporates an internal locus of control.
   d. Validity of Cognition (VOC) level: Determine a client rating of the gut-level validity of the positive cognition (where 1 equals "completely false" and 7 equals "completely true").
   e. Emotion: Identify the name of the disturbing emotion(s) that arises when the image and the negative cognition are linked.
   f. Subjective Units of Disturbance (SUD) scale level: Determine a client rating of the degree of disturbance that arises when the memory is stimulated (where 0 equals "neutral" or "calm" and 10 equals "the worst disturbance imaginable").
   g. Location of body sensation: Identify where the physical sensations are felt when the disturbing information is accessed.

Processing of an individual target involves the uses of bilateral stimulation during Phases 4 through 6:

4. *Desensitization Phase.* Initiate the processing of the target.
   a. All associated channels are cleared.
   b. The targeted event resolves to an SUD rating of 0 or as close to 0 as possible (a higher score is acceptable if ecologically appropriate).
5. *Installation Phase.* Incorporate the positive cognition.
   a. Check the appropriateness and VOC of the original or new positive cognition.
   b. Link the positive cognition with the target event.
   c. Attain a VOC of 7 or as close to 7 as possible (unless otherwise ecologically appropriate).

6. *Body Scan.* Eliminate any residual somatic disturbance.
   a. Have the client mentally scan for any residual physical sensation while holding the target event and positive cognition in mind.
   b. Target and process any disturbing sensations.
7. *Closure.* End the treatment session in a way that gives the client feelings of self-efficacy and accomplishment, as well as reasonable expectations.
   a. Ensure affect regulation: Use guided imagery or self-control techniques to dispel any disturbance that remains.
   b. Debriefing: Give posttreatment instructions to clients regarding potential ongoing processing, and using a relaxation recording and/or other self-control procedures.
   c. Instruct the client on how to keep a TICES log (see Appendix A) regarding any disturbance, which will be reviewed at the next session.
8. *Reevaluation Phase (takes place in the subsequent session).* Assess the effects of the previous session.
   a. Begin the session with a review of the log to assess client stability, interactional issues, and current stimuli, and help define the next target.
   b. If the client has not kept a log that week, the clinician should inquire about any changes in symptoms, patterns of behavior/reactions, new behaviors, "surprises," feedback from people around the client, dreams, and anything out of the ordinary.
   c. Reaccess the previously processed memory to assess the need for further treatment.

THREE-PRONGED PROTOCOL

A basic tenet of the AIP model is that symptoms that are not purely organic in nature or caused by inadequate information are based on stored experiences. These unprocessed memories set the groundwork for current dysfunction. During a comprehensive history taking, the client is evaluated across the entire clinical picture regarding current emotional distress, nonadaptive behaviors, interpersonal difficulties, and the overall integration within larger social systems. The clinician then uses direct questioning, Floatback, and/or Affect Scan techniques to trace the present difficulties to the earlier experiences that are feeding the dysfunction. The three-pronged protocol is used to identify, target, and process (1) the earlier memories causing the problems, (2) the present experiences triggering the disturbance, and (3) the skills and behaviors needed for adaptive future functioning and to incorporate positive templates for future action (see also Chapter 8).

PROTOCOL FOR A SINGLE TRAUMATIC EVENT

Whereas the standard three-pronged protocol guides the clinician through the overall stages of therapy, the single-event protocol identifies the specific targets involved in the reprocessing of the individual adverse life event. It must be underscored, however, that victims of PTSD will undoubtedly need the full three-pronged protocol reviewed in Chapter 8 in order to address all their symptoms.

For single traumatic events, the standard procedure should be applied to the following targets (assuming they are available):

1. Memory or image of the actual traumatic event.
2. Flashback scene (which may differ from the recalled image that represents the trauma).
3. Dream image, or the most traumatic scene in a recurring nightmare.
4. Present stimuli that trigger the disturbing memory or reaction (e.g., the sound of a car backfiring or being touched in a certain way).
5. Positive future templates incorporated for the previously triggering situations.

DISORDER-BASED PROTOCOL

A wide range of RCTs has validated EMDR therapy in the treatment of PTSD using the standard procedures (see Chapter 12). Applications to other clinical disorders have received varying degrees of research support (see Chapter 12 and Appendix D) and are likewise guided by the AIP model and the three-pronged approach. As reviewed in Chapter 2, a substantial body of research has supported the AIP tenet that early adverse life experiences are the basis of a wide range of disorders (see also Shapiro, 2014a). Therefore, when clinically addressing a specific diagnosis, the clinician identifies the past experiences that are fueling the various symptoms identified in the DSM and the *International Classification of Diseases* (ICD) as part of the disorder. Using the three-pronged protocol, (1) the past events and (2) current stimuli are fully processed, and after appropriate education and modeling, (3) positive future templates are incorporated. This targeting strategy is employed, regardless of the diagnosis.

For instance, when treating a client diagnosed with depression, the clinician uses direct questioning, Affect Scan and/or Floatback techniques to determine the earlier life experiences contributing to feelings of shame, powerlessness and lack of self-worth. These may involve early childhood experiences, other relational difficulties, or failures. The specific configuration of events is unique to the client. The clinician also determines what current situations stimulate the client's negative feelings, and what skills

training and other education are needed to allow adaptive functioning in the future. Although there is clear evidence that depression often remits after processing a major trauma in those diagnosed with PTSD (see Chapter 12), the diagnosis of major depression disorder (MDD) is often fueled by a wide range of adverse life experiences that should be identified and processed. Given that a low sense of engagement and pronounced negative affects of shame and lack of worth are associated with depression, a potentially useful addition to the standard EMDR therapy procedures for the treatment of this disorder was employed in an RCT (Gauhar, 2016) in which participants diagnosed with MDD were successfully treated. Participants were shown a list of negative cognitions (see Appendix A) and asked to choose those that most applied to them (e.g., "I'm shameful"; "I'm not lovable"; "I'm stupid"). They were then asked to choose the one they wanted to deal with first, to focus on that negative belief, and to identify an associated memory that came to mind, which was then processed. Completed processing included the full range of memories, associated current stimuli, and needed future templates. In general, it is preferable to arrive at a negative belief through a therapeutic discussion that facilitates the client's understanding of the personal meaning of the event. However, if a client cannot engage in such an interchange due to emotional or cognitive impairment (e.g., major depression), then the list can provide a helpful adjunct.

Each diagnosis is defined by specific symptoms and characteristics that must be addressed. For instance, in the case of personality disorders, which are classified according to their various characteristics, a diagnosis of antisocial, avoidant, borderline, narcissistic, obsessive–compulsive, or schizotypal personality disorder differentially guides the EMDR clinician to identify the earlier events that laid the groundwork for the various dysfunctional affective, cognitive, and interactional patterns that forged these characteristics. These memories are then clustered and accessed for processing. Likewise, anxiety disorders are addressed by identifying the adverse life events contributing to their various characteristics, whether panic disorder, agoraphobia, or social anxiety disorder. In all of these instances, the DSM and ICD offer a road map to the characteristics that need to be addressed through the standardized three-pronged protocol. The length of preparation and overall treatment depend on the level of dysfunction and the number of events in need of processing.

In short, the three-pronged protocol should be used for EMDR therapy treatment or research related to any identified disorder. Furthermore, it is important to remember the difference between symptom reduction and comprehensive treatment. In general treatment, the elimination of an identified disorder should take place within an evaluation of the entire clinical picture, in order to address both individual and relational difficulties, and to ensure an adaptive integration within the larger social system. Research is needed to more fully explore treatment efficacy and parameters for a wide range of disorders (see Chapter 12).

SYMPTOM-BASED PROTOCOL

While the previous discussion addresses a disorder-based treatment, most clients present with a variety of symptoms that need to be comprehensively identified and evaluated.

Although this symptom-based approach specifically uses current problems to identify the earlier targets for processing, it is also helpful to identify the client's 10 most disturbing memories to get a good overview of problems that have occurred across the lifespan. Targeting and processing these memories can open new areas of inquiry and investigation, leading to eventual self-efficacy. Clients may have normalized dysfunctional family interactions and not be aware of the variety of ways in which they are being inhibited. It is useful to remember that the negative behaviors and feelings clients may have, such as shame, are being fed by unprocessed memories, whether the primary diagnosis is obsessive–compulsive disorder (OCD), a phobia, PTSD, or body dysmorphic disorder. While the actual diagnosis is important in order to provide a better understanding of clinical parameters and potential areas of dysfunction, it should not limit the investigation of the wide variety of emotional, behavioral, and relational distress the client may be experiencing. Each of these areas is treated in EMDR therapy with the judicious application of the three-pronged protocol.

For instance, a woman may present for treatment due to anxiety about an upcoming presentation at work. While a public speaking anxiety is the pronounced symptom, the history taking reveals that the woman has difficulty expressing herself in numerous situations. Further questioning reveals that she has never had a satisfactory romantic relationship, and she suffers from an overall inability to assert or stand up for herself. Symptom reduction would include focusing treatment on the anxiety at work. This might involve processing memories of childhood humiliations in grade school. Comprehensive treatment would also involve identifying and processing the memories contributing to her relational difficulties (including poor modeling and fighting parents). The length of treatment needed is determined by the amount of preparation required to begin processing, the number of problems identified throughout the clinical picture, the number of memories that need to be processed for each problem, and the skills that need to be incorporated for adaptive future functioning. The three-pronged protocol is utilized for each of the identified problems. The following protocol for current anxiety provides a template for the treatment of present emotional and behavioral symptoms.

PROTOCOL FOR CURRENT ANXIETY

Clients may report a number of anxieties and behaviors that are currently disturbing them. Although most clients have anxieties that are not related

to major trauma, some type of adverse experience is generally involved. The following protocol helps the clinician focus on these problems. (To identify an early salient memory, the Floatback and Affect Scan techniques may be particularly useful; see Appendix A.)

For current anxiety and behaviors, the clinician assists the client to specify (1) the anxiety to be treated, (2) the initial cause and memory (if available), or earliest remembered distressing events, (3) the current situations that trigger disturbance, and (4) the desired response. Before moving to the third stage of the protocol, the clinician should determine whether the client needs to be guided through modeling, discussions, or specific instructions regarding skills sets required to achieve adaptive functioning.

The standard procedures are used and measurements (SUD/VOC scales) are taken as the targets are reprocessed in the following order:

1. Initial or earliest memory feeding the dysfunction.
2. The worst experience(s) feeding the dysfunction.
3. Most recent or most representative example of a present situation that causes anxiety. Dissimilar situations triggering the anxiety should each be targeted separately.
4. Future projection of desired emotional and behavioral responses. It is useful to include some challenging situations to incorporate resiliency into the future template(s).

In all cases, the client's log reports guide the clinician's reevaluation of the treatment effect by indicating any disturbances that arise in subsequent weeks when the client encounters challenging situations in the real world. As usual, it is vital that the clinician then target these as soon as possible after they emerge.

EYE MOVEMENT DESENSITIZATION

EMD is the procedure I developed in 1987 and tested in research that was published in 1989 (Shapiro, 1989a). The procedure is currently used in circumscribed situations to reduce arousal and/or increase stability. While standard EMDR processing provides more comprehensive effects, EMD can be helpful in the initial stages of treatment for more debilitated clients and/or in emergency situations. It allows the clinician to target disturbing memories, or intrusive aspects of a disturbing memory, that are contributing to affect dysregulation and lack of stability. Successfully processing these memories can increase the client's ability to stay present and incorporate a greater sense of self-mastery. Whereas EMDR processing fosters an associative process, EMD procedures minimize associations to other memories by a return to the target after each set. Therefore, it can be used for symptom reduction stemming from a memory, or part of a memory,

for selected clients who might otherwise become emotionally overwhelmed and dysregulated. Once clients are sufficiently stabilized, standard EMDR processing can be used. In all cases, Phases One and Two precede targeting.

The disturbing memory can be treated by requiring the client to maintain in awareness one or more of the following: (1) an image of the memory, (2) the negative self-statement or assessment of the event, and (3) the physical sensations. However, the procedures below were tested in the first RCT (Shapiro, 1989), and appeared to be both effective in desensitizing an identified adverse event and successfully limiting associations. EMD can also be used to target an isolated sensory experience such as a sound or smell. Intrusions can be treated by focusing only on the image.

Procedural Steps

1. Identify the memory or part of the memory.
2. Use an Assessment Phase, identifying the image, negative belief, desired positive belief, VOC score, emotion, SUD level, and location of physical sensations.
3. Instruct the client to hold in mind the image and negative cognition.
4. Apply short sets of bilateral stimulation (12–20), increasing the number of repetitions as needed. At the end of each set, instruct the client to: **"Blank it out"** (the image) or **"Let it go and take a deep breath."** To "blank it out," clients can be coached simply to draw a curtain over the material. Ask: **"What are you noticing?"** or **"What do you get?"**

   Note: If these are positive thoughts or emotions, they can be reinforced with sets of eye movements).
5. Return to the target image and negative cognition after each set and obtain an SUD.

   Note: If associations to other memories arise, return to the target and shorten subsequent sets. If going back to the target image and negative cognition evokes more distress, return to the image only after each set and obtain an SUD.

   Return to the target image and negative cognition after each set until the SUD reduces to 0 (or is otherwise ecologically appropriate). If the SUD stops decreasing, check to see whether the picture or emotion has changed. If the negative belief no longer matches the picture and emotion, drop the belief and focus only on the image and emotion. If processing is blocked as indicated by the SUD not decreasing, strategies include the following:

   a. Discontinue the negative belief if it no longer fits the emotion or changed picture.
   b. Have the client scan for any other disturbance (e.g., image, sound, smell, body sensation).

   c. If another memory or belief appears to be interfering, focus on the new material without allowing additional associations until it is desensitized. This is accomplished by returning to the new material after each set. Then reaccess the original target and resume treatment.
   d. If the SUD does not decrease after two sets, concentrate solely on body sensations for consecutive sets.
6. Once the desired treatment effect has been achieved, install the Positive Cognition (PC) until the VOC score is 7 or as strong as is ecologically appropriate.

PROTOCOLS FOR RECENT TRAUMATIC EVENTS

The standard protocol for most trauma involves focusing on the traumatic memory itself. Older memories may generally be treated by concentrating on one part of the event. The target is accessed by asking the client to identify a picture that represents either the entire incident or the most upsetting part of it. Targeting this one moment of the incident usually results in the whole memory being reprocessed as other aspects of the memory come fleetingly to consciousness or as the pivotal picture changes in some way. Thus, the reprocessing effect has become generalized to the entire memory.

However, I discovered that a different approach was needed when people came for EMDR treatment just a few weeks after the 1989 San Francisco Bay Area earthquake. At that time, I found that concentrating on one part of the memory had no effect on any other part of the incident. For example, when a client reprocessed the most traumatic part of the memory, such as the chimney collapsing and nearly burying him, this did not cause him to feel better when he thought of other parts of the event. It appeared that, on some level of information processing, the memory had not had sufficient time to consolidate into an integrated whole. This is an interesting phenomenon that may ultimately shed some light on the activation and physiological mechanisms of memory itself.

Clearly, the memory of a recent traumatic event is consolidated on some level, since the client can give a serial description of the experience, but on a crucial stratum of information association, the various aspects of memory are not integrally linked. Based on clinical observation, I estimate that in the natural course of a person's response to a traumatic event, the period required for consolidation is approximately 2–3 months. Presumably, future research will define this period more precisely. The clinician can tell that consolidation of a recent traumatic memory is complete when successful treatment requires only the standard application of the processing procedures, rather than the more extended protocol.

Recent Event Protocol

The recent event protocol (Shapiro, 1995a) is recommended for an isolated individual trauma that has occurred within the last 2–3 months, such as an accident, rape, or exposure to a postdisaster environment in a developed country that is then followed by a period of relative safety and calm. However, for events such as natural or man-made disasters in developing regions in which normalized conditions have not been restored, the other two protocols in this section have been most extensively used. Research regarding the different protocols can be found in Chapter 12. For the standard Recent Event Protocol, use the following:

1. Obtain a narrative history of the event, noting the most disturbing moments.
2. Target the most disturbing aspect of the memory first (if necessary).
3. Target the remainder of the disturbing moments identified in the narrative in chronological order.
4. Have the client visualize the entire sequence of the event with eyes closed and reprocess disturbing moments as they arise. Repeat until the entire event can be visualized from start to finish without undue distress.
5. Have client visualize the event from start to finish with eyes open, and install the positive cognition.
6. Conclude with the body scan.
7. Process present stimuli.
8. Incorporate positive future templates for each trigger.

When working with a recent memory, the clinician should ask the client to describe the event in narrative form. As the client recites the history, the clinician should take note of each separate aspect of the event (e.g., "I felt myself rocking, then I heard the dresser falling, then I saw the books dropping . . . "). Each of these experiences should be treated as a separate target and processed, including a cognitive installation to a 7 VOC score (or ecologically appropriate rating) for each target. The body scan, however, should not be used until the final segment of the memory has been treated and all the targets have been processed, for only then can one expect all associated body tension to disappear.

Specifically, the client is asked to identify any part of the memory that is so disturbing it might divert attention when trying to target another part of the incident. This might occur when, for example, a flood victim lost hold of a loved one in the rising water, when a beam almost fell on an earthquake victim, or when a rape victim felt the gun against her face. Whatever part of the memory is particularly upsetting should be targeted first.

If there is no single aspect that is particularly distracting, the clinician should target the part that occurred first. If the client's level of arousal is

interfering with cognitive assessment, since the most common reaction to a recent trauma is fear, the clinician can suggest the negative cognition "I am in danger" and the positive cognition "It's over; I'm safe now." Of course, the clinician should suggest these cognitions in a manner that allows the client to select another that better fits his personal experience. As the client concentrates on the first (or most distressing) part of the memory, the clinician implements the standard EMDR procedures up through the installation of the positive cognition.

After each of the reported aspects has been treated, the clinician should ask the client to close her eyes and visualize the experience as one might run a DVD. This part of the protocol should not be confused with the hypnotic exercise that calls for a dissociation of emotions as a movie is projected on a distant screen. The reprocessing of a target calls for the client to have a full association to the material. The client is asked merely to play the entire incident in her mind as if it were a video, so that she can assess her emotional reaction to the whole event and stop it at will. Most clients can scan visual content more easily if their eyes are closed, and this may be suggested. Therefore, the client is instructed that any time emotional, cognitive, or somatic disturbance arises during this "video presentation," she should stop, open her eyes, and so inform the clinician. At that point, the EMDR procedures, including the negative and positive cognitions, are implemented with regard to that part of the memory of the event. It is not unusual for various aspects of the memory that were not previously remembered to surface as disturbing. Metaphorically, the first round of reprocessing flattens the mountains, so that clients can more easily see the hills.

After all of these relatively minor disturbances have been addressed, the clinician should ask the client to "run through the video" again with her eyes closed. Once again, any newly revealed aspects of the memory that are distressing should be reprocessed.

If there are no further disturbances, the client should "run through the video" with her eyes open, holding in mind the positive cognition, while the clinician administers a long set. However, some clients may better be able to run through the video with their eyes closed, with the clinician providing tactile stimulation. The clinician should specifically ask the client to scan the incident mentally—even though the images will not be clear—and to give the stop signal when she is finished. As an additional check, ask the client to review the entire "video" with her eyes closed, holding in mind the positive cognition to ensure that the VOC score is a 7 (or ecologically appropriate) for the entire event (each frame). If not, target that frame and repeat the installation procedures until the entire event is linked with the PC and the VOC score is 7 (or ecologically appropriate). After this, the body scan can be done.

In addition to working on the actual memory, the clinician should be prepared to address any present stimuli that may be reported to cause a startle response (e.g., a truck rumbling by), nightmares, and other reminders of

the event (e.g., seeing a crack in the sidewalk) that the client still finds disturbing. Incorporate a positive template after the resolution of each relevant trigger. While the protocol appears lengthy, it can usually be accomplished in less than three sessions, since each aspect is generally dealt with rapidly. However, clinicians should not place time restraints on clients, since their responses are unique and therefore unpredictable.

It is particularly important to remain flexible regarding the time necessary for treatment, because there is no way of knowing to what earlier material the identified target (the recent traumatic event) is linked. For clients whose earlier history contains unresolved events that are associated with lack of safety and control, a longer treatment may be required. During processing, it is not unusual for some survivors of natural disaster to recall earlier distressing memories such as physical or sexual assault. If this occurs, the clinician should determine whether it is appropriate to continue with this channel of association or acknowledge it for later processing and return to the recent event target. Factors to consider include client preference, level of arousal, current dysfunction, and time constraints. If the associations to other events are potentially destabilizing, or otherwise inadvisable, EMD can be used to complete the recent event protocol. If a highly arousing earlier event continues to intrude, if possible, it should be processed to completion before returning to the recent event. In addition, as always, the clinician should take the appropriate steps to ensure client safety, even when the presenting complaint appears to be an isolated and recent trauma.

This protocol is generally applicable to events that are up to 2–3 months old. If the event is more than 3 months old, the clinician should first use the single-trauma protocol. However, he should be prepared to switch to the extended protocol if the entire incident is not appropriately reprocessed.

EMDR Protocol for Recent Critical Incidents

The EMDR Protocol for Recent Critical Incidents (PRECI; Jarero, Artigas, & Luber, 2011) is recommended for as long as 6 months after natural and man-made disasters in locations in which conditions have not returned to normal and there has been no window of postdisaster calm/safety. Clients experience such an extended period of disturbing events as one continuous trauma. For all intents and purposes, although the critical incident occurred months ago, the trauma has extended into the ensuing months of stressful conditions. From extensive work in such situations, the authors of the protocol discovered that asking the client to describe the critical incident resulted in a detailed description of not only of the initial event but also the full aftermath through to the present. This means that many events, including inadequate food and shelter for months following an earthquake, looting and other dangerous incidents, would need to be addressed and processed.

This protocol is similar to the recent event protocol previously described, with specific alterations to accommodate the continuum of dissimilar stressful events. In addition, the tactile Butterfly Hug (see the "Self-Directed Use of BLS for Stress Reduction" section later in this chapter) can be used as the BLS if the client cannot tolerate eye movements. Although the eye movements provide more rapid processing, the tactile stimulation appears to result in fewer negative associations. This form of tactile bilateral stimulation can also be used in a group format (Jarero & Artigas, 2010).

1. Each of these many incidents in the continuum may be associated with different negative and positive cognitions; therefore, the positive cognition is neither requested nor assessed until all the events in the continuum have been processed.

2. After all the events have been desensitized, the client is asked to think of the event, and a positive cognition is requested: **"When you bring up the event, what would you like to believe about yourself now?"**

3. During the Installation phase, rather than assessing the VOC score after each set, the clinician asks, **"What do you get now?"** and allows processing to proceed. If any disturbance arises, it is targeted and processed to resolution. If no disturbance arises, the positive cognition is installed to a 7 (or ecological) VOC score.

4. Since many different incidents exist in the continuum, the client is instructed: **"Close your eyes, think of the positive cognition, and review the whole sequence in your mind holding the PC."**

On completion, the clinician asks, **"Does the positive cognition feel less than true on any part of the sequence?"**

If so, then that aspect of the memory is targeted and processed to resolution until the PC is fully valid. The body scan is then conducted.

Recent Traumatic Episode Protocol

The Recent Traumatic Episode Protocol (R-TEP; E. Shapiro & Laub, 2008) has also been recommended for use with extended traumatic events and emergency situations. It posits a "trauma episode" to address disturbance related to a recent event that continues for the client through to the present. The primary strategy of the R-TEP for processing is "EMDr," which focuses on various points of disturbance within the trauma episode, one at a time, and restricts associations to the current trauma. The EMD strategy is advised for painful intrusions. If the SUD is not reduced after about six sets, then it may be expanded to the wider EMDr strategy. Similarly, if the EMDr strategy is not successful, it may be contracted to the narrowly focused EMD strategy to try to obtain movement. When the SUD levels

fail to reduce sufficiently, that likely indicates that earlier traumas may be blocking processing and need to be addressed. In that case, the standard EMDR protocol may be offered.

Basically, the R-TEP is used with the following alterations:

1. The client is told that treatment will focus, as much as possible, only on the traumatic episode.
2. During a continuous set of eye movements, the client is asked to narrate what occurred from before the critical incident, through to the present. The eye movements used are slower than usual (about one back-and-forth per second), in order to hear the story while assisting containment.
3. The client scans the episode for a point of disturbance during continuous BLS.
4. When it is identified, the point of disturbance is assessed and processed to resolution using SUD and VOC scores as in the recent event protocol. However, clinical strategies for processing vary:
   a. EMD is generally used to target disturbing visual, cognitive, or sensory intrusions related to the point of disturbance.
   b. Focused/restricted EMDr is generally used to process other points of disturbance, with the associations confined only to the episode by returning to target if other events emerge.
5. After the SUD and VOC scores are determined to be ecologically appropriate for the targeted point of disturbance, another scan for a new point of disturbance is initiated and processed to resolution.
6. After each of the points of disturbance are processed to resolution, and a new review of the entire episode reveals no additional disturbance, a PC is installed while scanning the episode and a body scan is completed.
7. If the entire episode cannot be brought to an ecologically appropriate resolution, with the client's permission, standard EMDR processing is used, as in the recent event protocol.

PROTOCOL FOR PHOBIAS

Many trauma clients have phobias that may require separate treatment. For other clients, the initial experience of fear has taken on traumatic proportions. In addition, clients with phobias may be continually traumatized by the "fear of fear" and of the ongoing phobic experience (e.g., the ever-present danger of encountering a feared object, such as a dog). Many clients have organized their lives around avoiding the feared object or event. Therefore, it is important that the clinician do the appropriate clinical work to help the client fully assimilate newly acquired fearless behaviors.

For the purposes of EMDR clinical evaluation, phobias may be divided into two classes, which are designated as "simple" and "process." A "simple phobia" is defined as fear of an object (e.g., a spider) that is circumscribed and independent of the client's actions. The fear is generated by the sight of the object and is independent of further participation. Many times, these phobias are easily handled by steps 1–3 below. However, since unexpected encounters and needs may arise, it is important to incorporate future templates involving approach anxiety to deal with the possibility. Furthermore, if a deliberate interaction with any feared object is needed in daily activity (e.g., approaching a dog at a neighbor's house or cleaning a spider-filled attic), it is important to address each aspect of the anticipated encounter.

A "process phobia," on the other hand, is defined as fear of a situation in which the client must actively participate with multiple actions over an extended sequence of time. For instance, a phobia of flying requires the participation of the client: In order to be in the feared situation, the client must purchase a ticket, drive to the airport, and get in the airplane. Therefore, when targeting a process phobia, the clinician must address all the pertinent aspects of the experience, including decision-making and anticipatory anxiety during all the needed activities. It should be remembered that the phobia diagnosis is given because of avoidance that debilitates the client's current life. Although the procedures for the simple phobia may eliminate the client's perception of fear, they may not overcome (without the full steps) the evolutionary biases (e.g., disgust at the sight of spiders or discomfort around snakes) or a surprise appearance that presents a challenge in daily life. Therefore, while Step 4 may not be appropriate for a simple phobia, it is advisable to include Steps 5 and 6 for all clients. The steps are as follows:

1. Teach self-control procedures to handle the fear of fear.
2. Target and reprocess the following:
   a. Antecedent/ancillary events that contribute to the phobia
   b. The first time the fear was experienced
   c. The most disturbing experiences
   d. The most recent time it was experienced
   e. Any associated present stimuli
   f. Any current catastrophic thoughts involving anticipatory fear
   g. The physical sensations or other manifestations of fear, including hyperventilation
3. Incorporate a future template for fear-free future action.
4. If appropriate, arrange a contract for action.
5. Run mental video of full sequence of action and reprocess disturbance.
6. Complete reprocessing of targets revealed between sessions.

During history taking, the clinician should ask questions to determine how the fear came about, which could be a personal or vicarious experience. Additionally, what does the client believe will happen if the feared event should occur in the future. It is useful to ask, **"What is the worst thing that would happen?"** The clinician should assess whether the client's fears are realistic, or based on faulty information. If the latter, the clinician offers the appropriate education.

The use of self-control techniques is particularly important for clients with phobias. Many phobias entail a fear of fear. Clients may report that they have avoided the activity so long that they no longer know whether they actually still fear it. Rather, they are afraid of being overwhelmed by the fear itself if it arises. This is a very appropriate attitude if the client has never been able to deal with fear adequately. In order to address this problem, the clinician should teach the client several self-control procedures, some of which are described later in this chapter. The client should practice these techniques in the office until she has achieved a degree of self-mastery and feels she can handle a certain level of anxiety and fear with a measure of confidence.

Most clients need to learn how to identify the physical sensations that accompany the cognition "I am afraid." Concentrating only on the global sense of the emotion can be overwhelming for clients. If, instead, a client can learn that the physical sensations he equates with fear are simply sensations felt in his stomach and chest, for example, and that they are amenable to change, he will gain a greater capacity for controlling them. The ability to identify these sensations also implicitly allows the client to perceive himself as larger than the fear, since he can cognitively separate himself from it and place it under his control.

If symptoms of fear, including hyperventilation, arise during the treatment session, the clinician should target those physical sensations with successive sets. The clinician should speak soothingly to the client as the fear arises, encouraging him as follows: **"Just notice the sensations; don't force them one way or another."** Continuing the set through the fear, even in the case of a full-blown panic attack, may dissipate the disturbing emotion and reprocess the client's fear of fear. After the fear has subsided, the clinician should review a self-control technique (e.g., a Safe/Calm Place exercise) with the client. This can reaffirm the client's ability to handle any fear that might arise.

While the protocols for both simple and process phobias are straightforward, the clinician must first explore the client's history in order to identify any secondary gain issues that may exist. For instance, a client had reported a fear of snakes as her presenting complaint. However, during the history taking, it became clear that there were several factors contributing to the phobia, including boundary issues, lack of assertiveness, and low self-esteem. An inquiry into the client's marital relationship revealed that

her husband was domineering and got his way on most issues; in addition, he was a camping fanatic. Thus, it appeared that the client's snake phobia conveniently provided her with an acceptable excuse to stay home rather than accompany her husband on overnight excursions. (The same factors would apply in the case of a process phobia in which the wife is afraid of flying, thereby keeping her traveling salesman husband from insisting that she accompany him on his cross-country trips.) Clearly, until secondary gain issues (often rooted in family-of-origin material) are handled, phobias will not be amenable to treatment.

As with all treatments, clients should be reassured that there will be no pressure to perform or to conform to any outside standard. Clients should also be made to understand that giving up the fear does not mean they must engage in any particular activity: Relinquishing a fear of snakes does not force one to take up camping; losing a fear of heights does not necessitate skydiving. The clinician should make it clear to clients with phobias that the right to choose is theirs and that their actions need not be motivated—or mandated—by either the presence of fear or its absence.

In all cases, the clinician must explore the genesis of the fear, because it may be rooted in an event that is apparently quite separate from the actual phobic response. For instance, one client reported a fear of driving a car. Every time she was confronted with an unanticipated situation while driving, she experienced a panic attack. History taking revealed that before her first phobic response, she had been an exchange student in Europe. Since she did not know anyone well, she had been delighted to be invited to a party by a fellow student. Unfortunately, after drinking some punch, she had begun to feel ill and had left the party. Once back in her room, she began to experience hallucinations, apparently because someone had spiked the punch with LSD (lysergic acid diethylamide). Frightened and alone and feeling completely out of control, the client had spent a terrifying night until the hallucinations subsided. Subsequently, while driving a car she had experienced a similar sense of loss of control during a near accident and had panicked. This feeling of panic evidently generalized to any experience of loss of control when behind the wheel of a car, even relatively minor ones. Obviously, before attempting to focus on the phobic response, it was necessary for the clinician to target the earlier experience of terror during the LSD hallucinations. Childhood experiences that may contribute to a "fear of fear" due to humiliations or unmet needs should also be explored.

Once the appropriate antecedents of a phobia are fully reprocessed, a full EMDR treatment, including installation and body scan, should be carried out on each event in the following order: The first memory is targeted first, because it is assumed to include the stimuli pertinent to the genesis of the fear and the physiological responses that need to be processed. The most frightening incidents are targeted second, because they are assumed to include exacerbating stimuli. Other disturbing experiences related to the fear (e.g., being humiliated) should also be processed. The most recent

memory is targeted third, because it is assumed to include stimuli that have become potent because of second-order conditioning. Additional stimuli should be processed separately, as there are various independent situations that can trigger the fear. For instance, in the case of a process phobia of flying, one client may become afraid only when a personal trip is imminent, another may be fearful whenever a family member has to travel, and still another not only may fear these situations but also may become fearful when hearing a plane overhead. Triggers should be appropriately reprocessed before attempting to incorporate any positive template for the future. For generalized phobias, such as claustrophobia, a representative incident of each anxiety-producing situation should be targeted (e.g., elevators, traffic jams, theater seats).

A helpful addition for some clients is the processing of "flashforwards" (Logie & de Jongh, 2014). If fear still persists once the past events and current external stimuli have been targeted and processed, the client is asked to imagine what would happen if he were to encounter the feared object or experience in the future. Some clients report fear based on a "disaster image" of what might happen. This is viewed as an internal stimulus, and it is treated like a present trigger. If it exists, the client is questioned to determine the worst possible outcome (e.g., **"What would be the worst thing about that happening?"**), and the imagined scenario is processed to resolution with the standard procedures. The authors suggest that useful negative and positive cognitions for these imagine scenarios, respectively, are "I'm helpless" and "I can deal with it." After all the past events and current triggers have been processed, a future template is installed.

With a simple phobia, a future template is incorporated by initially using a single image, for instance, to imagine being in the presence of a snake while feeling calm and relaxed. This projection should be reprocessed until it reaches a 6 or 7 on the VOC scale. Often, clients will stop at a VOC level of 6, because they feel a need to experience the feared object firsthand to be fully convinced that they are not afraid of it. The client is then asked to imagine a video of encountering the feared object (e.g., approaching a spider), and any disturbance is processed as well. Regardless of the client's anticipatory state, he should be cautioned to maintain a log of any negative responses, which will be used as targets for future treatment. The log entry should constitute a good snapshot of what occurred, including images, thoughts, and physical sensations. For the claustrophobic client, a future template should be installed for every trigger.

In the case of a process phobia (or when any object or situation must be deliberately approached with multiple actions), it is necessary to address the issue of anticipatory anxiety, as well as any cues that evoke fear owing to second-order conditioning. For instance, once a client who is afraid of flying can imagine herself riding without fear in an airplane, a contract is made to have her actually take a flight within the month. The client is then asked to close her eyes and imagine a video recording of the time between

the present session and the successful completion of her return plane trip. If any part is distressing, the client opens her eyes and each disturbing aspect of the process (choosing a destination, calling the airline, packing, driving to the airport, etc.) is reprocessed as a separate target. The process is repeated until she can view the entire mental video without fear.

The client must also report any fear or anxiety that arises as she takes the actions necessary to fulfill the contract. She should use the self-control techniques she has learned and keep an accurate record of each stimulus and her response to it for future processing. In all cases, the clinician should help the client to view her fearful reactions as feedback rather than as failure. It may be useful to emphasize for the client that some moments of fear are to be expected in the ensuing weeks and it is only necessary that she identify these moments for targeting. This may lower the expectation of treatment effects sufficiently, so that the client will not become unduly discouraged if fear momentarily emerges. The client should be encouraged to enter the situation that exposes her to the stimulus as an adventure of exploration, not merely as a prelude to successful resolution.

It is also possible that the primary phobic response will completely disappear when EMDR processing is applied only to the genesis event. However, the full treatment protocol should be implemented, when possible, to prevent future reactivation of the phobia. Occasionally, *in vivo* exposure may in some cases be helpful, particularly when triggers do not remit (see Shapiro & Forrest, 1997/2016). However, the real-life exposure is used simply to activate the fear in the presence of the therapist, so that it can be targeted and processed. The client is not asked to confront the situation and maintain the fear for an extended period, as in other forms of therapy. Another purpose of real-life exposure is to invite the client to participate in the previously feared event or encounter to ensure that the phobia is fully treated. However, unlike other forms of therapy, clients are asked to engage in the behavior and evaluate the outcome only when they feel confident and in control.

PROTOCOL FOR COMPLICATED GRIEF

The loss of a loved one is often a traumatic experience. The amount of suffering may be intense and last for varying amounts of time. Under normal circumstances, people eventually overcome their grief over the loss. However, this process of adjustment can suffer impediments, as indicated by a persistent high level of suffering and self-denigration. Using EMDR processing may prove difficult for clinicians who believe people need a set amount of time to "learn from their grief" or pass through a "natural" grief process. However, as we have noted, EMDR does not eliminate or even dilute healthy, appropriate emotions, including grief. Rather, it can allow clients to mourn with a greater sense of inner peace. For a comprehensive

explication, see the three-session verbatim transcript in the EMDR casebook (Shapiro & Forrest, 1997/2016). For detailed overviews of clinical application and additional case reports, see Solomon and Rando (2007, 2012).

Directly after the death of a loved one, a person may first experience a profound emotional shock accompanied by numbing that prevents him from feeling the emotional pain. Psychological first aid, rather than EMDR processing, is recommended at this stage (see Solomon & Rando, 2007). However, once the emotional impact is experienced, there is no reason to withhold processing, as long as the client has the capacity for dual awareness and the ability to stay present with the emotional pain. With excessively grief-stricken clients, the following should be targeted and reprocessed, as necessary:

1. The moment of realization of the loss, which is often when the mourner received the news of the death. However, it can also take place before it (e.g., "The moment when the doctor came out of surgery and shook his head").
2. Other actual events, including the loved one's suffering or death, or distressing events taking place after the death (e.g., "A month after the automobile accident I saw pictures of the car and realized nobody could have survived that crash").
3. Intrusive images, including vicarious images (e.g., some mourners, who were not present, may have images of what their loved ones suffered when they died).
4. Nightmare images.
5. Present triggers.
6. Issues of personal responsibility, mortality, or previous unresolved losses.
7. The Butterfly Hug (described later in this chapter) may be offered for self-soothing, until the therapy process is complete.

The EMDR protocol for excessive grief is similar to the standard protocol for trauma. Many clients report that their feelings of grief, sadness, and guilt are linked to intrusive memories, dreams, or fantasies of the loved one that seem to block their access to any pleasant memories or associations (see "Access Restricted to Negative Material" in Chapter 2). With EMDR therapy, processing the trauma of the loss allows the positive memories to reemerge. Research has also indicated increased positive recall of the deceased following treatment (Sprang, 2001). Therefore, the negative images should be targeted and appropriately reprocessed. For example, a mother whose daughter had committed suicide in a mental institution blamed herself for her child's death. Any reminders of her daughter elicited terrible images of her child's suffering during the mental breakdown, along with concomitant feelings of guilt and powerlessness. After the negative

images had been processed, the images that emerged when the clinician said, **"Think of your daughter,"** were of happy childhood scenes of play and a ballet. The use of EMDR processing allows clients to continue the period of adjustment and loss, but without the knife-sharp edge of intense pain.

Often, targeting the appropriate level of responsibility and any concerns clients have regarding their own present safety is crucially involved in the treatment of excessive grief (Solomon & Shapiro, 1997). Because these factors are likely to be masked by intense sadness and emotional pain, they may become apparent only during processing. It is important, therefore, that the clinician maintain a respectful, nurturing attitude when clients reveal these previously hidden aspects of their suffering. For example, a negative emotional response may be the result of guilt engendered by the client's memories of being harsh or unkind toward the loved one. These incidents should be targeted for reprocessing.

The client's suffering because of the loved one's death may be compounded by a reactivation of earlier experiences of unresolved emotional loss. Such losses should be processed as they emerge. In addition, because the target situation is the death of a loved one, it is crucial that the client be carefully questioned (for appropriate targeting) about any distress that he may have experienced between sessions, particularly thoughts about personal injury or the mortality of other family members.

The use of EMDR therapy should allow the grieving client to accept his painful personal loss and enable him to think back on various aspects of his life with the loved one, with a wide range of feelings, including, hopefully, an appreciation of the positive experiences they shared. EMDR processing appears to reactivate the blocked system that is symptomatic of pathological grief, to accelerate the processing of dysfunctional information, and to allow appropriate, healthy insights and emotions to emerge.

I cannot stress enough, however, that EMDR processing does not eliminate or neutralize appropriate emotions, and it does not forestall personal growth. Thus, when EMDR is used, a grief-stricken client will naturally—and in his own way—move toward acceptance of his loss, while simultaneously resolving impediments to recovery.

Even after a given treatment session, information processing and the enhancement of various stages of recovery continue. Therefore, the clinician need not feel obliged to decide for the client how long he should suffer before implementing EMDR processing. The clinician should feel free to use it at any time, especially since no clinical model can predict with certainty the optimal recovery time for a given client, and no clinician can fully appreciate the pain he is experiencing. Furthermore, setting an arbitrary time limit before EMDR processing can be attempted (e.g., **"You should grieve at least 3 months/1 year/2 years"**) is antithetical to the notion of the ecological validity of the client's self-healing process. As is true for all other clinical populations, if the felt emotion (and its intensity)

is appropriate for the grieving client, it will remain despite the application of EMDR.

One case of excessive grief involved a woman whose infant son had died. Just prior to his death, she had nursed him through the night while telephoning and begging her physician to admit him to the hospital. The doctor continued to reassure her and insist that she keep the child at home. Holding her son to her breast, she rocked him through the night until they both fell asleep. When the mother awoke the next morning, the baby was lying dead against her chest. Her feelings of pain over this death were immense, and she sought relief from an EMDR therapist. After the 90-minute treatment session, she said, "I can feel him in my heart. I'm grateful for the time we had together. He's in a better place." Such a dramatic release from suffering after a very brief period of therapy directly addresses the question of how long the clinician should withhold therapy from a client. The answer, I believe, is to leave the decision to the client.

PROTOCOL FOR ILLNESS AND SOMATIC DISORDERS

The following protocol is included to underscore that many victims of physical illness are suffering from psychological trauma. This is now widely recognized in the psycho-oncology literature, indicating the need for treatment (Antoni, 2013; Bower, 2008; Bruce, 2006; Bultz & Johansen, 2011; Chirico, Lucidi, Mallia, D'Aiuto, & Merluzzi, 2015; Hahn, Hays, Kahn, Litwin, & Ganz, 2015; Reiche et al., 2004; Thompson, Eccleston, & Hickish, 2011).

While trauma responses, such as PTSD, are easily diagnosed in clients who have suffered rape or battlefield stress, many clinicians do not recognize that the assault on the psyche of the client may be just as severe—or even more severe—when the perpetrator is perceived to be the client's own body. Although in DSM-5 illness is no longer designated as a Criterion A event for the diagnosis of PTSD, clinicians should take care to assess the client for a full range of symptoms. Whether the psychological effects are debilitating because of the pain and fatigue of chronic illness or because of the impact of a catastrophic disease, such as cancer or AIDS, such clients must be treated with the same nurturing concern afforded the rape or wartime victim. Indeed, in many instances, the psychological and social issues that must be addressed are similar. For detailed client applications, see the EMDR casebook (Shapiro & Forrest, 1997/2016). To date, RCTs have been published evaluating EMDR therapy with cancer patients and with multiple sclerosis patients (see Chapter 12). Additional research is needed to evaluate efficacy of both symptom severity and quality-of life-dimensions (see also Shapiro, 2014a).

In brief, the EMDR protocol for working with illness and somatic disorders is as follows:

1. Teach affect regulation techniques. Create an action plan to address real needs.
2. Identify and target intrusive thoughts and secondary gains.
3. Identify and reprocess relevant memories, present situations, and fears of the future dealing with
   a. Personal or physical constraints
   b. Social issues
   c. Medical experiences
   d. Chronic pain
4. Run "video" of the next 1 to 5 years. Process disturbance and fears and incorporate positive future templates.
5. Use log and self-care procedures.
6. If appropriate, use adjunctive imagery with cognitive groundwork.
   a. Identify suitable positive cognition.
   b. Link image and positive cognition.
   c. Assign homework with the self-use procedure.
   d. Use a log report.

This protocol addresses both psychological and physical factors related to somatic complaints. However, it should not be a substitute for appropriate medical care but an adjunct to it. Although the protocol will be discussed in the context of treating a cancer patient, it can easily be amended to apply to the psychological (and possibly physical) concomitants of any illness, physical complaint, or somatic disorder (for more detailed descriptions, including multiple case illustrations related specifically to working with cancer patients, see Faretta & Borsato, 2016; Murray, 2016).

For many clients with somatic complaints, addressing the psychological dimensions causes partial or complete remission of the physical symptoms. When primarily organic processes are involved, the psychological issues may be viewed as exacerbating the physical condition (Dupont et al., 2014; Everson et al., 1996; Hahn et al., 2015; McGregor & Antoni, 2009; Mitchell et al., 2011). While physical symptomatology may not remit, the clinical emphasis is on improving the person's quality of life. Very often, the client's psychological tension or self-identification as a helpless victim is the most debilitating factor. Since stress and negative psychological states such as depression appear to be correlated with reduced immune function (Lutgendorf & Andersen, 2015; McGregor & Antoni, 2009; Segerstrom & Miller, 2004), it is important to assess and process targets accordingly.

A perfect example of the psychological determinants of the quality of a person's life in the face of debilitating conditions is seen in the life of Ronald A. Martinez, who served as one of the EMDR Institute's first educational associates. When Ron was a 15-year-old sports fanatic, he made a simple dive into a swimming pool—and became a permanent quadriplegic. One day, many months later, he made the choice between remaining an invalid on the dole, which his friends told him was a completely acceptable

option, and making something of his life (Martinez, 1992). He chose the latter and became a loving and extraordinary clinician who inspired thousands of people. Ron remains the exemplar of a principle that has become central to EMDR therapy: "It's not what happens to you but how you deal with it that matters."

All clients should be prepared with affect regulation techniques to deal with the psychological and physical challenges inherent in their current conditions. Obviously, in the case of a permanent disability, the clinician should address issues of finances, career, relationship changes, and so on. EMDR processing will not eliminate the fears or anxieties related to issues that should be addressed by means of education or action. Only after devising a plan of action and addressing the client's most pressing needs should the clinician deal with the psychological ramifications of the disability. If this is not done, realistic fears may interfere with the client's ability to focus on and reprocess the dysfunctional material. Once a practical plan has been developed, the clinician can use EMDR processing to target any dysfunctional fears or doubts that the client may have about implementing it. However, an exception to this strategy is when the primary presentation is pronounced, intrusive symptomatology. In this case, the primary intrusions should be addressed before targeting the rest of the symptoms, because the fears engendered by the intrusive symptomatology can hamper the client's ability to think logically and effectively enough to construct appropriate action plans.

With cancer, as with most presenting pathologies, the EMDR model requires a search for the relevant memories, present factors, and fears of the future. EMDR processing should target all the identified problem areas. Research indicates that adverse childhood and other life events are correlated with the development of a wide range of physical disorders (Felitti et al., 1998; Kelly-Irving et al., 2013; Kendall-Tackett, 2009). When possible, these events should be identified and processed. In addition, a detailed client history may reveal patterns of self-sacrifice and difficulty in dealing with anger. With any illness, the issues of secondary gain engendered by these kinds of patterns must be addressed. For instance, practically everyone has had the experience of backing out of a social obligation by using the excuse of not feeling well. This is one of the few generic excuses that is met with sympathy rather than hurt feelings. The clinician should pay careful attention to the client's ability to draw appropriate boundaries, voice appropriate needs, and take appropriate levels of responsibility. Some clients can permit themselves to cease nurturing others only when they are physically unable to do so. For other clients, illness is the only way they can receive nurturing because of either earlier modeling or actual present-life circumstances.

The clinician should be sure to assess present factors, which in addition to the feelings of vulnerability, fear, and anxiety caused by the diagnosis itself, may include a no-win situation that is adding to or generating feelings

of helplessness and hopelessness. Special attention should be directed to the treatment of depression, which may have a variety of underlying causes in addition to the diagnosis. Furthermore, it is important to address the systems issues in relation to the disease. In the case of children with cancer, it is important to assess the parents' need for EMDR treatment to ensure their ability to give appropriate support. In the case of adults, not unlike the rape victim, the sufferer of a catastrophic illness must confront the reactions of family and friends. It is not unusual for the presumed support system to fail because friends are negatively affected by the client's disease. In some cases, they are so distressed at the thought of losing the person or by thoughts about their own mortality that they abandon the client. In other cases, friends may deal with the situation by minimizing the possibility of death or by exerting strong pressure on the client to maintain an optimistic facade. The full clinical picture must take into account these possible reactions and the client's emotions. It is not unusual for feelings of guilt and helplessness to dominate the client's consciousness to the point that she is unable to establish appropriate boundaries and personal stability without clinical assistance.

Besides addressing social issues, the clinician should assess the impact of medical procedures and professionals on the client's psychological stability. Memories of distressing medical experiences can be detrimental to client comfort. For instance, a cancer patient sought treatment with EMDR therapy because her only hope appeared to be a new experimental treatment for her metastasized cancer. The problem was her inability to decide whether the possible benefits of the treatment outweighed the possible adverse effects on her quality of life, because of intrusive thoughts related to an earlier negative reaction to chemotherapy. EMDR processing was used to metabolize the earlier memories and instill a feeling of control and ability to choose. When the client decided to undergo the experimental cancer treatment, EMDR was also used to process the inappropriate fear and to provide her with a variety of coping skills to be used during treatment, which were incorporated and strengthened through the use of future templates. After undergoing the chemotherapy, the client reported that her state of mind during the medical procedure allowed her to experience it with ease. She also noted that the experimental medical procedure had produced the fewest negative side effects of any cancer treatment she had undergone.

The clinician should also take care to assess and address the negative consequences of any insensitive remarks that may have been made to the client by medical personnel. The unfortunate tendency of some physicians to use fear to motivate clients to comply with treatment regimens can have a highly negative effect on client stability. Any disturbing events of this nature should be targeted at the initial stage of the protocol.

It is vital that the clinician address the client's future and pose (and perhaps target) questions such as "Who am I without the cancer?" and "What

do I have to change or confront?" If they apply, the memories that laid the groundwork for feelings of low self-esteem and powerlessness must be metabolized. Issues concerning parents, family, significant others, career, identity crises, and present disturbances must also be addressed through processing the triggers and incorporating positive future templates. Family therapy may be necessary to allow family members to adjust to a new image of a mortal parent or spouse and to concomitant feelings of anger, betrayal, and grief.

The clinician should work with family members to process any of their responses that are distressing to the client, thus enabling the family to provide the greatest support. If the client is forced to focus continuously on the dysfunctional responses of the family, his sense of helplessness and lack of control will be intensified. If family members are not available for treatment, EMDR processing should be used to help the client adjust to his family as they are, not as he wishes them to be.

Ultimately, the client must explore the question, "Do I want to live?" along with any negative concomitant emotions that arise. Processing of inappropriate fears and expectations can help the client arrive at an affirmative answer.

In order to process any residual dysfunction most effectively, it is useful to have the client envision himself in a healthy state in the future. The client is asked to "run a video," along with a positive cognition, of the next 1 to 5 years of his life. Whenever the client notices undue disturbance or doubts, BLS should be initiated. Clinicians should utilize the full three-pronged protocol as needed.

It is important for the client to keep an ongoing log during the week after each session and report any disturbing experiences in the subsequent session. EMDR processing should be used to address not only fear but also all the disturbing experiences related to the cancer, including feelings of body betrayal; the real or perceived callousness or indifference of medical personnel, family, and friends; and negative emotions related to hospital stays, medical tests, and operations. An additional important target, particularly with cancer, is fear of recurrence. Although it is often a realistic concern, too much fear and stress can negatively impact the immune system. The goal is to minimize future anxiety by shoring up personal strengths, resources, and beliefs such as "I can handle whatever comes my way."

While the following section addresses ways to potentially bolster the immune system in order to facilitate the healing process, premature death may be inevitable for some clients. It is important, therefore, to couch this material in a way that not only invites possible healing but also concentrates on the quality of life of the client who may, in fact, be dying. Ultimately, if the client must accept death from the illness, the clinician should use EMDR processing to target the client's ability to reconcile with her family and friends, put her estate in order, and cope with her fears of death itself (see also the case illustrations in Shapiro, 2012; Shapiro & Forrest,

1997/2016). An imagined video of the future may be played for this purpose as well. EMDR therapy has also been used in the hospital to assist clients suffering from intractable pain to let go of the guilt they feel about wanting to die and be released from their pain.

In attending to the psychological dimensions or the disease process itself, it is vital that the clinician help the client to feel empowered, not guilt-laden. When discussing the possibility of mobilizing resources to assist in the healing process, the clinician must take care that the client does not infer that she is responsible for her illness. Such a misperception can leave a client feeling that if she is not cured, it is her fault. This is devastating to treatment and should be avoided at all costs.

The client must be made to understand that she is not responsible for the disease because her susceptibility to stressors that inhibit the immune system may be genetic and the early modeling that encouraged some types of reactions and any contributing psychological characteristics were foisted on her long before she had any choice in the matter. The concept of a potential healing process must be explored in a way that does not contribute to additional tension or self-denigration. It is important to convey to the client that just because she is attempting to catalyze her own healing does not mean that she is to blame for the disease.

An excellent resource on bolstering the immune system and mobilizing all resources to combat the cancer disease process is a classic book called *Getting Well Again* (Simonton, Matthews-Simonton, & Creighton, 1992). Back in the 1970s, when working as a psychologist and radiologist team, the Simontons received referrals primarily of terminally ill patients. They were intrigued by the question of differential survival rates among these patients, and their analysis revealed that these rates were often correlated with the patients' attitude and mental imagery. In addition to psychosocial support and psychotherapy, the Simontons suggested helping patients to formulate a mental image of the immune system as a powerful entity capable in some way of defeating the weak cancer cells. In many instances, a positive effect on quality of life was reported as a result of enhanced mental attitude and these imagery exercises. Many researchers in the field of psychoneuroimmunology have supported the Simontons' early findings (Cousins, 1989; Pelletier, 1977; Roffe, Schmidt, & Ernst, 2005; Rossi, 1986; Siegel, 1989; Solomon & Temoshok, 1987; Walker et al., 1999). This adjunctive imaging technique may be useful in addition to the usual stress reduction techniques taught as part of the standard EMDR therapy protocol to further enhance the sense of self-efficacy. Clinicians who have incorporated this imagery report that patients have stated it helped them feel empowered in the face of such an event.

In order to assist the client in creating a positive mental state and potentially helpful imagery, I suggest a good cognitive groundwork. Assure the client that cancer cells are vulnerable in the body. This is why chemotherapy and radiation therapy work; they kill off the cancer cells while the

stronger, healthier cells survive. Often, EMDR processing may be used at this point to work on some problematic statements that may have been made by medical personnel regarding the cancer's potency. In addition, clients often report distress when remembering the look on their doctor's face as they received the diagnosis, a look they associate with the delivery of a death sentence.

One drawback to the imagery advocated by the Simontons is that it entails picturing the immune system as an overpowering force in a war-like state, for example, as wolves or as artillery whose job is to destroy the cancer cells, which are pictured as a weaker enemy. While this type of imagery was excellent for some clients, it was extremely troubling for others because of their pacifist views. It is important, therefore, that the imagery used by clients be geared to their psychological makeup and personal beliefs. A destructive, war-like force may be appropriate for some, whereas an image of the heart of Jesus or another spiritual icon sending in a healing light is a better choice for others. Once again, with EMDR therapy, it is important to employ a client-centered approach, which allows clients to choose the images and cognitions that work best for them. The objective is to provide a dynamic image of the cancer cells being destroyed and leaving the body.

Once an appropriate image has been selected, the ease of application, along with the choice of an appropriate cognition, should be addressed. One client who worked with the Simontons had developed an image of electricity coming through the top of his head and moving through his entire body, killing all the cancer cells. However, when presenting for EMDR therapy, he reported that he had used the imagery only rarely and, in addition, that the electricity often got "stuck" in certain parts of his body and would not proceed the entire way through. The EMDR clinician first asked the client to formulate a positive cognition to go with the picture. He chose "My immune system heals me." He was then instructed to hold simultaneously in mind the picture of the electricity and the positive cognition; then the eye movements were added, until the cognition became stronger. He was next instructed to close his eyes and imagine the electricity moving throughout his body. Whenever it got stuck he was to open his eyes, and the eye movements were used until the electricity began moving freely again. EMDR processing was used repeatedly in the office, targeting the linked cognition and image, until the client could easily access both of them, with an attendant sense of power. Homework was then assigned that instructed the client to use the imagery, cognition, and eye movements (self-directed use is discussed later in this chapter) at least three times a day. The client decided that he would rehearse the imagery every time he urinated, thus reinforcing his positive cognition with the thought that the cancer cells were being washed out of his system; that is, he simultaneously used the imagery, the eye movements, and the thought, "It will take away all the poison."

When possible, the image and positive cognition should be linked continuously when BLS is used. The clinician should instruct the client in the

self-directed use of BLS to ensure continuous processing during the imagery homework. The Butterfly Hug (described later in this chapter) would be the first choice. However, when that is not possible, such as in previous case, the eye movements may be prescribed. While it is usually inadvisable for clients to use the eye movement sets at home because of potential abreactions, an exception is made with this protocol, because the imagery and cognition that will be targeted at home have already been treated by repeated eye movement sets in the clinician's office. Therefore, any dysfunctional material in the channels associated with the target will already have been reprocessed before the client uses BLS at home. The client should record in his log any doubts, resistance, pertinent memories, or current upsets that may arise during the self-directed use. These should be targeted for processing during the subsequent session.

Once again, it should be emphasized that many victims of severe illness are likely to be suffering from posttraumatic stress symptoms as well. While this concomitant is quite apparent with rape or molestation victims, it may also occur when the perceived perpetrator is the victim's own body or immune system. Because the resulting sense of powerlessness and self-disgust can be quite paralyzing, the clinician must be careful to frame the work in terms of self-healing, a focus that helps to restore the client's sense of power and choice.

For all clients with somatic conditions, relaxation and pain-control techniques, such as those given later in this chapter in the section "Self-Control/Closure Procedures," can be helpful in producing a sense of self-efficacy. Encouraging clients to make use of supportive and/or psychoeducational groups (Edelman, Craig, & Kidman, 2000; Spiegel, 2014; Spiegel, Kraemer, Bloom, & Gottheil, 1989) and one or more alternative health care approaches, such as massage or nutrition, to promote a sense of self-nurturing and to mobilize psychological resources and a greater sense of control may also be beneficial. Self-care and the logging of doubts and fears are ongoing processes, and any client concerns or restrictions should be targeted by the clinician.

EMDR treatment may be considered essentially complete when clients can envision themselves as healthy and a body scan reveals no negative sensations. Although the image of good health is strengthened by EMDR processing, it must, of course, be done with realistic goals. In other words, EMDR can help to empower the client to do whatever it takes to attain a positive quality of life that is enhanced by a sense of control and self-efficacy, and through the present EMDR protocol, the body may be mobilized to do what it can to enhance the healing process. Ultimately, however, the client needs to reconcile himself to the outcome of his illness or injury, whatever that turns out to be. He must be convinced that although reaching for something does not ensure that it can be grasped, nothing can be accomplished without the attempt.

PAIN CONDITIONS

Several published case series (e.g., Grant & Threlfo, 2002; Mazzola et al., 2009) and three RCT (Gerhard et al., 2016; Maroufi et al., 2016; Rostaminejad et al., 2017; see Chapter 12) have reported positive effects in the treatment of pain. Treatment, described below, has combined the standard EMDR therapy three-pronged protocol and a variety of pain protocols (e.g., Grant, 1998). According to some reviewers (e.g., Ray & Zbik, 2001), the results achieved with EMDR therapy differ from those obtained by cognitive-behavioral therapy (CBT), in that with EMDR processing, the pain sensations can actually be substantially reduced or eliminated rather than merely controlled. From an AIP model perspective, for many clients, the current pain is caused by the physical sensations resulting from an illness or injury that are now stored as unprocessed memories. This is best typified in cases of phantom limb pain, in which the body part is no longer present (e.g., de Roos et al., 2010; Rostaminejad et al., 2017; Schneider, Hofmann, Rost, & Shapiro, 2008). In the majority of cases, by targeting the memories and sensations, EMDR therapy processing can result in substantial reduction or even complete elimination of the pain in three to 15 sessions. For those suffering from chronic pain, including phantom limb pain, relevant targets for processing that have been found useful, depending on client history and need, include (1) the event(s) during which the body part was injured; (2) the first incidence of pain; (3) any disturbing memories related to the injury (e.g., loss of a limb) or the pain, including an inability to function optimally and the reactions of other people to the disability; (4) the pain sensations themselves; (5) future concerns; and (6) sense of self in relation to the disability. In addition, it is useful to incorporate positive imagery along with a positive cognition that infuses a sense of mastery and resilience. The client should also be taught to use bilateral stimulation (e.g., the Butterfly Hug or another form of tapping) at home for pain control and self-soothing. In addition to having psychological benefits, the Light Stream technique described in the "Self-Control/Closure Procedures" section is particularly useful with acute pain (S. Levine, personal communication, 1982; Levine, 1991). The eye movement sets themselves have also been reported to be useful for pain management (Hekmat, Groth, & Rogers, 1994).

SELF-DIRECTED USE OF BILATERAL STIMULATION FOR STRESS REDUCTION

Eye Movement Sets: Caveats and Suggestions

It is difficult, if not impossible, to engage in intense, complete personal therapy without a clinician's assistance. It is not generally recommended that clients be taught the self-directed use of eye movements. There is no

way of knowing to what a given target or anxiety response is linked, and even seemingly innocuous disturbances can be rooted in extremely disturbing childhood memories. However, self-directed use of the eye movements can be extremely helpful for clinicians who wish to minimize the effects of vicarious traumatization by reprocessing their own response to clients' disturbing stories. The effects of vicarious traumatization, which have been well documented in the field of mental health (Abdendroth & Figley, 2013; Figley, 1995; Hensel, Ruiz, Finney & Dewa, 2015; McCann & Pearlman, 1990; Newell, Nelson-Gardell, & MacNeil, 2016), can interfere with the therapist's ability to maintain a detached clinical perspective, as well as her sense of personal safety and satisfaction. It can be extremely beneficial for the clinician to use the eye movements whenever client stories or images of atrocities are particularly disturbing. The sooner the sets are done with this material, the sooner it will be processed, assimilated, and resolved.

Clinicians should, of course, be aware that dissociated material may be activating their high level of disturbance in vicarious traumatization and might emerge as a result of the eye movement sets. If this occurs, they should seek appropriate assistance and not attempt to resolve the problem alone. Attempting self-directed therapy in these instances can also result in retraumatization, since the memory may merely be dissociated once more rather than reprocessed.

Technical Considerations

The following is a list of suggested strategies for the self-directed use of eye movements and other forms of dual stimulation (though it is by no means exhaustive):

1. Hold the head straight, look forward, then move the eyes to the extreme right and observe a distant object. The same movement is then made to the extreme left. Then the eyes are moved back and forth between the two objects.
2. Look alternately at one side of the room (or a point on the wall) and then another.
3. Sit with one hand, palm down, on each thigh (with legs parted) and raise one index finger at a time while the eyes move back and forth between them.
4. Move a lifted hand back and forth across the line of vision.
5. By far the easiest way to maintain the eye movements or other form of stimulation is to use an externally generated, moving focal point. Some individuals have hung a pendulum from the ceiling or used a light bar. Light bars with variable speed and direction have been tested and are available for use by therapists. Mobile devices apps are not recommended, as the screens are not wide enough to provide the full range of motion needed for BLS.

Butterfly Hug

The "Butterfly Hug" provides bilateral stimulation that can be self-administered to process traumatic material in the presence of a clinician for both individual and group work (Jarero, Artigas, & Montero, 2008).

Rather than asking the client to use long reprocessing sets and attend to emerging associations, as in trauma processing, this amended version retains focus on the targeted disturbance and uses short sets to limit associations. Therefore, with clients in the latter stages of therapy, it can also be recommended for self-soothing outside the office (Jarero & Artigas, personal communication, 2016).

The client is instructed to concentrate on a disturbing thought, affect, or image, and to use no more than six to eight repetitions to avoid stimulating any associations. It is best for the clinician to model the technique for the client, as below:

> **"Please watch me and do what I am doing. Cross your arms over your chest, so that the tip of the middle finger from each hand is placed below the clavicle or the collarbone and the other fingers and hands cover the area that is located under the connection between the collarbone and the shoulder and the collarbone and sternum or breastbone.**
>
> **"If you wish, you can interlock your thumbs to form the butterfly's body and the extension of your other fingers outward will form the butterfly's wings.**
>
> **"Your eyes can be closed, or partially closed, looking toward the tip of your nose. Next, you alternate the movement of your hands, like the flapping wings of a butterfly. Let your hands move freely. You can breathe slowly and deeply (abdominal breathing) while you focus on the disturbing thoughts or image."**

Depending on the results, the clinician can advise the client to use the technique between sessions for stress reduction.

SELF-CONTROL/CLOSURE PROCEDURES

Since it is vital that a client never be allowed to leave the office in the middle of an abreaction, an adequate closure procedure should be established prior to a treatment session. Such a procedure must provide the clinician with a means of ending the processing session, so that the client is in a state of relative calm even if the processing has been incomplete. Furthermore, since material can continue to undergo processing between sessions, the client should be equipped with a variety of self-control techniques and a stress reduction recording to handle any disturbing thoughts and emotions that may arise.

In the following paragraphs, I describe some of the many affect-regulation procedures that may be utilized for self-control and closure of an incomplete treatment session. Any procedure that allows the client to contain affect and control will suffice. The clinician should initiate one or more of these before EMDR processing begins to determine which works best for the client; the procedure can then be introduced with confidence if disengagement is called for during an abreactive response. Once a technique has proved successful in defusing emotional disturbances, the client can be reminded of this experience if and when subsequent abreactions occur.

Reassuring the client that her disturbance can be reduced by using the technique may encourage her to continue the processing to a successful conclusion. As stated earlier, if the client has always been overwhelmed by fear and anxiety, the "fear of fear" can disrupt the treatment process. Having a successful experience in handling a disturbing emotional state is an important factor in the client's ability to process material during the treatment session and to manage adequately between sessions. Self-control/closure techniques are particularly important when working with patients who are suffering from traumas, phobias, or panic disorders.

While clinician-guided hypnosis may be excellent for ending an incomplete treatment session, it does not provide the client with a sense of self-efficacy and self-reliance between sessions. Therefore, if the clinician has a favorite hypnotic technique, it would be useful to modify it after successful administration for the client's self-use between sessions.

SAFE/CALM PLACE IMAGERY

Before EMDR processing, clinicians should help clients construct a safe and/or calm place in their imagination (see also Chapter 5). If neither of these states are accessible, then identify another positive feeling state (e.g., secure, peaceful, restful, enjoyable). This allows the client to access a sense of comfort and equilibrium by focusing on a key image or phrase.

1. *Image*. The clinician and client identify an image of a safe place that the client can easily evoke and that creates a personal feeling of peace and safety. For those clients who are unable to feel safe because of the nature of their trauma (e.g., sexual abuse or combat), it is best to identify and focus on a place that allows them to feel calm.

> **"I'd like you to think about an experience you have had, or a place you have been or imagine being at that feels calm or safe. Perhaps being at the beach or in the mountains, or an activity you enjoy. What is coming to mind?"**

2. *Emotions and sensations*. The clinician asks the client to focus on the image, feel the emotions, and identify the location of the pleasing physical sensations.

> **"As you think of that experience, notice what you see, hear, and feel right now. What do you notice?"**

3. *Enhancement*. The clinician may use soothing tones to enhance the imagery and affect. He should take care to convey a sense of safety and security for the client, who is asked to report when she feels the emotions.

> **"Focus on your experience—its sights, sounds, smells, feelings and body sensations. What are you noticing?"**

4. *Eye movements*. The positive response is further expanded by including a series of eye movements. Rapid BLS paired with the development of the Safe/Calm Place can occasionally be activate and bring up negative associations. Instead, use slow BLS or omit it and take the following procedural steps.

> **"Bring up the image of a place that feels peaceful and safe [or calm]. Concentrate on where you feel the pleasant sensations in your body and allow yourself to enjoy them. Now concentrate on those sensations and follow my fingers with your eyes."** *(4 to 8 slow/short movements.)*

At the end of the set the clinician asks the client, **"How do you feel now?"** If the client feels better, the clinician should continue the sets as long as the positive feelings increase. If the client's positive emotions have not increased, the clinician should try tactile or no stimulation.

If feelings come up that are negative, identify another calm or safe experience to target.

5. *Cue word*. The client is then asked to think of the picture and identify a single word that fits it (e.g., "relax," "beach," "mountain," "trees") and to hold them both in mind along with additional eye movements.

> **"Is there a word or phrase that represents your safe [calm] place? Think of the picture and notice the positive feelings you have when you think of that word. Concentrate on those feelings and sensations and the word _____ and follow my fingers** (*BLS.*) (*Pause.*) **What are you noticing now?"**

Repeat and enhance positive feelings with sets of eye movements as long as the experience continues to strengthen.

6. *Self-cueing*. The client is then instructed to repeat the procedure on her own, bringing up the image and the word and experiencing the positive feelings (both emotions and physical sensations), without any eye movements.

> **"Now I'd like you to say that word _____ and notice how you feel."**

When the client has successfully repeated the exercise independently, the clinician points out how the client can use it to relax during times of stress.

7. *Cueing with disturbance*. The clinician asks the client to bring up a minor annoyance and notice the accompanying negative feelings. The clinician then guides the client through the exercise until the negative feelings dissipate.

> **"Now imagine a minor annoyance (SUD 1–2) and notice how you feel. Bring up the cue word(s) _____ and notice any shifts in your experience. What do you notice?"**

8. *Self-cueing with disturbance*. The clinician then asks the client to bring up a disturbing thought once again and to follow the exercise to its relaxing conclusion.

> **"I'd like you to think of another mildly annoying incident (SUD 2 or 3), notice how you feel, then bring up the words _____ by yourself, especially noticing any changes in your body when you focus on your cue word."**

The client is instructed to practice it at home every day by calling up the positive feelings and the associated word and image while she uses a relaxation CD or performs some other relaxation exercise.

EMDR RESOURCE DEVELOPMENT AND INSTALLATION

EMDR Resource Development and Installation (RDI), an affect regulation technique, has been recommended for use during the treatment of clients with complex PTSD (Korn & Leeds, 2002; Leeds, 1998). It basically follows the same framework as the Safe/Calm Place exercise, utilizing positive affects (e.g., control, courage) the client needs in order to deal with challenging situations, including processing itself. Resources appropriate for RDI are associated with positive affects (e.g., confidence, competency, mastery, interest, excitement, enjoyment, pride, triumph) and adaptive responses that the client admires in others or already possesses in some contexts. These may include the following:

1. *Mastery resources* (internal to the client): previous coping responses to challenging situations or experiences associated with relevant positive affect states (e.g., strength, self-compassion, confidence, competency, pride, triumph).

2. *Relational resources:* positive role models who have demonstrated capacities the client would like to incorporate, such as courage, persistence,

boundary setting, or truth telling. These may be people the client has known (e.g., caregivers, clergy, teachers) or knows of that embody the quality the client wants to develop (e.g., real-life heroes or public figures, or fictional characters from books or movies).

3. *Symbolic resources:* Any religious or archetypal figure, as well as those from the real world, such as an eagle, the ocean, or a tree that symbolizes a specific quality.

Client Instructions for RDI

1. *Identify needed quality*

   "What quality do you need [more of] as you consider [processing this traumatic experience/meeting this challenge]?" Or **"How would you like to be able to feel [about yourself] so that you can respond more effectively [in the challenging situation]?"**

2. *Identify the experience of the resource*

   "Can you remember a time when you personally felt this quality or experienced it when seeing someone or something else?"

3. *Image*

   "Describe the experience. (*Pause. Wait for a response.*) **What image represents this quality?"**

4. *Emotions and sensations*

   "As you think of that quality/resource, notice what you see, hear, and feel right now. What do you notice?"

5. *Enhancement*

   "Focus on that positive experience . . . what you see, hear, smell and notice in your body right now. Take a moment to enjoy your experience. (*Pause.*) **Tell me more about it."**

6. *Reinforce experience of the resource with BLS*

   "Bring up the image of this quality. Notice where you feel those sensations in your body and allow yourself to experience them fully. Concentrate on the experience and follow my fingers. (*8–10 slow BLS.*) **How does it feel to you now?"**

   If positive: **"Focus on that.** *(BLS.)* **What do you notice now?"** Repeat with several sets of slow BLS until the resource is fully strengthened. If negative: Redirect attention to another experience associated with that resource; or, consider another resource.

7. *Cue word*

"Is there a word or a phrase that represents this resource? Think of [*repeats word*] **_____ and notice the positive feelings you have when you think of that word. Concentrate on those sensations and the word _____ and follow my fingers.** (*8–10 slow BLS.*) **How do you feel now?"**

Repeat with several sets of BLS until fully strengthened.

8. *Self-cueing*

"Now I would like you to say the word _____ and notice how it feels."

9. *Future rehearsal using positive resource*

"Now imagine the situation that you would like to manage (or respond to) more effectively. Run a movie of your desired response using your resource. What do you notice?"

Add several sets of slow BLS until the desired scenario has been firmly established. Length of sets can vary depending on the client's ability to stay with the desired response without activating a negative association.

10. *Challenging situation (optional)*

"Now imagine a challenging situation that could arise. Run a movie of your desired response to this situation using your resource. What do you notice?"

Instruct the client to practice using the resource in situations that are stressful or hard to manage. Evaluate its usefulness in subsequent sessions.

An already established resource state can also be used to assist with closure of incomplete processing by helping the client return to a state of mastery.

RECORDED VISUALIZATIONS

Visualizations are offered on a variety of commercially available stress reduction audio recordings (e.g., Emmett Miller's [1994] "Letting Go of Stress"). These recordings are extremely useful for stress management and are highly recommended for client self-care. Clients should be encouraged to use one or more visualizations each day after the initial history-taking session. The client's favorite visualization may then be implemented in the office by the clinician and used before the first treatment session. If the

commercial stress-reduction recordings are not relaxing to the client, the clinician can tape her own for the client's home use.

THE LIGHT STREAM TECHNIQUE

The Light Stream technique is described here in detail because feedback based on its use during EMDR therapy trainings has indicated it to be effective for stress reduction approximately 90% of the time. This technique is also useful for the alleviation of chronic and acute pain and, in fact, is an expanded version of an ancient yoga exercise that has been used successfully with sufferers of chronic physical and emotional pain (S. Levine, personal communication, 1982; Levine, 1991). The clinician should be guided by the client's responses; the second set of questions is asked to determine whether it is appropriate to continue.

Before EMDR processing is begun, the client is asked to bring up some disturbing target and to concentrate on the body sensations that accompany the disturbance. Since the use of EMDR processing includes the identification of body sensations, this is also a good opportunity to see whether the client needs education on this skill. If so, the clinician asks the client to concentrate on a blank screen and notice how his body feels by mentally scanning it. Then the clinician asks the client to bring a disturbing target to mind and to notice the resulting changes in his body sensations. The clinician repeats this procedure until the client is easily able to identify body sensations that accompany disturbing material.

Once the client is able to concentrate on his body sensations, the visualization proceeds. The clinician tells the client that this is an imaginal exercise, and that there are no right or wrong answers. The clinician then asks the client to concentrate on body sensations: **"Concentrate on the feeling in your body. If the feeling had a shape, what would it be?"** After the client responds (e.g., the client might reply, "Round"), the clinician continues with **"And if it had a size, what would it be?"** (The same client might, for example, reply, "Like an apple"). The clinician continues this line of questioning by asking about the feeling's color, temperature, texture, and sound (e.g., **"If it had a color, what would it be?"**). When clients are asked about the feeling's sound, they are told to simply describe it as "high-pitched or low"; otherwise, they might become frustrated or anxious by trying to make the sound.

After the client has responded to these questions, he is asked, **"Which of your favorite colors might you associate with healing?"** It is important that the clinician accept the client's answer—unless it is the same one he offered for the color of the feeling in the body. In this case, the clinician should ask for another color. Once the client identifies a color, the clinician continues as follows:

"Imagine that this favorite colored light is coming in through the top of your head and directing itself at the shape in your body. Let's pretend that the source of this light is the cosmos: The more you use, the more you have available. *The light directs itself at the shape and penetrates and permeates it, resonating and vibrating in and around it. As it does, what happens to the shape, size, or color?*"

If the client indicates that it is changing in any way, the clinician continues, repeating a version of the italicized portion of the instruction and asking for feedback until the shape is completely gone, has become transparent, has assumed the same color as the light, or has undergone some other transformation. Change in the image usually correlates with the disappearance of the upsetting feeling. If no change occurs after the second attempt (the client might say, "Nothing is happening; the light is just bouncing off"), the technique should be discontinued and another one tried.

After the feeling that accompanies the disturbing material dissipates, the clinician may continue in a slow, soothing tone:

"As the light continues to direct itself to that area, you can allow the light to come in and gently and easily fill your entire head, easily and gently. Now allow it to descend through your neck, into your shoulders, and down your arms into your hands and out your fingertips. Now allow it to come down your neck and into the trunk of your body, easily and gently. Now allow it to descend through your buttocks into your legs, streaming down your legs and flowing out your feet."

Once the clinician perceives that the client is fully relaxed, he gives the client a positive suggestion for peace and calm until the next session. Then he asks the client to become awake and aware on the count of five. An audio-recorded CD ("Light Stream Relaxation") is available from Trauma Recovery/EMDR Humanitarian Assistance Programs (see Appendix F).

BREATHING SHIFT

Ask the client to bring up a good, happy, or positive memory. Try to access whatever affect is most useful. Ask her to notice where her breath is starting and to put her hand over that location in her body. Let her breathe a moment or two, and instruct her to notice how it feels. Now ask her to bring up a memory with a low level of disturbance and notice how her breath changes. Ask her to put her hand over that location in her body. Now ask her to change her hand to the previous location and deliberately

change her breathing pattern accordingly. This should cause the disturbance to dissipate. Teach it to the client for self-use.

VERTICAL EYE MOVEMENTS

To help close an incomplete session, the clinician can direct the client in sets of vertical eye movements (which seem to have a calming effect) and offer soothing comments such as **"We can put it away now,"** or **"It can be put in a box until next time,"** or **"We can let it go for now."** After the client agrees with this statement, the clinician may use the Safe/Calm Place or the Light Stream technique for further relaxation effects. Alternatively, the clinician may ask the client, **"What is the most helpful thing you have learned today?"** The client's answer is then reworded as a positive cognition and used with additional vertical eye movements. This can assist the client by increasing his sense of accomplishment and installing a meaningful positive cognition.

DEBRIEFING AND SAFETY ASSESSMENT

Whatever the form of hypnosis, guided imagery, or other procedure used to end a session, the clinician should give the client a thorough debriefing. Explain that regardless of what occurs during the week, the client should use the log and not hesitate to call if there is undue disturbance. An incomplete treatment has a tendency to continue processing between sessions at a level of disturbance that is higher than that following a completed one.

It is also vital that the client make an informed decision about driving a car after sessions. Regardless of the inconvenience, a client who is incapable of driving should not be allowed to leave until alternative arrangements are made for transportation. A client who is highly susceptible to hypnosis may often be helped to reassociate by asking him to become conscious of his feet or to imagine a cord connecting his spinal column to the center of the earth. The clinician should allow sufficient time at the end of each session to assess and provide for the client's needs regarding his ability to function safely. The visualization used to close a trauma processing session can itself be temporarily disorienting.

SUMMARY AND CONCLUSIONS

Clinicians should be comfortable with the use of the standard EMDR procedures as the basis for all clinical applications. Flexibility is also important, however, because the clinician may need to modify the procedures during a given client's treatment. Whether variations are used or not, the

clinician should take care to reaccess the target without distortion to determine whether any additional channels need processing and to properly conclude the session.

The reevaluation phase opens each subsequent treatment session and guides the clinician in the application of specific treatment protocols. Any number of protocols, both standard and specialized, may be necessary for an individual client. The standard three-pronged protocol reviewed in Chapter 8 provides the comprehensive targeting necessary for most trauma survivors. This is mandatory when the client shows full PTSD symptomatology. The additional protocols covered in this chapter are generally used in conjunction with the standard three-pronged protocol and apply to wide range of conditions. Applying EMDR processing to the memory of adverse life experiences includes targeting all pertinent representations of the event, as well as the associated present stimuli. Addressing a specific dysfunctional behavior also necessitates the incorporation of a positive template for future action.

The disorder-based protocol and symptom-based protocols are employed as necessary to address the dysfunction identified after a comprehensive assessment of the overall clinical picture. The standardized procedures are directed at all targets. Traumas that have occurred within the past 2 months may have to be treated with a protocol for recent events. If the standard protocol is used for events less than 3 months old (or more if the client continues in a disrupted environment), clinicians should switch to a protocol for recent events if treatment effects do not generalize to the entire memory. EMD has been recommended for restricted processing of recent events and for containment in complex presentations.

As with all clinical populations treated with EMDR therapy, clients with phobias should be investigated for secondary gain issues and taught self-control procedures to deal with any unforeseen disturbance. The multitarget phobia protocols should both incorporate a future template and address the anticipatory anxiety and specific needed actions when the client engages in a feared behavior or event. Log reports are necessary to ascertain currently conditioned stimuli in need of reprocessing.

The treatment of grieving clients indicates that while a period of adjustment and a deep sense of loss naturally accompany the death of a loved one, impediments to healing may cause persistent suffering and block the memory network, so that the client recalls only disturbing memories. Clinical observations indicate that EMDR processing does not cause clients to lose anything that is beneficial to them and that it may be applied at any time during the grieving process (subsequent to the shock and numbing phase) to allow healing to proceed more gently.

The protocols for illness or somatic disorders may incorporate the adjunctive use of Simonton-type imagery, along with the standard three-pronged attention to memories that have caused or contributed to the

disturbance, to present situations that exacerbate the condition, and to a future template that includes positive cognitions related to health and well-being. Processing can also be used to address chronic pain by targeting memories associated with the somatic condition, as well as the pain sensations themselves.

Safe/Calm Place and/or RDI techniques should be taught to the client during the preparation phase to assist in affect regulation. The self-directed use of stimulation sets can relieve minor disturbances but should not be attempted for complete personal therapy. As with any application of EMDR processing, there is no way of knowing what associations underlie the target, and an abreaction precipitated by disturbing material would prevent the self-directed user from continuing sets to completion. However, after the primary therapy has been concluded, such self-directed use can be added to the client's repertoire of self-control techniques. Clinicians can use the affect regulation procedures to bring closure to incomplete sessions, and clients can use them to dissipate disturbance arising between sessions. The Light Stream technique and self-administered tactile stimulation are useful for both pain control and stress control. A final debriefing and safety assessment is mandatory when these procedures are used to conclude a treatment session.

CHAPTER 10

The Cognitive Interweave

A Proactive Strategy for Working with Challenging Clients

As you go the way of life, you will see a great chasm.
Jump. It is not as wide as you think.
—From a Native American initiation rite

The cognitive interweave is an EMDR processing strategy that was developed to handle challenging sessions with highly disturbed clients. These clients often enter into cognitive and emotional loops that are not amenable to the simpler EMDR interventions. To develop a more proactive strategy, I turned to the clinical heuristic provided by the AIP model. The interventions I developed are strategies to "jump-start" blocked processing by introducing certain material rather than depending on the client to provide all of it. The term "cognitive interweave" refers to the fact that this strategy calls for the clinician to offer statements to elicit client responses that therapeutically weave together the appropriate neural networks and associations. The clinician initiates interweaves through questions or instructions that elicit thoughts, actions, affect, and/or imagery.

When working with populations characterized by particularly complicated pathologies, the clinician may find that a large percentage of clients require the cognitive interweave. However, any client in a given session may run into blocks that necessitate use of the cognitive interweave.

While the strategies for blocked processing described in Chapter 7 call for clients to concentrate directly on the emerging material, at times this will not be sufficient to allow the old dysfunctional material to reach resolution. When this happens, the clinician needs to use the cognitive interweave to introduce new information or a new perspective. Remember,

however, to use the cognitive interweave selectively, so that the client's own processing system can do the work necessary for the full integration of the information.

The cognitive interweave should be used when spontaneous processing is insufficient for the achievement of therapeutic goals. Specifically, clients need clinician-initiated processing in four situations:

1. *Looping.* Even after successive sets, the client remains at a high level of disturbance with repetitive negative thoughts, affect, and imagery. Processing remains blocked even after the clinician has used the EMDR processing procedural variations described in Chapter 7.

2. *Insufficient information.* The client's educational level or life experiences have not given him the appropriate data to progress cognitively, affectively, or behaviorally.

3. *Lack of generalization.* The client has achieved a more positive emotional plateau or cognition with respect to one target, but processing does not generalize to ancillary targets.

4. *Time pressures.* During the last third of the clinical session, the client has an abreaction or fails to process an abreaction sufficiently, or a target appears that is multifaceted in the number of negative cognitions associated with it (and therefore will require more time than the remainder of the session allows).

This proactive version of EMDR processing deliberately interlaces clinician-derived or clinician-elicited statements with client-generated material, instead of relying solely on the client's spontaneous processing effects. While extremely useful to the clinician, it should be used sparingly, because the most powerful changes for the client are almost always those that arise from within. Furthermore, when the client sees that the major insights and shifts of consciousness she is experiencing are due to her own internal processes, her sense of self-esteem and self-efficacy is greatly enhanced.

The information in this chapter should be used only after the clinician has become comfortable, through supervised practice, with the material covered earlier in this book. While use of the cognitive interweave is necessary to complete the treatment effects for a significant number of clients, generally clinicians will not be able to discriminate the indicators and appropriate timing for these interventions unless they are at ease using the basic EMDR methodology. After sufficient experience with EMDR, they will understand how far an individual client can process the target material without needing additional clinical intervention and will therefore be able to establish a baseline to indicate when the cognitive interweave is required.

Before using the cognitive interweave, the clinician should determine whether blocked processing may be due to overlooking any aspect of

treatment described in previous chapters, including adequate preparation and ensuring that the client has access to positive affect states (see Appendix A). The clinician should make sure the client feels safe in the therapeutic process and understands how processing works (e.g., that it requires the client to notice but not resist or force material to emerge during processing). The clinician should also make sure that there are no secondary gains or current situations that must first be addressed with an action plan, and that there are no blocking beliefs to handle. Any of these conditions can result in excessive looping.

In order to understand the use of the cognitive interweave, we need to go back to the fundamental concepts of the AIP model. We will briefly review the theoretical model as a refresher and as a reminder not to fall back on the old habits of talk therapy. The clinician should intervene only when needed and then as briefly as possible.

FOUNDATION OF THE INTERWEAVE

The AIP model states that dysfunctional material is held in a neural network in state-specific form. Therefore, each of these neural networks is dominated by the emotional and cognitive content of the traumatic event (i.e., by the client's affective and cognitive state of mind at the time of the trauma). In the case of trauma from childhood, this condition incorporates and maintains the perspective of the child; that is, it encompasses the state of cognitive and emotional understanding achieved by the child at the time of the event, which is stored in state-specific form. Moreover, it is isolated from any later adaptive interpretations and experiences the client may have had. While pathology can be seen as stemming from the intrusive and pervasive aspects of dysfunctional material from the past, clients obviously seek clinical assistance because of their belief that something needs to change in the present. However, this more adaptive view of the need for change can be seen to result from the accumulation of later information and more functional judgments about the traumatic event, all of which pervade another neural network—the adult perspective.

The outcome of an EMDR processing session indicates the linkup of the two networks: an assimilation of the painful material into its proper perspective (i.e., that it belongs to the past) and a discharge of the dysfunctional affect, with generalization of the adaptive cognitions through the hitherto isolated material. Thus, after the treatment of a trauma, the client is able to bring up earlier memories that are now fully integrated into the more adaptive perspective. Along with this new perspective comes the ability to act in a more appropriate and empowered way.

During the majority of EMDR sessions, the adaptive processing of information can be viewed as the spontaneous linkage of appropriate neural networks. Metaphorically, the train is laying down its own tracks as

it moves progressively from one stop (therapeutically adaptive plateau) to another. However, when the processing is blocked, the clinician can use the cognitive interweave as a means of deliberately laying down new tracks to link the appropriate neural networks. This linkage is accomplished by stimulating nodes that already exist or by infusing new information into the system.

By using the cognitive interweave, the clinician attempts to change the client's perspectives, somatic responses, and personal referents to the adult or adaptive perspective. Once the client demonstrates or cognitively accepts even the possibility of the adaptive perspective, the clinician adds a set of eye movements to forge the appropriate link between the network containing the targeted dysfunctional material and the network containing the positive perspective. Time permitting, the clinician then allows the client to return to spontaneous processing through successive sets that are performed without the intervention of the cognitive interweave.

Interweaves are used to elicit already stored adaptive material, or to infuse needed education to overcome a wide spectrum of barriers to adaptive processing. Some of these barriers are reviewed below. However, regardless of the number of interweaves used, the processing is not considered complete until the reaccessed target is fully addressed using the standard protocol. Interweaves are useful and often necessary, but the client must also be given an opportunity to spontaneously process through all associated channels once the blocks have been removed.

RESPONSIBILITY, SAFETY, AND CHOICES

Accurate timing and sequencing of the proactive interventions are necessary for the success of the cognitive interweave. In order to stimulate blocked processing, the clinician must try to duplicate as much as possible what would occur spontaneously. During their EMDR processing sessions, clients do not generally jump immediately from intense negative to profound positive affect or cognitions. Rather, there is a transmutation of information as progressively more adaptive material is sequentially integrated. Clinicians will be able to use the cognitive interweave most beneficially if they are aware of the relevant clinical issues and can introduce new adaptive perspectives in a progressive manner that parallels the typical client's natural healing process.

In this section, we will use the example of trauma clients, who generally confront three major issues—responsibility, safety, and choice. Thousands of EMDR therapy sessions have indicated that processing these three concerns, generally in this order, is an integral part of successful treatment. During processing, a client may spontaneously move through the three cognitive and emotional plateaus (inappropriate feelings of responsibility/guilt, perceived lack of safety, and helplessness) to a more mature and balanced

view. The clinician can observe this movement with respect to guilt when the client shifts during a session from a negative cognition such as "I am a bad person" or "I should have done something" to a positive cognition such as "I am a good person" or "I did the best I could." In other sessions, processing feelings of fear and lack of safety may transform a negative cognition such as "I am in danger" into a positive one ("It's over; I'm safe now"). A client's confidence in his ability to make future choices may be reflected in the shift from the cognition "I have no control" to "As an adult, I can now choose" or "I am now in control." When spontaneous changes do not occur, the cognitive interweave introduces the appropriate plateaus. Let us look at how this works.

Specifically using the cognitive interweave with the topics of responsibility, safety, and choice, in that order, can vastly accelerate the treatment of early trauma. The initial objectives are to help clients (1) recognize and attribute appropriate responsibility and (2) discard the guilt and self-blame that have undercut their sense of self-esteem and self-efficacy. Once these clinical goals have been achieved, it is easier for clients to recognize that they are no longer threatened and are able to make safe choices in both the present and the future.

For example, a client who was molested by her uncle still felt intense feelings of fear and guilt when she accessed the memory. Although now in her 30s, she felt as she had as a child, when she was unable to leave or get the help she needed. When processing does not cause a spontaneous change in such feelings, the clinician uses the cognitive interweave. Specifically, the clinician tries to elicit the client's awareness of more functional and adaptive perceptions by asking pointed questions (e.g., **"Whose responsibility is it?"**) or by offering appropriate information to lead the client to the desired response. Thus, in our example, as soon as the client decided, however tentatively, that the perpetrator was to blame (or at least that she was not responsible) for the traumatic incident, the clinician administered additional sets with the direction, **"Just think of that."** This was followed by a spontaneous processing that transmuted the affect from fear and guilt to disgust or anger at the perpetrator.

The following is an excerpt of the transcript of a treatment session in which the client in our example was processing the initial memory of sexual abuse by her uncle. This client also had a sexually inappropriate father, who made suggestive comments and remarks to her throughout most of her life, a factor that compounded the problem. The transcript shows the usual EMDR assessment and targeting, which is followed by the use of the cognitive interweave to assist the processing of a block.

THERAPIST: So, there were two memories having to do with your uncle. When you think of him now, which one's more upsetting?

CLIENT: The most vivid one.

THERAPIST: Describe that just a little.

CLIENT: It was just a fragment of memory of him holding me down and putting something, like a finger, in my buttocks.

THERAPIST: Okay. Now if you hold that memory in mind, what negative belief goes along with it, something negative that you're saying about yourself.

CLIENT: I'm bad.

[This cognition represents a common theme among sexual abuse survivors.]

THERAPIST: And if we could just change the belief, what would you like to have instead?

CLIENT: It's not my fault.

THERAPIST: And "I'm fine"?

[The clinician suggests an adjustment to the positive cognition.]

CLIENT: And I'm fine; I'm safe.

THERAPIST: As you hold the memory and the words "I'm fine; I'm safe," from 1, completely false, to 7, completely true, how true do the words feel?

CLIENT: About a 4.

THERAPIST: Okay. If you bring up the picture and you bring up that cognition of "I'm bad," what emotion comes up for you?

CLIENT: Terror.

THERAPIST: Zero to 10—zero is neutral and 10 is the worst you can think of.

CLIENT: About a 9 or 10.

THERAPIST: Where do you feel it in the body?

CLIENT: My lungs.

[The client's processing then became stuck after the initial memory was replaced by thoughts of her more recent difficulties with men. In the next segment of the transcript, she is focusing on a time when she was humiliated by a former lover and was unable to express her anger about it.]

THERAPIST: What do you get?

CLIENT: I was blaming myself for choosing somebody like that.

THERAPIST: Okay. Whose responsibility was it that you learned not to be able to express anger? That you learned to choose men like that? Whose is that?

[The therapist uses the cognitive interweave to address the issue of responsibility by asking questions that identify two of the sources of the client's predicament.]

CLIENT: My uncle.

THERAPIST: Just notice that. (*Leads client in a set of eye movements.*)

CLIENT: My father's, too.

THERAPIST: (*Leads client in a set of eye movements.*) What did you get?

CLIENT: My head started feeling a little tight; my heart is still palpitating some.

THERAPIST: Just notice. (*Leads client in a set of eye movements.*) What do you get now?

CLIENT: Those men were my uncle and my father.

THERAPIST: Just notice. (*Leads client in a set of eye movements.*) What did you get now?

CLIENT: It's something like my family sacrificing me to be abused.

THERAPIST: Where do you feel it?

CLIENT: I feel it everywhere.

THERAPIST: Just notice. (*Leads client in a set of eye movements.*) What did you get?

CLIENT: It's like I'm supposed to be the beautiful little china doll or something. Just supposed to look good and nothing else really matters. Sort of horror and anger.

THERAPIST: Just notice. (*Leads client in a set of eye movements.*) What did you get?

CLIENT: What I got was, it really wasn't my fault and that I'm not a hollow shell.

THERAPIST: Okay. That's good. Stay with that. (*Leads client in a set of eye movements.*) What did you get?

CLIENT: My heart is starting to palpitate again, and my head is feeling kind of tingly.

THERAPIST: Just notice that. (*Leads client in a set of eye movements.*) What did you get?

CLIENT: Anger at all of them for doing that. They still do it.

THERAPIST: They still do it?

CLIENT: They still just really see me for what I look like and not really who I am. There's still a big piece of that.

THERAPIST: And whose responsibility is that?

[Therapist again uses cognitive interweave to address appropriate responsibility.]

CLIENT: It's theirs.

THERAPIST: Think of that. (*Leads client in a set of eye movements.*)

[Clearly, no child is responsible for her molestation by an adult, and the sequelae of the abuse are directly attributable to the perpetrator. Making

this connection on an emotional level is one of the first stages of the healing process. When the processing is blocked or the client is looping, the clinician helps her to make the cognitive connection so that it can be emotionally assimilated as the processing proceeds.

After the clinician in this case study used the cognitive interweave to help the client reach the first plateau of appropriate responsibility, the client began to make additional cognitive connections. The subsequent plateaus of safety and choices emerged spontaneously.]

CLIENT: I don't have to attract men like those men, and I also don't have to be alone. I mean, sometimes I think I have to be with abusive men or totally by myself.

[The client makes a spontaneous assertion of her freedom to make choices that ensure her safety.]

THERAPIST: (*Leads client in a set of eye movements.*) What did you get now?

CLIENT: Just a picture of some of my friends. Just that it's safe to love them. They're not like any of my abusive family members.

THERAPIST: Good. (*Leads client in a set of eye movements.*)

CLIENT: They love me for who I am, not for what I look like. And, ironically, they are all beautiful. It's comforting.

[The client is aware of the beneficial choices available to her.]

THERAPIST: Notice that. (*Leads client in a set of eye movements.*)

[The client then returned to the target memory and began making additional associations about other areas of dysfunction. For instance, her relationships had always been with abusive men. She found herself sexually attracted only to men who had narcissistic qualities and who ended up hurting her. Memories emerged of dreams and nightmares that always included her uncle and father, generally along with other angry or violent men. Because the client's feelings of safety had not fully generalized to the associated material, the clinician used another cognitive interweave (which places the memory in the past) to reinforce them.]

CLIENT: It's something about my nightmares. Sometimes I'm afraid to go to sleep or go back to sleep when I wake up.

THERAPIST: Notice that. (*Leads client in a set of eye movements.*)

CLIENT: The statement that "It's okay." I can feel the fear around going to sleep as in the past.

THERAPIST: Notice it. (*Leads client in a set of eye movements.*)

CLIENT: It's just how everything scared me as a kid. And how I couldn't really be spontaneous.

THERAPIST: Okay, just notice it. (*Leads client in a set of eye movements.*)

THERAPIST: What do you get?

CLIENT: I just feel a little calmer.

THERAPIST: What happens if you think the words, "It's over, I'm safe now?"

[The therapist uses cognitive interweave to help the client separate past from present, to help her recognize that she is no longer a vulnerable child.]

CLIENT: I don't know. I'm not sure.

THERAPIST: Just think about it.

[The client does not have to embrace the statement wholeheartedly at first. Simply attending to the suggestion allows the adaptive information already inherent in her memory system to be stimulated.]

CLIENT: Okay.

THERAPIST: (*Leads client in a set of eye movements.*) Good. What did you get now?

CLIENT: That he won't do that to me again. I won't let him. He won't do that to me again because I am an adult and I can keep myself safe.

[The client's words indicate a spontaneous emergence of the recognition that she can make adult choices.]

THERAPIST: What do you get?

CLIENT: Sore over here. (*Points to neck.*) And I hate them. And it's not my fault.

THERAPIST: Just notice. (*Leads client in a set of eye movements.*) What do you get?

CLIENT: That it's okay to be safe, and it's okay to be loved.

THERAPIST: Good.

CLIENT: And I love my father.

THERAPIST: Notice that. (*Leads client in a set of eye movements.*)

[The client's admission of love for her father is ecologically appropriate. Independence does not mean hatred.]

THERAPIST: What do you feel?

CLIENT: I'm feeling more flexibility in my neck. My head feels like kind of moved around.

[The flexibility indicates a somatic shift, a release of state-dependent sensations that apparently accompanied the original event, during which her head was pinned down.]

THERAPIST: Just notice it. (*Leads client in a set of eye movements.*)

CLIENT: I hate my uncle. It felt like a little older version of "I hate my uncle." A little older than five.

[The client's words indicate that an adult perspective is emerging.]

THERAPIST: Good. (*Leads client in a set of eye movements.*) What did you get now?

CLIENT: Starting to feel more adult-like. That I can hate them and I can move on. I'm just angry that it happened at all.

[Notice that the client uses the word "adult" to describe her present feelings. These kinds of client statements serve as an ecology check. Even though the goal of reprocessing is to incorporate this adaptive perspective, the therapist does not use the word "adult" to the client. It emerges spontaneously during processing.]

THERAPIST: Just notice. (*Leads client in a set of eye movements.*) What did you get now?

CLIENT: Angry that I had to take care of people to get any semblance of nurturing. That I couldn't just get it because I deserved it.

THERAPIST: (*Leads client in a set of eye movements.*) What do you get now?

CLIENT: A sensation around my neck again.

THERAPIST: How's it feel?

CLIENT: It feels better.

THERAPIST: Good, notice the sensations. (*Leads client in a set of eye movements.*)

CLIENT: Now what came up was of keeping men away who are like the men I am attracted to and being able to say no to them.

[The client spontaneously imagines asserting herself to make choices in the future.]

THERAPIST: Good. Notice it. (*Leads client in a set of eye movements.*) What do you get?

CLIENT: What came in was the fear that I can't say no and that that connects with my nightmares.

THERAPIST: What happens when you think the words "As an adult I now have choices"?

[The therapist uses cognitive interweave to reinforce further the third plateau of the client now having the ability to choose.]

CLIENT: It feels great.

THERAPIST: Okay, just think of that.

CLIENT: I'm an adult, I now have choices. Okay.

THERAPIST: (*Leads client in a set of eye movements.*) What do you get now?

CLIENT: What came up is an image of my uncle holding me down and telling me that I didn't have choices, and then this image of me kicking him in the face.

[Client's comment indicates a spontaneous change of imagery.]

THERAPIST: Great. Just notice the image and think of the words "As an adult I now have choices." (*Leads client in a set of eye movements.*) What do you get now?

CLIENT: Me saying to my uncle, "You have no power over me."

THERAPIST: Good.

CLIENT: And my head just eased up a little bit, too.

THERAPIST: (*Leads client in a set of eye movements.*) Okay. What do you get now?

CLIENT: Kicking my uncle in the face again and screaming at my father.

THERAPIST: How does it feel?

CLIENT: Still scary.

THERAPIST: Just notice it. (*Leads client in a set of eye movements.*)

THERAPIST: What do you get now?

CLIENT: Men merging with my father and my uncle again. Me saying to my father, "You broke my heart," and then my ex-boyfriend sort of coming into that. It's all sort of merging together.

THERAPIST: What happens when you go back to the image with your uncle and you think the words "I am an adult and now I have choices"? How does that feel?

[The therapist directs the client back to the pivotal image in order to reinforce the positive cognition.]

CLIENT: It feels empowering, and I still want to kick him in the face.

THERAPIST: Good. If you bring up the statement "As an adult I now have choices," and 1 means completely false and 7 is completely true, how true does it feel?

CLIENT: 6 to 7.

THERAPIST: Okay. Again, just hold the image. Hold the statement "As an adult I now have choices." And notice. (*Leads client in a set of eye movements.*) What did you get?

CLIENT: I kicked my uncle in the face and he got off of me.

THERAPIST: (*Leads client in a set of eye movements.*) What did you get?

CLIENT: I was telling my uncle that he can't do that to me, and telling my father he has to stay in his own room.

THERAPIST: (*Leads client in a set of eye movements.*) What do you get?

CLIENT: I deserve love.

It is clear from countless EMDR processing sessions with trauma survivors that the shift to appropriate attributions of responsibility by the client is a necessary condition for positive treatment effects. Theoretically, this shift may reflect the client's need to achieve appropriate developmental stages of maturation, the first of which is "personal differentiation," which involves distinguishing appropriate boundaries. Abuse victims often seem buffeted by feelings of guilt and self-denigration because of their

participation in the event. Frequently, they identify with the actions of the perpetrator—or hold the almost magical belief that they have caused the abuse—a fact that is manifested by their inability to establish and distinguish appropriate boundaries between self and others.

As long as clients remain at this undifferentiated state, they cannot escape the perceived danger; it is fully internalized. By allowing responsibility for the abuse to rest squarely on the shoulders of the perpetrator, however, the client is able to move from primary identification with the trauma (with the concomitant fear and self-condemnation) to an externalized vantage point of appropriate judgment. This first plateau appears consistently in the processing of childhood traumas. The clinician should initiate the plateau if the client is looping at a high level of disturbance and should test it with a probe question if it has not emerged spontaneously. Clearly, the two subsequent plateaus—reaching an awareness of one's present condition of safety and gaining confidence in one's ability to choose alternatives—are more difficult to achieve if one is unable to differentiate self from the sources of danger.

Once the first plateau is achieved and the danger is externalized, the typical trauma victim generally moves from a state of terror to one of fear. The second plateau, which entails a sense of present safety following recognition that the assault occurred long ago, should then be inaugurated. This usually defuses the fear and allows the client to express anger or disgust with the perpetrator. These emotions should be ventilated in the clinician's office before moving to the final stage, which evokes the client's sense of confidence in being able to make effective choices in the future, and which should incorporate an internal locus of control. This stage generally emerges with an accompanying sense of calm and well-being. Each achieved plateau sets the stage for the possibility of the next one, and each may be accessed in turn by using a probe question to elicit the appropriate response or by offering appropriate information to educate the client, if necessary.

FITTING THE INTERVENTION TO THE CLIENT

If a probe question—such as **"Whose responsibility is it?"** or **"Whose fault is it?"**—does not elicit the desired response, namely, that it is the perpetrator who was at fault, the clinician should engage in a discussion (see next section) that will stimulate such a response. As soon as the client indicates a cognitive understanding of the issues (although perhaps with some hesitancy), the clinician should add a short set, with the instruction **"Just think of it."** The set is kept purposely short (24 movements) to quickly determine whether the intervention was appropriate, by the client's response to **"What do you get now?"** If EMDR procedures are properly applied (without major demand characteristics) and if the information offered by the clinician is

accurate, a new perspective will be assimilated. If the information is not accurate, it will be rejected. In the latter case, after the set is over, the client generally remains disturbed; he may also come up with a variety of reasons why the assertion is not true. These counterstatements are generally very productive and worth exploring. If they involve blocking beliefs, they should be processed, and if they involve a lack of understanding, the clinician should offer the proper explanations. If the clinician is wrong, she must acknowledge it.

It is mandatory for this intervention, and for all subsequent variations, that the clinician make the statement **"Just think of it"** in a suggestive, not directive, tone of voice. The object of this intervention is to assist the client in holding the information in consciousness (stimulating the appropriate neural network) while the processing system is activated, so that the material can be appropriately assimilated. Any counterexamples or fears initially voiced by the client should be explored cognitively before the clinician repeats the request **"Just think of it"** and initiates another set.

Only when the clinician maintains an open and exploratory manner will the client feel free to report any hesitancies he has regarding the positive resolution and to discuss material that may initially make him feel "disloyal" to his family or to the perpetrator. Unless misdirected feelings of submission and attachment, which are often part of the pathology of the childhood abuse victim, are handled delicately, clients can feel bullied and mistreated. The clinician should take care to assure the client that whatever appropriate connections he has with his parents will remain. Because trauma victims often have great difficulty in asserting themselves, it is vital that the clinician not allow her demand characteristics or position of authority to inhibit the client.

The goal of EMDR treatment is a full integration of the more adaptive material. This means that any feeling of disturbance on the part of the client should be evaluated to determine whether the proposed intervention is ecologically inappropriate or the client needs new or additional information to enhance cognitive understanding. Because EMDR processing does not appear to allow anything to be assimilated that is not appropriate for the client, the clinician must be willing to accept the possibility of being wrong. If the client does not feel free to disagree or if the clinician is unwilling to admit that she has offered an inaccurate interpretation, the EMDR session may increase, rather than decrease, the client's disturbance.

When an accurate intervention is offered in an appropriate manner and is followed by a set, the client will either accept the clinician's interpretation or become conscious of an important corollary, or a significant variant of it. Either response should be viewed as a sign that processing is occurring and should become the focus of a new set. It is important that cognitive progressions be paired with a focus on the corresponding body sensations in a way that is not disruptive to clients and allows a full processing. Often, as new material is offered, clients report a feeling of disturbance

such as fear, anxiety, or tension. If so, the body sensations should be targeted to facilitate processing. No new information can be considered fully integrated if the client has any residual feelings of fear or physical tension when it is held in consciousness.

INTERWEAVE CHOICES

According to the AIP model, the clinician attempts to link the neural network containing the dysfunctional information with a neural network containing appropriate, or adaptive, perspectives. Some clients will already have learned and stored the appropriate information, and will be able to express it. But this will not be the case for others, owing to deficits in education, parenting, or modeling, and the clinician must offer this information to them. The alternatives discussed in the following paragraphs may be used to introduce or elicit the information necessary for therapeutic resolution with the cognitive interweave.

New Information

The clinician may need to supplement the client's understanding of personality and interpersonal systems dynamics with education about the effects of modeling or physiological imperatives. For instance, if the client's response to the question **"Whose responsibility is it?"** is self-denigrating because he enjoyed the physical stimulation of the abuse, the clinician should explain the automatic nature of physical responses and the occasional unavoidability of sexual arousal in a variety of otherwise unpleasant situations. Likewise, clients may have to be instructed in the dynamics of modeling and in how the need for even negative or forced attention may be the heritage of certain kinds of family dynamics. Once the client accepts the information cognitively, if only with pronounced hesitation, a set should be administered. The following is an example of how a therapist might provide a client with new information:

CLIENT: It was my fault that it happened.

THERAPIST: Children have to be taught how to fight effectively, just as adults have to model social skills and learning skills. It's not something they are born with. Did anyone ever teach you?

CLIENT: No.

THERAPIST: Think of that. (*Leads client in a set of eye movements.*)

One may view appropriate processing as the transmutation of dysfunctionally stored material as it links up with more adaptive information. When the client lacks sufficient information to modify maladaptive

cognitions, knowledge should be gently supplied by the clinician, who then initiates another set, which accelerates the adaptive linkage. The maladaptive cognition is the verbalization of the stored dysfunctional affects. Both transmute during unblocked processing after the successful use of the interweave.

"I'm Confused"

When the clinician believes the appropriate information already exists within the client, he uses a different alternative to elicit it. This strategic intervention is used to elicit the more adult or adaptive perspective on a cognitive level. Since self-denigrating affect may block progression to more appropriate cognitions, it may be useful to repeat aloud the client's statements of self-blame in order to reveal the cognitive fallacy to her in a nonthreatening way (e.g., moving it from the personal to the general). Once the cognitive link is established, processing may resume. Say, for instance, a client insists she is to blame for the sexual abuse she suffered as a child. When the clinician asks why, her response might simply be, "I caused it." The clinician should then introduce a cognitive interweave, perhaps by responding in an apparently bemused fashion: **"I'm confused. Are you saying that a 5-year-old girl can cause an adult to rape her?"** When the client responds with doubt ("Well, no . . . "), the clinician should gently respond, **"Just think of it,"** and then initiate a set.

"What If It Were Your Child?"

A variation on the previous strategy can be used to great advantage with clients who have children in the family toward whom they are lovingly protective. If the client responds to the probe question with a negative self-judgment, the clinician should respond with the following: **"I'm confused. Do you mean that if your child were molested, it would be her fault?"** This statement usually elicits a vehement "Of course not!" to which the clinician should gently respond, **"Just think of it,"** and then initiate a set.

Combat veterans, as well as molestation victims, have been successfully treated with this variation. For instance, one veteran continued a line of self-denigration for having followed a direct order by a commanding officer to keep his head down when his best friend was shot. It was clear that the client would have been killed if he had done otherwise, but he nonetheless blamed himself for not doing something to prevent his friend's death. The clinician gently asked, **"If it had been your 19-year-old daughter, what would you have told her to do?"** The client responded, "To keep her head down." The clinician asked him to **"Just think of that,"** and then began a set. The client's response to the set revealed grief and a lessening of his guilt, and processing then resumed. For another veteran, the ability to forgive himself for his participation in the war (and the deaths that

resulted) was evoked by the therapist's asking, **"Would you forgive your son if he had been in the war?"**

This variation not only appears to link the dysfunctional material with preexisting nodes of appropriate information but it also often opens pathways of self-nurturing and acceptance at extremely profound levels. During these sessions, there are often tears and other displays of grief for the pain and isolation of the traumatized child or youth the client once was. Quite often, the perception shifts for the client from having been a bad child to having been a scared child, and there emerges a feeling of almost parental care for the wounded self. At this point in treatment an image of the client as a child may spontaneously emerge into consciousness. The client may now offer—or be encouraged to offer (as in other forms of psychotherapy)—to the scared child the appropriate assurances and nurturing so that he feels safe, understood, and protected. While the client imagines this, the clinician initiates additional sets.

Metaphor/Analogy

The use of stories to impart therapeutic lessons is completely compatible with EMDR processing and may forge the connective links to more adaptive material. By means of fables, fantasies, history, or the therapist's own life story, parallels can be drawn to the client's situation; by following this intervention with a set, information processing may resume. Remember, however, that the session is not complete until the client can reaccess the original traumatic material without disturbance. These strategic interventions are used to jump-start the blocked information-processing system. Once processing is resumed, by means of any interweave strategy, the standard EMDR processing procedures should be fully implemented.

"Let's Pretend"

Asking the client to visualize a possible positive alternative to the problem can often break through feelings of fear or concerns fed by secondary gains issues. Since a goal of the cognitive interweave is to allow clients to accept the possibility of change, a noncommittal approach may give the client sufficient security to make the useful connections. For instance, to enable the client to express feelings of violation to an authority figure, the clinician might say, **"Let's pretend. If you could say something to him, what would it be?"** If the client answers in a way that reveals the appropriate attribution of responsibility, the clinician responds, **"Good. Now just imagine it and pretend you are saying it,"** and then initiates another set.

This strategy can also be used to assist a client who is locked in a disturbing scene from the past. In the transcript given earlier, the client spontaneously saw herself kicking the perpetrator. If processing had been blocked, the clinician might have guided the client through a set after asking her to

imagine doing exactly that. The clinician can either suggest a particular action or, preferably, invite the client to imagine a new (unspecified) action by asking, **"If the perpetrator tried it now, what would you do?"** While the client is imagining the new scene, the clinician leads her through a set.

Similarly, to break through responsibility issues, the clinician may ask the client to imagine how tall she was in relation to the perpetrator at that age. With an image in mind that shows the height disparity, the sets are added. Likewise, the image of a "sad victimized child" often spontaneously emerges in the client's mind after processing has removed the sense of undue responsibility and blame, and she has achieved a mature, adult perspective. Often clients are spontaneously motivated to hold and reassure that "child self." This should be encouraged, and at times suggested as an interweave, depending on the client's immediate need and capacity.

Socratic Method

The clinician can also use the Socratic method to shape the client's thinking processes. In this time-honored tradition, the clinician uses a series of easily answered questions to lead a client to a logical conclusion. This method is a useful adjunct to EMDR processing. It can help educate the client about deficits in her development or in her parents' modeling, allowing her to see that no blame can be attached to her past actions. The following dialogue illustrates the clinical use of the Socratic method. In this part of the client–therapist exchange, the client has just declared that as a young child she was primarily to blame for a dysfunctional relationship with her father.

CLIENT: I feel guilty that it wasn't different.

THERAPIST: Whose responsibility was it that it wasn't different?

CLIENT: Both.

THERAPIST: Both in what way?

CLIENT: Feels like I could have spoken my piece of mind. If I had angry feelings, I could have said something to him.

THERAPIST: How did he usually react to anger?

CLIENT: I don't know. I never got angry at him.

THERAPIST: Did you observe other people getting angry at him?

CLIENT: No.

THERAPIST: Nobody ever got angry toward him?

CLIENT: No.

THERAPIST: So how could you have known that you could do that?

CLIENT: Well, actually I didn't know. I really didn't think I could.

THERAPIST: Just think of it. (*Leads client in a set of eye movements.*)

The dialogue between clinician and client must be conducted in an exploratory vein, not as a parrying contest. The idea is to open the connective pathways to the new information in a way that is nonthreatening to the client. Any hint of manipulation or intrusion is likely to be detrimental to the therapeutic goals.

ASSIMILATION

The cognitive interweave is used to break through abreactive looping, or blocked processing, as well as to allow assimilation of new information for use in appropriate future behaviors. As noted earlier, the primary points of focus for the trauma victim during the initial processing of traumatic material are information plateaus regarding (1) responsibility, (2) present safety, and (3) present and future choices. If the clinician uses the recommended procedural variations to help the client reach the first plateau of responsibility, processing may spontaneously progress to adaptive resolution. In other instances, after external responsibility has been established, the clinician may observe the client's emotional disturbance diminish from terror to fear and will then need to ask another probe question to help the client reach the plateau of safety.

When dealing with cases of molestation, the clinician must determine early in treatment the current location and condition of the perpetrator. This information may be used to help the client attain the second plateau. For instance, if the perpetrator is dead or disabled, or lives in a distant location, the therapist may ask, **"Can he hurt you now?"** Either the client says no and a set is added, or the clinician employs strategies to instill in the client the recognition that there is no present danger. The clinician may use the Socratic method to lead the client to that recognition, review the differences between the present situation and the past trauma, or use images showing that the relative heights of the client and the perpetrator are different now than when the client was a child. In all cases, the clinician initiates sets of BLS, with evaluation of the client responses to determine whether processing has resumed. If not, additional questions are asked to determine the source of the blocks that need to be addressed.

VERBALIZATIONS AND ACTIONS

At this point, once the fear is past, it is not unusual for the client to feel extreme disgust or anger at the perpetrator. It is often useful to urge the client to voice her anger or pain to the abuser (e.g., "It was your fault that it happened. You shouldn't have treated me that way"). Earlier (in Chapter 7), the clinician was instructed to regard tension in a client's jaw and throat as an indication of a need to verbalize feelings. If use of the cognitive

interweave is indicated, however, the clinician should initiate the verbalization based on the client's emotional state and may even prompt the client with some appropriate words to use. A new interweave reinforcing the client's sense of safety and ability to vocalize may be needed to help her fully vent her emotions. The following transcript illustrates the use of this strategy with the client who was molested by her uncle (see also Appendix B):

CLIENT: I just had another part of my memory, too. Him holding my head down.

THERAPIST: How's it feel now?

CLIENT: Okay. My heart's beating pretty quickly.

THERAPIST: Okay, just notice it. (*Leads client in a set of eye movements.*)

CLIENT: (*Cries.*)

THERAPIST: What did you get?

CLIENT: I was just thinking of why aren't my parents taking care of me.

THERAPIST: (*Leads client in a set of eye movements.*) What did you get?

CLIENT: It's still there, particularly my father. Why didn't he take care of me?

THERAPIST: Just notice. (*Leads client in a set of eye movements.*) What do you feel?

CLIENT: Disgust and anger at him.

THERAPIST: Just notice. (*Leads client in a set of eye movements.*) What are you feeling?

CLIENT: More of my anger at my uncle. How could he do that?

[By asking the client about her feelings, the therapist is inviting her to vocalize her emotions.]

THERAPIST: Good. If words come up spontaneously to say in your mind or out loud, just let yourself do that.

CLIENT: To tell him what?

THERAPIST: To tell him how you feel about what he did. If you want to do that in your head, that's fine. Just raise your hand for me when you've completed it. Just say what you need to say.

CLIENT: Okay.

[The following dialogue continued during a prolonged eye movement set. Clinicians should encourage clients through both verbal and nonverbal cues.]

THERAPIST: Just say what you need to say.

CLIENT: Just say, "I hate you, you son of a bitch"?

THERAPIST: Right.

[The clinician is acting as a cheerleader to encourage the client to vent her emotions.]

CLIENT: (*To perpetrator.*) How do you do that to a 5-year-old girl?

THERAPIST: Really, really.

CLIENT: It's not fair.

THERAPIST: That's right.

CLIENT: It's cruel.

THERAPIST: Whose fault is it?

[The therapist is using the cognitive interweave to reinforce the client's present perspective.]

CLIENT: It's his fault.

THERAPIST: That's right. Tell him.

CLIENT: (*To perpetrator.*) You destroyed my childhood. How could you do that? How could you do that?

THERAPIST: Tell him how you feel.

CLIENT: (*To perpetrator.*) I hate you!

THERAPIST: Right.

CLIENT: (*To perpetrator.*) I hate you, I hate you. I wish you were dead.

[The client states this forcefully and with finality. Therefore, the clinician stops the prolonged eye movement set to attend to any possible dysfunctional emotions or cognitions accompanying the statement. Such possibilities are discussed later in this chapter.]

THERAPIST: Good, good. What do you feel now?

CLIENT: I feel okay.

THERAPIST: Okay, just notice the feelings. If there's more to say, say it. (*Initiates another prolonged set.*)

CLIENT: (*to perpetrator*) I just hate you. How could you do that?

THERAPIST: Let it out.

CLIENT: I could never say it, and I still can't.

THERAPIST: (*Stops set to identify what prevents full venting of feelings.*) What is it now?

CLIENT: It feels more opened up. My chest feels more opened up. I still feel some stuff in my head.

THERAPIST: When you say you "can't" and you "still can't," what does that mean?

CLIENT: I've never confronted him with it.

THERAPIST: And if you did?

[The therapist is attempting to clarify the client's beliefs, so that the cognitive interweave can be used. This does not mean that the therapist is advocating an actual confrontation with the perpetrator. The client will be debriefed about this after processing is completed.]

CLIENT: He'd probably deny it.

THERAPIST: And so? That's not saying you need to.

CLIENT: Right.

THERAPIST: You have a choice to.

CLIENT: Right.

THERAPIST: And if he denies it?

CLIENT: He denies it.

THERAPIST: It's not his salvation you care about.

CLIENT: Right, right, right.

THERAPIST: Just think about it. (*Leads client in a set of eye movements.*)

[The cognitive interweave is completed.]

THERAPIST: What do you get?

CLIENT: I still feel a little tension in my head—right up here.

THERAPIST: The tension—just notice it. (*Leads client in a set of eye movements.*) Okay, what do you get?

CLIENT: It's better. It's better up here. (*Points to her head.*)

THERAPIST: Just notice it. (*Leads client in a set of eye movements.*)

CLIENT: It's like something popped in my head.

THERAPIST: (*Leads client in a set of eye movements.*) What do you get?

CLIENT: It's all right. It feels like it's breaking up.

THERAPIST: Good. Just notice it. (*Leads client in a set of eye movements.*)

CLIENT: Something else came up around my mom. My mom was really screaming and raging at me, and there was really no room to tell anybody.

THERAPIST: (*Asking for clarification.*) No way for you to tell them about him?

CLIENT: Yeah.

THERAPIST: Think of it. (*Leads client in a set of eye movements.*) What did you get?

CLIENT: What came up is, it's not my fault.

THERAPIST: (*Leads client in a set of eye movements.*) Good. What do you get now?

CLIENT: It's more the anger at my mom and the statement "It feels safer."

THERAPIST: Okay. Just notice. (*Leads client in a set of eye movements.*) What do you get now?

CLIENT: The statement came up that "I feel safer and I can sleep."

[The therapist adds an additional set to reinforce the positive statement and feelings.]

As indicated in this transcript, inviting the client to say or do what was previously impossible often helps to resolve further the issues of safety and present control. The client may initially choose merely to think the words during the set, but she should be encouraged eventually to say them out loud, so that the clinician can assess the level of emotion in her voice. Alternatively, the clinician may ask the client to imagine what she would say to the perpetrator if he were abusing a friend of hers. Clients generally are able to vocally defend a friend or beloved relative more easily than themselves. The client is asked to vocalize such a statement until it becomes strong, then to substitute herself in it. The following transcript shows the use of this strategy with an assault victim:

THERAPIST: What do you want to say to him?

CLIENT: I don't know. (*Shows confusion and fear.*) I can't defend myself.

THERAPIST: What would you say if he was hurting your best friend? What would you say to defend her?

CLIENT: (*To perpetrator.*) Stop it, get away from her, you have no right to do that.

THERAPIST: (*Leads client in a set of eye movements.*) That's right. Good. Again.

CLIENT: (*To perpetrator.*) Stop it, get away from her. You have no right to do that.

[The clinician repeats encouragement and adds sets until the client's voice is strong and firm. As the client begins to defend her friend emphatically, the clinician prolongs the set and coaches her with the following words.]

THERAPIST: Now try, "Get away from me."

CLIENT: (*To perpetrator.*) Get away from me. You have no right to do that.

[The clinician repeats encouragement and continues the set until the client's voice becomes equally strong and firm in her own defense.]

Clients often begin with a hesitant and tentative verbalization, denoting a high level of fear and intimidation. As sets are repeated during the verbalization, the client's fear begins to dissipate and her tone of voice becomes stronger and steadier. The clinician should ask her to repeat the words until her anger is expressed with a sense of sureness and justification.

Specifically asking clients to vocalize anger may be useful even when processing is not blocked. Even in cases in which parental neglect or humiliation did not approach the level of molestation or bodily harm, the pent-up anger and fear can nevertheless be debilitating to clients. The client's inability to express these emotions becomes the target of the EMDR processing. If a client reports a feeling of holding back or being blocked, this physical sensation should be targeted directly. As the fear is reduced, the client's ability to speak with undiluted anger increases, then, most often, reverts to a calm sense of empowerment. Often, clients who are urged to express themselves during the set make a declaration of independence to the parent. The sets are continued as the clinician urges the client to elaborate or repeat these words until they are said with a firm, confident, and steady voice. The resultant feeling is often described by clients in terms denoting full emancipation and adulthood. This personal resolution also allows adaptive reconciliations, when appropriate, because the reservoir of dysfunctional emotions is drained.

Naturally, in order to time these verbal promptings correctly, a good clinical ear is necessary. The clinician should make sure before proceeding that the client either has a cognitive understanding of his anger or spontaneously comments on its meaning. The clinician should also encourage and reinforce the client, regardless of the visual or auditory depictions of violence that may be presented. Anger untapped for an entire lifetime can be extremely frightening to the client. The clinician should reassure him that this anger is simply the manifestation of the childhood rage that has been locked in his brain. The clinician might say, for example, **"This too is just the scenery passing by while you are on the train."**

Regardless of the cause of the client's anger or the words used to express it, the clinician should indicate agreement by means of nonverbal cues (e.g., nodding), expressions such as **"That's right,"** and encouraging vocalizations. This holds true whether the client's anger is directed at a perpetrator or at the parent who failed to provide protection. The clinician must be careful to give the client complete permission to vent his anger and pain without attempting to redirect it. At this point, logical discussions of how the parent was not omnipotent are neither called for nor helpful. Nevertheless, as processing progresses, the more tempered and judicious view will spontaneously emerge for most clients. However, as with all other facets of EMDR, the client should be allowed to take the lead in the maturation process, as long as no blocking is evident. Appropriate debriefing and checks for ecological appropriateness should supplement all EMDR processing sessions.

In some instances, the primary emotion that the client may need to verbalize is grief. Whether he is confronting the death of a loved one or the loss of his childhood innocence, the client should be encouraged to give full expression to his grief. The impact of unspoken words of grief was evidenced strongly in a session with a Gulf War veteran. While the

initial target was the scene of his best friend being blown up, the death of his parents came quickly to mind, and he made the wrenching declaration, "I wasn't able to say good-bye." Using a cognitive interweave, the clinician encouraged the client to visualize his parents and express his emotions, and engaged him in successive sets until he experienced a feeling of peace. This feeling was reinforced with further sets.

In certain instances, physical action is useful. For instance, with another veteran, the pent-up anger and frustration was dispelled by asking him to pound alternately with his fists. In another case, the feelings in the client's legs indicated a need to run, so the clinician encouraged that movement during progressive sets. In any instance in which a body sensation appears to represent an inhibited movement, the movement should be encouraged during sets of stimulation.

While some of these EMDR procedures may appear similar to Gestalt techniques, it is the addition of the sets that appears to facilitate the profound and lasting change usually observed. I believe that staying fully present—that is, being compassionate, aware, and sensitive—with a client during an EMDR processing session allows the clinician to rediscover the wisdom of every major current psychological modality. Clearly, these modalities all have something to offer therapeutically or they would not have stood the test of time. The purpose of encouraging specific actions or a particular focus during an EMDR processing session is to inaugurate activities in a deliberate fashion that evolved spontaneously in other clients during effective processing. Many clients have cried out their love, sorrow, anger, or hatred automatically during successive sets. Others have made spontaneous body movements that overcame previous inhibitions. Clinicians invite blocked clients to do the same, that is, to open blockages by stimulating the appropriate neural networks.

EDUCATION

The third plateau to be addressed is the ability to make adequate and life-enhancing choices in the present and in anticipation of the future. Clearly, for many clients, the experience of childhood is one of relative powerlessness, dependence on a dysfunctional family, and attacks by an adult that she had no means of resisting. In general, a client's childhood emotional experience of lacking safety and alternatives is an accurate one. Part of the EMDR treatment is to resolve the past affect, including feelings of low self-worth, and to allow the client to embrace an appropriate sense of adult power in the present. For instance, with female clients who have reprocessed early memories of molestation, experiences that have resulted in a fear of men and an inability to forge lasting romantic relationships, the clinician might ask, **"How do these words sound: 'As an adult I can now choose who I want to be with.' "** Even tentative approval from such a client

is sufficient to start successive sets focusing on any feelings of fear or tension that may exist. Additional sets may focus on the new behavior to be actualized.

Clearly, in many instances, it is necessary to educate the client about social skills, assertiveness, dating customs, and so forth. These can be addressed by helping the client to understand the information at a cognitive level and to imagine the concomitant behavior (actions that would naturally result from such understanding). After this, successive sets should be initiated. As described in Chapter 8, this procedure helps clients to actualize the material before attempting it in real life. However, this incorporation of a positive template for appropriate future action cannot generally be inaugurated until the residual primary fears related to the early childhood events have been metabolized. Little behavioral headway can be made until the client feels himself to be at or near a VOC level of 7 concerning the statement, "As an adult, I can choose." The clinician should identify for appropriate targeting any blocking beliefs that prevent the attainment of a VOC of 7. However, if the client reports a VOC of 6 (or less) because deficits in her background are causing her to feel too unskilled or inexperienced to cope successfully with a projected situation, the clinician should recognize this as an ecologically appropriate response and initiate the appropriate education.

The cognitive interweave may be used extensively in the educational process as the clinician alternates sets with instructional and imaginal material. The clinician can offer specific instructions regarding a task, ask the client to imagine it, then add the sets. However, as in all EMDR processing, the clinician must be prepared for the possibility that the client will remember an earlier event that is connected with some level of disturbance. If this occurs, the memory should become a primary target and education suspended until the memory has been thoroughly reprocessed.

The cognitive interweave allows the clinician to become more creative by including his usual clinical interventions and skills within the EMDR framework. For example, a clinician well-versed in creative visualization may guide the client through "inner child" or other metaphor explorations, and one trained in art or movement therapy may offer assistance through the use of these creative strategies. Furthermore, a clinician with expertise in a specialty population can cognitively assist the client to greater understanding of his problem before helping him assimilate the emotionally corrective material through the sets. The accelerated processing and assimilation of the information can be accomplished within the standard EMDR procedures. The sets are alternated with the individualized creative work, just as the cognitive interweave choices reviewed earlier in this chapter are used to open abreactive blocks.

In addition, the clinician should complete the full protocol, including reaccessing the initial target, initiating sets to discover whether other channels of dysfunction are present, and leading the client in the cognitive

installation and body scan. This helps ensure that the dysfunctional information is fully processed and that the client will not be hampered in future actions by inappropriate disturbance. As always, the clinician should debrief the client during the closure phase and use the client's log to help reevaluate the treatment effects.

SUPERVISED PRACTICE

The more proactive form of EMDR processing described in this chapter should not be used until the clinician is comfortable with the standard EMDR procedures and has become familiar with a baseline of client responsiveness to the interventions described in Chapters 7 and 9. At this point, clinicians may practice the cognitive interweave to help bring more challenging cases to a successful resolution. Information from Chapter 11 should be used to address diverse clinical populations.

SUMMARY AND CONCLUSIONS

The clinician should use the cognitive interweave to (1) treat looping and other blocked processing, (2) address the lack of generalization of treatment effects, (3) incorporate needed information, and (4) defuse an abreaction or address a multifaceted target when there is not enough time remaining in the session for resolution. According to the present model, the clinician elicits information that links the appropriate neural networks, that is, allows adaptive perspectives to modify dysfunctional ones. The clinician initiates interweaves through questions or instructions that elicit thoughts, actions, and/or imagery. Short sets should then be used to obtain immediate feedback, and full integration demands attention to physiological responses. Regardless of the number of interweaves used, it is considered only one channel of information. Before processing is considered complete, the original target is reaccessed and addressed according to the standard protocol.

In addition to a wide variety of specific issues, three generic processing plateaus that the clinician may need to help the client reach, particularly if he is a victim of early trauma, are those associated with issues of (1) responsibility, (2) safety, and (3) choices.

A variety of strategies allow the clinician to elicit the appropriate material, then weave it back into the client's information-processing system. Regardless of the strategy used, it is important to maintain the client's sense of power and to retarget the critical information subsequent to the cognitive interweave to ensure that the client has appropriately integrated it.

Alternative strategies may be used to educate clients who may be suffering from learning deficits or to elicit information and perspectives that have already been incorporated. According to the AIP model, this adaptive

information is held in a neural network that must be deliberately linked to the targeted material. For instance, the self-denigrating client may fully understand that another child is not responsible for a molestation by an adult; the cognitive interweave gently leads the client to apply this adaptive perspective to himself, thus dispelling the guilt and self-loathing generated by his own trauma.

With the exception of the instances covered in this chapter, the clinician should generally refrain from using the more proactive version of EMDR processing, so that clients can progress as far as possible on their own. Answers coming from the client himself are decidedly more empowering than answers provided by the clinician.

Cognitive interweave strategies must be used judiciously by a clinician who is willing to accept the client's rejection of her suggestions, and who is willing to admit being wrong. Because EMDR processing appears to neither invalidate perceptions that are true nor add anything that is inappropriate, the cognitive interweave must be used in a flexible, exploratory way, so that clients feel free to voice any concerns or counterexamples they may have. This more proactive version of EMDR processing is mandatory for successful treatment effects with many highly disturbed clients. Furthermore, it is a prime example of the interactive nature of treatment, in that clients must be allowed to verbalize their pain and their needs and participate in the creation of the positive templates to be incorporated for future action. See Appendix B for an additional client transcript demonstrating the cognitive interweave. In Chapter 11, we look at specific populations that may particularly benefit from the cognitive interweave.

CHAPTER 11

Selected Populations

Most of us have lost that sense of unity of biosphere and humanity which would bind and reassure us all with an affirmation of beauty. Most of us do not today believe that whatever the ups and downs of detail within our limited experience, the larger whole is primarily beautiful.

—GREGORY BATESON

This chapter opens with a discussion of generic issues of noncompliance, which may apply to the more challenging clients in all clinical populations, then addresses the issues involved in using EMDR therapy to treat trauma with a variety of clinical populations: clients with complex PTSD, sexual abuse survivors, military personnel, survivors of disaster, couples and children, and individuals with addictions and dissociative disorders. As we will see, the cognitive interweave, discussed in Chapter 10, is necessary with most clients suffering from multiple traumas, including dissociative disorders.

It is important for clinicians to remember that EMDR processing is not suitable for every client in a given clinical population. For instance, although EMDR is widely applied in the treatment of PTSD, the selection criteria discussed in Chapter 4 preclude its use for certain trauma victims. Likewise, clinicians should not assume EMDR processing will be effective with all clinical populations. The applications of the therapy are guided by the AIP model, which emphasizes the role of psychological experience in both the etiology and treatment of dysfunction. Pathologies with organic or biochemical bases are not assumed to be resolvable by treatment with EMDR procedures. It is extremely unlikely, therefore, that EMDR therapy will be found to be the primary treatment of choice for a client with a purely endogenous depression. However, once again, diagnoses are not as

relevant as the individual evaluation. For any client, the experiential factors that contribute to the dysfunction may be amenable to EMDR treatment, even if other aspects of the pathology are not. Furthermore, while EMDR has proven to be effective with a wide variety of clinical diagnoses, additional special protocols and customized treatment regimens are sometimes necessary (see Chapter 9; Shapiro & Forrest, 1997/2016).

This chapter offers guidelines to assist clinicians in conceptualizing the problems presented by specific populations. Appropriate case formulation and management are important aspects of any form of psychotherapy, and many suggestions in this chapter may be broadly applicable. However, thousands of treatment sessions have indicated certain patterns of response that are particularly relevant to focused EMDR work. These guidelines and patterns should help the clinician choose targets and develop useful cognitive interweaves.

While this chapter gives a basic overview of considerations for working with selected populations, it is by no means comprehensive. Clinicians should never use EMDR therapy with a specialty population with which they do not have experience without consultation.

ISSUES OF NONCOMPLIANCE

Regardless of the clinical population to which they belong, some clients are particularly resistant to change. Of course, resistance to treatment or noncompliance with the clinician's recommendations for targeting or homework may arise with any form of therapy. I believe that the following set of principles applies to noncompliance and may prove useful as a clinician checklist. Remember, EMDR is a client-centered therapy; treatment must move at the client's pace. It is our job to ease the way for clients, not to force them through a protocol.

1. *The boundaries of the therapist's ability should not be construed as the limitations of the client.* Too often, what the clinician dismisses as the result of client resistance is actually due to the limitations of the clinician's model, repertoire of interventions, or ability to interact with the client. While client resistance and noncompliance may certainly be hurdles that need to be overcome, the interaction between the client and the clinician should not be discounted as a factor contributing to the lack of therapeutic effect.

In EMDR therapy, clinician variables that influence the treatment effect include the ability to target the appropriate part of the pathology, to order the targets appropriately, and comfort with the multifaceted approach. For full therapeutic effect of EMDR the clinician must be able to (a) establish a level of rapport that allows the client to reexperience comfortably the various aspects of the trauma; (b) identify accurately the appropriate targets;

(c) use insight and sensitivity to assist in the completion of processing; (d) provide education about a variety of coping skills and systems information; and (e) offer appropriate modeling, when necessary.

Fortunately, the client-centered approach allows most of the therapeutic work to be done in the office rather than by means of between-sessions homework assignments. Therefore, in the absence of unprocessed real-world triggers, continued client resistance or noncompliance is most likely due to inflexibility of the clinical approach and indicates the need for more client preparation and appropriate targeting.

2. *Both clinician and client should participate in determining the goals of therapy.* The positive or negative effects of any therapy are based on an interaction among client, clinician, and method. Part of this interaction is the appropriate selection of goals agreed upon by both client and clinician. If the client is being asked to reexperience disturbing aspects of a targeted trauma, the reasons for doing so should be acceptable to him. While there can be no guarantees regarding the outcome, the reasons for choosing to experience the discomfort of reprocessing clearly include the possibility of liberation from the ongoing debilitating effects of the trauma. The client must recognize these potential effects in order to accept the discomfort generated by the processing. In addition, the negative therapeutic consequences of noncompliance should be frankly discussed with the client.

The client should approve of the clinician's goals, and the clinician should evaluate the client's goals for appropriateness. For instance, the client's aim of never getting angry while driving may be impossible to achieve, and may be part of an inappropriate self-assessment, such as "I can't succeed," that underlies the reason for noncompliance. Clients should be helped to understand that noncompliance prevents achievement of specific goals that they themselves have chosen, not goals foisted on them by the therapist.

3. *Noncompliance is viewed as a part of the pathology.* If the goals of therapy have been arrived at jointly, noncompliance can be viewed as part of the pathology that needs treatment. Just as we do not tell our clients to return for help only when they are less depressed, so we should not ask them to come back only when they are more compliant. With this understanding, consequences of noncompliance become part of the ongoing debriefing of the client.

Issues underlying noncompliance may include fear of failure, fear of success, and fear of terminating therapy. Appropriate assessment can be made by asking the client to respond to the question, **"What would happen if you were successful?"** or **"What is the worst that would happen?"** After the clinician addresses these fears, EMDR processing can be used to target any feeling of tension or resistance that may remain. Unless secondary gains are appropriately identified and addressed, little therapeutic progress can be made.

4. *Targets must be properly prioritized*. EMDR therapy calls for the sequential targeting of memories that influence the pathology. Earlier memories should be targeted within a symptom cluster, and care must be taken regarding feeder memories. Regardless of the ordering of targets, if blocking beliefs are not appropriately addressed, therapeutic effects will be minimal.

In addition, EMDR therapy calls for the clinician to address directly the appropriateness of the client's fears. When fears appear to be based on real issues, an action plan should be in place before targeting the dysfunction; for example, if the client fears losing a disability check if her PTSD is relieved, it is necessary for the clinician to help the client devise a plan for finding a new source of income. When appropriate fears are addressed through education and action plans, the residual fears or concomitant beliefs (e.g., "I cannot succeed even if I try") are viewed as suitable targets for reprocessing. After these have been processed, the trauma targets may be approached more effectively.

5. *The fears that underlie the lack of compliance may be based on early life experiences*. The clinician should evaluate noncompliance in terms of several factors: the client's spiritual beliefs (e.g., "Life is suffering"), parental injunctions (or the need to remain loyal to parents through shared suffering), and the client's need to manipulate others or to have power over them. Memories underlying these factors may be targeted before processing the targets that are the cause of the primary presenting complaint; after the memories underlying the noncompliance factors have been reprocessed, the present stimuli that elicit the negative affect or behavior should be targeted and processed. In addition, a positive template for appropriate future action should be installed. With issues of noncompliance, the client should be asked to imagine doing the task easily and comfortably. Targeting with EMDR processing opens up possibilities of new positive behaviors and allows the client to resolve any residual feelings of discomfort.

6. *Treatment must be flexible*. The feedback log is an extremely useful part of treatment. If the client does not accurately report to the clinician any disruptive feelings or experiences that occurred subsequent to reprocessing, further targeting may be ineffective. Ironically, except for the client's refusal to engage in the treatment itself, the log is the major source of noncompliance in EMDR treatment and can be used as an appropriate reprocessing target. Specifically, the client can imagine keeping the log, and his feelings of resistance to the task, along with any negative cognitions and pertinent memories, can be addressed as they arise in the office. The clinician may conduct an EMDR processing session to help install a positive template regarding future use of the log (or of alternatives such as making audio recordings or drawings of the triggers and disturbance). Results are then reported after the client is again assigned homework to do between

sessions. Only behavioral changes that occur outside the office are considered signs of successful treatment.

In summary, while attending to issues of noncompliance, the clinician should choose a treatment plan that is flexible enough to work around most clients' resistances until they are resolved. This can often be accomplished by using EMDR processing, since most of the work is done during the treatment session. However, in some instances, the client's adamant beliefs may resist change. For instance, my most noncompliant client believed it was spiritually inappropriate to use self-control techniques. In his case, I had to accept this as a limitation of treatment and explain the consequences to him. Because of the nature of this client's complaint, we created a contract about what we could and could not accomplish under these conditions before proceeding with therapy. Had the client been more severely dysfunctional, however, I would have been able to use the EMDR framework only to conceptualize the case, assess and identify problem areas, and provide guidance; I would not have been able to use it to process the information with the usual once-a-week outpatient treatment regimen. It is important for clinicians to remember that they have other therapeutic methods available, and that EMDR processing should be used only when appropriate.

COMPLEX PTSD

We don't see things as they are; we see them as we are.
—Anaïs Nin

It is extremely important to be aware of the continuum of traumas that potentially exist within any client who is presenting for treatment. An adult-onset trauma, by its very definition, can be an overwhelming event that causes the individual to be unable to cope with current life. The clinician accepting such a person for EMDR therapy may assume that a brief, three-session treatment, as supported by research, will be sufficient to address the symptoms of PTSD. However, many clients who have suffered abuse or neglect in childhood have normalized the experience and have been living lives of "intense quiet desperation." An adult trauma can trigger these early childhood experiences and result in a high level of dysfunction that needs to be addressed by comprehensive processing. Since the research (as reviewed in Chapter 2) is clear that adverse childhood experiences increase a client's susceptibility to PTSD and a wide variety of other diagnoses, it is important to take a good clinical history for every client. This includes an examination of potential areas of dysfunction in both individual and relational domains.

Although the DSM does not include Complex PTSD as a specific diagnosis, the ICD-11 (WHO) proposes separate diagnoses of PTSD and

Complex PTSD (Maercker et al., 2013). Expert consensus supports the latter diagnosis as including the symptoms of PTSD, in addition to pronounced disturbances in three areas: (1) affect regulation, (2) self-concept, and (3) relational domains. Early childhood experiences interrupt the development of an integrated sense of self and set the groundwork for later dysfunction. Sustained or repeated experiences of abuse or deprivation often leave an individual with pervasive feelings of shame or guilt, lack of safety, and an inability to express needs appropriately and/or experience true intimacy. The clinician's work in these cases first involves a compassionate exploration of the client's history in a way that projects a sense of teamwork. It is important for the client to feel safe, actively accompanied, and in control. The clinician may sometimes feel challenged, because pathological reactions stemming from the inadequately processed memories of childhood (e.g., extreme responses to perceived threat) can make it more difficult to forge an appropriate therapeutic relationship. The clinician should try to keep in mind that regardless of the age of the client at the time she entered therapy, the unprocessed memories from childhood contain the affects, physical sensations, and beliefs that were engendered during experiences with parents or other adults who deeply wounded rather than protected her. For example, the child who was hit or ignored or pushed away by the parent instead of being comforted, learned that it was futile to express needs or desires. The therapeutic relationship, then, becomes more central to the process as the client experiences a "re-parenting," of sorts that offers adult understanding, as well as an adaptive resolution to childhood attachment experiences. As a result, the client can develop a healthier sense of self that includes having more satisfying relationships with others, as well as an increased ability to self-soothe. These clients, however, often enter treatment lacking a coherent sense of self, have labile emotional states, and are unable to interact appropriately with others. These personal characteristics test the therapeutic skills of even the most experienced clinicians. Therefore, it is imperative for the clinician to have his own repertoire of effective self-regulation skills (see Chapter 9) and to monitor his own reactions, along with the client's, during sessions. Maintaining a sense of safety and stability throughout even the most challenging interactions is essential to successful treatment outcomes.

Many excellent generic and EMDR therapy-specific references now exist in the literature and should be consulted in working with complex populations (Briere, 1996; Boon, Steele, & van der Hart, 2011; Briere & Scott, 2006; Chu, 2011; Cloitre, Cohen, & Koenen, 2006; Courtois, 1999, 2010; Forgash & Copeley, 2008; Herman, 2015; Knipe, 2015; Korn, 2009; Lanius, Paulsen, & Corrigan, 2014; Lazrove & Fine, 1996; Leeds & Shapiro, 2000; Manfield, 1998; Parnell, 1999; Solomon & Siegel, 2003). However, below is an overview of issues and considerations when utilizing EMDR therapy in dealing with complex trauma. Separate discussions of sexual abuse survivors, combat veterans, and individuals with addictions

and dissociative disorders appear in this chapter, along with an additional overview of complex PTSD in the section on children.

For all clients, the full eight phases and three-pronged protocol described in previous chapters should be thoroughly implemented. However, flexibility regarding sequencing is important, because some clients need preparation work before they can even begin to discuss their history. Others may need to begin with rehearsing scenarios and the incorporation of future templates in order to address unstable or challenging situations in their present lives prior to any trauma-focused work. Generally, for clients with complex PTSD, a slower, more extensive history-taking phase is needed in order to identify the extent of the present dysfunction and the full range of exposure to trauma. The clinician needs to pace the exploration, observing in real time the client's response to recalling past events that are disturbing. The client's ability to stay present to his experience while recalling prior events is an important factor in assessing readiness for memory processing. If, however, the client feels easily overwhelmed, resorting to dissociation for self-protection or sliding into shame and self-hatred, it is likely that additional stabilization measures will be needed before processing is initiated. In that case, the preparation phase needs to be carefully implemented, potentially over a longer period of time than usual, to ensure stability during processing and between sessions. However, it should be kept in mind that the amount of time needed for preparation will vary from one client to another. Often, more experienced EMDR clinicians can, after the standard preparation phase, begin memory targeting, alternating if needed between stabilization work and reprocessing. Readiness for processing should be assessed by the client's capacity for self-regulation, using various strategies (e.g., accessing positive emotions through one of the techniques) and ability to maintain dual awareness when accessing a disturbing memory. The client must be able to tolerate accessing the affects, sensations, and knowledge associated with traumatic memories and triggers without resorting to defensive or maladaptive actions (e.g., dissociation, self-injury, addictive behaviors, avoidance). The sooner memory processing can safely begin, the better, for it is the unprocessed memories that are causing the client's affect dysregulation.

Clients with complex PTSD typically experience the world as an unsafe place. Their problems with affect regulation are caused by unprocessed memories, which result in high arousal and negative affect states and, as well as difficulty distinguishing past experiences from present circumstances. Since their upbringing gave them little or no sense of a solid foundation, the clinician should attempt to provide an oasis where they feel safe in revealing their thoughts and emotions. It is useful to give the client an understanding of the AIP model, and explain how he was poorly cared for, with experiences that would have overwhelmed the information-processing system of any child. Consequently, the unprocessed memories of these experiences get triggered in the present and cause a high level of disturbing emotions and

physical sensations. It is important to explain that whatever the emotion (fear/lack of safety, shame, guilt, defectiveness, etc.), the feelings he is having are completely understandable, but feeling them does not necessarily make them true. Processing the memories that contain those emotions will free him to take control of the present. In addition, two excellent books written for laypeople dealing with childhood abuse can help clients by normalizing their responses, helping them understand their symptoms as something that is expected as a response to extraordinary events, not a reflection of them as the problem (Brown, 2015; Courtois, 2014). With the client's understanding and agreement, a further exploration of his issues and symptoms can begin. This includes evaluating issues related to anger, self-harm, substance abuse, and other self-defeating or destructive behaviors. However, the clinician should evaluate the client's ability to remain stable and present during this time. For many clients, it is important to develop alternative coping strategies. It can be useful to teach a simple affect regulation technique, such as the Safe/Calm Place, before delving into the past in more detail.

A comprehensive history is needed to identify the individuals and situations that have contributed to current dysfunction. The developmental trauma experienced during the formative years may have involved direct or vicarious experiences of physical or mental abuse, neglect, or other forms of household dysfunction. In addition to direct questioning, the Adverse Childhood Experiences questionnaire (see Appendix A) can be very helpful. It can normalize the experience for the client by making clear that the entire mental health profession recognizes the profoundly negative impact of an upbringing like his, and that he is to be admired for his intention to heal. A thorough assessment of individual and relational domains is important to identify the extent of the client's current capacities in the areas that need to be addressed. Of particular importance are assessments of the client's level of dissociation, hyper- or hypoarousal, (positive and negative) affect tolerance, self-regulating capacity, and self-concept and relationships, both past and present. During this time the clinician will also evaluate the client's ability to connect and engage during an interactive process, as well as his degree of internal awareness and self-reflection.

During the Preparation Phase, a range of techniques can be taught to the client. These include ones that increase relaxation capacities and build affect regulation skills along with those that can be used in disturbing situations to shift the emotional state. Examples of the former include guided imagery exercises, meditation techniques, and progressive muscle relaxation. In the latter category, we can include the Safe/Calm Place technique, Resource Development and Installation (RDI), diaphragmatic breathing, and other brief exercises a client can use effectively throughout the day as needed (see Chapter 9). The Preparation Phase should be customized to the client's need by assessing her current ability to stay present and to shift, when needed, from a state of distress to one of calm, or to tolerate a high level of distress without negative consequences. However, due to their early

childhood traumas, many clients are terrified by the prospect of remembering and feeling, and may not even be aware that they are challenged in this way. They need help orienting to their experience, both affectively and somatically, and to learn to approach it rather than avoid it or block it out. They may also need to learn to put their experience into words and to tolerate the vulnerability associated with experiencing affect, as well as remembering aspects of their childhood experiences that were intolerable at the time. Consequently, preparation with these clients can be more protracted as they discover how to access their experiences and learn that they can tolerate them, while maintaining awareness that the conditions are different in the present and their capacities are greater than they were in the past. All these skills need to be in place in order for successful processing to occur. Again, however, it should not be assumed that an extensive history of abuse necessitates extensive preparation for all clients. Some individuals with chronic, extensive exposure to trauma show remarkable resilience, with noteworthy self-capacities. They somehow managed to develop these capacities despite the paucity of resources in their early lives. Some clients with horrendous parental interactions had a significant person in childhood who gave them an experience of self-worth and well-being. Clinicians implementing various stabilization techniques should ascertain whether clients can access memories of such people or experiences in the present. For instance, the use of the EMDR RDI protocol can be extremely helpful with this population (see Korn, 2009; Korn & Leeds, 2002). Providing access to a range of positive affects can prepare clients to tolerate or shift out of distress when needed, both during and between sessions. This can allow them to feel sufficiently secure to engage in memory processing with a greater sense of control. RDI can also be used to assist clients in preparing for current distressing situations. Through RDI they can learn to self-regulate distressing responses in the clinician's office when imagining an imminent challenge, and be prepared in advance with a positive affect on which they can draw. Whatever the affect regulation techniques that are taught for client stabilization, the clinician should not postpone memory processing until she manifests a complete lack of disturbance between sessions. RDI and other stabilization interventions are applied with the goal of helping clients learn to manage their experience more effectively, helping them develop a greater sense of agency in preparation for trauma processing, as well as being able to manage their emotional responses in between sessions. Again, it is important to remember that the negative affects in the present are being caused by the activated unprocessed memories, which need to be directly targeted. Processing can generally begin at the point that the client can utilize an affect regulation technique in the office and stay present with the clinician when a disturbing memory is accessed. In addition, consecutive day treatment during initial processing of highly disturbing childhood memories should be considered, if possible, as a means to maximize stability and further accelerate recovery.

While the standard EMDR therapy processing usually begins with the past experiences that set the groundwork for the dysfunction, for many clients with complex PTSD, it is preferable to begin processing by first targeting recent, adult-onset traumatic experiences or the present disturbing situations or triggers. The current event is assumed to be less affectively loaded than a childhood memory of abuse. Successful processing that carefully monitors and maintains affect regulation can give the client a greater sense of control and mastery in helping to defuse current distress. Also, clinicians can use EMD to titrate the emotional experience by minimizing associations. This can be particularly useful in the early stages of therapy, when the client is facing an imminent challenge. For instance, anxiety about an important meeting at work may be addressed through the use of EMD, the introduction of RDI to access and enhance the feeling of confidence, and the installation of a future template after role play and discussion. However, these strategies are viewed as temporary measures until the full processing of earlier experiences can be implemented.

When the client is sufficiently prepared, processing should target the full range of adverse life experiences, including the childhood events that set the foundation for dysfunction. If needed, childhood memories can also be addressed with a fractionated approach by telescoping attention to various frames of the event, processing each disturbing frame as with the Recent Event Protocol, while encouraging the client to use an affect regulation technique, if needed, to maintain control and balance. This strategy can assist the client in overcoming long-standing phobias of inner experience, assist him in becoming mindfully aware of somatic and affective responses, and help him develop a sense of mastery in the ability to change the automatic reactions. During processing, the emphasis is on the clinician conveying the message, **"It's old stuff, you are in control and I'm here with you,"** thereby helping the client to actualize that experience throughout the processing. The clinician, by her compassionate stance, as well as her ability to be a witness to the client's painful experiences, is essentially co-creating with him positive memory networks of support, safe attachment, compassion, and the ability to ask for and receive help. For many clients, this may represent a first-time experience of secure attachment.

During processing, clinicians should track somatic and verbal responses; assess for hyperarousal and hypoarousal, particularly signs of dissociation; and be ready to utilize the strategies discussed in Chapter 7 for blocked processing. In addition, the clinician should be prepared to actively use cognitive interweaves during reprocessing to support the client when needed. These may be used to assist with moment-to-moment affect regulation, with phobias of affect and somatic experience, with vulnerability to dissociation, and with the steps of developmental repair (helping the client to imagine getting what he never got before). For instance, during processing the clinician can assist the client to imagine new, reparative experiences, such as offering aid as an empowered adult to the injured, traumatized child.

Dissociative features and pervasive affects of shame, guilt, defectiveness, and lack of safety and power have resulted in clients who may feel continually buffeted by both external forces and internal feelings, emotions, and physical sensations they cannot control. During processing, the clinician acts as a co-regulator of the client's emotional experience, using verbal and nonverbal cues to help him move through the distress and determine when breaks or cognitive interweaves (see Chapter 10) are needed to facilitate the processing toward a successful resolution. In all cases, the three-pronged protocol should be used to target the earlier events that set the groundwork for the dysfunction, and the current situations that trigger disturbance, followed by the installation of templates for appropriate future action. It is important to use modeling and future templates to educate and prepare clients for satisfying relational interactions they may look forward to—especially since they generally did not have these foundational experiences in childhood. Positive templates should address previously challenging situations, helping clients develop the necessary skills to respond more effectively to these demands in the future. These scenarios are identified and agreed upon by both clinician and client and may include activities such as meeting new people by joining clubs, and engaging in other social experiences to help the client achieve happiness and stability across the entire clinical spectrum. The need to educate clients about the possibilities of a joyful life should be kept in mind, given their previous hardships and limited worldview.

SEXUAL ABUSE VICTIMS

> It takes two to tell the truth: One to say it
> and another to hear it.
> —Henry David Thoreau

Clinicians should already be familiar with many aspects of the issues and cautions listed in the following paragraphs. However, these are especially important during the EMDR treatment of sexual abuse survivors. While such survivors constitute a large proportion of therapy clients, many clinicians have never treated one. This section aims to clarify certain points, but it is not a substitute for adequate supervision and consultation if the clinician has had no previous experience with survivors of sexual molestation.

Appropriate Goals

The ability to accurately retrieve memories of abuse, or large segments of forgotten childhood events, is questionable even under the best of circumstances. While some clients enter therapy to determine whether or not they were molested, the EMDR clinician should not consider this an appropriate therapeutic goal. EMDR processing is not designed to bring visual

memories to the surface but, rather, to process information that is dysfunctionally stored in the brain. Clinical observation indicates that even with otherwise full-blown sexual abuse symptomatology, only half of EMDR clients experience the emergence of a visual memory of such abuse. Therefore, the clinician should concentrate on the client's symptoms and on what can be done to alleviate the emotional (and possibly physical) pain. The following statement can be helpful in explaining to a client how EMDR processing can bring about a shift in dysfunctional reactions and triggers even without a visual memory of the original trauma: **"Just as a video can play whether or not the TV monitor is on, so too can you process past traumatic events without having to actually see them."**

As with any type of therapy, the clinician and the client should agree on the specific goals of EMDR. For example, they should explore whether it would be acceptable to the client to alleviate his problems (e.g., panic attacks, difficulty with intimacy issues, and sleep disturbances) without being 100% certain of their cause. If the client does not agree to this condition, EMDR should not be offered as the only treatment, as it is by no means certain that the actual memory will surface.

Ironically, the same restriction applies to a molestation victim who has clear memories of her abuse but insists that the clinician focus exclusively on her present-day problems, such as a difficulty with her boss. Since there is no way to prevent the molestation memories from emerging during EMDR processing (especially if they are part of the memory network associated with the present-day target), the clinician cannot guarantee that the client will be able to entirely avoid them. Therefore, if the client is adamant in her refusal to think about the molestations, the clinician should probably not utilize EMDR processing.

Client Readiness

While many of these factors have been covered in Chapters 4 and 5, I want to stress that the use of EMDR processing with sexual abuse victims necessitates special attention to the client's emotional containment and current life situation. When there are a number of real problems in the client's present-day life, such as job or family crises, work on early traumas should be kept to a minimum. Until the client is stable enough to handle current problems, the clinician should not risk adding the emotional load of processing early traumatic experiences. Any between-sessions disturbance caused by processing can increase the client's difficulty in handling the anxiety-laden issues in his current life that are out of his control and cannot be put on hold.

Remember that the cautions about using EMDR processing with a given client include the need to make an appropriate assessment of all of his real-life constraints. If the exhaustion or distress that sometimes arises with EMDR processing would be detrimental to the client's present functioning, affect regulating and resource development procedures should be

employed. EMD can also be considered to address distressing current situations until the client is ready for a full processing.

Safety and stability are of primary importance when dealing with sexual abuse victims. It is crucial that clients be carefully prepared for EMDR processing because of the likely emergence of somatic responses, intense fear, and hitherto dissociated memories. Unless the client is prepared for the potential speed with which these can emerge and the potential intensity of the emotional response, she may break off EMDR processing in the middle of an abreaction and refuse to resume treatment. Therefore, all of the cautions and criteria for client selection described in Chapters 4 and 5 should be implemented with even greater thoroughness when working with sexual abuse victims. The clinician should always give the client an initially positive experience with EMDR by using the Safe/Calm Place exercise and teaching her a variety of relaxation techniques to relieve any disturbance that may arise between sessions. Also, when sexual abuse is suspected, it is vital that the clinician adequately screen the client for the possibility of a dissociative disorder.

Evaluating indicators of clinical safety and the client's sense of control is mandatory when working with this population and extends even to the use of the eye movements. Some molestation clients may find the clinician's moving fingers threatening; therefore, it may be necessary to use objects, such as a pen or ruler, or to switch to the use of tactile or audio stimulation. In addition, because of their tendency to feel their personal space has been violated when people are in close proximity to them, some molestation victims may prefer that the clinician sit a greater distance away from them than is usually recommended with EMDR treatment. In short, the clinician should be flexible enough to adapt the standard format in any way necessary for client safety and comfort.

Structure

While clinicians should be flexible in their choice of the focal points they use with molestation clients, they should nevertheless stick closely to the structure of the standard protocols. Although, at times, it can be useful to process current situations first, as discussed in the section on Complex PTSD, generally the three-pronged protocol is advised. Specific old memories, when available, should be targeted first, because they have the greatest likelihood of rapid and complete processing, which in turn will give the client a sense of accomplishment. When a specific old memory is available, using the associated image, cognition, and body sensation will generally result in a more controlled and contained session than attempting to target diffuse feelings of despair, hopelessness, or generalized negative statements such as "I wish I were dead."

A specific old memory that incorporates the negative aspects can be more easily processed and put in perspective than a more recent one, since the former is already part of the historical past and is no longer a danger.

Targeting only a current emotion or cognition rather than a specific event can start the processing, but it may be much more difficult to complete it, inasmuch as current material is stimulated without the specific goal of laying an old memory to rest.

The controlled use of the EMDR therapy eight-phase, three-pronged approach, along with the standard processing procedures, offers specific baseline and assessment measures, such as the SUDS and VOC ratings, that set realistic expectations for the client and help strengthen her sense of structure, safety, and understanding. While flexibility is vital when working with sexual abuse survivors, it should not circumvent the many safeguards that are built into the standard EMDR protocols and procedures. The clinician should try to use the standard approach first, deviating from it only if the client is uncomfortable or unresponsive. The more specific the targets and goals, the greater the likelihood of success.

Integration

The clinician should be especially sensitive to the amount of time the client needs in order to integrate the material that surfaces. Many sessions may be needed to discuss the intrapsychic and interpersonal needs revealed by a new information plateau, to offer modeling of new behavior, to identify interactional pressures, or to target dreams and present reactions that have arisen from the processing of earlier traumatic material.

The clinician should not continue to target new memories until the previously elicited ones and their reverberations have been treated. For instance, the week after reprocessing a major molestation memory, a client reported a pronounced sense of sorrow, stating, "I never before grieved for my father's death." The clinician realized it was necessary for the client to focus on this plateau next, rather than attempt to move on to another memory. The log that clients are asked to keep is vital for identifying any new avenues, emotions, or perspectives that are emanating in a troubling way from a previous target and should be used to explore the ramifications of the memory work. This record keeping should include nightmares, disturbing or unsettling aspects of the revelations, emerging interpersonal needs in relation to integration, and so on.

Just as clients vary in their need to rest or talk or integrate between sets, so, too, do they vary in the amount of time they need between EMDR processing sessions. The clinician must be certain that the client has an adequate repertoire of self-control techniques to deal with any discomfort that arises between sessions. If the client's log reveals a great deal of distress, the clinician should take measures to relieve his emotional pressure. Prolonged distress is detrimental to therapeutic effectiveness, because it can reinforce the client's feelings of low self-esteem and lack of control.

The clinician should also encourage the client to allow sufficient time to pass to assimilate treatment effects before she determines the objective truth of any emerging memories or decides to confront her suspected

perpetrator, either personally or legally. Traumatic events are often stored as fragments, a fact that makes their interpretation difficult. For instance, one client whose sexual dysfunctions and intimacy problems were targeted by EMDR processing reported experiencing sensations of being violated at the same time that an image of her father's face emerged into consciousness. Given this association, it would have been logical for both clinician and client to conclude that she had been assaulted by her father. However, a subsequent targeting of the memory fragment revealed that her attacker was a high school boy, and that the image of her father involved his coming to her rescue.

The aforementioned case underscores two important points: (1) Clinicians should refrain from interpreting clients' memory fragments, and (2) clients should be cautioned to **"just let whatever happens, happen without judging it,"** and without launching into confrontations with presumed perpetrators because of it. The need of clients to confront or receive acknowledgment from relevant family members is strongest during the early stages of therapy, when the memories are not yet metabolized and are a source of great distress. Once the client has processed these memories and much of her disturbance is removed, she is better able to judge the need or advisability of confrontation. Therefore, recommending that the client take sufficient time to integrate the therapy effects is strongly urged, regardless of the clinical modality being used.

Information Plateaus

When reprocessing a sexual trauma, remember to utilize the cognitive interweave, if necessary, to establish the plateaus of (1) appropriate responsibility, (2) safety, and (3) choice. These plateaus seem particularly relevant for the molestation victim who is psychologically frozen in the horror of a childhood assault.

In addition, many clients feel an urge to imbue the tragedy with some meaning. The clinician can often assist this goal by using the cognitive interweave to explore the ways in which the abuse has resulted in the client's having achieved higher levels of sensitivity, compassion, or understanding for other people's suffering. (Indeed, it is not unusual for survivors of abuse to become mental health professionals.) This awareness assists many clients by engendering in them a sense of significance (purpose, self-esteem, or success), in that they were able to triumph by abstracting meaning from their pain. The sense of a spoiled or wasted childhood is, of course, deeply distressing for many clients and should be directly targeted by the clinician if it emerges.

Emotional Stages

When processing a sexual trauma, it is not unusual for the client to go through a variety of emotions and stages of healing. The denied or

dissociated material can shift to feelings of guilt and shame, and then to rage, anger, sadness, and, finally, acceptance—and possibly forgiveness. The stage of sadness can occur before, during, or after the rage or anger. As one client expressed it, "He stole my childhood from me. How can anyone steal something so precious?" While anger might be the client's dominant emotion, the underlying sadness must also be carefully targeted and addressed.

The importance of the client-centered approach is vital when working with sexual abuse victims; other clinical models can actually be detrimental to full therapeutic effect. For instance, many clinicians believe that the client should get in touch with her anger about the molestation and that this is an empowering state of being. While anger is undoubtedly of great consequence for almost all victims, it may be useful to recognize it as indicative of only a single stage of processing. Rather than terminating the EMDR processing once the client has started to experience her anger, the clinician may find it more productive to continue by targeting the rage or anger and requesting that the client verbalize it during the set. This invitation often allows the client to engage fully with the emotion and make a declaration of independence that firmly establishes her personal boundaries.

During the stage of rage, the client may also experience images and thoughts of taking revenge on the perpetrator. He should be assured that this is childhood rage surfacing, and that the images should simply be noticed and the thoughts safely verbalized during the session. Completing this cycle of processing allows the client to release the accumulated tension of all the suppressed pain. Processing these images and verbalizations may obviate the client's need for direct confrontation, an action that might ultimately be futile or disruptive to the family relationships the client wishes to maintain. For instance, a client may feel at peace after her verbalization to her dead father, who molested her, and may not require further acknowledgment from her psychologically unstable elderly mother. However, the clinician should ensure that the client reprocesses all of the dysfunctional emotions related to the abuse, including the rage and feelings of betrayal toward the parent who, knowingly or not, allowed the abuse to occur.

After the client's rage has been processed, he may experience a nondisruptive level of anger, which may be an appropriate and healthy final stage for him, at least at this point in his life. It is not unusual, however, for clients to move into a stage of calm acceptance. In addition, the client may spontaneously remember certain aspects of the perpetrator's history that contribute to a genuine feeling of forgiveness. For example, the client may remember that "Mother was also molested," or "Father was abused." Such realizations may help the client recognize a repetition compulsion or dissociation that explains why her parent abused her. This in turn may precipitate a feeling of compassion for the perpetrator and a sense of forgiveness that transcends the injury and gives the client a profound sense of peace.

If the stage of anger does not evolve into forgiveness, it is probably because this shift is not yet appropriate for the client. However, the clinician should discriminate between dysfunctional rage and appropriate anger. With EMDR processing, the violence and personal turmoil of the rage can transmute into an appropriate level of justified anger that is outwardly directed at the perpetrator and no longer fed by unremitting feelings of pain and fear. Remember, EMDR is a client-centered approach that allows the client to process information appropriate for health and integration. If the client does not process his anger after verbalizing it in alternation with successive sets, the anger should be viewed as ecologically sound and a suitable positive cognition should be installed. The client may need to integrate this plateau by setting firmer boundaries with family members and by having appropriate conversations or even confrontations. It would be unfortunate, however, if the client remained stuck in his anger simply because the clinician felt that forgiveness of the perpetrator was inappropriate and therefore prematurely closed the EMDR processing session.

Remember that reprocessing does not eliminate anything that is healthful or ecologically appropriate for the client. If the client does move on to forgiveness, it does not mean she has forgotten the abuse or condones the perpetrator's behavior. Rather, achieving forgiveness may entail a strong sense of self-renewal and empowerment, a sense that the victimization no longer defines the self. Unfortunately, however, some mental health professionals tell victims it is necessary to forgive their perpetrators in order to be completely healed. Insisting that the client achieve this stage of acceptance can often be traumatizing in its own right, since she is powerless to attain it by force of will. Since forgiveness can neither be mandated nor controlled, the EMDR clinician is advised to allow it to emerge spontaneously, when (and if) it is ready to do so.

False Memory

There exists a concern regarding the possibility that false allegations of sexual abuse are being made as a result of inappropriate therapy. Although some of these claims may be coming from perpetrators in denial, it is clear that there is a need for quality control in the mental health profession. There is no question that some therapists are using psychological tools, such as hypnosis, with little or no training and are therefore ignorant of the limitations of these tools and of their potential for contaminating memories or creating false impressions.

Consequently, it is not surprising to learn that some clients have been led to accept images that have surfaced under hypnosis, guided visualization, or dream analysis as definitive evidence of actual memories, even when corroboration is impossible. Clinicians should be aware of their boundaries of competence and of the limitations of their methods before utilizing them in clinical practice. This is why it is vital that the use of EMDR therapy be

restricted to trained, licensed clinicians who have been supervised in its practice. Simply reading the cautions offered in the following pages is not a substitute for adequate training.

Cautions Regarding Memory Work

When treating victims of sexual abuse, the clinician must carefully evaluate the interaction between EMDR and other forms of treatment. For instance, since one of the legacies of the psychodynamic model is the belief that uncovering memories is a necessary prerequisite for working them through, it may be tempting for the clinician to use a combination of EMDR and hypnosis for memory retrieval. While hypnosis has been a highly successful and standard procedure for many years, its potential interaction with EMDR therapy has not been systematically investigated. Therefore, some words of caution seem appropriate, since each clinician is bound to approach issues of possible "repression" and "resistance" in a highly subjective manner. The points are made in the following paragraphs in order to highlight factors that might be overlooked by some clinicians in the merging of various therapeutic orientations.

Hypnosis

The combination of hypnosis and EMDR therapy should be carefully assessed (Shapiro, 2001). Some clinicians using EMDR have been successful in inducing light trances in dissociative disorder clients to assist in stabilization and to close incomplete sessions (see also Fine & Berkowitz, 2001; Phillips, 2001; Twombly, 2000). In addition, a light trance may be used to assist targeting. However, inducing deep trances during the EMDR treatment session may be contraindicated, because the altered physiological state of hypnosis may not permit all the information to be processed adequately. Just as the clinician should retarget any traumas after the client has been taken off medication, in order to check for any unprocessed material left in state-specific form, so, too, should they retarget events if hypnosis has been used with the client.

Clinical observations indicate that delusions may not be susceptible to change with EMDR processing until the experiential origin of the delusions has been targeted. For example, in order to treat a husband's delusion that his wife had been kidnapped, it was necessary to target, in one of his more lucid moments, the actual event of her leaving him by choice. Similarly, some hypnotically induced fantasies and memories may not be modifiable with EMDR processing. It is important for clinicians to realize that, while they may take a judicious approach to the use of hypnosis with clients, they may have inherited clients who were ineptly handled by previous therapists.

When targeted memories do not undergo the expected treatment effect, either during the session or in follow-up, the clinician should implement

a more thorough screening for dissociative disorder and for the presence of previously implanted hypnotic suggestions. For instance, some victims are the recipients of hypnotically induced "memories" that were implanted during childhood, but they are unaware of the fact. When targeted with EMDR, these "memories" may be resistant to processing and are therefore extremely disturbing to clients. There is currently insufficient clinical feedback to definitively address this concern. More importantly, in many courts, the use of hypnosis in any phase of a client's treatment can contaminate his ability to take legal action against the perpetrator.

The Fallibility of Memory

There is often no way of knowing whether a memory that emerges is true. Indeed, the very attempt at memory retrieval as a therapeutic goal may establish the belief in the client that a memory of abuse exists, that it should be revealed, and that there was indeed a perpetrator. Thus, this scenario could provide the perfect conditions for eliciting "false" or mistaken memories. When a memory is reported during EMDR processing, there is a possibility that (1) the image is a symbolic representation, (2) the event in question was only vicariously experienced (e.g., through identification with a character in a story), (3) the image is the result of trickery (e.g., a perpetrator in disguise), or (4) it is valid.

The fallibility of even a "nondelayed" memory is illustrated by the following case. A client presented the intrusive thoughts and images of having been raped by Satan (Young, 1992). She was quite definite that the event had occurred, because she had retained a clear image of it since childhood. When the memory was reprocessed, she noticed that the horns appeared to be made of plastic and recognized the voice of one of her father's friends. She was then able to recognize that she had been tricked, and the real identity of the perpetrator became clear (although without appropriate corroboration, it should not be accepted at face value). The important point here, however, is that the incident was so abusive that it might easily have been dissociated at the time it occurred and might only have emerged decades later during EMDR processing. If the friend's father had been better at disguise—perhaps using a full face mask, wearing a costume, and changing his voice—the memory would have emerged as an apparent rape by Satan. This obvious fallacy should underscore the point that perpetrators can also convince children that their parents are witnessing and approving of the abuse from a different part of the room. If a memory of an abuse incident that occurred under such a circumstance emerges during processing, there is no way to guarantee that EMDR will adequately disclose the trickery. Clinicians should be cognizant of the limitations and distortions of memory itself before advising clients about the accuracy of any memory that emerges during EMDR processing. Because clients recall what they perceived at the time of the event, their memory will be influenced by the

developmental phase in which the trauma occurs and by the functional capacity of the brain to encode information at the time (e.g., the client was abused while under the influence of a drug).

The issue of vicarious traumatization (Figley, 1995) is also significant here. In one case, a client asked for help with PTSD symptomatology that included flashbacks of having been killed at Auschwitz during the Holocaust. While two specific scenes had repeated themselves in nightmares and flashbacks for many years, the client had no idea of their genesis. In fact, he was not old enough even to have been in the Holocaust. The first scene, of standing in line to enter the concentration camp, was targeted for reprocessing, and the client reported a rapid reduction in SUD level after completing the sets. It was not until the second memory, of being gassed in a chamber, was treated that the client suddenly exclaimed after two sets, "It's not me, it's my uncle!" He then remembered all the stories he had been told as a child about his uncle dying in Auschwitz during the war. The impact of the vicarious traumatization was sufficient to cause the client's pronounced symptomatology, although the actual trauma had happened to someone else. It is vital for clinicians to remember that the genesis of a symptom may be masked by a representation or screen image that may never be penetrated. For instance, in this case the first "memory" was reprocessed without revealing the true cause.

Likewise, symptoms of sexual dysfunction or of difficulty with intimacy issues may be caused by vicarious traumatization or by traumatic events that have no relation to sexual abuse. For instance, sexual abuse was suspected in another client because she manifested many of the attendant symptomatology: panic reactions; problems with men; and fears of intimacy, betrayal, and abandonment. However, during EMDR processing, she discovered that she had dissociated a memory of her father being killed while he was driving her to her birthday party. Her symptoms had nothing to do with sexual assault.

Remember that the use of EMDR processing involves a client-centered approach that attempts to follow rather than lead clients. The clinician should specifically refrain from asking for details or interpreting events. This will decrease the possibility of contaminating memories or creating false impressions. All clients should be instructed regarding the fallibility of memory in a way that does not denigrate their experience. Many true memories will surface for the first time, and clients should be supported in any appropriate action they choose to take as a result. Nevertheless, it is important that clients draw their own conclusions about these memories, using all possible sources of corroboration, and not be led by the clinician.

Again, clinicians must keep in mind that the emergence of a scene during an EMDR processing session does not mean that it is true in a literal sense—even though it may have been truly experienced by the person. For instance, a client may have been tricked by the perpetrator into thinking that a cult or large group was involved. This might have been done in order

to increase the client's fear and the likelihood of his future silence or to make any later revelations about such ritual abuse appear too fantastic to be true. As previously stated, perpetrators can also fool children into believing that their parents are present and approve of the abuse. Because of this ambiguity it is necessary to exercise clinical caution and to encourage the client who is determined to discover the truth to attempt to find corroborating evidence, including physical signs, witnesses, or hospital records. Whether there are corroborating data or not, the primary emphasis must be on client safety and appropriate support during the therapeutic process.

Remember that revelations of horrible abuse (whether true or not) can be extremely disturbing to the client; for the clinician to insist that the memories are true (or false) may only add to the client's distress. A more appropriate stance for the clinician to take is that it may be impossible to know for certain that a specific memory is true, and that the focus of therapy should be on the present symptomatology or distress. Clearly, focusing on the client's internal reaction to the event or possible perpetrator is necessary, whether or not the memory is accurate. Supporting clients through the experience and reprocessing of their targeted images remains crucial, whether the event is true, symbolic, or due to vicarious traumatization.

On the other hand, if extensive or ritual abuse is suspected, it is also vital that the clinician do a thorough check for dissociative disorder. Chronic abuse is a leading cause of dissociative disorder, and it may remain hidden unless a thorough screening is performed. No client with dissociative disorder should be treated with EMDR processing unless the clinician is skilled in that specialty area (see the Dissociative Disorders section later in this chapter).

COMBAT VETERANS

Blessed is the warrior who hears
the whisper of peace in his heart.
—ANONYMOUS

Since its inception, EMDR therapists have provided treatment to military personnel, veterans, and their families. Eric, one of the first veterans ever treated with EMDR, showed me—in a way I will never forget—that his 20 years of postcombat suffering were based on his nobility. Put simply, Eric's most painful memories were not those in which missiles fell around him or machine gun fire rattled past his helmet. They were memories in which he had tried to save someone's life and failed, or in which he believed he was responsible for someone's death. The tragedy is that a great many young men and women who go off to war believe deeply in the fundamental principle, often taught by their religions, that life is sacred. They go to do their duty but discover that they have to take the lives of others or are unable to

save or protect lives, or must witness the kinds of horror only war can generate. One of Eric's most painful memories was of learning that the artillery fire he had had to call in to protect the position of his platoon caused shells to land near a village, probably causing the death of many children. Although he had had no choice but to follow his sense of duty and save the lives of his men, the shelling of the village haunted him for two decades (for transcripts of these sessions, see Shapiro & Forrest, 1997/2016).

Eric's successful treatment with EMDR therapy opened the door for many suffering veterans. Although there are a number of controlled studies with combat veterans (see Chapter 12), there is only one RCT that has provided a full 12 sessions of EMDR treatment (Carlson, Chemtob, Rusnak, Hedlund, & Muraoka, 1998), as used in research of other forms of therapy (see Chapter 12). Posttreatment and 9-month follow-up showed positive and stable effects, with 78% of participants no longer having PTSD, and with zero dropouts. For a comprehensive overview of clinical application, the information in this section should be supplemented with additional resources (Lipke, 2000; Russell & Figley, 2013; Silver & Rogers, 2002).

Many veterans find resolution in coming to understand that they are not the moral monsters they might think they are, for such people would not still be suffering over what they did in the past. Resolution for combat veterans often includes the realization that the past cannot be changed—no one has a time machine—but personal suffering may keep them from doing something worthwhile with their lives. The key is to allow veterans to find their own resolution rather than try to impose what the therapist believes is the "best" one.

During deployments, veterans often do not notice the symptoms of trauma, since their assigned duties require total focus on mission operations. Some veterans acknowledge that keeping an established routine kept them from dealing with the fragmented memory processes they would otherwise experience if they had had the free time to stop and think. Multiple deployments in combat areas can further enhance the fragmentation of their memories, resulting in more complex trauma symptoms. For many, it is only after being home for a few months that they realize their difficulties are not due to life transitions in being home or dealing with relationships now that they are back, but their own struggles with changing moods, emotions, and behavioral issues (i.e., symptoms of combat stress). Such challenges can exasperate the veteran and family members.

Once home, away from the combat deployment, the veteran can benefit from understanding that his continued symptomatology, including the bouts of intense anger, are caused by the experiences in combat that are locked in his brain. Continued substance abuse, if present, is often caused by a need to medicate both physical and psychological pain. For many veterans it becomes an attempt to self-regulate when coping skills are limited. However, therapy often founders when the therapist's attempts to "lead" the veteran to an understanding of the specific sources of his continued

symptomatology; such attempts at direction can clash with a trauma survivor's need for control and disrupt the flow of therapy. In addition, the therapist may be unaware of the underlying dynamic. For instance, the most devastating thing about being a military survivor is often not what he did but just that he survived: "How do I justify my survival when others did not survive?" This self-questioning may be far more relevant to a veteran than "How do I live with what I've done?" Therefore, the therapist should avoid imposing a particular viewpoint. Generally, with EMDR processing, the veteran's own brain will provide the degree of conscious insight needed for resolution of the disturbances coming from his life experiences. There is no "one size fits all" kind of understanding or insight needed for resolution, and the therapist's position should be one of recognizing that, ultimately, the veteran's own ecologically appropriate understanding is what is important. Thus, an introduction of EMDR therapy to the client might include recognition of this point, with the EMDR therapist saying, for example,

> **"A lot of the vets I've worked with have said they've had the same thoughts and feelings you've described. Many have felt their thinking and feelings could never change, especially when lots of other people have told them that all they had to do was think differently, feel differently, just recognize it's something in their brains, or just put it behind them. The nice thing about EMDR is that it doesn't direct you, or tell you how to think or feel. Rather, it helps you, your brain, figure things out and find the answer, the resolution, that fits for you."**

Care should be taken to evaluate veterans for subthreshold PTSD—that is, having experienced clinically significant symptoms of PTSD but not meeting the full diagnostic criteria for posttraumatic stress as a clinical disorder. Fortunately, the issue of distinguishing between PTSD and subthreshold PTSD is not an obstacle with EMDR, as the treatment and the protocol are the same with either condition. Nonetheless, the investigation of subthreshold PTSD might reveal other psychiatric disorders that coexist with these symptoms.

Special care must be taken with elderly veterans who present themselves for the treatment of PTSD symptomatology late in their lives. It is possible that these delayed clinical signs result from the fact that they have reached a point in their lives where they are no longer able to distract themselves with employment and raising a family. EMDR therapists should be alert to any physical conditions, including cardiac or respiratory issues among veterans, that influence the client's ability to endure intense treatment sessions. This is particularly true for elderly veterans whose physical stamina and medical conditions might negatively impact their well-being during treatment. When such conditions exist, it is important to seek clearance from the veteran's physician. The presence of such medical issues may require carefully delivered treatment, particularly in terms of pacing or,

on rare occasions, outright exclusion from treatment because of potential health risks due to abreactive responses.

Dealing with Feelings of Lack of Control

The appropriate clinical framework for the treatment of combat veterans is crucial for positive therapeutic results. When EMDR therapy is offered to the client for the first time, it can arouse fears about experimentation or depressing reminders of other, previously provided treatments that were ineffective. Since veterans are typically survivors of multiple traumatic events and decades of often unremitting pathology, the clinician must take care to prepare the client well for the intensity of the emotional processing that occurs both during and between sessions. These precautions are important because of the generally high attrition rate of veterans in treatment programs.

It can greatly help if veterans understand that their symptomatology is actually governed by cause-and-effect principles. Since the combat experience was often one of chaos and lack of control, veterans may experience the same feelings during therapeutic exploration of the material and the triggered symptomatology. For greater clinical effectiveness, the clinician should provide the client with a sense of order and explain the guiding principles of treatment. This can help set the parameters for a systematic approach to overcoming the pathology.

It is important for the clinician to convey to the veteran the idea that other memories of life experiences, including some that are traumatic, may emerge during EMDR processing and that these should be reported during feedback between sets. Because the emphasis on treating veterans has focused so heavily on the impact of combat, the nonservice history of the client has often been ignored. Because other life experiences before or after military service may remain unresolved, war veterans, as with all trauma survivors, should be informed of the possibility that these other experiences may emerge during processing. The occurrence of any such associations to other memories is not an indicator that the veteran is "doing the therapy wrong" but rather a sign that his brain has identified additional unresolved experiences contributing to his current problems. Clinicians should explain that, if such memories appear, reporting them is important so as to take advantage of the work his own brain is doing. For example, if the veteran was abused as a child or victimized by situations out of his control (e.g., having an alcoholic parent), the war experiences may be associated with these already-established nodes. During EMDR processing, the client will often recall childhood experiences that must be reprocessed. If the veteran purposely ignores these memories because she considers them to be unimportant, beneficial therapeutic effects will be hampered. Therefore, the clinician should help the veteran to understand the importance of her childhood and other, nonmilitary experiences and should be encouraged to disclose the memories if they arise.

Secondary Gain Issues

As discussed in Chapter 4, secondary gain is considered part of the pathology and needs to be addressed and targeted directly if positive therapeutic effects are to be obtained. Secondary gains particularly applicable to veterans include their identification as warriors, their reliance on wartime trauma as justification for years of failure, the postservice vigilance that provides safety, and the need for financial security in the form of U.S. Department of Veterans Affairs (VA) benefits.

The clinician should keep in mind that offering to use EMDR therapy to take away the veteran's nightmares, intrusive thoughts, and flashbacks may also threaten his and his family's livelihood, which comes from a disability check. Obviously, for the veteran who has not successfully held gainful employment for years and has few marketable skills, this prospect can be terrifying. Therefore, if the clinician fails to make a realistic assessment of the potential secondary gains, and to give appropriate reassurance and take steps to allay the veteran's fears through realistic and reasonable action plans, there is a risk of inhibiting the therapeutic effect. A realistic sense of hope developed from the veteran's abilities and intrapersonal resources can provide an essential role in treatment.

Affiliation and the Fear of Forgetting

Another fear that EMDR processing can stimulate, one that is of particular importance to veterans, is that of forgetting significant memories. The clinician should make clear to the veteran that resolving her psychological distress or loss of a particular image does not represent amnesia and that she will not forget about the combat experience or forget to honor the dead. Furthermore, she should be assured that by gaining the ability to live a healthier and more productive life, she will have more choices and a greater capacity for honoring her comrades' sacrifices. For instance, after successful treatment, the client can offer more useful help to other veterans and to the widows and children of fallen comrades, which will continue a sense of connection to those who served and died. Also worth addressing with some veterans is their fear of losing their "edge"; the clinician should make clear that the client's ability to react appropriately to any real danger will not be diminished by EMDR therapy. After the appropriate debriefing of any secondary gain issues, the clinician should directly target any residual client fears.

The question of affiliation is extremely important to the veteran population. For many, war constitutes the deepest bonding experience of their lives. Through shared horror and heroism, a sense of deep connection emerges, a connection that can appear threatened if the veteran feels the pain of wartime memories dissipating. Therefore, it is important that veterans be reassured of their continued connection, especially during the periods when they may be making more therapeutic progress than members

of their peer group. This precaution is particularly important when working with veterans in inpatient units or in groups within a VA hospital. A sense of alienation may arise when the client is no longer fixated on wartime memories but hears the same stories being rehashed by other veterans. The clinician should take care to defuse any attendant frustration or sense of impending loss of companionship. Using these emotions as targets for EMDR processing may assist the client during this transitional state.

Dealing with Denial, Moral Injury, and Transition States

Other issues that must be carefully addressed concern veterans who have been in denial about harmful actions they took in the past. Because of the ability of EMDR processing to engender appropriate client insight, this treatment may represent the first time the veteran's actual level of responsibility for certain incidents is brought to light. In one instance, a veteran continued to feel a great deal of rage for the enemy. Having gone to war with his best friend and watched him die, he had vowed to avenge his friend's death and had returned for five tours of duty in order to kill as many of the enemy as he could. He became a "cowboy," recklessly leading his platoons into dangerous situations because of his need to kill. During EMDR processing, this veteran's anger began to dissipate, and he remarked suddenly, "Maybe I was just as bad as the people I was trying to kill. I didn't care at all about my own men dying around me."

Guilt or shame frequently contribute to feelings of moral injury among veterans. In contrast to clinical diagnoses such as anxiety, depression, and PTSD, moral injury is represented across gradations, with no specific cutoff score that demarcates its presence. Moral injury is distinct from PTSD and results from the violation of one's personal values by committing, witnessing, or learning about acts of transgression that are contrary to a person's moral beliefs and expectations (Litz et al., 2009). Moral injury may be precipitated by acts of commission or failure to act, as well as by experiences of personal or organizational betrayal. Shame perpetuates the self-loathing associated with moral injury and may promote blocking beliefs, such as the veteran believing "I don't deserve to get over this" or "I am a monster." This transitional stage, in which past actions are acknowledged, is one in which veterans are very vulnerable. They are in great danger of terminating the therapy because of the pain that accompanies their insights. They need to be thoroughly supported in order to make the transition to the next plateau. The clinician should take great pains to help clients address the issue of responsibility by, for example, using the cognitive interweave to point out how young they were when they went to war, or how they did what they were trained to do, and how the pressures, chaos, drugs, pain, and anger contributed to their actions. In using the cognitive interweave, it can be useful for the clinician to keep in mind the following concepts: First, if the veteran were as bad as he thinks he is, he would not still be suffering;

bad people do not suffer over something they did years ago. Second, his suffering now does not help those who were harmed, but it does keep him from doing something worthwhile. Useful questions to pose during the interweave may involve variations of **"Have other Marines experienced similar responses? What would you say to them?"**

The memory of forgotten events may emerge suddenly during processing for some veterans who have denied culpability for harmful actions. Whether the denial of such actions is caused by lack of insight or by dissociation, EMDR therapy can cause an emotional breakthrough—but only with the appropriate therapeutic alliance and clinician availability. If these psychological supports are not in place, the client may respond to the emotional pain with self-medication or self-sabotage, and all therapeutic benefits may be lost.

While many EMDR therapists utilize 50-minute sessions effectively, when possible, 90-minute sessions can be helpful in working with disturbing transitional states in veterans. Offering increased clinical availability ensures the ability to rapidly target the distressing material and complete the processing. Consecutive day treatments are also useful for this purpose (Hurley, in press-a, in press-b). It is not necessary for the veteran to remain in a state of prolonged guilt or sorrow just because these emotions have only recently arisen. Remember, it is not useful to mandate a set amount of time for client grief and suffering, because the appropriate levels of insight and meaning will be gained by the client as reprocessing of the information occurs.

Emotions are considered dysfunctional when they are not empowering and enhancing for the client. Immediately targeting the veteran's feelings of intense guilt as they emerge can help him in the transition to an appropriate level of responsibility for his actions. For many clients, this entails a desire to expiate past acts. In these cases, resolution often involves the adoption of new behaviors, typically of benefit to others, which helps an individual balance his moral scales (see Silver & Rogers, 2002). For, instance, it may be useful for the clinician to suggest that such clients offer their assistance to war widows and their children and to other veterans, give talks to high school students on their war experience, or offer their services as a Big Brother or Big Sister. Such acts are likely to provide the veteran with a sense of fulfillment and purpose. All of these explorations and suggestions can be accomplished, when necessary, with the help of the cognitive interweave.

Dealing with Anger

Experiencing and managing anger can be extremely difficult for the combat veteran. Many veterans suffer from uncontrollable bouts of anger in response to minor disturbances, a symptom of special consequence because of the spouse or child abuse that may occur as a result. Not surprisingly, many marriages have suffered or been destroyed by the veteran's

overpowering attacks of rage. It may be useful to explain to the veteran that much of this anger may also be directly linked to the war experience. The client should be assured that reprocessing the memories and targeting the appropriate present-day triggers will allow him to be in greater control because, among other things, his rage will be reduced. Metaphorically, the information processing will drain the pool of anger so that it will be less likely to overflow. In addition, it is important to offer clients a variety of self-control techniques (described in Chapter 9) to use in the meanwhile if the anger wells up. The Safe/Calm Place exercise is particularly useful for this population, because part of the client's pathology may involve the need to remain vigilant under almost all conditions.

A variety of creative interventions may have to be employed to assist clients in dealing with their rage. An example of the need for innovation during treatment came to light during a session targeting a client's reaction of extreme anger about a variety of seemingly innocuous business situations. Since most of this client's combat experiences had already been reprocessed, these incidents were noted as part of his log report. As per the standard EMDR therapy protocol, these stimuli were discussed and targeted. However, in the middle of the first set, the client held up his hand to stop and declared his unwillingness to continue. When asked for a reason, he said, "I just realized that this is the same anger that kept me alive during combat and let me do what I had to do. I'm afraid if we continue that I will hurt you." The clinician thanked the client for his concern and examined the parameters of his fear. He said he was afraid that if he allowed himself to access the full force of his emotion, he would automatically act out against anyone around him. The clinician felt sure of the client's actual level of stability, but honoring the client's need for safety was vital. The clinician therefore instructed the client to go to a nearby area that contained no people and allow himself to feel the emotion and pound the ground while verbally expressing any thoughts that arose. The clinician instructed him to return when he felt ready. Approximately half an hour later, the client emerged with a face of happy wonder. He had found that he had not been overwhelmed by the emotion; instead, as he allowed himself to express it, the emotion had subsided. He said that he felt he would no longer be the victim of his emotion but, rather, its master. These thoughts were used as the positive cognitions in successive sets. The current stimuli were then reprocessed without further incident. Follow-up sessions revealed that the client's anger was now rarely triggered at work, was at a much reduced level when it did occur, and was easily handled with self-control techniques.

Military Sexual Trauma

The information in the previous section on sexual trauma applies to veterans. However, we consider *military* sexual trauma to be a special case, because of the unique environment of military service. It is a situation often

characterized by tremendously high levels of mutual trust, bonding, and shared responsibility, and one in which individuals may view themselves as competent, even powerful, figures. This being the case, a traumatic sexual experience can be doubly devastating because of its violation of trust and one's self-concept.

Survivors of military sexual trauma (MST) frequently experience shame regarding their sexual assault. The assault leaves them feeling violated and damaged interpersonally, while being disillusioned about the trust and security of the military command. Being assaulted by someone believed to be trustworthy, particularly within the military, is extremely injurious psychologically. Previous self-referencing negative beliefs held by the veteran fuel the diminished self-worth following sexual assault. The sense of worthlessness often leaves the person socially isolated and with a desire to avoid memories of the assault event. Furthermore, the existence of previous adverse childhood experiences may exacerbate the impact of the MST, including the development of severe psychological symptoms. Dependency on alcohol and other substances may develop as an effort to self-regulate emotional pain. MST survivors are often left with a distrust of their own judgment and decision-making skills. In preparing to discuss the client's history it is helpful to prepare her for the possibility of feeling a sense of shame at the end of the first session (Hurley, 2016b). Preparing the client for this possibility before the session conveys the assurance that the therapist is experienced and has sensitivity in treating clients with similar issues in their healing journey. The therapeutic alliance can build a relational bridge of trust and rapport as important components of the treatment plan.

Survivors of MST with histories of early childhood abuse may exhibit symptoms of complex PTSD due to their repetitive exposure to abuse. Loss of meaning, difficulty in self-regulation, and dissociative exhibitions are often noted in persons with repetitive abuse histories. The EMDR therapist should be aware of this possibility. Persons with complex PTSD often benefit by the therapist beginning with a reduced number of passes (20–25 repetitions) of BLS, and increasing the number of passes only as the client demonstrates the ability to be present and self-regulate. During processing, the client frequently experiences plateaus at various levels of intensity as the targeted memory networks become resolved and other distressing associated memories are accessed and processed to resolution. The therapist will often observe the client's variation in distress levels (SUD) until the associated memories are processed and the target incident is totally resolved.

Using the Cognitive Interweave

The plateaus of processing discussed in relation to military sexual trauma victims and other sexual abuse victims also apply to the general treatment of the combat veteran. Using the cognitive interweave to help clients recognize the appropriate level of responsibility, present safety, and future ability

to choose can be extremely helpful. For instance, a veteran was abreacting with respect to an incident in which a new recruit was killed because the two men exchanged positions on patrol. The exchange had been unavoidable, because it followed a direct order, but the client's guilt was nevertheless overwhelming. The clinician used the cognitive interweave by asking, **"If your nephew had been in your situation, what would you have wanted him to do?"** The veteran freely admitted that he would have wanted his nephew to obey the order, since it was the right thing to do. The addition of a set shifted the plateau, and the memory was successfully processed.

Another veteran was similarly relieved of his guilt about participating in the war by being asked if he would blame his own son for participating. The veteran reacted with tears, and the remnants of 20 years of guilt were effectively drained. While this cognitive interweave will not work with every veteran, it frequently proves useful, particularly when posed as a question. Even if an answer is not immediately forthcoming, all the veteran need do is think about the question during successive sets. Veterans suffering primarily from the locked-in fear of the life-threatening combat itself can often be assisted by a cognitive interweave that elicits the statement, "It's over; I'm safe now."

Anniversary Dates

Many military personnel and veterans know the names, dates, and locations of fellow soldiers who were killed during combat operations. These dates are frequently memorialized on bracelets or body tattoos. Anniversary dates tend to elicit mood changes each year as the veteran is reminded of the loss of combat friends. These losses should be directly addressed, because they can change how the veteran views himself and his world. Often the loss can be identified as a targeted event and treated with the EMDR standard protocol. It is said that everyone who returns from deployment is changed, some with survivor's guilt and others with performance guilt, believing they should have accomplished more and done better. Many become stuck in the guilt and unresolved grief over loss. Any reminders of the loss become triggers that change their moods to such a degree that their lives are continually being jerked around with emotional reactions. Their triggers rob them of living in the present as they continue to be lost in reliving memories of distressing past events. All such disturbance should be processed with the three-pronged protocol.

As anniversary dates approach, family members may notice the veteran becoming moody and withdrawn. It has been reported by Gene Schwartz (see Silver & Rogers, 2002) that intense reaction to anniversary dates can also be reduced or eliminated by taking a frame-by-frame approach. Focusing on the anniversary date, the clinician has the client run through the entire experience, as with the recent event protocol, and stop when encountering any disturbance. The client focuses on that feeling as bilateral stimulation is administered, until it disappears. This is repeated throughout the

entire event until all disturbance, including all physical sensations, smells, sounds, and so forth, are completely resolved.

Complicated Grief

For many war veterans, who are trained to compartmentalize their intense experiences, emotions are viewed as a hindrance to mission performance. The duties of the soldiers often determine how they will deal with anger. Medics who focus on caring for the wounded sometimes report, "I was too busy trying to keep people alive to get angry, but I *am* angry!" They often internalize the death of a soldier in their care with a heightened sense of responsibility, anger, and unresolved grief as they carry with them misplaced guilt about the soldier's deaths. In comparison, combat soldiers frequently view their anger to be empowering during military operations, as their military duty requires them to be aggressive in combat both to accomplish their mission and survive. The medic and the infantry soldier often cope with their emotions differently; whereas one ignores the anger, the other relies on anger to help him accomplish the mission. Both ways distract from the healthy processing of emotions, including the grief; that is, the unprocessed anger contributes to unprocessed grief. The clinician should be mindful of the level of suffering engendered by this grief and recognize that this suffering is no less severe than that borne during the combat experience itself. During therapy, the clinician should carefully nurture these veterans through any abreactions that may be precipitated by EMDR processing and, when necessary, use the cognitive interweave, to remind them of the comfort they brought to those men who would otherwise have died alone.

Veterans may have been haunted for years by intrusive thoughts of the faces of the dying soldiers and of the scenes of suffering and disfigurement. These intrusions remain as unprocessed complicated grief. When an event is associated with sadness and grief, the emotions are often avoided and go unprocessed. The pathology of unprocessed grief often affects the overall well-being of a veteran as sorrow becomes embedded and pervasive in her life. During treatment these emotions can erupt as an intense discharge, leaving the soldier or veteran feeling momentarily overwhelmed and out of control. It can be helpful during history taking to learn how the veteran's family of origin dealt with the death of any deceased family members, as well as learn her family's rules for handling emotions. When veterans struggle with emotions, asking questions such as **"When did you first learn that emotions are to be avoided?"** can be helpful. Preparing the veteran to accept the processing of emotions can assist in addressing grief-related target events. The processing of targets involving loss may result in the veteran experiencing relief now that the emotions are released or may initiate a grieving process with its accompanying sadness over a period of time. Using a cognitive interweave such as **"Would it be okay to get over this?"** can be a helpful introduction into processing the grief. Clinicians

should carefully monitor such clients and offer as much support as needed until a sense of resolution and peace is achieved.

Overall, we as clinicians have the ability to help these men and women, who have sacrificed so much, to reclaim their lives. With EMDR therapy, they can rapidly process events that have left them feeling shameful and guilty for years. They can do so without having to divulge any details of the memories that they wish to withhold. Knowing this can give them a sense of control that allows them to face their worst fears and obtain relief. To achieve this, it is crucial that clinicians become knowledgeable in this area by reading the available texts (e.g., Hurley, 2016; Lipke, 2000; Russell & Figley, 2013; Silver & Rogers, 2003) and receive appropriate supervision before working with this population.

POSTDISASTER RESPONSE

Our greatest glory is not in never falling,
but in rising every time we fall.
—Confucius

Following natural disasters there is often an outpouring of emotion and a strong desire to help the victims. The use of EMDR therapy has rapidly increased throughout the world to assist those who have experienced large-scale disruptions, such as typhoons, earthquakes, or flooding, and for those who have suffered from the trauma of war, relocation, or acts of human aggression. While it can be stressful for the postdisaster responder both logistically and emotionally, this work is also very rewarding. Early EMDR Interventions (EEIs; see Chapter 9) have the power to decrease acute reactions in a relatively short time, as well as prevent the development of longer-term mental health problems in disaster-affected populations. Recipients of these services are often grateful to feel their symptoms rapidly decrease and to have the human connection with a calm and caring clinician. The dedication of EMDR clinicians to disaster response is increasing as data continue to validate the effectiveness of EEIs (see Chapter 12). The following brief introduction serves as an overview of this work, but there are many details to consider when planning a disaster response. Please refer to general publications plus EMDR resources specific to this population (EMDR Research Foundation, 2014, 2015). This section presents an overview of recommendations from colleagues across five continents who have been involved in postdisaster response.

Special Considerations

While many individuals recover from disaster without treatment, about 33% of those have experienced a traumatic event and continue to experience symptoms for 3 years or longer and have an increased risk for secondary

problems (National Institute for Clinical Excellence, 2005). Since it is difficult to predict exactly who will recover completely and who will develop symptoms, it is suggested that a wide net be cast for screening, and that early and appropriate intervention always be considered. Typically, clinicians administering EMDR stabilization at or following a disaster are an integral part of a community or national disaster response team and have been familiarized with the procedures and chain of command in an organized disaster response. However, if this is not the case, every effort should be made to work within existing structures. Because team members may be working in shifts, explaining the extent of the therapeutic contract, such as the focus of treatment, the number of sessions available, and whom to contact in case of an emergency is essential, as is keeping accurate records for the next treatment provider. Emotions may be strong, and both clinicians and survivors may experience a heightened sense of emergency and vulnerability. For these reasons, special attention must be given to safety and containment. Having a clear contract and procedures will help maintain focus and keep interventions on track.

EMDR Intervention at the Time of the Event or within the First 48 Hours

EMDR stabilization procedures have been used within minutes or hours of a disaster to successfully stabilize survivors and witnesses. These interventions can readily be offered in postdisaster settings, enabling clinicians to adapt their services so they can be used at the scene of the event, in tents, at schools, in an emergency room, or at an emergency triage or treatment center. Some survivors and witnesses may present with heightened arousal and are readily identified as distressed and in need of services. Others may be experiencing some degree of dissociation from their experience and appear to be highly functional, even if disconnected from their own injuries or emotional trauma. Still others may be in a state of silent terror, unable to move or speak. It is important to recognize these widely varying presentations, make an assessment, and select interventions appropriate to the situation.

EMDR Interventions 48 Hours or More Postdisaster

When the individual is sufficiently stable to engage in reprocessing, the full eight-phase protocol can be utilized. Typically, this can be initiated about 48 hours following the event, although this can vary depending on the individual. As with all psychotherapy interventions, a signed consent for treatment should be obtained, along with current contact information. It is important to include the number of sessions to be provided and clearly indicate that treatment will focus on traumatic experiences linked with this event, current triggers or reminders, and related fears about the future,

but will not delve into other aspects of the person's life during this brief intervention.

If collecting data to evaluate the treatment, a sentence indicating consent to use and publish that data is usually required in the consent form. Administration of a brief rating scale, such as the Impact of Events Scale—Revised (IES-R), before and after intervention helps to evaluate the degree of disturbance and the effectiveness of the intervention. This should be done as early as possible in the intake and is often used as part of screening and triage. More information is available through the EMDR Research Foundation (2014, 2015).

If the intervention occurs weeks or months after a disaster, response teams may come from other locations and find themselves working in cultures with which they are unfamiliar. Therefore, throughout the process, cultural awareness and sensitivity are essential.

Phases of Treatment

It is important for the clinician to understand the nature of the survivor's experience during the disaster and to obtain a history of recent or past events that are specifically related to it. Frequently, the most difficult part of a disaster is not the event itself but the survivors' resulting loss of home and work relationships, and even their concerns about the future. Because clinical intervention often occurs before the survivor's memory of the disaster has had time to consolidate, the story of the event may be delivered as separate memories that are often sequential in nature. All of the recent event protocols take this lack of memory consolidation into account as part of history taking and organizing the treatment plan (see Chapter 9). Brief and focused history taking includes all three prongs of standard EMDR therapy and includes information relevant to both psychological triage and the establishment of a treatment plan. History taking should include any prior psychiatric or psychological treatment and concerns about immediate danger. From the AIP model perspective, past unresolved traumas influence both present symptoms and coping strategies. Not only can memory networks that are linked to past traumatic events be reactivated, but dysfunctional ways of dealing with stress may also be triggered. For example, the incidence of alcohol use often climbs after a disaster. Therefore, it is important to ask about strengths and coping strategies during history taking. If resources allow, successive-day treatment can be considered as part of treatment planning.

Adequate client preparation requires, at minimum, brief psychoeducation about normal reactions to a critical incident or disaster, an explanation about EMDR therapy and what the survivor may expect, introduction to the mechanics of the treatment, and an assessment of stability and readiness for reprocessing. Most survivors are relieved to hear that what they are experiencing during the postdisaster period is typical, and that EMDR

therapy works with their natural healing process to help relieve symptoms and return them to their usual level of functioning. A resource state such as the Safe/Calm Place should always be developed if possible. This may be the first time since the event that these disaster survivors have been able to experience comfort or safety. The technique can also be used between sessions as a means of rapid self-help. Unfortunately, it may not always be possible to create a safe place, since the word "safe" may cause the person to experience hyperarousal. If this happens, the clinician should switch to additional grounding or self-soothing techniques, such as a positive or comforting feeling or the 4 Elements exercises (earth, air, water, and fire; E. Shapiro, 2007; see also EMDR Research Foundation, 2014, 2015).

The clinician should follow the assessment phase according to the selected protocol (see Chapter 9). If this is an early intervention, it may be difficult or impossible to obtain cognitions. The goal of this phase is to access and activate the traumatic memory for subsequent processing, as well as to obtain a baseline measure of disturbance. If the client is currently highly disturbed about the experience, it is clear that it has already been accessed. The clinician may need to make her best estimation of the measurements and move ahead with reprocessing.

As mentioned earlier, both safety and containment need to be monitored during the course of treatment. It is important to help clients to stay present and within their window of emotional tolerance, as well as contain the reprocessing to the agreed-upon current events. The clinician may need to be more active in the use of standard EMDR strategies to facilitate processing by assisting clients to maintain dual awareness and to manage hypo- or hyperarousal. Some of the EEI protocols specifically utilize the EMD and EMDr strategies to limit associations to other memory networks by regularly returning to the target after each set of BLS, or when a response is given that is not directly related to the disaster. These strategies help contain the reprocessing and desensitize the memory fragment being targeted. Since heightened responses are often felt physically, it can be useful to focus specifically on sensations after sets of BLS by first asking, **"What are you noticing?"** If physical sensations are not included in the client's response, follow with **"And what are you noticing in your body?"** If unrelated trauma memories emerge, the clinician can note this, then return to the targeted memory. The EEI strategies are described more completely in Chapter 9. The emergence of guilt during reprocessing is common among disaster survivors and can stall reprocessing during the desensitization phase. It includes guilt for living when others did not, as well as guilt over actions taken or not taken that might have endangered others. The experience of guilt can vary according to the specific situation and the individual's personal sense of responsibility. A survivor may feel guilty because she survived and a neighbor did not, or because she couldn't protect a relative or a friend, or the fact that she still has housing and others do not, or even because she was on vacation and avoided the event

altogether. These irrational beliefs often require the use of cognitive interweaves, followed by BLS, to facilitate access to the adaptive information. Examples might be, **"I'm confused, are you saying that you wish you had been hurt more severely?"** or **"If you had known this was about to happen, you would have done things differently. Did you know this was about to happen?"** If necessary, survivor's guilt can be explained as the way our minds attempt to regain safety and control by imagining ways in which the tragedy could have been avoided or the damage prevented if we could only foretell the future.

Even soon after a disaster the goal of Phase Four is to reprocess the memory to an adaptive resolution and to bring the SUD level to 0 or to an ecologically appropriate level of disturbance. The clinician should follow the usual procedures to try to attain this goal. If memories of additional traumatic experiences emerge during the course of the intervention, the survivor can be informed during debriefing or at the end of treatment that additional trauma therapy may be helpful, and an appropriate referral can be made.

Phase 5, Installation, should proceed as directed by the selected protocol. The essential difference in this phase is that the recent target memories are not yet consolidated. The goal is to influence each portion by having the client hold the adaptive positive cognition in mind while running through the entire experience like a movie. The positive cognition may simply be "It's over," or it may include elements of appropriate responsibility, present safety, and control or empowerment. Again, the goal is to be able to review the entire event without disturbance and to confirm that the positive cognition is entirely true. Generalization may not happen spontaneously but may require that the clinician ask about potential upcoming situations when the client will want to remember the positive belief, or when she thinks it would be useful. The body scan is typically completed as in the standard protocol. Because somatic activation is an integral part of the emergency response, physical symptoms may be the last to resolve. It is important to include this part of the protocol to obtain as much resolution as possible.

Closure should include the usual goals of bringing completion to the trauma processing work, assessing the stability of the client, ensuring access to affect regulation skills and resources if needed between sessions, and helping to integrate gains made during the session. Special attention should be paid to stabilization if the reprocessing is incomplete or if there are ongoing traumatic events. If necessary, return to the Safe/Calm Place and strengthen it. During the first days after a mass disaster, clinicians can help survivors to shift affect states and remind them of coping skills by helping them plan actions for their next hours and days. Useful questions to ask during Phase Seven (Closure) include **"What are your plans for the next few hours and with whom will you spend them?"** and **"What will you do about dinner?"** Posing practical questions such as these helps the person to take control over her present life.

Clinicians engaged in a disaster relief program usually work in shifts. Therefore, in order to pick up and continue a selected protocol, a clinician new to a particular survivor must be aware of what this person has been experiencing and what has been accomplished so far in the therapeutic process. Again, good record keeping is essential. It is important before saying good-bye to the survivor after the session that the therapist tell her how much he appreciates having been allowed to be a part of her life in this most difficult time, and to wish her well. Reevaluation is completed just as in the standard protocol. If several targets were processed during the prior session, each should be evaluated.

Vicarious Trauma

Members of the disaster response team, whether first responders, chaplains, or EMDR therapists, are eyewitnesses to the trauma and grief of their clients. Even though they tend to have a higher tolerance for these things than is typical in the general population, they naturally have their limits. Vicarious traumatization may necessitate psychological treatment, which may also be necessary if they are to provide the psychological environment their clients require. If clinicians are disaster survivors, they may need the help of other EMDR professionals who have not themselves been exposed to the traumatic events. It is recommended that local clinicians be evaluated and, if indicated, engage in their own focused EMDR therapy before starting to work with the general population.

Disaster relief programs need to be flexible, yet carefully organized to provide constant assessment, containment, and treatment of vicarious traumatization. This can be done individually, or by using one of the EMDR Recent Events group protocols that address the most disturbing aspects of their experiences (see Chapter 12).

Following participation on a disaster response team, EMDR clinicians report that the experience was positive and enriching for them both professionally and personally. They feel gratified to be able to work with survivors at such a vulnerable point in their lives, and to be able to provide services that truly make a difference.

COUPLES

> In order to be utterly happy, the only thing necessary is to refrain from comparing this moment with other moments in the past, which I often did not fully enjoy because I was comparing them with other moments of the future.
>
> —André Gide

EMDR therapy must be used within the context of an interactional dynamic. The processing of childhood adverse life experiences and current

situations that negatively affect the client may offer a number of challenges to intimacy that are best addressed by an informed partner who is willing and able to participate as a support. Couple therapy may be an appropriate intervention to help the client more easily integrate new perspectives and behaviors within the family context. It can also teach the couple better communication skills and enable the client's partner to more easily accept her changing self-concept and the consequent shift of identified roles.

There are usually two different goals for the use of EMDR with couples. The first is for the client's partner to provide support for the client, who is working on personal past material in EMDR therapy. The second use is to address relationship issues, which may be preexisting, that stem from unresolved historical traumas or relate to current marital distress. The following is an overview of some of the issues that may need to be addressed when treating clients in committed relationships. For a comprehensive discussion of the integration of various forms of family therapy with the EMDR therapy, see Shapiro, Kaslow, and Maxfield (2007).

Partner Providing Support

When a client requests that her partner attend treatment sessions, alerting the couple to possible systems issues can help to minimize areas of confusion and disturbance. There may be advantages to meeting with the couple to determine the reasons for the request and to acknowledge the important role of the partner in the client's life and recovery. A therapy appointment with the couple can help reassure the partner, identify potential problems, establish boundaries, and explain how confidentiality will be handled. The partner's role as support person (not client, not therapist) must be addressed and decisions made about how the partner can be involved. This may help the partner to accept more easily the client's changing self-concept and the consequent shift in interpersonal dynamics.

The partner of the client undergoing intensive EMDR treatment for childhood traumas may become the recipients of the client's emotional distress when memories of molestation are triggered. Sexual dysfunction, depression, and angry accusations on the part of the client may exacerbate the usual relationship tensions and contribute to a dysfunctional dynamic. In other cases, as the client progresses with treatment, the change in relationship dynamics may create tension and conflict, as the client attempts to be assertive and to establish appropriate boundaries. It is possible that such situations can be simply resolved by occasional couple sessions for psychoeducation and debriefing. The goal of these sessions is for the partner to learn how to better support the client and understand the situation. In circumstances in which the emotional relationship is more volatile, the EMDR clinician should consider whether seeing the client and partner jointly is acceptable, or whether a referral should be made for couple counseling (see also Kaslow, Nurse, & Thompson, 2002).

Sometimes a client requests that the partner become more involved with treatment by providing support during EMDR processing sessions. In this circumstance, there are several elements that should be considered and which should be discussed with the couple. The first is that the client may filter or screen her expressions because of the partner's presence, and this may interfere with completion of treatment elements. The second is that the partner may react emotionally to the material being processed or to seeing the client in intense distress. For instance, if the client begins to remember an early molestation or humiliation, feelings of shame and guilt might cause her to be reticent about revealing the material in the presence of her partner. Or she might fear that when her partner hears about what was done to her, he will seek out the perpetrator for revenge. Either contingency can cause the client to attempt to dissociate or minimize the disturbance, which can lead to insufficient processing and retraumatization. Another negative dynamic can emerge if the partner becomes emotional and the client minimizes his suffering because she needs him to be a stoic male protector. The clinician should therefore proceed with utmost care when considering whether to attempt processing with a client in the partner's presence.

Clinicians need to use their own best judgment about what will be beneficial to their clients. For example, one EMDR-trained clinician reported engaging in the reprocessing sessions with the partner present because she thought it would increase the bonding of the couple. When the wife abreacted while processing a memory, the husband was so touched by her level of pain and his own involvement that it became a beneficial experience for both of them. However, in the case of another couple, the husband fell asleep when the wife began to abreact, a response that, needless to say, did not bring the two partners closer. Since many treatment outcomes are obviously possible, the clinician needs to evaluate the couple carefully before making a decision about whether including the supportive partner in EMDR sessions will be useful.

Marital Therapy

Since EMDR therapy reduces reactivity, which in turn has a direct impact on attachment style (e.g., Wesselmann & Potter, 2009), it often results in changes in a client's interactions and relationships. Couple therapy may be an appropriate intervention in order to help the client more easily integrate new perspectives and behaviors within the family context.

Regardless of the obvious reason for referral, the first joint session when working with couples is used to set agreements about why therapy is being sought. If both partners agree that they love each other and that the purpose of the therapy is to improve or save the marriage, this understanding is made explicit, and any future disturbance is designated as a "cry for love." Agreements are made with respect to the standard issues of good family therapy, namely, acting as a team, truth telling, time-outs, and so

on. The joint meeting also allows the clinician to assess the couple's communication styles and to arbitrate any major problem areas. Further joint sessions are used to assess progress in communication and interaction, as well as to continue the arbitration process, if necessary, and to address specific challenges within the relationship.

EMDR therapy is used to reprocess all the psychological baggage that has accumulated over the years (i.e., all the "Why-did-you," "How-could-you," and "Why-didn't-you" grievances). These sessions can be conjoint sessions in which the clinical goal is to allow the partners to react to each other in the present rather than continue to be burdened by the weight of the past. By using EMDR processing to defuse painful earlier memories (e.g., mistakes in childrearing or lack of support), the couple can achieve a healthier dynamic and give appropriate weight to present problems or disagreements.

Sometimes, however, it is preferable to carry out these individual reprocessing sessions in the absence of the partner. Obviously, if both members of a couple have presented themselves for therapy, it is likely that there are intimacy problems and safety issues that may inhibit full client disclosure. If a painful issue emerges during processing, it may be preferable for the client to be able to proceed without worrying about the partner's reaction. The challenge of having separate versus conjoint sessions has been handled in various ways by different therapists. Some provide conjoint sessions, addressing the issues that arise during the session. Others provide separate processing sessions interspersed with conjoint debriefing and couple therapy sessions. Still others complete EMDR processing with each spouse individually, before working on couple issues in marital sessions. The therapist must determine what structure is likely to work best for a given couple based on his knowledge of the couple and his sense of how they might respond to each of the approaches. In addition to reprocessing the couple's memories of their past problems, it is useful to target the present triggers that cause disturbance. A husband may find that the sound of his wife's voice is similar to a particularly disturbing tone that his mother habitually used, and a look on her husband's face may remind a woman of the expression her father wore during childhood beatings. In addition, by virtue of second-order conditioning, some current situations that habitually provoke the troublesome tone or look may in themselves be highly disturbing. Taking care to reprocess the memories and the present referents can greatly relieve the couple's current dysfunctional interactions. In addition, the present situations that independently cause difficulty (e.g., the wife staying out late with her women friends or the husband leaving the cap off the toothpaste tube) should also be targeted, the adverse reactions dissipated, and alternatives explored. In summary, the full three-pronged protocol should be used to address the past event that is contributing to the negative interactions, defuse current triggers, and provide the education and/or modeling needed to incorporate positive templates for appropriate future interactions.

Infidelity

When a couple presents for therapy because of the aftereffects of an extramarital affair, the clinician should be sure to evaluate both the causes and consequences of the incident. In addition to implementing the previously discussed couple therapy work, the clinician should assess the betrayed partner for PTSD-like symptoms. The betrayal of trust can have a devastating effect on the partner's sense of safety in the world and on his ability to trust his own perceptions. Accompanying this may be a variety of sequelae consistent with feelings of violation. In addition, many such clients present symptoms of intrusive thoughts of, for example, the actual scene when they discovered the infidelity or imagined scenes of the partner in a variety of assignations. To allow the couple's psychological injuries to heal, the partner's intrusive imagery should be targeted as soon as possible after the appropriate agreements have been made. The feelings of anger and pain generated by the betrayal can also be targeted most easily if safety has been established by the wronged partner's acceptance of the unfaithful one's sincere apologetic assurance that the affair has been permanently terminated.

Once the aftereffects of the affair are reprocessed, the underlying causes need to be addressed and resolved. As is usual in the treatment of recent trauma, unlike that of early-trauma processing, the obvious acute cause of the symptoms is treated first. In addition to the applications already discussed, EMDR therapy may be used to attempt to clarify the present concerns that one or the other partner might have about continuing the marriage and to reprocess dysfunctional fears that may be dictating inappropriate choices. In the case that one or both partners decide to end the marriage, the clinician should also use EMDR processing to assist the transition. She should target the intrusive thoughts and feelings of rage, self-denigration, and inappropriate fear felt by either partner. Not only will this improve the present circumstances, but it will also help to prevent dysfunction in future relationships. In addition, if there are children involved, negative feelings about their parents' divorce, including self-blame and fear of abandonment, should be reprocessed as early as possible.

CHILDREN

> Life is all memory, except for the one present moment
> that goes by so quick you can hardly catch it going.
> —Tennessee Williams

Included in the many pleasures of working with children is the satisfaction of seeing the traumatic residue disappear quickly and of knowing that they will be spared years of suffering and not be driven to engage in behaviors that repeat the abuse on others. Eight randomized controlled studies demonstrate that EMDR therapy effectively eliminates clinical symptoms

related to trauma in children (see Chapter 12). To ensure the successful use of EMDR therapy with children, the clinician must pay special attention to creating a safe psychological environment. As with any other therapy, EMDR should not be used with children unless the clinician is already comfortable working with them. This basic overview should be supplemented with additional information that can be found in other EMDR therapy books written for this population (Adler-Tapia & Settle, 2016; Gomez, 2013; Greenwald, 1999; Lovett, 2007, 2015; Tinker & Wilson, 1999; Wesselmann, Schweitzer, & Armstrong, 2014).

History Taking

During the initial history-taking phase it is useful for the clinician to arrange to speak first with the parents about the child's history and problems, without the child present. This allows the parents to speak freely, without creating any upsetting feelings for the child. Next, the clinician should meet with the parents and child together. Finally, the parents leave the room while the child presents his version of the situation. This three-step process may allow the parents' authority to be tacitly transferred to the clinician and may give the child a sense of being special when the clinician's full attention is turned exclusively to him.

If needed, many playful strategies are available to assist young children in identifying targets. Children can use bags or boxes, in which they put their drawings of the "yucky things" they have experienced. Children can create maps, time lines, and storybooks of their lives, through which the clinician can identify potential targets, as well as potential resources. It is important that children with complex trauma, dissociative tendencies, and/or reduced ability to tolerate affect should have reached an appropriate level of stability before exploring traumatic events and developing the EMDR treatment plan. In addition, particular consideration should be given to the assessment of dissociative experiences during the initial phases of treatment (see treatment description of complex PTSD at the end of this section).

Preparation Phase

During the preparation phase, while the clinician must use the language of the child to explain EMDR therapy, it is preferable to refrain from referring to EMDR therapy as a magical cure—even if the child spontaneously adopts such an expression (e.g., "It's magic") when noticing how much better she feels. Rather, as with all EMDR clients, it is preferable to provide the child with a sense of self-healing and self-efficacy. If the clinician indicates instead that the power to remove the negative affect is vested in the method or in her own expertise (e.g., by saying, "I'm going to make it go away"), the child is likely to remain at a level of dependency and powerlessness that is detrimental to overall therapeutic goals.

Before attempting to target dysfunctional material, the clinician should make sure the child is able to move from a negative emotional state to a positive one through the use of a Safe Place or any other state change strategy. Mastery experiences may be enhanced. For instance, a feeling of safety and assurance could be induced in the child through use of BLS in the context of an actual positive experience. The clinician might ask the child to remember a time when he was in control and felt good and might have him imagine looking, feeling, and acting in a positive way. As the child holds this scene in mind along with the emotions and where they are felt in the body, the sets are repeated until the child feels happy or positive, as in the imagined scene. This positive experience allows children to trust the process, since pleasant feelings may be evoked, and they are left with positive associations to the therapeutic experience. Alternatively, sand tray, collage, drawing, or painting can be used to encourage the child to create a picture of himself in an imagined safe place. For example, he may create and then focus on a visual image of himself in a fairy tale castle during sets of eye movements or hand taps. If further preparation is needed beyond the safe place, children can create their own containers where they learn to put all their worries, triggers, trauma memories, and so forth. These containers can be created by using boxes, bags, and the like.

Some of the difficulties that clinicians generally encounter with young children may be due to concentration problems and relatively short attention spans. However, if the EMDR procedural steps are used playfully, children can tolerate a full 50-minute session. Fortunately, despite their comparative brevity, such sessions are likely to be therapeutically effective, because children appear to respond favorably to EMDR therapy very rapidly.

Holding the Child's Attention

In order to assist children in eye tracking, the clinician can draw happy faces on her fingers or use puppets or other toys. Puppets or toys may also be used in the two-handed approach described in Chapter 3. This technique is often useful with young children because of their inability to cross the midline. For instance, when he is asked to draw a line on a piece of paper from the far left to the far right of his body, a young child will start drawing, then lift the pencil in the middle, putting it down again to complete the line. If the single-hand technique is used with a young child, his head will often move along with his eyes. This is acceptable and can achieve treatment effects, but a full range of eye movement should still be attempted.

For children who have an eye-tracking problem because of dyslexia, using small elliptical movements about 3 inches in diameter at the usual 12- to 14-inch distance from the eyes may be effective. Children with dyslexia (even when older) generally cannot track a wide range of motion.

Some children have a tactile defensiveness that makes them uncomfortable when in close contact with the clinician. These children should be

asked to move their eyes back and forth between two spots on the wall. To engage their attention, these spots may be in the form of colored circles, cartoon figures, or comic book heroes.

For many children the best form of stimulation is tactile. With fingertips, the clinician may apply alternating taps on the child's hands or knees or may gently squeeze the child's hands or feet. Games of "patty-cake" have been used to engage the participation of children as young as 18 months (Tinker & Wilson, 1999). Drumming can also be used. An excellent form of BLS is the "Butterfly Hug" (see Chapter 9) which, combined with repeatedly drawing the target memory, has been successfully used to treat groups of traumatized children all over the world (Aduriz, Bluthgen, & Knopfler, 2009; Artigas, Jarero, Mauer, Lopez Cano, & Alcalà, 2000; Boel, 1999; Fernandez, 2007; Fernandez, Gallinari, & Lorenzetti, 2004; Jarero, Artigas, & Hartung, 2006; Jarero, Artigas, & Lopez-Lena, 2008; Wilson, Tinker, Hofmann, Becker, & Marshall, 2000). Children place their arms across the chest, with the right hand on the left shoulder and the left hand on the right shoulder. The child accomplishes the dual stimulation by tapping each shoulder alternately.

Assessment Phase

When working with children, the language used should be developmentally appropriate. Instead of asking for the image that represents the worst part, clinicians may ask for the "yuckiest" part or the yuckiest picture. During the Assessment Phase, children can convey their stories in various ways. Whereas some children may be able to tell their stories using verbal communication very well, others may need more assistance. Drawings, as well as the use of playful strategies, may be used. The clinician can ask the child to create in a sand tray the memory that is going to be reprocessed. If needed, to lessen disturbance and create a greater sense of distance, the clinician may ask the child to create a world or a story about another character. At that point, when following the procedural steps of the Assessment Phase, the questions may be about an animal or doll that represents the child. For instance, instead of asking the child for the negative thought associated with this event, the clinician asks: **"What is the mixed-up thought that the horsey has about himself as he thinks about the bear** *(perpetrator)* **hitting him?"** This level of distance allows the child the freedom to communicate about the affect and the disturbance associated with the memory. If clinicians do not have a sand tray, doll houses or other settings may be used for the child to create the "story" of what happened that was traumatic or adverse.

When working with school-age children, it is preferable to elicit the negative and positive cognitions rather than merely suggest them, even though they might not be ideally constructed. The clinician may ask for a "mixed-up thought" or a "bad thought" to help elicit the negative cognition.

It can be helpful to ask children to choose their thoughts from a stack of negative and positive cognitions cards. It may be helpful to initiate a set of eye movements after asking the child to imagine the scene and respond to questions such as **"What thoughts do you have?"** or **"What do you think about in the picture?"**

While clinicians typically attempt to contribute to an initial internal locus of control when working with an adult client, it is important for them to remember that children may frequently be in threatening environments and that they are indeed powerless. In addition, the child may not have a well-developed cognitive structure. Therefore, the clinician should offer the child the closest approximations to self-efficacy statements (e.g., "I'm okay" or "I feel good"), without needing to adhere completely to the guidelines about positive cognitions for adults.

Instead of obtaining the SUD by asking for the level of distress or disturbance, the clinician may ask the child how "yucky" it feels or how "upsetting" it is on a scale from 0 to 10. Alternatively, clinicians can have young children use their hands to indicate the magnitude of a feeling. For example, holding the hands at chest level, with arms parallel to the arms of the chair, can be defined as "very bad/terrible/awful" or some other word that evokes the child's negative experience. Clasping the hands can be defined as feeling wonderful or as feeling "as good as looking at bunny rabbits." Children can also be taught to report accurately any changes in distress by indicating these concretely; for example, holding the hand close to the floor can indicate a little hurt, whereas a hand held at shoulder height means a big hurt. Another option is for the clinician to draw on a piece of paper a horizontal line with a smiling face on one end and a crying face at the other, and to ask the child to indicate where he is located on the line. Aids for this purpose have been used successfully with traumatized children in many countries and are available from the Trauma Recovery/EMDR Humanitarian Assistance Programs (see Appendix F).

Children may have difficulty providing a number rating on the VOC scale. In this case, using a playful approach, the clinician may create the 1- to 7-point scale on the floor, so the child can walk, hop, or jump on the scale while noticing how much she feels the "good thought" is true for her. For younger children, the same approach may be used, but instead of numbers, the clinician may use pictures with different intensities of the same color to represent the VOC scale.

It can be more fun and more clear for young children to identify their feelings by pointing to feelings cards or faces. If needed, there are many creative ways of assisting young children with the process of scanning their bodies. For instance, a child may be provided an outline of a body and invited to color the parts of the body where the sensations are experienced. The child may also put stickers on the body to represent feelings or imagine looking for feelings with a telescope.

Desensitization and Installation Phases

Clinicians should use their clinical judgment regarding the presence of parents during the EMDR processing sessions. Some children focus better with parents in the room, whereas older children may prefer the feeling of independence in working one-on-one. Some parents are unable to provide emotional support due to their own instability or other types of issues. However, when possible, the presence of supportive parents help the traumatized child to access difficult memories and emotions. Parents who remain present are informed regarding the procedures and the importance of remaining silent but attentive.

During reprocessing, the child is asked to concentrate on the upsetting picture and an associated negative cognition, such as the words, "I'm not safe," "Nobody's helping," or "It's scary." Following processing, the clinician may offer (without any special fuss) an easy cognition, such as "I'm fine" or "Mommy/Daddy will take care of it" or "I'm safe now." During processing it can be useful for young molestation victims to address and replace the negative cognition "Don't tell" or "I can't tell." Having the child concentrate on these negative cognitions during successive sets, without pressing for details, allows the fear engendered by these injunctions to dissipate. Then, substituting the words "I'm safe now" or "It's okay to tell" with BLS during the Installation Phase can have excellent effects.

In order to increase the child's level of involvement when processing a traumatic memory, the clinician should be prepared to engage the child in a variety of ways. For example, during the eye movement sets, the clinician might vocalize a lively tune such as the William Tell Overture and should be prepared to make rapid rhythmic movements with his upper body to maintain the child's attention. The clinician may also attempt to harness the child's imagination. For example, the clinician may initiate the EMDR processing session by asking the child to **"imagine what happened"** or to **"bring up the picture."** After the eye movement set, the child may be asked to **"blow up the picture"** or **"explode"** it. The clinician can assist by making the sound of an explosion and by using gestures that the child can mimic. The clinician then asks, **"How does it feel now?"**; after redirecting the child's attention to the picture, the clinician adds a set of eye movements and repeats the request to **"blow up the picture."**

A variety of publications describe the efficacy of the creative process (e.g., drawing, painting, sand-tray play) in the treatment of children (e.g., Cohn, 1993; Gomez, 2013). One clinical case example involves the pre- and posttreatment pictures drawn by a young boy. When the child was asked to make a picture of the problem, he drew a big black cloud that covered nearly the entire page. He was then asked to hold this picture in mind during successive sets. After showing signs of relief, he was asked to draw the situation again: It now appeared as a small black speck being chased out of the room. The child was then asked to hold this picture in mind for

one or two additional sets, after which it was supplemented with a positive cognition.

For a child who has difficulty verbalizing what is occurring after every set, the clinicians can invite her to draw a picture of what she is noticing. Once the child has accomplished this, the clinician can take the sheet of paper and use it to provide the eye movements by asking the child to follow the drawing. Once the child draws the next picture, the clinician then takes the new drawing and uses it to provide the eye movements. Drawings can assist children suffering from mutism or verbal challenges and those who have a difficult time focusing, concentrating, or keeping still.

Sand-tray play, dolls, and pieces of games all may be used to develop targets for children if the proper foundation is laid to allow them to link their feelings about the negative incident or perpetrator to themselves. The full EMDR procedures may be implemented using these targets. However, the clinician should eventually return to the primary trauma images to check for complete resolution.

Cognitive Interweaves

Although EMDR therapy generally proceeds rapidly, information processing can get blocked. The attuned clinician can assist the child through the use of EMDR interweaves. Children in general may have less patience and tolerance than adults about remaining in a negative affective state. Sometimes it may be necessary for the clinician to offer the child an interweave relatively quickly in order to prevent him from becoming resistant. Otherwise the clinician might just say, **"I do not want to do this, I just want to play."** Interweaves may be playful: For example, the clinician may invite the child to draw a picture of the feeling he is having at the point at which information processing got stuck. If the child reports feeling "too much anger," he may be asked to just feel a "little spoon" of this feeling. The child may be asked, **"If you were the story director, what would you have liked to do or say?"** and then be encouraged to do it. He may be invited to bring in special powers to deal or respond to an abusive figure, or he may be invited to imagine his favorite superhero helping or rescuing him.

Due to their young age, children often lack pertinent adaptive information that would be helpful in resolving their traumatic memories. The clinician should be alert to the need for cognitive interweaves to provide appropriate information. For example, one child was processing an incident of physical abuse along with the negative cognition, "I'm bad." The clinician recognized that the child was missing important knowledge related to the behavior of the perpetrator. Between sets of eye movements the clinician stated, **"I'll bet you didn't realize that no child ever deserves to be abused, no matter what he has done. I'd like you to think about that and follow my fingers again."** The interweave was new information to the child, who was

able to reach an SUD level of zero after a few more sets. The Installation Phase was initiated by asking the child to hold in mind the incident along with the positive cognition, "I am a good kid."

Closure and Reevaluation

Some children need a short closure at the end of the session, while others may need to use the container they created during the Preparation Phase, their safe place, and an additional few minutes for free play. Activities that involve play, laughter, and connection may assist at the end of EMDR sessions. Children may choose to have the parent involved in activities such as blowing and popping bubbles, singing, or playing with clay.

For the Reevaluation Phase, clinicians may provide scales to parents and children to monitor changes in behaviors and symptoms at the beginning of each session. Clinicians may target and strengthen the positive changes and mastery experiences reported. Parents may also be asked to bring, in writing, any positive changes or challenges observed, to prevent situations with parents who have the tendency to highlight what is problematic about the child in her presence, potentially creating a negative tone before her processing even begins. Alternatively, clinicians may meet briefly with parents one-on-one prior to bringing the child into the office.

Working with Caregivers

The inclusion of the caregiver, when adverse events have occurred within the parent–child relationships, is critical. However, it is important for the clinician to assess whether the parent is able to give appropriate support. It is important during the initial intake to explore past and present parent–child attachment experiences and interactions, and to stay alert to signs of unhealthy dynamics, as parents with unresolved trauma may engage in wounding interactions with their children. The child's behaviors and needs can activate the parent's own traumas and prevent the parent from viewing the child from an adult perspective. In these cases, parents should be encouraged to personally undertake EMDR therapy and work through their dysfunctional memories. The processing of the parent's own maladaptive memory networks has the potential of enhancing his capacity to relate to the child and stop the wounding dynamics.

When the parent is capable of being a supportive presence, she is prepared by the clinician to engage in the child's processing sessions when needed with interweaves that repair. At the appropriate time between sets of BLS, the parent may be invited to verbalize statements such as, "I am sorry I did not take care of you the way you needed, but now I am here to be the Mom you need" or "Mommy and Daddy did not get divorced because of anything you did. You are an amazing kid." The therapist then continues the BLS and with the usual procedural steps.

If the child and the parent both experienced a traumatic event, and the parent has not processed it, he may continue to reinforce maladaptive responses. For example, a 12-year-old processing the memory of a horrendous sexual assault became stuck in the area of responsibility. Despite interweaves aimed at assisting this child in assigning responsibility more realistically, she continued to blame herself for the attack. The clinician met with the father, who disclosed that he blamed his daughter for going to a party without permission, which resulted in her being raped. He admitted to verbally and nonverbally conveying this to the child. He agreed to receive EMDR therapy with another therapist and processed the memory of his daughter's rape. Two weeks later, the girl and her therapist continued to process the memory of the rape. This time the father was prepared to be a companion and a witness, with the roles clearly delineated. He was invited into the session with his daughter's permission. When the girl again became stuck on issues of responsibility, the clinician involved the father in an interweave. He looked into his child's eyes and said, "I am sorry you had to go through this. This is not your fault, and you did not cause it." With additional sets of eye movements, the memory was fully resolved. Because the father had sufficiently resolved his personal trauma, he was able to fully support his child. Once again, it is important for the clinician to have previously assessed whether the parent is able to fill this role.

Generalizing Treatment Effects

In cases of child abuse, in addition to treating individual memories that the child might reveal, it is advisable to do additional EMDR processing during which the child concentrates on the perpetrator alone, that is, without imagining the perpetrator engaging in a specific action. Using such a procedure assists in generalizing the treatment effects throughout the entire associated memory network. An example is the case of a 5-year-old molestation victim who was ritually abused by her father while he was wearing a black gown and mask. In addition to targeting her memories of abuse, which included seeing her dog killed, she was asked to hold in mind the picture of her father in his gown and mask. Using a still picture (in this case, the image of the father in mask and gown) instead of one in which the perpetrator is taking a particular action, allows a desensitization effect to generalize to all memories that include the cue of the still picture (in this case, the image of the father in mask and gown).

Children as young as age 2 years are quite capable of bringing up an image on request. Be prepared for especially rapid treatment effects, presumably because young children have had relatively few experiences and therefore have fewer associations to be accessed. The child may start smiling happily after only a few sets, which is quite consistent with high therapeutic effectiveness. The clinician should check for subsequent changes in symptomatology, such as bed-wetting, nightmares, and panic attacks,

which may disappear after only one or two sessions. However, while such behaviors may cease for one child after a single session devoted to processing a molestation incident, their cessation may require many more sessions for other children. In short, do not view EMDR sessions as a race. The rate at which treatment effects occur varies from one client to another.

Intellectual Disability

It is known that individuals with an intellectual disability (ID; an IQ of 85 or less) have relatively high rates of exposure to trauma and adverse life events, which may include bullying; sexual, emotional, and physical abuse; medical problems, surgeries, and treatments; parental divorce; and placement outside the home. However, they also lack coping resources, which impedes the natural process of recovery. This conjunction makes them particularly vulnerable to the development of PTSD and other trauma- and stressor-related mental health disorders. It is assumed that such disorders in an individual with an ID do not manifest atypically but instead are congruent with the individual's developmental age. For children with a mild to borderline ID (IQ 50–85), for example, this has been demonstrated through a reliable and valid interview to assess PTSD (Mevissen, Didden, & de Jongh, 2016a; Mevissen, Didden, Korzilius, & de Jongh, 2016b). Though trauma- and stressor-related disorders are expected to be common in individuals with ID, they are largely underdiagnosed and undertreated. Misinterpretation of symptoms is the most likely explanation for this. In clinical practice, (1) trauma symptoms in the form of severe behavioral and emotional problems may be falsely interpreted as belonging to the ID itself, so-called "diagnostic overshadowing" or (2) trauma symptoms may be misinterpreted as features of other psychiatric disorders such as anxiety and mood disorders, autism spectrum disorder (ASD), attention-deficit/hyperactivity disorder (ADHD), conduct disorder, or psychotic disorders. As a consequence, treatment is frequently inappropriate or simply not offered.

EMDR therapy appears to be safe and applicable for individuals with various levels of ID. Because emotions and physical sensations instead of complex thoughts are the key features of their unprocessed memories, EMDR therapy often results in rapid and impressive positive effects on their posttraumatic stress symptoms and well-being (Mevissen, Didden, Korzilius, & de Jongh, 2017). EMDR therapy does not rely on frequent and lengthy exposures to trauma-related stimuli and requires no homework or practice outside the sessions that might otherwise strain the person and his caregivers. Together with its nonverbal components, EMDR therapy is suited for children and adults with IDs.

It is critical that instructions on how to activate the trauma memory and support provided the individual during processing be adjusted to the person's developmental level and correspond with the EMDR child

protocol variations described earlier in this section. It is also important for the therapist to hold a directive attitude, to simplify and repeat his instructions, to use visual cues, and to allot sufficient time for treatment. Because persons with ID need long-lasting support from others irrespective of their chronological age, it is important to involve parents, caregivers, family members, or other trusted persons in therapy. These loved ones can motivate and reassure the child and are an important source of information for the therapist. By closely adhering to the therapeutic process, the trusted person may support opportunities for positive changes in daily life, such as the enhancement of independence, instead of maintaining forms of protection that are no longer needed after the successful processing of traumatic memories. In the case of very limited verbal and/or cognitive abilities, a storytelling method (Lovett, 1999) can be applied to identify and process target memories, in which case the trusted person may take the role of co-therapist.

Autism Spectrum Disorder

ASD occurs in persons with and without intellectual disabilities and refers to persistent deficits in social communication and social interaction, and in restricted, repetitive patterns of behavior, interests, or activities. ASD often goes along with hyper- or hyporeactivity to sensory input. Modifying EMDR protocols to make them appropriate for children with ASD may require changes similar to those used for those with ID: simplified instructions, the addition of visual cues, and an extension of the time used. However, the details of the protocols vary according to the needs and abilities of the child. Some children with ASD are virtually nonverbal, while others are verbal to a fault; some show little affect, while others are hyperemotional or even abreactive. Such issues can significantly affect the time required for treatment, increasing it for children who are slow to process information, and lessening it for those who are fast to do so. It is important to carefully select the kind of BLS considering any sensory hyper- or hyporeactivity. Since it is particularly difficult for children with ASD to reflect on thoughts, feelings, and behaviors, working closely with parents or caregivers is clearly necessary.

Complex Trauma in Children

Children may present with the memories of numerous serious traumatic events such as chronic parental abuse or neglect, witnessing violence, substandard orphanage or foster care, medical conditions causing pain, or loss of or separation from parents. They may presently reside in out-of-home placements such as guardianships or foster or adoptive homes, or within a residential facility. They may live with biological parents who are still

struggling with emotional or substance abuse issues or with parents in recovery. The stored, unprocessed negative perceptions and affects related to developmental trauma may become triggered and result in severe emotional and behavioral dysregulation. Dissociation should be thoroughly explored with children who have experienced complex, early, and chronic trauma, and a variety of assessment tools are available for this purpose (Water, 2016).

Children suffering from complex trauma often exhibit symptoms similar to those of adults, in addition to lying, stealing, defiance, and aggressive behaviors, among others. Whether the child lives with biological or nonbiological parents, the parent–child dyad may be stuck in negative interactional patterns. Parents are often frustrated with the child's behaviors, and many parents respond with punitive methods. When parents have a traumatic past, their stored unprocessed memories can exacerbate their reactivity to the child's behaviors. EMDR therapy can help them achieve resolution and improve their capacity to respond to their children with sensitivity. Children with a history of complex trauma need supportive parents or other significant adults to provide co-regulation and emotional support for addressing painful memories, as well as help in understanding their own inner worlds. In cases where parental problems are creating an unsafe environment for the child, the clinician should involve Child Protective Services.

EMDR therapy history taking is conducted with parents, caseworkers, or other adults without the child present, in order to prevent severely traumatized children from becoming destabilized by discussions about their past. After meeting with the parents, the therapist should do likewise with the child to begin developing rapport and making observations about her mental status.

The Preparation Phase should include family work to strengthen the parents' understanding of how the child's experiences cause the problem behaviors and to help them respond in a more emotionally attuned manner. The Preparation Phase includes the development of a safe place, and when that is not possible, Resource Development and Installation (RDI) involving experiences of strength, confidence, connection, mastery or maturity to stabilize, as well as providing the child with tools for changing affect state. Future rehearsals and templates can help children with complex trauma to begin building confidence and skills for managing day-to-day challenges. EMDR processing may commence by targeting current triggers to help with stabilization and increase the child's comfort level before processing traumatic events.

Traumatic events often include preverbal trauma, which should first be addressed through discussions with the child about her history and the creation of a time line or a life storybook. In general, children should be told the truth about their past histories, as processing and integrating difficult

information is much easier for younger children than for adolescents or adults. However, the clinician should use his professional judgment when talking with current caretakers about how much detail to share with the child, using language that does not needlessly vilify the previous caretakers or sensationalize events. To help the child understand his history and the critical sequence of events, the clinician can act out the early story with puppets, stuffed animals, or dolls (Wesselmann, Schweitzer, & Armstrong, 2014), and write out this story by means of a format that invites her to contribute feeling words to it, as well as negative and positive cognitions (Lovett, 2007). Although children cannot consciously remember preverbal events, they often have an imagined picture related to the distressing parts of their story. For example, an 8-year-old girl who struggled with separation anxiety was asked to draw a picture of the most upsetting part of her early story. She drew a picture of her birth mother in China leaving her at the door of orphanage as a newborn. After eliminating the disturbance surrounding this preverbal event, her negative cognition, "I am all alone," was replaced with the positive cognition, "My birth mother couldn't take care of me but I have a good family today."

Because children typically develop the ability to self-reflect through the sensitive responses of attuned parents, those with a history of complex trauma need extra assistance to recognize and articulate what they feel. As the Desensitization Phase commences, keeping supportive parents or other caregivers in the room can help the child overcome fear of her feelings and memories, as well as avoid dissociation. The parents are instructed to remain quiet but emotionally supportive throughout. A preparation meeting with them is advised in order to make the process predictable and clarify their role during the session. The therapist should not rely on the child to provide verbal cues about affect states during EMDR processing, but should carefully observe the child and provide assistance with distress as needed. The therapist should offer verbal reassurance without interrupting the child's processing and also signal the parent to provide affectionate touch and verbal comfort when needed, to ensure that the child feels connected and present during even the most challenging portions of the trauma work.

Often, a child affected by severe trauma is able to process only one small piece of the event at a time. For example, she may draw a picture or make a sand tray, then be directed to focus on just one part of it as the target. The therapist should stay attuned to the child's level of tolerance for trauma processing and adjust accordingly. Some children may do best processing in 15- or 20-minute segments with more playful activities in between, while others may be able to tolerate full processing sessions. The more playful and engaging the session arranged by the clinician, the more processing time the child may tolerate. After completing a significant piece of trauma work, it may be best to spend the follow-up session in play, skills work, or EMDR stabilization activities.

Due to the effects of early trauma on development, some children show slower and less mature processing than their same-age counterparts. During EMDR processing, cognitive interweaves provide education, and corrective experiences can assist children with making the appropriate associations and reaching adaptive resolution. One area of processing in which children may need assistance concerns perceptions of self-efficacy versus hopelessness and helplessness. While adult clients are able to develop an adult perspective on childhood experiences, child survivors of trauma have only a child perspective. They cannot access present-day feelings of power or control, because they remain dependent on adults for their safety and welfare. During EMDR processing of trauma, it is important to help children recognize the present-day safety and protection provided by the adults in their lives. When processing gets stuck on issues of feelings of powerlessness, the therapist can prompt the parents to provide a cognitive interweave. For example, after a set of BLS, the therapist asks the parent, **"How do you keep your child safe today?"** or **"What would you do if you could go back in time and help your child?"** If the child was emotionally wounded in the parent–child relationship, the parent can be prompted to make a repair between sets of BLS by asking, **"Mom/Dad, what do you wish you would have done, knowing what you know now?"** As the parent responds with an appropriately supportive answer to the therapist's question, BLS and processing is resumed until the SUD related to the incident moves to 0 or 1. It is important that the clinician assesses the readiness of the parent to provide a meaningful and truthful repair during the initial phases. The same strategy may be used for meeting unfulfilled needs the child may have had.

Throughout treatment, the clinician may move back and forth among the three prongs of past, present, and future. Looking for the events or situations that preceded problem behaviors often serves to identify present triggers. For example, an angry look on a teacher's face may be the precipitating trigger for aggressive behaviors in a child who experienced physical abuse. Following the processing of an imagined picture of the teacher's angry face, a future template may be developed in which the child imagines himself taking deep breaths and staying calm in the presence of the angry teacher. As much as possible, the child is invited to be an active participant in deciding what he would like to be able to say or do in the presence of this teacher. After the future template is reinforced with BLS, the clinician and child can choose another memory as the next target for reprocessing. EMD strategies may also be used with triggers and trauma memories to prevent the child from accessing too many channels of association, which could result in emotional flooding.

With appropriate customization of the eight phases, EMDR therapy is an effective and efficient treatment for addressing complex trauma in children. More information may be found in several EMDR therapy books

(Adler-Tapia & Settle, 2016; Gomez, 2013; Lovett, 2007, 2015; Wesselmann, Schweitzer, & Armstrong, 2014).

ADDICTIONS

The first question—always—is not "Why the addiction?"
but "Why the pain?"

—Gabor Maté

The relationship between adverse life experiences, PTSD, depression, attention deficit disorder (ADD) and ADHD, and other psychiatric conditions co-occurring with addictions, is now firmly established in the literature (Brady, Back, & Coffey, 2004; Brady & Sinha, 2005; Felitti, 2004; Felitti & Anda, 2014; Felitti et al., 1998; Kessler et al., 2010; Ouimette & Brown, 2003). These data suggest a need for treatments that target the conditions underlying the development of addictive behavior, as well as those that induce relapse (Brown, Gilman, Goodman, Adler-Tapia, & Freng, 2015; Felitti, 2004; Ouimette & Brown, 2003; Shapiro, Vogelmann-Sine, & Sine, 1994).

The Adverse Childhood Experiences (ACE) study (Felitti et al., 1998) conducted collaboratively between Kaiser Permanente in San Diego and the Centers for Disease Control and Prevention (CDC), is the largest epidemiological study on the impact of 10 categories of adverse experiences up to the age of 18 on future health and well-being. It revealed indisputably what therapists who treat addiction have long known: that trauma, neglect, and abuse histories are the most common and consistent presentation of addicted clients. The study showed that there is a powerful, dose-proportionate relationship between the number of endorsed ACEs (maximum score of 10) and the subsequent development of addictions and other mental health and medical disorders (Felitti et al., 1998). For example, an ACE score of 4 or more increases the risk for adult alcoholism by 500%, and an ACE score of 6 in males indicates a 4,600% increased likelihood of becoming an intravenous (IV) drug user (Felitti, 2004; Felitti et al., 1998; see Appendix A for a 10-question ACE Questionnaire). Since EMDR therapy is demonstrably effective in the treatment of trauma, it is an obvious choice in the addressing this challenging and complex population. However, more research is needed (see Chapter 12).

The dictum "first do no harm" is particularly important to bear in mind when undertaking the treatment of addiction, since EMDR therapy can evoke strong emotional reactions during processing. I cannot overemphasize that clinicians treating this population with EMDR must be trained and skilled in both the therapy and addictions in order to employ it safely with a minimum of risk. Clients who struggle with addictions can sometimes present with life-threatening circumstances, particularly when the addiction of choice is drugs and/or alcohol.

Addiction through the Lens of the AIP

From an AIP standpoint, drug abuse and other compulsive behaviors start out as positive, because they mask or distract a person from the underlying negative affect, but are ultimately maladaptive, a concept supported by the ACE Study (Felitti, 2004; Felitti & Anda, 2014; Felitti et al., 1998). The ongoing presence of maladaptive negative emotion encoded in linked associated networks, as described by the AIP, contributes to the allure of addictive substances and behaviors. It is believed that addictions assist avoidance of the underlying trauma that threatens to surface in sobriety. It is proposed that the more intense the need for an emotional or physical state change a particular addiction offers, the greater the likelihood of fixation on that specific substance or behavior. In other words, the choice of addictive focus is not random (Suh, Ruffins, Robins, Albanese, & Khantzian, 2008; Khantzian, 1985). One pursues what one is seeking to feel the most.

Client Readiness and Stages of Change

Anyone who has ever worked with addicted clients knows how baffling it can be to watch someone spiral completely out of control, lose everything (marriage, jobs, children, health, and home), yet continue to chase the addiction, whether alcohol and drugs, pornography or gambling, shopping or food. The importance of a client's readiness and motivation to change cannot be overestimated when it comes to when and how to utilize EMDR processing with this population. Clinicians must learn to be a "welcoming holding container," regardless of the lack of readiness expressed by the client to let go of the addiction at the beginning of therapy. They should demonstrate patience, empathy, and acceptance, allowing the client to determine his own goals for treatment. For some, that may be harm reduction; for others, complete abstinence. This is a challenging area for clinicians who may have strong beliefs of their own about what the client's goal "should be." Employing motivational interviewing techniques (Miller & Rollnick 1991) can be helpful in increasing motivation in an accepting and respectful way. The stages of change model proposed by Prochaska and DiClemente (1983) is also a useful construct when employing EMDR therapy with this population to help move the client toward active engagement (see Abel & O'Brien, 2014). The information below offers a brief overview of pertinent clinical issues and concerns when treating clients presenting with addictions.

Safety and Stabilization

Addictions often begin in adolescence, a time when clients are supposed to be learning social, interpersonal, and life-management skills. Therefore, it is important to identify and install positive resources often needed by

adults struggling with addiction, such as empowerment, determination, honesty, worthiness, and acceptance. It is also useful to develop and install a "positive goal state" (Popky, 2005), wherein the client imagines a time in the near future when there will no longer be an interest in the addiction: "What will she be doing instead? How will she be behaving and feeling?" Imagining an experience of a sober future that is achievable and realistic helps develop an adaptive network. If clients can't imagine their own movie, clinicians can assist them by telling them other people's stories.

Addiction is often referred to as an "affect regulation strategy." Therefore, additional preparation procedures (e.g., teaching safe coping alternatives and mindful, affect management skills) are recommended before trauma reprocessing commences. There exist several group-oriented, manualized treatment programs, including dialectical behavior therapy (DBT; Linehan 1993) and Seeking Safety (Najavits, 2002), that have been combined effectively with EMDR therapy in diverse settings. One such integration occurred in a drug court program in which Seeking Safety was offered to addicted, nonviolent offenders who endorsed a trauma history, followed by voluntary individual EMDR therapy. Improved program outcomes such as higher graduation rates and lower postprogram recidivism were reported for those who also completed the EMDR therapy portion (Brown et al., 2015; see Chapter 12).

Timing of Treatment

Most clinicians agree that a certain level of stability is necessary to accomplish significant trauma work. However, many clients may never get clean and sober unless some of the emotional charge is taken out of their traumatic past (Zweben & Yeary, 2006). It appears that unprocessed trauma "pushes" addiction, while euphoric recall and other rewarding affective states "pull" one toward the behavior (Khantzian, 1985; Knipe, 2015; Müller, 2013). Ideally, a period of sobriety, a solid support system, and the ability to demonstrate agreed-upon healthier alternatives before beginning to uncover underlying disturbance, is the best way to enter into trauma work. However, most EMDR therapists who specialize in addictions believe sobriety will best be attained and maintained long term by beginning to address the person's unresolved trauma as early as possible in treatment. Although controlled research is needed in this area, it is proposed that once disturbing traumatic memories are reprocessed with EMDR therapy, they will no longer hold the physical, emotional, or cognitive distress that contributed to the addiction in the first place (Brown et al., 2015; Cox & Howard, 2007; Knipe, 2015; Kullack & Laugharne, 2016; McLaughlin, McGowan, Paterson, & Miller, 2008; Shapiro, Vogelman-Sine, & Sine, 1994), thereby reducing the risk of relapse. Not all psychiatric disorders are life threatening, but because substance use and abuse can be, it is recommended that

EMDR therapy for substance abuse be administered as a phased model within the established eight-phase standard protocol, similar to how it is administered with other complex trauma disorders, such as with clinically significant dissociation. As indicated previously, EMDR therapy should be used with this population only by practitioners with specialized training and consultation with those who have expertise in both clinical areas (EMDR and addiction), as well as complex trauma.

Suggested Targets for Reprocessing

The standard three-pronged protocol is used to address the early memories of adverse experiences contributing to the addiction, current triggers, and templates for appropriate future action. Other types of memories might also be useful targets for processing. The term "addiction memory" was defined by Boening (2001) as a nonconscious, implicit memory, with craving as its conscious manifestation. In AIP terms, addiction memories may be thought of as channels of information containing both negative (disturbing) and positive (rewarding) elements within the same network. For example, trauma or adversity present at the onset of an addictive behavior or substance can become powerfully linked (associated) with the relief, distraction, and/or euphoria associated with it. The specific elements of a recent relapse and the rituals involved in the behavior may also be part of the addiction memory network. A randomized controlled trial (RCT) and clinical reports indicate that targeting this type of memory, as opposed to a trauma, can result in a significantly lower incidence of craving (see Chapter 12).

Although any disturbing emotion can trigger addictive behavior, none is quite so powerful as *shame,* which is often generated by the harsh stigma carried by the term "addict" and society's negative view of addiction. A core sense of shame generates negative cognitions (NCs) such as, "I am disgusting, shameful, defective, broken, or unlovable" and is then reinforced by the behaviors engaged in during active addiction, such as lying, stealing, and criminal activities (e.g., purchasing illicit drugs, prostitution in exchange for drugs, or fraud to pay gambling debts). The maladaptive behaviors characteristic of addiction are typically at odds with the client's core values (e.g., "I can't believe I stole from my own parents"), resulting in deep shame, that is, "I *am* bad," not "I did something bad." The NCs associated with these behaviors are targeted with standard EMDR processing, in which shame is almost always the most intense and pervasive affect. As clients are able to see that in their nonaddicted state they would never engage in such behaviors, shame begins to subside, while compassion for themselves within the context of their addiction increases. Pervasive shame is one of the primary reasons people don't ask for help; therefore, when they do, diminishing shame as quickly as possible is paramount. This can be initiated during rapport building by giving clients a simple explanation of how

addictions develop in connection with trauma. Giving information about the ACE study, especially along with the brief questionnaire (see Appendix A), often helps in this process, validating the connection between the client's history of pain and suffering, and the short-term benefit of pain relief he discovered. The ACE questionnaire may be used to determine specific targets for reprocessing (e.g., negative cognitions linked to ACEs), as well as the preferred substance or behavior that provided initial relief for the identified distress. Further reduction in shame can be expected when clinicians are able to give clients a basic explanation of how the brain's healthy interests and goals get "rerouted" by addictions once they take hold. Addictions are known to "hijack" the survival circuitry of the brain, displacing natural rewards such as food, social connection, and loving sexuality, leaving the addiction as the primary focus of motivation, attention, and pursuit (Hyman, 2005; Volkow, Fowler, & Wang, 2004). We want to help the client separate the concept of maladaptive brain function associated with addictive disorders from the sense of "self." Shame often induces negative cognitions such as "I am a shameful, disgusting person." Reprocessing often leads to the positive cognition, "I am a good person with a challenging disorder." Of course, the overall goal is to use the presence of self-worth and empowerment to arrive at state of stable abstinence.

Additional Precautions and Guidelines

Extra care must be taken when treating addictive disorders in the presence of clinically significant dissociation. All individuals struggling with addiction have ambivalence about getting sober. One of the most common statements clinicians hear from addicted clients is, "Part of me wants to quit and part of me doesn't." For some, the addiction has been their most important attachment—friend, comfort, and salvation in an otherwise intolerable existence, internal or external. Therefore, there is generally a great deal of fear about the loss of this coping mechanism. However, it is important to distinguish between ambivalence and dissociation. As discussed in the next section, assessment for dissociation is important when considering treatment with EMDR therapy. Although one might think of addictive behaviors as "chemically assisted dissociation" (Knipe, 2015), some addicted individuals suffer from a diagnosable dissociative disorder. It can easily go undetected if the treating clinician is unfamiliar with dissociation and unnecessarily endangers the addicted client. For example, Sarah met criteria for dissociative disorder not otherwise specified (DDNOS). Although the part of her that sought out treatment sincerely wished to stop drinking, the part that drank alcoholically had no desire or intention of quitting. Sarah was completely unaware of this division. If there is significant dissociation, the part that drinks to manage the trauma will sabotage the effort being made to get sober, further frustrating and confusing the client. See Knipe (2015) for more detailed guidance in this area.

In summary, there is solid research linking adverse childhood experiences, trauma, neglect, and attachment deficits to the development of addictive and compulsive behaviors as an effort to manage the disturbing affects, cognitions, and sensations associated with these prior life experiences (Felitti et al., 1998). More RCTs are needed to confirm the improvement and recovery reported by clinicians through the judicious use of EMDR therapy with addictions, compulsions, and other related maladaptive behaviors (see Chapter 12 for a research review).

To reiterate: "First do no harm." It is not recommended that clinicians practice outside their scope of expertise, which in this case involves training and proficiency in the treatment of both addictive disorders and EMDR therapy.

DISSOCIATIVE DISORDERS

Let us be kinder to one another.
—ALDOUS HUXLEY (on his deathbed)

I have received feedback for many years from clinicians regarding the use of EMDR therapy, and these responses have shaped the format of training and the cautions covered in this book. By far, the most frequently reported difficulties and stories of clinical problems and potential harm through the improper use of EMDR therapy have involved clients with dissociative disorders. On the other hand, clinicians trained in working with this population report that the proper application of EMDR therapy greatly accelerates and eases treatment of these clients (see Fine & Berkowitz, 2001; Forgash & Copeley, 2008; Knipe, 2015; Lanius et al., 2014; Lazrove & Fine, 1996; Paulsen, 2009). Therefore, I will review issues regarding these clients to emphasize their importance.

No clinician should use EMDR therapy with a client suffering from a dissociative disorder unless he is educated and experienced in working with this population and has been trained in the use of the cognitive interweave. The clinician should also have a clear understanding regarding appropriate strategies for assisting the client in managing intense affect during EMDR processing, the client's dissociated system (see Paulsen, 2009), and the client's defensiveness and resistances (see Knipe, 2015). The potential for harm with this type of client is great if EMDR reprocessing is used inappropriately or injudiciously (as discussed in Appendix E). It is mandatory that clinicians have considerable experience with EMDR therapy and feel confident in their skills, since the cognitive interweave and the alternative strategies for managing intense affect and somatic sensations (see Chapter 10) are often necessary for treatment success.

This section provides an overview that should be used in conjunction with supervision and consultation. It is offered in order to provide a general

description and to act as a reminder for clinicians who have received the proper instruction from experienced, trained EMDR therapy clinicians qualified to act as consultants with this population.

The lack of adequate screening, preparation, or implementation of EMDR processing can be significantly destabilizing for this population. Accurately diagnosing a client is essential to how the EMDR therapist organizes the treatment plan (Ross, 2015). This includes clarifying whether the client has a severe dissociative disorder, complex PTSD, bipolar disorder, major depressive disorder (MDD), or some other diagnosis. For instance, an apparently successful EMDR treatment session can exacerbate the dysfunction for a number of dissociative identity disorder (DID) personality states and result in suicide attempts, other self-injury, or the need for emergency medical services. Regardless of the modality used, the treatment of DID by clinicians uneducated in the nuances and special needs of this population is a matter of grave concern and should be addressed throughout the mental health field. Some years ago, the "false memory" controversy dramatically drew attention to the lack of quality control in psychotherapy.

While clearly a separate category in the DSM-5 and ICD-10, dissociative disorders are viewed by the AIP model as a neurological configuration created by pronounced and sustained abuse. The result of this abuse leads to compartmentalizations of experiences held in state-specific form (Braun, 1988; van der Hart et al., 2006; Watkins & Watkins, 1997). According to the AIP model, the DID "alters" represent network configurations that perceive themselves to have lives of their own. The personality components represent information stored in "alter" states within the separated neurological networks.

The amnestic barriers that characterize DID are symptomatic of state-specific compartmentalization around pivotal incidents or affects (emotions and somatic sensations) associated with specific memories of childhood and adolescent trauma. Once EMDR has reprocessed the traumatic memories, these networks are able to link with each other and the amnestic barriers dissolve. After appropriate exploration and stabilization, fears of integration or fusion, or loss of identity or "death" may be addressed as negative cognitions and reprocessed accordingly. However, many EMDR clinicians report that spontaneous integration and fusion also occur. For instance, after traumas are reprocessed, clients report that some alters spontaneously say, "I feel it's time to say good-bye."

As with other treatment modalities that may precipitate abreactions, appropriate client preparation, including understanding the personality system and how it is organized, is paramount (Boon et al., 2011; Chu, 2011; Forgash & Copeley, 2008; Kluft, 2006; Kluft & Fine, 1993; Lanius et al., 2014; Loewenstein, 2006; Putnam, 1989). When possible, clients should be educated about the necessity for all parts of themselves to participate. Many clinicians instruct clients with DID about ways to focus the attention of all the participating personality states through the eyes of the host

or of the particular alter being treated. Other clinicians implement EMDR reprocessing with the individual alter, but only after making sure that there is no opposition from any other internal states that represent the rest of the system. If appropriate diagnosis and preparation are not carried out (unless the system as a whole consents to the work), a seemingly successful session may prove only temporary and may result in the activation of uncontrolled "switching" and the emergence between sessions of distraught or harmful personality states. It is essential that the therapist working with highly dissociated patients understands their personality states (Kluft, 2006) and can keep them stable and functional during reprocessing of traumatic memories (Loewenstein, 2006).

While standard abreactive protocols for using hypnosis with this population often include time distortions, this intervention should not generally be attempted with EMDR therapy. Although light hypnosis may be used for relaxation or to enhance a sense of safety, the clinician should evaluate the client's needs in relation to time distortion suggestions, bearing in mind that EMDR processing causes the material to move rapidly on its own. Additional time distortion accelerating the reprocessing can cause the client to feel overwhelmed and is therefore not recommended. In addition, since many clinicians report that clients do not generally submerge into the material (as they generally do during hypnosis), physical or hypnotic restraints may not be necessary when using EMDR. Furthermore, the need for such restraints is an important cue and may mean EMDR processing is not yet appropriate; for instance, the patient may be on the verge of dyscontrol and may need inpatient therapy.

The fractionated abreaction protocol (Fine, 1991) dovetails quite well with EMDR therapy. This protocol often enables the creation of a more stable environment for the client with DID and is used by a number of EMDR clinicians on an outpatient basis. A "wreathing protocol" has also been suggested (Fine & Berkowitz, 2001). Regardless of the protocol used, all of the usual clinical cross-checks employed by the clinician experienced in treating dissociative disorders should be administered to determine whether the material has actually been integrated or merely further dissociated (Lanius et al., 2014; Lazrove & Fine, 1996). This precaution also includes checking the continuity of memory by obtaining a detailed narrative of the targeted event.

The standard EMDR therapy protocol may be used as long as special attention is paid to the negative and positive cognitions and body scan. The negative cognitions may be difficult to ascertain, because different dissociated states may hold different beliefs. However, having the alters associated with the target memory come to some consensus regarding the negative and positive cognitions will be helpful for the reprocessing. In certain instances, utilizing phrases with such themes as danger or loss may be appropriate to activate the target event. Positive cognitions must

be carefully defined to include all the pertinent alters. Using a standard positive cognition such as "I am in control" or "I am powerful" can be problematic in view of the systems configuration and the interpretation of suicidal or homicidal alters.

After some reprocessing has occurred, the individual memories should be retargeted to determine whether all of the dysfunctional emotions/somatic components have been appropriately resolved. Visual, cognitive, and somatic checks are necessary for this purpose. The body scan should be utilized and, according to many clinicians in the field, carefully addressed to each alter separately. This procedure may be time-consuming, but unless a somatic check has been carried out and no disturbance has been observed in any personality state after memory material is retargeted, the clinician should not assume that the dysfunctional material has been metabolized.

Once again, the treatment of dissociative disorders with EMDR therapy should be undertaken only after the clinician has received appropriate education, training, and supervision for DID and other dissociative disorders. The EMDR protocols for these diagnoses are evolving as more expertise in these areas is tapped, and clinicians should make efforts to acquaint themselves with the latest suggestions. In Appendix E are the guidelines for assessment and treatment drafted by the Dissociative Disorders Task Force. In addition, all the selection criteria and cautions outlined in previous chapters should be followed with extra diligence when dealing with this population. This holds true across the whole spectrum from ego-state disorders to complex DID. Additional suggested reading includes Forgash and Copeley (2008), Gelinas (2003), Kluft (2006), Knipe (2015), Lanius et al. (2014), Paulsen (2009), and Twombly (2005).

OVERALL EVALUATIONS

EMDR therapy is neither a panacea nor a magic bullet. Appropriate clinical cross-checks should be used to determine if a memory has been fully processed, dissociation adequately resolved, or a complaint satisfactorily handled. No therapy should be assumed to be successful without applying appropriate clinical and behavioral measures over an adequate period of time. This caveat underscores the importance of a log and an ongoing feedback system. The clinician should maintain an open line of communication with clients after treatment so that they can report subsequent problems, if any. Additionally, other memories may surface because of client readiness or the convergence of particular triggers. Clearly, not all dysfunctional material will (or needs to) surface at any given time. The clinician should always leave the door open for the emergence of new memories.

While flexibility and creativity on the part of the clinician are often central to clinical success, it is important to remember that, as with any

therapy, the suitability of EMDR for every new client should be rigorously evaluated. The efficacy of combining approaches, such as EMDR and hypnosis, should be carefully assessed, rather than assumed, by the clinician.

Evidence of prolonged distress and inadequate resolution of memories after the use of EMDR processing is a sign that other methods should be used in addition to or in place of it. Some clients are unable to process memories without the clinician's use of the cognitive interweave and additional abreactive strategies (see Chapter 10). These are offered for use with clients who remain blocked on a plateau of information, with no more processing taking place.

If the clinician is uncomfortable using the cognitive interweave and finds that a client continues to evidence distress with regard to targeted memories, he should discontinue EMDR treatment until appropriate supervision and additional practice are obtained. If the clinician has been adequately supervised in the use of the cognitive interweave, yet finds that a client continues to "loop," she should discontinue the use of EMDR and contact a more experienced consultant (see Appendix F).

Obviously, EMDR therapy is not appropriate for every client. It requires only a few sessions to determine its suitability in a particular case; one simply observes the level of processing that has (or has not) occurred. Clearly, the clinician should not let months go by while the client experiences pronounced distress before deciding to change methods. If adequate processing does not occur during the first few sessions, and especially if exacerbated disturbance appears, then either the method is being inadequately applied or it is inappropriate for the client at that time. Indeed, for some clients, it may never be appropriate.

It is important to remember that, as with most forms of therapy, the evidence for the efficacy of various EMDR therapy protocols with most disorders has not been confirmed by RCTs. Therefore, it is the responsibility of the clinician to use all of his clinical skills to assess its effectiveness with a given client or population. At this point, the only adequate measure of success is the individual client's response. As I have said repeatedly, EMDR is client-centered in terms of servicing the needs of the client. Using demand characteristics to pressure clients into continuing EMDR therapy or intimating that the treatment they are receiving is the only way they can be healed can easily backfire. Remember, respect for client defenses is paramount. Clinical work with EMDR is a dance—and the client is the one who leads.

SUMMARY AND CONCLUSIONS

For work with clients in the populations covered in this chapter, the issues of resistance and noncompliance may be of concern. The clinician should

make sure that the appropriate therapeutic relationship, goals, and prioritization of targets have been established. Flexibility and creativity are also critical.

Clinicians working with clients who suffer from complex PTSD, dissociative disorders, sexual abuse, war trauma, and addictions will find the cognitive interweave indispensable for achieving consistent therapeutic success. In addition to being comfortable with EMDR, the clinician should also be well versed in working with the clinical population with whom she proposes to use the therapy. Put simply, clinicians should never use EMDR in a specialty area they would not treat without it. Education, consultation, and supervised experience are highly recommended for any specialized clinical population.

It is important that clients with complex PTSD receive comprehensive treatment to address all areas of dysfunction after a thorough assessment and adequate stabilization has been achieved. It is advised that they learn a variety of affect regulation techniques to enhance their sense of safety and control. Because of the special vulnerability of these clients, all clinical cautions should be intensified. For sexual abuse survivors, it is vital that appropriate goals be established before treatment begins and that informed consent regarding possible forensic issues is obtained. While a variety of previously dissociated and unresolved memories may surface during treatment, it is important to recognize that they may be based on vicarious traumatization or trickery. Clients should be given sufficient time to integrate the new information plateaus and emotional stages they attain before proceeding with the processing of new issues.

The treatment of combat veterans is often hampered by secondary gain issues, not the least of which is the fear of losing disability compensation. A treatment plan is necessary that takes into account such factors, as well as the client's premorbid history, possible perpetrator guilt, and excessive anger. There are also special concerns related to the treatment of older veterans and veterans who are survivors of sexual trauma.

Postdisaster treatment has been used internationally with early intervention procedures for immediate relief of acute trauma in projects taking place within the first few hours through 6 months later. EMDR stabilization procedures are best used during the first 48 hours. After that time, the full EMDR early intervention protocols can be successfully used with the appropriate assessment and adjustments. Processing is generally restricted to the disaster event. Given the possibility of vicarious traumatization, it is crucial that the disaster response team members also be assessed for potential treatment.

Couples should be treated only by clinicians with a background in family or couple therapy. However, in general, individual partners should be treated singly with respect to disturbing memories of past interactions, childhood experiences that contribute to present problems, and present

circumstances that exacerbate the disturbance. Special attention must be given to partners of sexual abuse survivors, as well as to partners suffering the aftermath of an extramarital affair or any history of domestic violence.

Children as young as 2 years old can be treated successfully if appropriate alterations of the standard EMDR procedures are made. A safe environment must be provided in which the child sees that the parents' authority has been tacitly given to the therapist. The creation of a positive initial experience with EMDR, plus the use of techniques for facilitating concentration, produces rapid positive effects for children. As always, the creativity of the clinician is vital for success.

Research has firmly established the link between trauma and addiction. However, it is vital that only those clinicians also knowledgeable in the field of addictions use EMDR therapy with this population. After sufficient stabilization, the complete three-pronged protocol is used. The brief, 10-question ACE questionnaire is highly recommended to identify targets for processing the childhood events contributing to dysfunction. Additional targets include those that are associated with the positive affects related to the substance or behavior that are fueling the addiction. A thorough assessment for dissociative disorders is vital when treating this population.

The category of DID includes some of the highest-risk clients to be treated with EMDR therapy. While high success rates have been reported, clinicians must not only be knowledgeable in this specialty area but also be comfortable with the cognitive interweave and familiar with the necessary adjustments to the standard EMDR procedure. All clients should be screened for dissociative disorder before EMDR therapy is initiated. Additional guidelines and suggestions for training in the area of dissociative disorders appear in Appendix E.

It is vital that the clinician use all the pertinent cross-checks and precautions to evaluate apparent treatment effects. Open lines of communication with clients are necessary to continue work, if needed. It should be remembered, however, that some clients are not amenable to EMDR treatment. Continued distress in any client is a red flag indicating that other methods should be initiated. Although consultants are available through the various EMDR associations internationally (see Appendix F), the ultimate arbiter of a client's suitability for EMDR therapy is the clinician's own observation.

CHAPTER 12

Theory, Research, and Clinical Implications

Five senses; an incurably abstract intellect; a haphazardly selective memory; a set of preconceptions and assumptions so numerous that I can never examine more than a minority of them—never become even conscious of them all. How much of total reality can such an apparatus let through?

—C. S. Lewis

The first section of this chapter examines some theories regarding the underlying basis for EMDR therapy treatment effects. In addition to RCTs evaluating various mechanisms of action, new studies emerging from the field of neuropsychology have intriguing implications for theories about how EMDR and all forms of psychotherapy work. The second section delineates some basic research criteria, reviews the research on EMDR therapy for PTSD and other clinical applications, and makes suggestions for further studies. The final section deals with the clinical implications of current research and the use of EMDR therapy.

THEORETICAL EXPLANATIONS

EMDR therapy was launched because of my chance observation in the park, and its development and continued refinement are the result of clinical observation and ongoing research. Theories that explain why EMDR works arose after the fact, and various hypotheses have been investigated and supported by controlled research. All information-processing models (e.g., Brewin, Gregory, Lipton, & Burgess, 2010; Chemtob et al., 1988;

Ehlers, 2010; Foa, 2011; Lang, 1977, 1979; Teasdale, 1999) invoke the neurophysiology of memory. Given the relative infancy of the field of neurobiology, the physiological foundations of all psychotherapies are currently unconfirmed, and, as such, all information-processing models are speculative. Yet our current inability to definitively explain the neurobiological mechanisms is not as relevant as the development of the clinical procedures derived from the conceptual paradigms, because the efficacy of these procedures are testable.

It was the observations of EMDR treatment effects that led to the Adaptive Information Processing model (AIP, see Chapter 2). The principles that evolved as the model was developed were successful in predicting new treatment applications, procedural variations, and protocols for clinical practice. The information-processing model has proved useful as a therapeutic road map and a unifying concept that integrates the salient aspects of most of the major psychological modalities (see Shapiro, 2002a). In physiological terms, the model incorporates the physiological notions of network activation and the assimilation of emotionally corrective information, which is then accommodated within comprehensive adaptive networks. This means that during processing, the stored memory of an event is brought to consciousness, relevant information needed to experience and remember it in a healthy manner becomes incorporated within it, the person learns from it, and the memory takes its place as a functional part of the client's overall life history. It is no longer a "trauma" with ongoing negative effects; it becomes one of many past experiences that appropriately inform and guide.

It may also be that a major outcome of EMDR therapy is the physiological reconsolidation of memory (Shapiro, 2014a) in which the memory is changed through the associative processing and then restored in its altered state (Elsey & Kindt, 2017; Suzuki et al., 2004). This proposed reconsolidation process represents a distinction between EMDR therapy and exposure-based trauma-focused CBT in that the underlying mechanism of the latter is held to be a combination of habituation and extinction. Thus, in contrast to EMDR therapy, in traditional exposure therapy, the original memory of the traumatic event is posited to be left intact as a new one is created. Empirical support for this distinction has been reported by Suzuki et al. (2004), who indicated that long exposures (characteristic of CBT) result in extinction, whereas the short exposures (characteristic of EMDR therapy) result in reconsolidation. According to Craske et al. (2006), " . . . recent work on extinction and reinstatement . . . suggests that extinction does not eliminate or replace previous associations, but rather results in new learning that competes with the old information" (p. 6). Reconsolidation may explain the apparent efficacy of EMDR in treating chronic limb pain. While this syndrome is notoriously difficult to treat (Niraj & Niraj, 2014), EMDR therapy has achieved substantial success (see Diverse Somatic Conditions section). The key to the advantage of EMDR

therapy with this clinical condition is that it targets the traumatic memories associated with the limb damage, greatly reducing and even eliminating the phantom limb pain, with long-lasting maintenance at follow-up (e.g., de Roos et al., 2010; Rostaminejad et al., 2017).

The preceding observations are congruent with the AIP model, which holds that unprocessed memories include the negative emotions and physical sensations that were present when the traumatic event took place. Thus, with successful EMDR treatment, the processed memory is stored in a form stripped of these dysfunctional affects and sensations (Shapiro, 2001, 2014a). Because in this reconsolidation process the original memory has been processed, transformed, and stored in altered form, the pain (both emotional and physical) is permanently eliminated. In general clinical practice, reconsolidation has important implications for the maintenance of treatment effects, since the original dysfunctional memory can no longer be triggered.

A clinical mnemonic for EMDR therapy processing is "Access, Stimulate, and Move": (1) Access the dysfunctionally stored information network, (2) stimulate the information-processing system and maintain it in dynamic form, and (3) move the information by monitoring the association process and initiating procedures to make sure that the target transmutes into an adaptive resolution. Generally, whenever information processing stops progressing appropriately, the clinician deliberately elicits and interweaves the corrective information stored in more adaptive networks. During any successful treatment, the associative network containing the target information is activated, the negative effects are mitigated, and the resultant information is transmuted to adaptive form, then functionally stored in memory. Basically, EMDR processing causes this delayed learning to take place at what appears to be a more rapid rate.

EMDR therapy is composed of elements synthesized from all of the major psychological orientations. For instance, the free association of psychodynamic therapy (Freud, 1900/1953; Jung, 1916; Wachtel, 2002), the identification of dysfunctional beliefs (Beck, 1967; Ellis, 1962; Meichenbaum, 1977; Resick et al., 2008; Young et al., 2002), the focus on emotions (Bohart & Greenberg, 2002; Greenberg, 2010), the client-centered approach of experiential and feminist therapies (Brown, 2002; Gendlin, 1996; Rogers, 1951), and the use of standardized protocols that attend to present stimuli and conditioned responses (Foa, 2011; Smyth & Poole, 2002; Wolpe, 1958) are only some of the salient aspects of EMDR that contribute to its positive effects (see Shapiro, 1999, 2002a, 2014a).

In addition to the more traditionally used elements, EMDR therapy also includes the use of eye movements and other forms of bilateral stimulation (BLS). Much attention has been paid to the BLS component, and we will review these studies in a later section. To explore the theories of how EMDR works, we will first review explanations that were advanced in an early article (Shapiro, 1991a), then move on to more recent hypotheses.

PROCEDURAL ELEMENTS

Any assessment of the therapeutic effectiveness of EMDR therapy must take account of all of its procedural elements. Many of these elements are drawn from disparate traditions that collectively contain the aspects of effective psychotherapy (Hyer & Brandsma, 1997; Shapiro, 2002a). Many of these are designed to provide an emotionally corrective experience, traditionally considered to be important for effective psychotherapy, and articulated by foundational psychodynamic, strategic, and cognitive-behavioral theorists (e.g., Alexander, 1956; Alexander & French, 1946; Foa & Kozak, 1986; Lang, 1979; Watzlawick, 1987). The following sections discuss some aspects of EMDR processing that may foster such an experience.

Exposure

Interrupted exposure with clients who have been thoroughly prepared for the experience is considered an important procedural element of EMDR processing. As reviewed in Chapter 1, various forms of exposure are generally thought to be the primary active ingredient in cognitive-behavioral treatments of PTSD (Schnyder & Cloitre, 2015). For instance, prolonged exposure (PE) therapy, which is based on the principles of extinction learning, has proved to be a consistently effective means of treating PTSD (Powers, Halpern, Ferenschak, Gillihan, & Foa, 2010). Extinction occurs when a conditioned stimulus (CS) is repeatedly presented without the presence of the unconditioned stimulus (US). Imaginal exposure is grounded in the principles of extinction learning, in that the client is repeatedly confronted with the trauma memory (CS) in the absence of the traumatic event (US). It appears that the greater the reductions of across-session distress to one's trauma memory, the better the outcomes of exposure-based PTSD treatment (Bluett, Zoellner, & Feeny, 2014). Imaginal and *in vivo* homework are also used daily as an integral part of treatment.

Direct comparisons of PE and EMDR with trauma survivors (see section on Adult PTSD) have indicated comparable effects achieved with fewer EMDR treatment sessions and without homework. In addition, a direct comparison of initial processing sessions of EMDR and PE in an RCT (Rogers et al., 1999) demonstrated different response patterns, with significant reductions of distress with EMDR, and an increase in the PE condition. Larger reductions of distress with EMDR therapy were also reported in the first session analysis of another RCT (Ironson et al., 2002). Therefore, although exposure is most certainly a necessary element of EMDR treatment, it does not suffice as the sole explanation for the rapidity of the treatment effects obtained.

EMDR therapy is an integrated approach containing many elements in addition to interrupted exposure. Nevertheless, the clinician's preparation of the client, which increases his ability to maintain contact with

the disturbing imaginal experience, and the alternation of short doses of exposure with cognitive debriefing are very important aspects of EMDR treatment. The outcomes of this alternating exposure for high levels of disturbance are contrary to those predicted by the standard extinction/habituation model that governs prolonged exposure therapies (see Chemtob, Tolin, van der Kolk, & Pitman, 2000; Rogers & Silver, 2002). In fact, although some early reviewers advanced the notion that the effects of EMDR are due solely to traditional exposure (e.g., Lohr, Tolin, & Lilienfeld, 1998; McNally, 1999), Boudewyns and Hyer (1996) have noted: "In strict exposure therapy the use of many of ['a host of EMDR-essential treatment components'] is considered contrary to theory. Previous information also found that therapists and patients prefer this procedure over the more direct exposure procedure" (p. 192; see also Pitman et al., 1996a).

Boudewyns and Hyer (1996) point out that EMDR therapy serves to structure procedures in which the client moves from exposure to metacommunication, back to exposure, then back to metacommunication. Rennie (1994) identified a similar process as the "best" in psychotherapeutic storytelling. Thus, the client shifts from the position of nonreflexive/participant to reflexive/observer, thereby creating an interplay between inner and outer dialogues. The exact physiological reasons for the success of this type of exposure regimen are, however, beyond the scope of this text, except for the clinically based conjectures described later (for a comprehensive analysis, see Rogers & Silver, 2002). However, the rapid treatment effects documented in numerous studies, including the elimination of single-trauma PTSD within 4.5 hours of treatment (e.g., Marcus et al., 2004; Wilson et al., 1997), indicate that other aspects of EMDR are also responsible for its success. Some of the factors that may contribute to the effectiveness of EMDR therapy are explored in the following sections.

Perceived Mastery

When active processing is inaugurated, a sense of perceived mastery (Bandura, 1977, 2000; Seligman, 1995) and stability is encouraged through the use of several procedural elements (Hyer & Brandsma, 1997). For instance, clients are assisted in the repeated creation and dismissal of their traumatic imagery, actions that may give them a sense of mastery in their ability to mentally circumscribe and manipulate the disturbing internal stimuli. This newfound capacity to mentally circumscribe and control disturbing internal stimuli may serve an important function. Research suggests that the perceived uncontrollability of intrusive symptoms increases the severity of distress (Benight & Bandura, 2004; Ehlers, Mayou, & Bryant, 1998). In addition, focusing attention on the disturbing material for short periods of time, while hearing reassuring therapeutic statements from the clinician and becoming aware of the safety of the clinical context, may foster counterconditioning. At the very least, the client's short bursts of attention to

the traumatic memories, along with the therapist's reassurance, provide a therapeutic context that offers the benefits of repeated exposure, a condition antithetical to the avoidance reaction that is part of the pathology and maintains it.

Attention to Physical Sensation

Clients are encouraged to attend, for a prescribed amount of time, to the physical sensations created by the traumatic imagery. This contact may allow them to identify and separate the sensory effects of the trauma from the cognitively laden affective interpretations of these sensations (which can result in identification with a labeled emotion; e.g., "I am afraid" or "I am angry"). Clients can come to perceive themselves as larger than the pathological condition by observing their reaction to the target. They do this by shifting focus from an undifferentiated and overwhelming feeling of fear to a cognitive awareness such as "I am feeling sensations in my stomach that are associated with a feeling of fear. Now I am feeling sensations in my chest that are associated with feelings of fear. . . ." This cognitive separation allows clients to recognize the changeability of the sensations, which can increase their sense of self-awareness and self-efficacy. These short periods of attention to sensations may afford the same benefits of counterconditioning and exposure as those caused by alternating periods of creation and dismissal of traumatic imagery. The use of "felt sense" as a primary therapeutic agent is well known in some experiential and somatic therapies (e.g., Gendlin, 1996; van der Kolk et al., 2014; Warner, Spinazzola, Westcott, Gunn, & Hodgdon, 2014).

Cognitive Reframing

Helping clients identify the negative self-assessments stemming from the traumatic event may allow them to perceive their irrationality and recognize the impact of the event on their current self-concept. The restructuring and reframing inherent in formulating positive cognitions have long been recognized as means of supporting the therapeutic process (Beck, 1967; Ellis, 1962; Meichenbaum, 1977; Young, 1999; Young et al., 2002) and may additionally facilitate information processing by forging a preliminary association with more adaptive information that contradicts the negative experience. The positive cognition also serves to increase the client's awareness of his cognitive distortion and offers a "light at the end of the tunnel," thereby encouraging and motivating him to persist with treatment. During EMDR processing, clients often spontaneously express cognitive insights, and the Installation Phase is structured to consolidate such insights. For many clients, there is a profound shift in self-concept, integrating self-acceptance with new positive and realistic perceptions of the self.

Alignment of Memory Components

The alignment of the primary aspects of the trauma memory by focusing on the image, the negative cognition, and physical sensations helps clients access the dysfunctional information. This state-specific information is subsequently linked to emotionally corrective information through the positive cognition. The therapeutic alignment of target components in EMDR appears consistent with the BASK (behavior, affect, sensation, and knowledge) model of dissociation posited by Braun (1988). The procedural reconnection of the traumatic material, which helps the client make sense of the experience, may serve to forge the appropriate connections and facilitate the storage of the information through a process of reconsolidation in semantic (or explicit) memory (Lane et al., 2015; van der Kolk, 2002).

Free Association

Clients are instructed simply to notice their internal experiences and, at the end of every set of BLS, asked, **"What do you get now?"** this automatically brings new pieces of information to mind. These are targeted in the order of their appearance. Clients may spend very little time exposed to the details of the presenting trauma and may instead move sequentially through related material. This successive targeting may be a much more effective way to access the most relevant distressing material than the procedure (used in systematic desensitization or exposure therapy) of returning repeatedly to the initial traumatic image (see Rogers & Silver, 2002). Free association appears to ensure that the salient aspects of the entire memory network are accessed and processed. Clearly, this is an aspect of therapy well recognized in the psychodynamic tradition (Wachtel, 2002).

Mindfulness

The instructions, **"Let whatever happens, happen"** and **"Just notice"** the trauma and the attendant disturbance were initially included (Shapiro, 1989a, 1989b) in order to reduce demand characteristics. It appears that these instructions help the client maintain a sense of present safety and allow the internal processes to function without interference. They may increase the therapeutic benefits by counteracting the client's tendency to be afraid of the fear, an inclination that can contribute to her ongoing distress and inhibit the treatment effects. Research has determined that negative reactions to symptoms increase symptom severity (Ehlers et al., 1998; Segal et al, 2006) and can interfere with information processing. It is interesting to note that this cultivation of a stabilized observer stance in EMDR is inherent in a variety of Eastern meditative practices (Kabat-Zinn, 1990; Krystal et al., 2002) and appears similar to the "mindfulness" of

dialectical behavior therapy (Linehan, 1993) and the "radical acceptance" of acceptance and commitment therapy (Hayes, Wilson, & Strosahl, 1999).

The importance of this aspect of EMDR therapy was emphasized and articulated by Servan-Schreiber (personal communication, December 2, 2000) in relation to the theoretical framework of Teasdale and colleagues (Teasdale & Barnard, 1993; Teasdale, 1999), who developed a framework that delineates how different "states of mind" may facilitate or, contrariwise, hinder the processing of emotional information to a point of resolution. In the description of their theory of "interactive cognitive subsystems," Teasdale and Barnard (1993) and Teasdale (1999) drew distinctions among "mindless emoting," "conceptualizing/doing," and "mindful experience/being" as three of the dominant states that can be evoked during psychotherapy. In the mindless emoting mode, clients are "immersed in, and identified with, their affective reactions, with little self-awareness, internal exploration or reflection" (Teasdale, 1999, p. 568). Psychotherapy process research (Carryer & Greenberg, 2010; Greenberg & Safran, 1987) suggests that such experiences in therapy are predictive of poor outcomes. Research has indicated that the therapy evoking the cultivation of mindful awareness can decouple such negative reactivity effects (Kuyken et al., 2010).

It may be that part of the effectiveness of EMDR therapy arises from its ability to evoke exactly the right balance between (1) reexperiencing emotional disturbances and attaining a nonevaluative "observer" stance with respect to the emotion and (2) the flow of somatic, affective, cognitive, and sensory associations that arise when this stance is maintained continuously for 30 seconds or for minutes at a time, without interruptions from the therapist or caused by an excessive level of arousal. In addition to the previously described instructions, it may be that the BLS draws the client's attention away from the disturbing material just enough to prevent mindless emoting and excessive conceptualizing/doing, and so almost forces the client into a "mindful experiencing" mode of processing of the disturbing material. Each EMDR processing session would therefore consist of repeated and frequent experiences of this mode of processing, guided by the therapist's control of the session's flow and facilitated by the sensory stimulation applied with each set of BLS.

Eye Movements and Alternative Bilateral Stimuli

A variety of physiological mechanisms may be activated by the eye movements and alternative BLS used in EMDR processing. These appear to contribute to the therapeutic effect of EMDR therapy by simultaneously maintaining the client's external awareness during a period of internal distress and activating brain functions inherent in both the movements and the attention paid to two simultaneously present stimuli. Although saccadic eye movements (i.e., rapid and ballistic; greater than 30 degrees per second; Levine & Shefner, 1991) were first advocated for therapeutic use (Shapiro,

1989a, 1989b), slower tracking movements and alternative stimuli such as bilateral taps and tones have been used clinically to good effect since 1990 (Shapiro, 1991, 1994b), and any theory needs to account for all of these observations. These possibilities are explored in the following sections. I should also underscore that an interaction of a number of different systems may be pertinent and contribute to differential treatment effects, depending on client characteristics. Parameters for component analyses are reviewed later in this chapter.

ORIENTING RESPONSE

One of my early conjectures about EMDR (Shapiro, 1991a) was that the client's response to accessing the traumatic memory involves automatic physiological states (fused in a state-specific configuration). The addition of the eye movements may cause another configuration of physiological states and responses to intrude on earlier associations. This may, in turn, cause a disruption of the complex of habitual physiological responses elicited by the traumatic memory. The disruption engendered by the simultaneous dual configurations may allow further processing to occur.

The elicitation of an orienting response has been posited by a variety of theorists as a prime contributing element in instigation of processing. It is a natural response of interest and attention that is elicited when attention is drawn to a new stimulus. This physical and physiological reflex occurs in response to sudden, potentially dangerous stimulation, and initially increases sympathetic tone (MacCulloch & Feldman, 1996). Since this orienting response occurs during an EMDR session in the absence of actual danger, the reflex is followed by the relaxation associated with parasympathetic activity, potentially facilitating the access and desensitization of the traumatic memories without avoidance. On the basis of current neurobiological findings, Stickgold (2002, 2008) independently expanded this theory to explain the effects of the BLS used in EMDR therapy, which forces the client to constantly shift attention across the midline. He hypothesizes that this orienting response induces REM-like neurobiological mechanisms that facilitate the activation of episodic memories and their integration into cortical semantic memory (see also the section "Component Analyses").

WORKING MEMORY

The dual attention task involved in pairing of inner attention to the target memory and external attention to the bilateral eye movements (EMs) that trigger the orienting response is also pivotal in the working memory hypothesis. This has been posited as the underlying mechanism by which EMDR therapy and its attendant BLS cause negative memories to become

less graphic and disturbing and how this, in turn, results in PTSD symptom relief. Baddeley's (1986) model of working memory suggests that each component of working memory has a limited memory resource capacity, such that when two tasks make simultaneous demands on the attentional capacity of a component, performance on the primary task deteriorates. During EMDR processing sessions, both EMs and visual imagery of the trauma draw on the visuospatial sketchpad, one of the subsystems that integrate and coordinate working memory. The competition of such a dual task, with or without fixed attention (Andrade et al., 1997), impairs imagery, thereby reducing its vividness and emotionality. This would provide psychological distance from the traumatic memory and facilitate therapeutic action (Andrade et al., 1997; Kavanagh, Freese, Andrade, & May, 2001; van den Hout, Muris, Salemink, & Kindt, 2001; see also the section "Components Analyses").

DISTRACTION

One obvious interpretation of the role of the eye movements (or any other BLS) is that they distract the client from the trauma (Shapiro, 1991a). Originally proposed by Dyck (1993), this presumed distraction was posited to cause deconditioning because of the client's inability to concentrate on the traumatic image; that is, the distraction prevents the traumatic material from being reinforced by the previously anticipated anxiety. This, according to Dyck, constitutes an extinction trial. However, a number of attendant problems with this hypothesis are worth noting. First, Dyck suggests that the kind of distracter that should be used is related to the dominant modality of the trauma. For instance, auditory distracters should be most effective on auditory components of the traumatic memory, and visual distracters most effective on visual images. However, this conjecture has not been supported, because thoughts and cognitions also undergo immediate therapeutic modification as the result of EMs alone. Second, Dyck posited that a series of traumas or a trauma that occurred over an extended period of time would be less amenable to treatment by EMDR than would an individual event. Once again, however, this has failed to find support in numerous clinical trials. While more events necessitate more treatment time, each event is amenable to individual processing. Furthermore, although the research findings have been mixed, a number of experiments have indicated that distraction lessens, rather than increases, long-term therapeutic effectiveness (e.g., Grayson, Foa, & Steketee, 1982, 1986; Kamphuis & Telch, 2000; Satory, Rachman, & Grey, 1982; Schmid-Leuz, Elsesser, Lohrmann, Johren, & Sartory, 2007; Telch et al., 2004; also see Goetz, Davine, Siwiec, & Lee, 2016). It appears, therefore, that the concept of distraction does not make a significant contribution to understanding EMDR effects. It is possible, however, that the eye movements and other forms of BLS serve

to titrate the client's response to the memory in other ways that, as Dyck (1993) suggests, make the dosed exposure a deconditioning experience.

HYPNOSIS

It is not unreasonable to consider the possibility that a particularly rapid psychotherapeutic effect is due to hypnotic suggestion. However, EMDR therapy and hypnosis are very dissimilar in their clinical effects, and a large number of hypnosis theorists have noted the distinctions (e.g., Fine & Berkowitz, 2001; Frischholz, Kowall, & Hammond, 2001; Phillips, 2001). As an example, hypnotic abreactions seem to involve a moment-by-moment ("frame-by-frame") sequence of events, whereas clients treated with EMDR tend to jump from one key element of the memory to another. EMDR clients appear more alert and conscious, and less susceptible to inappropriate suggestion than hypnosis clients. For instance, clinical reports consistently indicate that clients will reject a suggestion that is not ecologically appropriate and may even become agitated as a result of the suggestion. Likewise, EMDR processing has not been reported to take away any belief that is objectively true. Beliefs, as well as anxiety, that are appropriate and currently useful appear to remain intact. The lack of suggestibility of clients during EMDR processing (Hekmat, Groth, & Rogers, 1994) as compared with those in a hypnotic state, may be a result (or correlate) of differences in the dominant brain waves elicited by the two procedures. Pronounced theta (Sabourin, Cutcomb, Crawford, & Pribram, 1990), or alpha (Meares, 1960) waves are reportedly characteristic of hypnotized subjects (De Benedittis, 2015; Jensen, Adachi, & Hakimian, 2015; Kihlstrom, 2013). However, EEG readings of EMDR therapy clients do not replicate this pattern (Pagani et al., 2012) and therefore indicate they are not in a state of hypnosis.

NEURAL NETWORK CHANGES

The resolution of traumatic memories begins when activation of the memories of dysfunctional material leads to a chain of events that differs from those normally initiated by recall of the material. It is conjectured by numerous theorists that the EMs appear to shift the current state of the brain into one that facilitates the healthy reprocessing of these memories, allowing it to identify and strengthen new associations to the traumatic memories and eventually weaken the hold of the familiar, stereotypical associations and emotions that had blocked the adaptive resolution of the traumatic memories (see Stickgold, 2002, 2008). Thus, previously weak associations are strengthened, and previously strong ones are weakened. We still cannot say how EMDR (or any successful therapy) produces this

shift in brain states, but over the last decade, several brain processes have been identified that may contribute to the efficacy of EMDR. (See also the section "Neurophysiological Research.")

At the systems level, research has now shown that different brain networks and brain states combine to control the types of associations the brain makes. REM sleep appears to facilitate the activation of weak associations, whereas non-REM sleep leads to a nearly exclusive activation of strong associations (Stickgold, Scott, Rittenhouse, & Hobson, 1999). Thus, changes in brain state can lead to changes in the types of associations the brain makes, shifting from more focused, predictable, and habitual associations to more distant, unexpected, and potentially creative ones as processing shifts anatomically to the right hemisphere and as the brain moves functionally into REM sleep. However, it is important to underscore that the following speculations are offered primarily as intellectual stimulation, not as a necessary precursor to establishing or obtaining EMDR treatment efficacy.

As discussed earlier, the resolution of many traumatic memories appears to entail a transmutation from the dysfunctional to the adaptive perspective. Because it appears that the adaptive perspective can emerge progressively and rapidly during EMDR treatment, it may be useful to imagine a sequential linkage of associated information that is brought about by a shift in the rules guiding associative linkages within the targeted network. To help increase conceptual understanding for all those without a neurocognitive background, I enlisted the expertise of a cognitive neuroscientist currently conducting research in this area (Stickgold, 2015; Stickgold & Walker, 2013).

The present formulation is based on the pivotal relationship observed in EMDR between affect and the transition from dysfunction to resolution. The initial dysfunctional state, the intervening stages of processing, and the final functional perspective revealed by the client may be conceptualized as verbalizations of the sequential stages of identifying new associations during the adaptive integration of the past and present experiences, which in turn provide access to new affective associations. The observation in EMDR treatment sessions that information is at least partially organized through affect is not new or unique to this therapy (e.g., Bower, 1981; Reiser, 1990).

Extrapolating from the concepts elucidated earlier in this text, Figure 12.1 depicts the additional speculation that associative networks (and their cognitive content) are organized, in part, by affect, so that once an affect is activated, the related network tends to settle into a stable pattern that primarily accesses memories and associations linked to that particular affect. The stronger the dysfunctional affect, the greater the network's stability and the more difficult it is for the network to shift out of its habitual set of associated memories and feelings. Therefore, the target trauma is prevented from linking with more adaptive information by the high resistance of the neural network to perturbation.

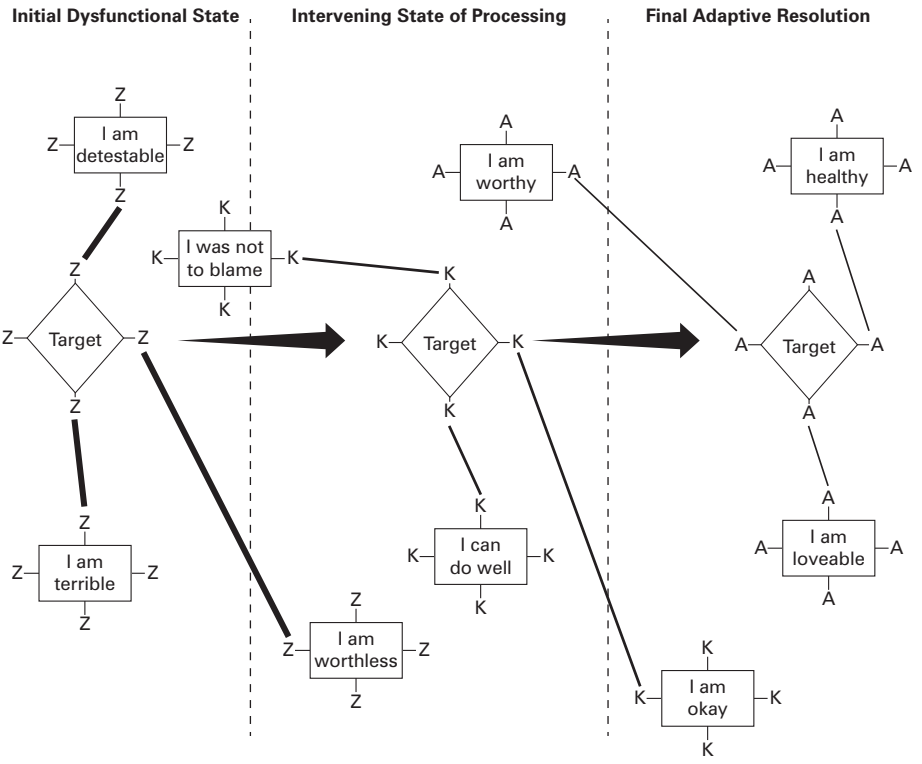


FIGURE 12.1. The relationship between association, valence, affect, and cognition in information processing.

Let us say that the target memory (Z) in Figure 12.1 has been observed clinically to contain the affect of guilt and shame and the accompanying cognition, "I am detestable and worthless." The stored information about this memory is encapsulated in a neural network that is greatly constrained by the high level of dysfunctional affect. It is hypothesized that the Z networks contain information with the most self-destructive affect and self-assessment, whereas the A networks are associated with the most adaptive and appropriate affect and assessment, such as "I am a lovable/worthy/healthy." In this model, the valences of the affects are associated with the respective neural networks, which separately store various information sets and levels of adaptive information, with the letters Z through A. It is hypothesized that the highly negative valence of the target network (Z) precludes it from linking up with the more adaptive information that is stored in other networks with neutral-to-positive valences; that is, there are distinct, affectively defined networks associated with each level of affective valence, so that the networks with the highest positive valence contain

memories of positive material such as mastery experiences, compliments, and information from self-help books.

It is posited that when the processing system is catalyzed by EMDR, two critical events take place. First, by a cellular mechanism similar to that seen in conditioned rats in which protein synthesis in the amygdala was inhibited while the condition stimulus was replayed (Nader, Schafe, & LeDoux, 2000), the association between the target memory Z and the affects of shame and guilt is weakened, allowing the memory to move figuratively to the right in Figure 12.1. But in addition, by shifting the brain state such that it is biased in favor of the weaker associations, EMDR makes it possible for the brain to form and strengthen associations with affect networks that are progressively less negative and then more positive in their valences, and thus to incorporate the more adaptive information stored there. An example of such a linkage is the movement from a high level of dysfunction, say, from the Z valence associated with the cognition, "I'm always to blame," to the lower valence of K, which is associated with a cognition, such as "I can do well." This shift is made apparent by the progressive disconnect from the negative affect, the evolution of more adaptive cognitions, and the emergence of positive memories into conscious awareness and their association to the original target memory.

The affect/valence hypothesis has a variety of clinical implications. For example, molestation victims often report horrific nightmares in which they are being dismembered by monsters. If we suppose that an attempt is being made by the REM sleep mechanism to process early traumatic events, then a nightmare of being dismembered by monsters is the cognitive counterpart to the high level of affect locked in the network containing the early memories. Let us say, for example, that at the time of the original trauma, a molested child experienced great terror when an adult entered the room and pulled her legs apart. The affect associated with this memory now locks this memory into a neural network defined by these negative affects, so that when the brain attempts to reprocesses the memory during REM sleep, the terror is resurrected. Such a level of fear would not be generated in an adult client by another adult in the present but could be associated with a confrontation with an uncontrollable monster. The symbolism of the monster is the cognitive construction of the affect state during the period of processing in REM sleep.

When EMDR is used to target the dream image, a high level (Z valence) of terror is evoked. As a sufficient amount of information is processed, the affect shifts rightward. The more positive valence allows the appropriate cognitive connections to be made by the linking of different neural networks. With the shift in affect, the symbolic representation, or cognitive construction, can be eliminated, and the client perceives the present without distortion. For instance, a molestation victim who dreamed of being chased by a monster through a cave exclaimed, after a number of eye movement sets, "That's my stepfather chasing me through my childhood home."

Other symbolic representations are often found to be the cognitive counterpart of an affective state or physical sensation. One example, described in Chapter 11, is from the case of a client whose intrusive images of being raped by Satan resolved during EMDR treatment into a memory of being raped by her father's friend, who assaulted her while he wore a set of plastic horns. The two different interpretations may result from the activation of a cognitive network of parallel valence that contains different information. Thus, the level of affect stimulates cognitive content of equivalent valence.

Another possible extrapolation from the affect/valence hypothesis is the escalation of self-destructive behavior, such as the increasingly severe self-mutilation (cutting) or escalating dangerous sexual encounters that have been observed in many clients. Clients may be driven to maintain a high level of pain because of the reactivation of early abuse memories that incorporate states of self-loathing or other aspects of psychological disturbance (Calof, 1992). It is possible that the affect of the core memories and the corresponding valence become associated with certain behaviors that are consistent with the client's subjective level of pain. As the behaviors become desensitized through repeated exposure, the valence of the core memories stimulates other behaviors that had been higher on the disturbance hierarchy but are now merely parallel to that level of affect. For example, a relationship becomes more abusive, but the client experiences it with the same level of affect. Therefore, what appears to be a level of escalation when viewed by an observer is actually behavior generated internally from the client's unchanged level of affect.

Again, although neurobiological mechanisms are largely conjecture, such attempts to understand what is observed clinically in EMDR treatment may prove to be useful in furthering our understanding of dream imagery, self-destructive behaviors, and other clinical phenomena. Theorizing about observed clinical behaviors may also contribute to the development of therapeutic methodology. For example, an earlier conceptualization of the EMs in EMDR (Shapiro, 1991a, 1995a) as causing the equivalent of a low-voltage current affecting receptors (i.e., their synaptic potential; Arai & Lynch, 1992; Barrioneuevo, Schottler, & Lynch, 1980) resulted in the successful innovation in EMDR practice of using different directions and speeds for the eye movements. It is hoped that these new conceptual formulations will likewise lead to further successful therapeutic innovations.

DREAM SLEEP

One of my earliest suggestions (Shapiro, 1989a) was that the directed eye movements stimulate the same processes that occur in REM sleep. I posited that the relationship of EMs and stress may be one of reciprocal inhibition; that is, the EMs help inhibit the stress, but sufficiently high stress will

inhibit the EMs. Independent sleep studies offer support for these ideas, inasmuch as the most traumatized individuals appear to suffer from dysfunctional REM sleep states. For instance, the combat veteran awakens in the middle rather than at the end of the nightmare (Ross et al., 1990), presumably because of the high level of stress. Furthermore, the conjecture that cognitive or memory processing is linked to EMs is supported by numerous studies of the role of REM sleep in memory processing. These studies have shown that emotional memories are preferentially processed during REM sleep (Walker & van der Helm, 2009), REM sleep facilitates the integration and abstraction of memories generally (Walker & Stickgold, 2010) and, as noted earlier, weak associations are preferentially activated upon awakening from REM (Stickgold et al., 1999).

Despite this evidence that REM can support forms of memory and emotional processing critical for trauma recovery, there is currently no direct evidence that EMDR induces similar processing during the waking state. However, Stickgold (2002) has posited direct neurobiological correlates between EMDR- and REM-state functions and has also posited appropriate tests of this hypothesis. Data dovetailing with the hypothesis have also been reported (e.g., Christman et al., 2003; Elofsson, von Schèele, Theorell, & Söndergaard, 2008; Kuiken, Bears, Miall, & Smith, 2002; Kuiken, Chudleigh, & Racher, 2010). Stickgold (2002) proposed that the repetitive redirection of attention in EMDR processing induces changes in regional brain activation and neuromodulation similar to those produced during REM sleep. Activation of these systems may simultaneously shift the brain into a memory-processing mode similar to that of REM sleep, facilitating the integration of traumatic memories into associative cortical networks. Given the cognitive and affective processing similarities, it would be interesting to compare sleep and REM patterns in clients before and after successful EMDR treatment. Brain wave studies comparing EMDR and REM patterns might also provide useful information for clinical application. To date, research has indicated that EMDR improves sleep patterns, including a reduction in awake time after sleep onset (Raboni, Alonso, Tufik, & Suchecki, 2014; Raboni, Tufik, & Suchecki, 2006). However, additional research is needed with larger samples.

RELAXATION RESPONSE

I originally posited (Shapiro, 1989a, 1991a) that the EMs in EMDR might induce a relaxation response. This response could be induced by way of the reticular formation (which causes muscular inhibition during the REM state) or other mechanisms that activate the parasympathetic nervous system. The parasympathetic system would in turn inhibit the sympathetic nervous system, which is associated with the "fight-or-flight" fear responses that are engendered by traumatic experiences. Hedstrom (1991)

and Stickgold (2002) have independently advanced conjectures about such an inhibitory effect. Research has supported this hypothesis by finding that EMs appear to cause a compelled relaxation response (e.g., Barrowcliff, Gray, MacCulloch, Freeman, & MacCulloch, 2004; Eloffson et al., 2008; Sack, Hofmann, Wizelman, & Lempa, 2008; Schubert, Lee, & Drummond, 2011; Wilson et al., 1996). However, the finding that the parasympathetic nervous system is activated during tasks that demand visual convergence (Monnier, 1968) might explain the positive treatment effects also noted in studies in which an eye fixation control condition has been used (Pitman et al., 1996a; Renfrey & Spates, 1994; Sack et al., 2016).

INTEGRATIVE EFFECT

One of the simplest ways to explain the effects of EMDR is to consider its activation of the information-processing system. Target events remain unprocessed because the immediate biochemical responses to the trauma have left it isolated in neurobiological stasis. When the client tracks a moving finger or concentrates on a hand tap, tone, or even a fixed point on a wall, active information processing is initiated in order to focus on the present stimulus. If the client is asked to attend simultaneously to both this stimulus and the traumatic memory, the active information-processing mechanism is linked to and processes both the target event and the current stimulus. This processing mechanism is physiologically configured to take the information to an adaptive resolution. Perhaps the rapid processing occurs because the clinician guides the client to the appropriate targets (and to the proper alignment of the components of the targeted experience), and because other procedural elements prevent client avoidance and/or induces the associative process.

The full range of neurological concomitants of this process may not be confirmed for decades. However, the rapid treatment effects of EMDR offer an opportunity to observe the standard patterns of memory association and emotional or cognitive processing, as well as the differential effects of processing long-standing and more recent memories. Thus, in many ways, EMDR may provide a window to the brain.

NEUROPHYSIOLOGICAL RESEARCH

Investigations of the neurobiological concomitants of EMDR treatment effects have rapidly expanded in the past two decades. To increase the conceptual understanding of readers lacking a neurophysiological background, I enlisted a neuroscientist currently conducting research in this area, Marco Pagani (Pagani et al., 2007, 2011, 2012, 2015; Pagani, Högberg, Fernandez,

& Siracusano, 2013), to review what is currently known. An annotated list of the referenced studies can be found in Appendix D. In recent years, awareness of the importance of neuroimaging in disclosing the neurobiology of various psychotherapies has steadily grown. With respect to EMDR therapy, neuroimaging, as well as psychophysiological research, has focused primarily on its mechanism of action, in particular the brain changes that occur during and after EMDR processing. Much of this research has been aimed at understanding the effects of the repetitive bilateral EMs, generally considered to be an active ingredient of EMDR treatment and a distinguishing difference between EMDR and trauma-focused and standard exposure psychotherapies.

As indicated previously, it has been shown that during the EM phase of EMDR processing sessions, stress-related arousal is associated with changes in respiratory patterns and decreases in heart rate and skin conductance (e.g., Elofsson et al., 2008; Barrowcliff et al., 2003; Sack et al., 2008; Schubert et al., 2011). These effects are consistent with autonomic activity in which the action of the parasympathetic nervous system increases relative to sympathetic functioning. In general, research indicates that EMDR processing causes a specific somatic de-arousal response, possibly resulting from central cortical and subcortical changes associated with the EMs and driven by the autonomic activity (Wilson et al., 1996; Kapoula et al., 2010). See Appendix D for an annotated list of studies investigating mechanisms of action.

Alternatively, it has been assumed that EMs enhance interhemispheric interaction, thereby facilitating retrieval of episodic memories (Christman et al., 2003; Christman, Propper, & Brown, 2006; Parker et al., 2009). In this vein, an electroencephalographic (EEG) investigation during EM in healthy controls (Propper et al., 2007), limiting the analyses to a pair of electrodes positioned on the prefrontal cortex, found a decrease in interhemispheric coherence in the anterior prefrontal cortex. EMs facilitated episodic memory and fostered consolidation of traumatic memories, leading to a decrease of memory intrusions. However, doubts were cast on the interhemispheric interaction hypothesis by another EEG investigation (Samara, Elzinga, Slagter, & Nieuwenhuis, 2011) in which no evidence was found of EMs altering interhemispheric coherence or being correlated to improvements in recall. More recently, further EEG investigations recording brain activity from the entire scalp did not find any alteration in interhemispheric connectivity. Pagani et al. (2012) reported a decreased intrahemispheric connectivity during BLS between left posterior cingulate and prefrontal and anterior cingulate cortices in gamma band in patients as compared to controls. Farina et al. (2015) found an increased coherence in beta band between left parietal and temporal cortex in patients after EMDR. These interregional connectivity changes speak in favor of disconnection of pathological networks and reconstitution of physiological multisensory circuits following successful EMDR therapy.

It has been further posited (Stickgold, 2002) that the putative EM-elicited orienting reflex causes electrocortical changes similar to those of the REM phase of sleep in which memory consolidation occurs. During EMDR therapy, such a state would promote the reorganization, contextualization, and adaptation of traumatic and/or emotionally charged autobiographical memories from a subcortical level into semantic networks at a cortical level. This model has been supported by evidence that EMDR improves sleep quality and decreases sympathetic activation, thereby helping to restore normal sleep patterns that are strongly linked to REM phases (Raboni et al., 2014). Further, based on neurobiological findings, it was recently suggested that bilateral stimulation initially elicits an electrophysiological response similar to that occurring during Slow Wave Sleep (SWS). This in turn would initiate the movement of traumatic memories to the neocortex, causing an immediate sense of relaxation and reduced vividness (Pagani et al., 2017), followed by memory integration typical of the REM state.

A variety of neuroimaging techniques have been used to perform neurobiological investigations, including structural magnetic resonance imaging (MRI), functional MRI (fMRI), single-photon emission computed tomography (SPECT), near-infrared spectroscopy (NIRS), and electroencephalography (EEG). The major contribution of MRI investigations to our understanding of the effects of EMDR therapy has been to disclose the anatomical changes occurring in patients with PTSD as the result of treatment. In PTSD, the physiopathological model proposes that when reliving trauma, symptoms are the result of an imbalance between the hyperactivation of subcortical regions, such as the amygdala and hippocampus, and the lack of control exerted by the frontal cortex on such hyperaroused regions. Two MRI studies reported that successful EMDR therapy led to anatomical changes in the amygdala and hippocampus, indicating the reversal of the trend toward atrophy of these structures under stressful conditions (Laugharne et al., 2016; Bossini et al., 2011, 2017). Other structural analyses found that EMDR resulted in a change in brain network topology in the parahippocampal gyrus (Bossini et al., 2017; Jung et al., 2016) and thalamus (Bossini et al., 2017), possibly increasing communication between subcortical and cortical structures, and facilitating trauma processing and symptoms disappearance (Jung, Chang, & Kim, 2016).

Grey matter differences before therapy were found between clients who later responded to EMDR therapy and those who did not (Nardo et al., 2010). Again, the volume of the amygdala, hippocampus, and other limbic structures was found to be significantly lower at baseline in nonresponders to EMDR than that in responders. Even though the sample was small and the number of sessions limited, it is likely that the relatively more severe cortical atrophy caused by the long-lasting cortisol release in the former group of patients with PTSD accounted for the therapy failure due to the lack of the interregional brain connectivity necessary for memory integration and adaptation. However, in a longitudinal study using structural MRI it

was found that in four frontal lobe clusters grey matter increased following EMDR therapy in the recovery group as compared to the wait-list group (Boukezzi et al., 2017). A recent fMRI investigation (Landin-Romero et al., 2013) found that the amelioration of symptoms after EMDR therapy in a patient with bipolar disorder was associated with the normalization of one of the most important brain connectivity systems, known as the "default mode network," which is activated at rest during self-directed mentation and subject to disruption in traumatized patients with bipolar disorder.

Four functional neuroimaging investigations performed with SPECT reported blood flow normalizations in limbic structures implicated in PTSD following successful EMDR therapy (Levin et al., 1999; Oh & Choi, 2004; Lansing et al., 2005; Pagani et al., 2007). Although the studies were very heterogeneous in terms of type of trauma, symptoms, and number of subjects, all demonstrated that symptom disappearance was associated with increased activation of frontal regions and decreased activation in subcortical ones. One of these investigations pointed out how the failure to respond to EMDR was associated with persisting abnormal hyperactivation of the hippocampus, fusiform gyrus, and visual cortex, and hypoactivation of the lateral frontal cortex, resulting in the continuation of symptoms in the form of intrusive memories, images of the trauma and hallucinations, respectively, processed in the above mentioned still-hyperaroused regions (Pagani et al., 2007).

Recently, the most encouraging progress in understanding the neurobiological impact of EMDR processing and its mechanisms of action has come from studies performed by means of fMRI, NIRS and EEG before and after therapy sessions, as well as during the BLS. In a recent fMRI investigation on healthy subjects, Herkt et al. (2014) observed an amplifying effect of bilateral auditory stimulation on amygdala hyperactivation and frontal lobe hypoactivation during intense negative emotional stimulation. The latter neurobiological effect replicates the decreased activity in the prefrontal cortex during trauma-related recall with EM that was found in a NIRS study (Ohta ni, Matsuo, Kasai, Kato, & Kato, 2009). These changes in limbic cortex activation suggest the presence of an enhanced cognitive control mechanism during bilateral stimulation. Consistent with these findings, a NIRS study with healthy participants found the superior temporal sulcus to be hyperactivated when bilateral tactile stimulation occurred in conjunction with the recall of pleasant memories (Amano & Toichi, 2016a) and hypoactivated when EMs were elicited during the reliving of traumatic events (Amano & Toichi, 2016b). These studies underscore the importance of this structure in memory processing, as well as the net neurobiological effect of all bilateral stimulation techniques.

Similar results were obtained in a series of EEG investigations in which the subcortical hyperactivation associated with the symptomatic phase of PTSD was normalized after successful EMDR therapy in which EMs served

as the BLS (Pagani et al., 2011, 2012, 2015; Trentini et al., 2015). These four studies were performed on different groups of patients whose EEGs were monitored during EMs and trauma exposure. The results following EMDR processing revealed a highly significant shift of activation from cortical and subcortical regions (i.e., amygdala and orbitofrontal cortex) with high emotional valence to cortical regions (i.e., the multimodal associative cortex) in which cognitive and associative functions are processed. Furthermore, these investigations confirmed the findings of a previous study by Harper et al. (2009), reporting that during bilateral stimulation, EEG signals mimic those recorded during the slow-wave sleep phase in which information and memories are transferred to neocortical areas, where they are strengthened during REM sleep. These results appear to provide neurobiological support to the working memory and orienting response theories (see detailed review in the following sections). In fact, the relaxation response and the reduction of the strength and vividness of traumatic memories experienced during EMDR processing may be associated with a REM-like state in which bilateral stimulation reproduces the neurophysiological conditions favorable for episodic memory integration in the associative neocortex memory networks. In this respect, one of the most important aims of future research will be to try to disclose the actual changes occurring in the central nervous system during all phases of EMDR therapy, including the installation of positive cognitions. This would involve (1) systematically assessing cortical and subcortical activations during EMDR sessions, both with and without bilateral stimulation; (2) investigating the changes in sleep physiopathology taking place before and after therapy; and (3) correlating clients' neuropsychology with clinical and neurobiological changes.

Taken together, all the physiological and neurobiological studies converge in describing a significant reduction of the sympathetic arousal and subcortical limbic hyperactivation during EMDR therapy, specifically during the periods of bilateral stimulation. This suggests that such changes indicate that brain activity normalization is related to emotion regulation, relaxation, and positive feelings or other physiological responses associated with bilateral stimulation of EMDR therapy (see also Pagani et al., 2013).

COMPONENT ANALYSES

The repetitive lateral EMs that are the most common form of BLS used in EMDR therapy have been subject to intense experimental scrutiny. Although their usefulness was initially questioned in a meta-analysis (Davidson & Parker, 2001) of RCT component analyses, as indicated in the Practice Guidelines of the International Society for Traumatic Stress (Chemtob et al., 2000), significant flaws in the included studies (e.g., insufficient

treatment doses, inappropriate populations, and lack of statistical power) precluded any valid conclusions. For instance, the RCTs included the treatment of combat veterans while employing only two sessions and/or treating only one or two memories in this multiply-traumatized population (e.g., Boudewyns & Hyer, 1996; Devilly, Spence, & Rapee, 1998; Macklin et al., 2000; Pitman et al., 1996a). Subsequent research in the form of over 30 RCTs has strongly confirmed the usefulness of the EMs. The positive effects of this form of BLS include an immediate decrease in emotional arousal, negative emotions, and/or imagery vividness, as reported in approximately 20 RCTs (e.g., Barrowcliff et al., 2004; Engelhardt et al., 2011). Other beneficial changes are seen in improved attentional flexibility (e.g., Kuiken, Bears, Miall, & Smith, 2001), memory retrieval (Christman et al., 2003; Nieuwenhuis et al., 2013), and recognition of true information (e.g., Parker et al., 2009; see Appendix D for an annotated list of RCTs). Further confirmation of the positive effects has been summarized in a recent meta-analysis of 26 RCTs (Lee & Cuijpers, 2013) in both clinical settings demonstrating a moderate average effect size (Cohen's $d = 0.41$), and laboratory experiments demonstrating a large effect size (Cohen's $d = 0.74$). These studies have been evaluated with respect to the three dominant hypotheses discussed in the following sections.

WORKING MEMORY ACCOUNT OF EMDR

Working memory entails the temporary storage of information, such as that needed to do mental arithmetic or dial a telephone number. According to Baddeley (1986), the three components of working memory—visuospatial sketchpad, phonological loop, and central executive—have limited memory resource capacity. Thus, when two tasks make demands on the attentional capacity of one of the components, performance on the primary task deteriorates. In EMDR therapy, the EM component has the effect of dividing the client's focus of attention between the stimulation and the targeted negative memory. The result is that the EM overloads working memory capacity, causing the image of the negative event (which is held on the visuospatial sketch pad) to deteriorate due to competition for limited resources. As a result, the memory becomes less vivid and disturbing, which, according to several investigators (e.g., van den Hout et al., 2012), is then reconsolidated in that form.

Numerous studies have provided empirical evidence for the working memory explanation of the effects of EMs in terms of reduced vividness and the emotional concomitants of negative autobiographical memories (e.g., Barrowcliff et al., 2003, 2004; Englehard et al., 2010, 2011; Gunter & Bodner, 2008; Kavanagh, Freese, Andrade, & May, 2011; Maxfield, Melnyk, & Hayman, 2008; Smeets et al., 2012; van den Hout et al., 2001, 2011; see Appendix D for an annotated list of RCTs).

Other studies have delved more deeply into the hypothesis to examine more specific questions. Two RCTs (Homer et al., 2016; van den Hout et al., 2011) and two uncontrolled studies with patients diagnosed with PTSD (De Jongh, Ernst, Marques, & Hornsveld, 2013; van den Hout et al., 2012) have found EMs to be superior to audio tones. Three studies testing working memory did not support its predictions. One RCT (van Veen et al., 2015) showed that the more working memory taxation was applied, the more the images were degraded, but it failed to find support for the prediction that highly vivid images are more affected by fast EMs and less vivid images are more affected by slower EMs. Another RCT (Engelhard, van Uijen, & van den Hout, 2010) reported that a comparison of Tetris and eye movements revealed no difference in effects on imagery vividness, even though Tetris was predicted to tax working memory to a greater extent. An uncontrolled study (van Schie et al., 2016) did not support the hypothesis that EM speed should be adjusted to the working memory capacity of the individual. Despite occasional failures to support the fine details of the working memory hypothesis, the consensus conclusion is that this mechanism is an important aspect of EMDR processing. Furthermore, the theory has led to the utilization of targeted images to process the disturbance associated with flash forwards (Engelhardt, van den Hout, et al., 2010; see Chapter 9) and the positive affects associated with addiction cravings (Littel, van den Hout, & Engelhard, 2016). However, two other proposed mechanisms of action have also received research support and appear to contribute to EMDR therapy's clinical effects. They will be discussed in the following sections.

ORIENTING RESPONSE

The hypothesis that the EMs in EMDR therapy elicit an orienting response that facilitates memory processing has also accumulated empirical support. The orienting response is a natural, innate response of interest that is elicited when attention is drawn to a new stimulus (Pavlov, 1927; Sokolov, 1963). Pavlov (1927, p. 12) described the behavioral component of the orienting response as a "what-is-it" reflex in humans and animals, in which the slightest change in the world around them causes them to stop what they are doing and focus their sensors on the source of the stimulation to investigate. Russian physiologist Eugene Sokolov (1963) proposed that the orienting response has two distinct phases. The first is an alerting reaction in response to a novel stimulus in the environment, and the second is a gradual weakening (habituation) and ultimate disappearance of the reaction with repeated presentations of the stimulus, assuming it is nonthreatening.

In the field of psychophysiology, the orienting response is a heavily researched reflex with a well-defined physiological profile (Öhman,

Hamm, & Hugdahl, 2000; Sokolov & Cacioppo, 1997). The psychophysiological profile of an orienting response is characterized by a combination of responses in the body elicited by changes in stimulation (Bradley, 2009). First, an initial startle and freeze reaction is reflected in a skin conductance response and an arrest in breathing, respectively. If the stimulus remains but is assessed as nonthreatening, this reaction is short-lived (less than 10 seconds) and habituates quickly (Bradley, 2009; Sokolov, 1963). Then, de-arousal occurs through an increase in parasympathetic tone (reflected by cardiac deceleration and increased heart rate variability), and decreases are seen in respiration rate, skin conductance, and skin temperature (Bradley, 2009; Sokolov, 1963).

The body of research examining the presence of an orienting response in EMDR in terms of its psychophysiological correlates during treatment sessions is not extensive. However, the physiological effects of EMs have been described in the literature for many years, in laboratory studies (Barrowcliff et al., 2003, 2004), and in treatment studies with nonclinical (Schubert et al., 2011; Wilson & Covi, 1991; Wilson et al., 1996) and clinical PTSD populations (Elofsson et al., 2008; Sack, Lempa, Steinmetz, Lamprecht, & Hofmann, 2008; Sack, Hoffman, et al., 2008; Schubert et al., 2016). Research has consistently found that EMs produce distinct psychophysiological effects, the primary one being their association with physiological de-arousal.

Two decades ago, Armstrong and Vaughn (1996) proposed that the therapist's hand movements in EMDR are a stimulus that elicits an orienting response. Both Armstrong and Vaughan and MacCulloch and Feldman (1996) proposed that orienting responses elicited by the directed EMs in EMDR facilitate continuous attention to, as opposed to avoidance of, the trauma material being processed. Attention to this material allowed for learning of new trauma-related information. The physical de-arousal, assumed to result from repeated orienting responses elicited by EMs during trauma memory processing, has also offered support for an account of EMDR therapy that put forward counterconditioning through reciprocal inhibition as a working mechanism of EMDR therapy (Dyke, 1993; Söndergaard & Elofsson, 2008; Wilson et al., 1996). The theory of reciprocal inhibition states that two incongruent responses (relaxation and anxiety) cannot coexist (Wolpe, 1991). Thus, pairing physical de-arousal, or a parasympathetic relaxation response, with exposure to traumatic memories associated with anxiety and distress, weakens distress and leads to the extinction of anxiety. The de-arousal, or relaxed state associated with EMs in EMDR, has continued to be recognized as a potential mechanism for facilitating attention to trauma-related material by increasing one's ability to sit with and tolerate the stress and discomfort of EMDR trauma memory processing (Barrowcliff et al., 2004; Elofsson et al., 2008; Sack, Hofmann, et al., 2008).

REM SLEEP

The third process proposed as a mechanism for EMDR therapy that has received research support is associated with sleep. Research on EMDR processing in which eye movements are used as the BLS has indicated that some of the physiological changes associated with these EMs are characteristic of the de-arousal correlates of the orienting response (i.e., decreased heart rate and skin conductance, increased heart rate variability), while others are accompanied by physiological changes generally associated with arousal. An independent theory of EMDR proposed by Stickgold (2002) is that the EMs in EMDR therapy, possibly through recurring orienting responses, moves the brain into a mode of memory processing that is akin to REM sleep, which in turn promotes the integration of episodic traumatic memories into general semantic networks. Stickgold was the first to bring together information-processing theory and possible neurobiological and physiological explanations of how EMDR may facilitate recovery from PTSD. Like an orienting response, REM sleep has recognizable physiological characteristics. EMs are characteristically present in both the orienting response and REM sleep (Wright & Ward, 2008), while features of REM sleep entail momentary cholinergic activation (Stickgold, 2002). Thus, some researchers (Elofsson et al., 2008; Schubert et al., 2011, 2016) have concluded that physiological data collected during EMDR sessions offer support for the presence of both orienting responses and a REM-like state during desensitization of traumatic memories.

The only clear function of REM sleep is the processing of information and the consolidation of memories. Research has shown that deprivation of REM sleep leads to detrimental effects on concentration, memory consolidation, and learning (Dang-Vu, Desseilles, Peigneux, & Maquet, 2006). Activating an REM-like state while awake is hypothesized to aid in the process of integrating episodic memories into general semantic networks. On the basis of dismantling laboratory research, the types of EMs used in EMDR have been shown to enhance episodic memory retrieval (Christman & Garvey, 2000; Christman et al., 2003), and facilitate attentional orienting (possibly inducing an REM-like state), and induce semantic and cognitive flexibility (Kuiken et al., 2002). Kuiken, Chudleigh, and Racher (2010), in an analogue study that examined the potential relationship between orienting response theory and REM sleep mechanisms, concluded that the attentional flexibility associated with EMs facilitates transformations of traumatic memories and exploration of insights into narrative representations of trauma experiences, similar to the metaphoric shifts that occur in memory during dreaming.

To review, the three dominant hypotheses regarding the mechanisms of action of EMs used in EMDR therapy that have been supported by research are that (1) dual attention taxes the limited capacity of working memory,

resulting in a degradation of the visual image and consequent lessening of disturbance; (2) the bilateral EMs elicit an orienting response that causes a parasympathetic reaction associated with a decrease of disturbance; and (3) the EMs stimulate the processes akin to REM sleep. As elaborated by Stickgold (2002, 2008), REM is characterized by the processing of episodic memories, resulting in (1) their integration into existing semantic networks, (2) the elimination of associated negative affect, and (3) the increase in insight and comprehension. A transcript of an EMDR processing session focusing on the experience of a medic who responded to a mass casualty in Iraq (Hurley, 2016b) can help illustrate changes in affect and spontaneous cognitive restructuring that need to be assessed for an appropriate evaluation of the three hypotheses.

"Jim" was treated for PTSD related to his two tours in Iraq and the feeling of guilt he experienced when responding to a mass casualty event because he was not able to save all the wounded soldiers. He reported a 12 on the SUD scale because the guilt, anger, and anxiety were "so intense." Holding in mind a disturbing image that represented the event, the negative cognition "I am inadequate," and the negative physical sensations in his stomach and chest, the following transcript reveals Jim's responses after each set of EMs:

- "Medics have a unique responsibility. If we do our jobs we save lives and if we don't people die."
- "If Pete hadn't pulled me off him I would still be trying to revive him."
- "I kept him alive until we got to the CSH [combat support hospital] and the docs said, 'He's gone!' I was mad and had blood all over me. I said, 'I did it all for this?!' "
- "Pete pulled me away and said, 'Come over brother, let's go.' "
- "I don't feel as angry as I did before."
- "Even surgeons lose people."
- "I did what I was trained to do; I actually saved people's lives."
- "It's time I stopped beating myself up over this. As of right now, I determine to stop beating myself up."

Processing resulted in a score of 0 on the SUD scale; the positive cognition, "I am effective," was a VOC score of 7 (increased from a 2 in pretreatment), with no physical disturbance during the Body Scan. Subsequent to the session he enrolled in emergency medical technician training to prepare for a civilian career.

This example underscores the need to carefully examine the three proposed hypotheses. While the decrease in disturbance can be interpreted through the lenses of both the working memory (WM) and orienting response (OR), and WM further accounts for decreases in imagery vividness, they are insufficient to explain the elicitation of the corrective

information that spontaneously emerged from his memory networks that resulted in insight, an increase in positive VOC score, and a sense of resilience and adaptive resolution. However, in conjunction with the REM hypothesis, the clinical phenomena are accounted for, in addition to other commonly observed reports during EMDR processing such as the spontaneous increase in positive imagery, thoughts, and memories. Therefore, given the previously cited studies (for an annotated list of RCTs, see Appendix D), it is probable that all three theories are correct, and that they manifest themselves at different stages of memory processing. Future research should evaluate the treatment effects with suitable clinical populations in order to explore further the neurophysiological bases of the associative processing phenomena.

FUTURE RESEARCH

More than 30 RCTs have confirmed the contribution of the bilateral EMs to EMDR therapy. Nevertheless, more research is recommended to evaluate the effects of varying the kinds of EMs that are used in terms of speed, cadence, direction, and other parameters. Likewise, the effects of the alternative forms of BLS (i.e., audio, tactile) on memory and how they compare to those of EMs are in need of greater attention in diagnosed trauma populations, particularly in relation to various types of memory targets (e.g., positive vs. negative/etiological vs. secondary) and clinical populations (e.g., simple vs. complex trauma).

It has long been known that EMs are associated with cognitive processing mechanisms (Antrobus, 1973; Antrobus et al., 1964). A series of systematic experiments revealed that spontaneous EMs are associated with unpleasant emotions and cognitive changes. According to Antrobus et al., "The attempt to break up a thought sequence when it is unpleasant or anxiety provoking may very well lead to a series of almost desperate rapid shifts in cognitive activity with consequent ocular motility" (p. 251). The authors speculated that the series of saccades was associated with an automatic attempt at thought dispersal. It was the subjective observation of this phenomenon that served as the springboard for the development of EMDR (Shapiro, 1989a, 1989b) and the subsequent recommendation to clinically engage in rapid eye movements at a comparable speed. When engaged in processing with use of eye movements, clients visually track the therapist's finger as it moves rapidly from side to side before them. The speed of this motion is approximately two back-and-forth movements per second (a total of four 30- to –35-degree movements per second). Although there is likely to be a smooth pursuit component to this eye motion, especially after several cycles of this predictable stimulus, it will also have a significant saccadic component (Collewijn & Tamminga, 1984). A visual target moving

that quickly is very difficult to track without occasional "catch-up saccades." Indeed, the most commonly cited limit is 100 degrees per second (Meyer, Lasker, & Robinson, 1985). In addition, there will undoubtedly be "catch-up" saccades at each reversal point that are necessary to maintain or regain fixation of the target (De Brouwer, Yuksel, Blohm, Missal, & Lefèvre, 2002; Welch, 1996). Supported by consistent clinical observations over the past 30 years, rapid eye movements are recommended as the most efficient means to facilitate associative processing of disturbing memories, which also appear to facilitate generalization affects. However, slower, tracking, eye movements are recommended for the incorporation of positive affect states with the use of the Safe/Calm Place technique, as they do not appear to generate associative links to other potentially disturbing memories. Future studies should further investigate these differences.

Of particular clinical interest are studies with diagnosed populations comparing the effects of various forms of BLS with no stimulation in conjunction with resource development and installation (RDI) procedures. Such research should include the full standardized procedures with diagnosed populations. Currently, two nonrandomized studies have reported conflicting results. A within-subject experiment with 53 undergraduate students (Hornsveld et al., 2011) evaluated a truncated version of RDI by comparing the effects on positive memories of horizontal EM, vertical EM, and recall only. Outcomes were measured in terms of strength of the positive affect, vividness of memory, and pleasantness. The standardized procedures of RDI (Korn & Leeds, 2002) were not used, because the associations were eliminated in this study. Results indicated significant decreases on all measures in the eye movement conditions compared to recall only, leading the researchers to recommend against the use of BLS in RDI. Another study (Amano & Toichi, 2016a) evaluated the full RDI procedures using bilateral tactile stimulation with 15 healthy volunteers. Outcomes were measured by means of near-infrared spectroscopy, which indicated positive biological effects, and the Profile of Mood States, which revealed significant decreases in negative emotions (e.g., anxiety, depression, fatigue) and increases in positive feelings. Participants also reported increased accessibility of the positive memory and of relaxation. A trend toward significance was reported, suggesting increased memory vividness, and no difference was found for strength of the resource. Overall, the researchers concluded that the BLS increased the effectiveness of RDI.

Conclusions based on these two studies are confounded by the lack of fidelity to the RDI procedures in the first study, the different BLS used, and the small sample size in the second study. Definitive conclusions will need to be based on RCTs with larger samples of diagnosed population using the complete, standardized procedures. Clearly, BLS during standard EMDR processing results in increased positive affects and self-assessments, as demonstrated by the increased ratings on the VOC scale in more than 30 RCTs of the clinical procedures that obtained substantial clinical

effects (see Appendix D). Adequate fidelity to the standardized procedures includes an Installation Phase, which is not concluded until the VOC score reaches 7 or is otherwise ecologically appropriate. Furthermore, as clearly seen in the client transcripts included in this book, positive imagery, affects, and beliefs spontaneously emerge during the associative process. RDI also includes an associative process that should not be eliminated when investigating the technique. However, it may be that tactile stimulation is more suited to this intervention, and future studies should evaluate this possibility. It is suggested that future research investigate the use of fast and slow EMs as compared to tactile and no stimulation. Clinicians employing the Safe Place technique have long been advised to use short sets, together with a speed the client finds comfortable (Shapiro, 2001), and, for RDI, clinicians are instructed to use short sets (6–12 bidirectional movements; Korn & Leeds, 2002). Identifying the most effective speed, length, and form of stimulation in RCTs with a large clinical sample would be useful to guide future practice.

In an attempt to determine the underlying working mechanism of the EMs, a recent component analysis using a PTSD population (Sack et al., 2016), compared bilateral eye movements, eye fixation and an exposure control. Both eye conditions were found to be equally effective and superior to exposure alone at posttest. The researchers concluded, "Our study queries the specific role of bilateral stimulation by inducing eye movements in reducing symptoms of PTSD, because fixation on the nonmoving hand is a continuous and not an alternating stimulus" (p. 364). However, this is not neurophysiologically accurate. Even when clients are required to fixate a visual target, the eyes are not actually motionless, but rather engage in movements without which normal visual acuity is not possible. As stated by Benedetto, Pedrotti, and Bridgeman (2011, p. 1), "Visual perception takes place during fixations, with saccadic suppression interrupting it during saccades roughly three times per second." These movements, termed "microsaccades," are believed to occur to keep the retinal image from fading, to be generated by the same neural mechanisms as large saccades (Hafed & Krauzlis, 2012; Martinez-Conde, Macknik, & Hubel, 2004). In contrast to the finding regarding eye fixation, an RCT using EMDR therapy comparing bilateral and continuous tactile stimuli with PTSD participants, (Servan-Schriber et al., 2006) found faster reductions in distress with the bilateral stimulus. An additional six RCTs with healthy participants also reported superiority for the bilateral eye condition when compared to fixation (e.g., Barrowcliff et al., 2004; Kuiken et al., 2010; Parker et al., 2009). The contradictory findings of the Sack et al. (2016) study highlight the difficulties of evaluation given the potential confounds involved when using all of the EMDR therapy procedures, compounded by the neurophysiological complexity of the eye fixation condition. In addition, the finding by Sack et al. (2016) of three times the number of abreactions in the fixation condition as in the EM condition also raises interesting questions about clinical

application. It is recommended that future research designed primarily to examine underlying mechanisms of action avoid the eye fixation comparator when using all of the EMDR procedures with diagnosed populations. Researchers should evaluate the nature of the processing effects observed during treatment, as well as report the clinical outcomes at posttest and follow-up when comparing different forms of BLS. It may be that eye fixation will prove to be a useful alternative in clinical practice. However, neurophysiological studies appear better suited to determine the underlying neurophysiological mechanisms of action than are purely clinical studies.

In that vein, further research to confirm the physiological correlates of EMDR is warranted, utilizing larger sample sizes with active controls and a wider range of physiological variables. Future protocols should also incorporate finger temperature (or a more dynamic measure of vascular tone) to determine whether REM-like mechanisms are involved and, if so, to differentiate between the mechanisms of EMs being an orienting response and/or REM-related. To examine the REM hypotheses of EMDR further, it would be interesting to determine whether the startle responses associated with the EMs in EMDR occur in concert with brainstem-initiated ponto–geniculo–occipital (PGO) waves, as REM sleep is the only state known to generate PGO waves (Hobson, Stickgold, & Pace-Schott, 2000; Stickgold, 2002). Most importantly, future examinations of the physiological changes that occur in EMDR therapy should by design clarify the physiological profile of the orienting response that may occur in EMDR processing sessions. For example, given an orienting response and a possible startle-and-freeze response prior to a relaxation response, analyses should align the timing of these events to a standard response element. Standardizing timing of measurement periods across research studies would also overcome differences in interpretation of physiological data and facilitate advances in this field of inquiry.

SUMMARY OF RECOMMENDATIONS FOR COMPONENT RESEARCH

1. The use of analogue populations is suitable only in basic component action research that examines individual components in isolation from the rest of the clinical procedures. In clinical component trials, only clinical populations should be used. The remaining EMDR procedures are predicted to have a positive effect, making the fine discriminations needed for component analyses extremely difficult to achieve. Attention to this caveat about the need for clinically diagnosed populations has long been urged for the testing of all clinical methods (Wolpe, 1991).

2. Clinical studies should utilize the complete EMDR methodology and include checks of treatment fidelity.

3. Measures should include standard tests of therapeutic results (including behavioral measures) in a wide range of clinical domains and use treatment time as one of the independent variables.

4. Many of the procedures integrated into EMDR therapy (in addition to the BLS component) should be individually examined.

5. Regardless of the component being evaluated, appropriate clinical component analyses should alter only one aspect of the procedure in any one of the cells and test it against the standard administration of EMDR. Altering more than one procedure in any of the control conditions results in a confounded examination of the agent of change.

6. It is urged that experimental tests of procedures use diagnosed populations with a sufficient number of participants to achieve the statistical power needed to make fine discriminations. Whether using single-subject or control-group designs, the amount of treatment time should be commensurate with the clinical diagnosis, especially if global measures (e.g., Clinician-Administered PTSD Scale) are used.

7. Subjects for experiments in which the entire EMDR methodology is being tested should be limited to those suffering from PTSD, because this is currently the only clinical population for which the therapy has been extensively tested.

8. Matching effects should also be examined before concluding that a given component is unnecessary, because it is likely that a particular component will be necessary in some situations but not in others. For example, the negative cognition may be necessary only when the other components have failed to adequately access the state-dependent memory network (as indicated, for example, by a low SUD rating). The randomization process can obscure treatment matching effects, so unless these effects are explicitly tested, they will be undetected.

9. RCTs to determine the neurophysiological mechanisms underlying the BLS should incorporate neurophysiological measurements.

CONTROLLED CLINICAL RESEARCH

The investigation of any therapy must include both clinical and laboratory observations. The following sections describe (1) the EMDR therapy controlled clinical outcome studies in the area of PTSD, (2) research regarding diverse clinical applications, and (3) recommendations for future studies evaluating clinical outcomes. The chapter concludes with an overview of more general clinical and professional concerns.

TREATMENT OF PTSD

As discussed in Chapter 1, I introduced EMDR in 1989 with an RCT (Shapiro, 1989a, 1989b). The initial study, which attracted much attention, served the important purpose of stimulating further research. Because of the small number of subjects and other factors, the study could only be considered preliminary and in need of confirmation by independent replications and careful clinical observation.

Subsequent EMDR RCTs (reviewed in the following sections) have been strengthened by the incorporation of standardized diagnostic criteria and symptom measures, as well as by a separation between the therapist and the measurement of effects. However, the studies published in the decade following the seminal research also suffered from a number of flaws that provide important lessons for evaluating any form of psychotherapy. Table 12.1 presents EMDR outcome studies that were published during that initial period (simple component analyses are not included) and indicates the number of "gold standards" (Foa & Meadows, 1997) achieved by each, in addition to other standards that appear to allow for even more clinically relevant evaluation (Maxfield & Hyer, 2002). The review revealed that the more rigorous the study, the larger the clinical effect (Maxfield & Hyer, 2002). Although many more studies have been conducted in the last 15 years and are reviewed below, the delineated standards are still relevant and I refer to Table 12.1 in the discussion of some of those studies.

Given the current size and rapidly expanding nature of the research base, this section will provide an overview of findings and issues that are the most relevant to the practicing clinician.

Trauma and PTSD

Approximately 30 RCTs and 22 nonrandomized studies have confirmed the efficacy of EMDR as a therapeutic treatment for psychological trauma (Shapiro & Solomon, 2017; For an annotated bibliography of RCTs, see Appendix D). This strong empirical support has led to its designation as an effective treatment for PTSD in the practice guidelines of both national and international organizations, including the International Society for Traumatic Stress Studies (2009), Department of Veterans Affairs and Department of Defense (VA/DoD, 2017), and the World Health Organization (WHO; 2013).

Children

Empirical evidence supports EMDR therapy as an effective trauma treatment across the lifespan (e.g., WHO, 2013), although the procedures must of course be developmentally appropriate when applied to children (see Chapter 11). In fact, treatment has proven successful with children

TABLE 12.1. Revised Gold Standard Scale and Effect Size

	Gold standards											Effect sizes		
PTSD studies	Total	#1	# 2	# 3	# 4	# 5	# 6	# 7	# 8	# 9	# 10	EMDR	Control	Comparison
Boudewyns & Hyer	7.5	1	1	1	1	1	1	0.5	0	1	0	0.67	0.38	0.46
Carlson et al.	8.5	1	1	0	0.5	1	1	1	1	1	1	1.53	1.24	1.44
Devilly et al.	4.0	1	1	0	0.5	1	0	0	0	0.5	0	0.37	–0.01	–0.01
Devilly & Spence	6.0	1	1	0	0.5	1	0	0	1	0.5	1	0.75	1.81	–0.67
Jensen	4.5	1	0.5	0	0.5	1	1	0	0	0.5	0	–0.50	–1.0 (wl)	1.01 (wl)
Lee et al.	8.0	1	1	0	0.5	1	1	1	1	0.5	1	2.07	1.37	0.62
Marcus et al.	8.0	1	1	0.5	1	1	1	0.5	0.5	0.5	1	2.30	1.13	0.76
Rogers et al.	6.5	1	1	1	0.5	1	1	0.5	0	0.5	0	1.10	0.20	1.13
Rothbaum	8.0	1	1	1	1	1	0.5	1	0.5	0.5	0.5	2.22	0.56 (wl)	2.85 (wl)
Scheck et al.	7.0	0.5	1	1	1	1	1	0.5	1	0	0	1.60	0.52	0.76
Vaughan et al.	7.5	0.5	1	1	1	1	1	0.5	0.5	0.5	0.5	1.38	0.60	0.69
Wilson et al.	7.5	0.5	1	1	0.5	1	1	1	1	0	0.5	1.49	0.19 (wl)	1.50 (wl)
Means	6.92	0.875	0.958	0.542	0.708	1.00	0.792	0.542	0.542	0.500	0.458	1.23	0.58	0.88

Note. Gold standards: #1, diagnosis; #2, measures; #3, blind independent assessor; #4, trained reliable assessor; #5, manualized treatment; #6, randomization; #7, EMDR treatment fidelity; #8, no concurrent treatment; #9, interview assessment; #10, adequate number of sessions. Rating of each gold standard: 1, criteria for the standard fully met; 0.5, criteria partially met; 0, criteria not met. Effect size = Cohen's *d*. "wl" = wait-list control. Based on Maxfield and Hyer (2002).

as young as 2 years old (Hensel, 2009). As of this writing, nine RCTs have reported positive EMDR treatment effects for traumatized children (see Appendix D; Shapiro, Wesselmann, & Mevissen, 2017). In four of those studies, EMDR therapy was compared to trauma-focused cognitive-behavioral therapy (TF-CBT), and it was demonstrated in three RCTs that the successful treatment of children required fewer sessions for EMDR (De Roos, Greenwald, den Hollander-Gijsman, Noorthoorn, van Buuren, et al., 2011; De Roos, van der Oord, Zijlstra, Lucassen, Perrin, et al., 2017; Jaberghaderi, Greenwald, Rubin, Dolatabadim, & Zand, 2004). In the third RCT (Diehle, Opmeer, Boer, Mannarino, & Lindauer, 2014), equal effectiveness was reported in an equivalent number of sessions. A meta-analysis concluded that EMDR therapy (as compared to no-treatment or therapy-as-usual control groups) substantially reduced PTSD symptoms in children ages 4–18 (Rodenburg et al., 2009). The authors noted additionally that when compared to TF-CBT, both were effective, although EMDR therapy added "a small but significant incremental value" (p. 604) in the reduction of traumatic stress symptoms.

Two other RCTs assessed children with behavioral issues and disturbing memories. In a study by Soberman, Greenwald, and Rule (2002), boys in residential or day treatment who exhibited conduct problems and symptoms of traumatic stress were randomly assigned to either a control condition of "treatment as usual" (TAU) or a condition of TAU plus three sessions of trauma-focused EMDR. Compared to the control group, a large, statistically significant decrease in memory-related distress was exhibited by the EMDR group at posttest, and at a 2-month follow-up, a large and significant reduction in behavioral problems was reported. In another RCT (Wanders, Serra, & de Jongh, 2008) children suffering from behavioral and self-esteem problems were randomly assigned to four sessions of either EMDR therapy or CBT aimed at treating their distressing memories. Reports from parents, mentors, and children were obtained before and immediately after the sessions, as well as at a 6-month follow-up. For both treatments, the children's behaviors and self-esteem improved significantly, although the gains in target behaviors were greater for the EMDR group at follow-up. Additional rigorous RCTs are needed to explore further the remediation of negative behaviors and increases in self-esteem subsequent to treatment, as well as provide long-range evaluation of the participants' consequent life trajectories.

The positive effects for EMDR with children obtained in the preceding RCTs are consistent with evidence from 13 nonrandomized studies. Of particular interest in this research are the studies evaluating efficacy in relation to age and single-session treatment. Hensel (2009) reported the results of one to three EMDR treatment sessions with 36 children between ages 2 and 18 years who had experienced a single traumatic event. Substantial benefits were reported at posttreatment and follow-up observation, with comparable improvement regardless of age. Additionally, Puffer,

Greenwald, and Elrod (1998) reported the results of a delayed treatment comparison in which 17 of 20 children with symptoms from a single traumatic incident evidenced significant improvement after one session. It will be important to substantiate the outcomes of these studies with a wide range of standardized measures in rigorous RCTs.

Another area of importance for future research stems from the reports in noncontrolled studies of the substantial treatment effects obtained with children after as few as one 50- to 60-minute session using the EMDR Integrative Group Treatment Protocol (EMDR-IGTP; Jarero et al., 2006). Several EMDR-IGTP therapy studies have obtained positive results with respect to trauma symptoms after natural or man-made disasters (Aduriz, Bluthgen, & Knopfler, 2009; Fernandez, Gallinari, & Lorenzetti, 2004; Jarero, Artigas, & Hartung, 2006; Jarero, Artigas, & Lopez-Lena, 2008). In addition, a nonrandomized trial with Palestinian children (Zaghrout-Hodali, Alissa, & Dodgson, 2008) reported that four sessions of the group-administered EMDR protocol were sufficient to eliminate PTSD symptoms, reduce behavioral problems, and increase resistance to the effects of subsequent trauma. Given the dire consequences of childhood trauma for both present and future generations (see Shapiro, 2014b), it is vital to evaluate this group protocol with RCTs to confirm that treatment can be administered efficiently and effectively in the aftermath of disasters and in war-torn regions.

Several case studies have shown that EMDR therapy can successfully treat PTSD symptoms in children (as well as adults) with intellectual disabilities, even in cases of comorbid autism spectrum disorder (ASD; e.g., Barol & Seubert, 2010; Mevissen, Lievegoed, & De Jongh, 2011; Mevissen, Lievegoed, Seubert, & De Jongh, 2012; Mevissen, Didden, & De Jongh, 2016). These outcomes should be thoroughly investigated in multiple baseline studies with large samples, in addition to other controlled studies. Furthermore, the AIP model hypothesizes that EMDR processing can catalyze learning to build intrapsychic structures and help incorporate the social education required by those with developmental deficits. Examination of such development is needed, and could potentially be measured by interpersonal and behavioral changes.

While EMDR therapy has been validated in the treatment of PTSD across the lifespan, its clinical use has also been extended to a broad array of other symptoms and functional problems, including generalized anxiety disorder, separation anxiety, phobias, depression, disruptive mood disorder, adjustment disorders, ASDs, and poor self-concept. RCTs are needed to investigate further the effects of EMDR therapy on these symptoms. Furthermore, children with complex trauma symptoms typically have experienced multiple adverse events during their formative years. As a result, they frequently suffer from a broad array of dysfunction, including affect dysregulation, negative beliefs about themselves and others, disturbed attachment patterns, behavioral regressions, and aggressive behaviors. Although

not necessarily meeting the formal criteria for PTSD, they may have some combination of comorbid diagnoses that can include generalized anxiety disorder, disruptive mood dysregulation disorder, oppositional defiant disorder, ADHD, or reactive attachment disorder. RCTs are needed to explore all of these areas in children with or without Complex PTSD.

A case series (Wesselmann, Schweitzer, Armstrong, Davidson, & Potter, in preparation) evaluated 23 children who were suffering from complex trauma due to maltreatment and foster or orphanage care and were now residing in out-of-home, permanent placements. Results indicated that by means of outpatient integrative EMDR and family therapy that included an EMDR resource development activity to strengthen trust and connection with caregivers, the majority improved measurably with 6 months of treatment in terms of scores on attachment, traumatic stress, and behavioral measures. All of the children continued with integrative treatment until most scores reached nonclinical levels (at approximately 1 year, on average). Separate case studies show similar effects with abused and neglected children in out-of-home placements who have been treated with integrative EMDR and family therapy (e.g., Wesselmann, 2013; Wesselmann et al., 2012). These promising findings should be further evaluated with long-term follow-up studies. Also of interest are two evaluations by Jarero, Roque-López, and Gómez (2013; Jarero, Roque-López, Gómez, & Givaudan, 2014) of week-long, multimodal residential programs for children with severe interpersonal trauma in which group and individual EMDR therapy, as well as resource building activities were implemented in a phase-based approach (Courtois & Ford, 2009). The investigators reported substantial decreases of trauma symptoms, which were maintained at follow-up. Independent evaluations of these integrative program protocols are needed.

Rigorous RCTs are needed to explore the impact of EMDR therapy on complex trauma in children and to identify specific factors and components of treatment associated with the greatest symptom reduction. Further studies are needed to investigate the impact of Preparation Phase strategies such as EMDR resource development activities that might stabilize children who reside in residential care, foster care, or juvenile detention facilities. Research is also needed to determine the effects of EMDR therapy on the functioning of adolescent parents and parents who are involved with the child welfare system. Considering the devastating impact of childhood adverse events on long-term health, longitudinal studies with maltreated children who received EMDR therapy could identify whether EMDR therapy has a positive effect on health and wellness through the lifespan.

Adults with PTSD

Three RCTs assessing the effects of EMDR therapy with civilian adults suffering from a single-event trauma have established that approximately 5 hours of treatment results in 84–100% remission of PTSD (Marcus et al.,

1997, 2004; Rothbaum, 1997; Wilson et al., 1995, 1997). These studies have established the baseline expectation for EMDR therapy outcomes in clinical practice across the lifespan. While single traumas can be effectively treated in one to three processing sessions without homework, the amount of treatment time for multiply traumatized populations depends upon the number of adverse life experiences to be processed and the amount of preparation time to address affect instability.

Research has also shown comparable EMDR treatment effects whether sessions last 90 minutes or only 50 minutes. Two of the RCTs of single-trauma survivors found that 84–90% of participants lost their PTSD diagnosis after three 90-minute sessions (Rothbaum, 1997; Wilson, Becker & Tinker, 1997). Likewise, an EMDR study performed at Kaiser Permanente (Marcus et al., 1997, 2004) found that six 50-minute sessions eliminated PTSD in 100% of single-trauma victims and 77% of multiple-trauma victims. The difference in outcomes between single- and multiple-incident trauma survivors underscores the need to provide sufficient treatment depending upon the complexity of the individual client. The need for sufficient treatment time is also indicated in a National Institute of Mental Health (NIMH) study (van der Kolk et al., 2007) that compared the effects of eight sessions of EMDR therapy on PTSD symptoms and depression versus 8 weeks of treatment with the antidepressant drug fluoxetine. EMDR therapy produced a greater decrease than did the drug regimen, and at follow-up, 88% of the EMDR group no longer met the criteria for PTSD diagnosis, as compared to 73% for the fluoxetine group. Additionally, 58% of the EMDR group was completely asymptomatic, in contrast to 0% of the fluoxetine group. However, this research also highlighted the importance of looking beyond the PTSD diagnosis and investigating a wide range of treatment effects. Although the investigators found no statistical difference between adult- and child-onset groups in terms of the percentage who had lost their PTSD diagnosis when measured at the 6-month follow-up (91.7 and 88.9%, respectively), there was a large difference in the percentage that was completely asymptomatic at that time (75 vs. 33.3%). This research underscores the importance of investigating the comprehensive clinical picture and affording sufficient treatment time to address the wide range of adverse life experiences that may impede client functioning, particularly for those suffering from childhood trauma. The Adverse Childhood Experience (ACE) checklist (see Appendix A) is highly recommended for screening and treatment purposes, and identification of potential targets.

Another RCT (Hogberg et al., 2007, 2008) highlights the need to assess specific clinical complaints in order to determine the appropriate treatment dose. Five sessions of EMDR resulted in the loss of PTSD diagnosis in 67% of the clients. To explain this relatively low remission rate compared to other EMDR RCTs, it is only necessary to examine the nature of the problems that confronted the participants, many of whom were train conductors or staff involved in "under the train" accidents, potentially witnessing

death and a sense of moral injury. As with combat veterans, issues involving a sense of responsibility for the death of another should be evaluated in studies using sufficient treatment time. Future research should more closely examine this issue to determine the optimal length of treatment.

Several meta-analyses of studies in which EMDR therapy was compared to trauma-focused cognitive behavior therapy (CBT) in terms of the reduction of PTSD symptoms have obtained comparable effect sizes (e.g., Bisson et al., 2013; Ho & Lee, 2012; Watts et al., 2013). It is important to note, however, that while the therapies appear to be clinically equivalent, EMDR is the more efficient of the two, as seen in the fact that CBT typically entails 1–2 hours of homework daily, while EMDR therapy generally requires only a few moments (see Schnyder & Cloitre, 2015). CBT prescribes specific tasks related to cognitive assessment and/or exposure, while EMDR homework involves only noting the occurrence of disturbance and, if needed, practicing an affect regulation technique. A meta-analysis (Kazantzis, Whittington, & Dattilio, 2010) revealed a significant contribution of homework to CBT, while a meta-analysis of RCTs for the treatment of PTSD (Ho & Lee, 2012) indicated that "EMDR achieves its results without copious hours of homework which is an essential part of TFCBT" (pp. 258–259).

Research to date has shed light on both the efficacy and efficiency of treatment in direct comparisons of EMDR therapy with various standard CBT treatments using general trauma populations. A more detailed overview of these studies is given since CBT constitutes the dominant paradigm in many countries and has long been considered a validated standard trauma treatment. Three RCTs have compared the effects of EMDR therapy and prolonged exposure (PE) therapy. Rothbaum, Astin, and Marsteller (2005) examined the effects of both treatments with 74 adult female rape victims. Although the EMDR group was significantly worse at pretest, both groups demonstrated equivalent declines on all measures from pretest to posttest and at 6-month follow-up. The PE group received standard in-session treatment plus imaginal and *in vivo* exposure homework. However, as reported by the researchers, "An interesting potential clinical implication is that EMDR seemed to do equally well in the main despite less exposure and no homework. It will be important for future research to explore these issues" (p. 614). A small RCT (Johnson & Lubin, 2006) reported the effects of 10 sessions of PE (plus homework) versus six sessions of EMDR, using nine participants in each condition who were also receiving ongoing supportive individual psychotherapy. Results indicated equal positive effects on trauma symptoms. Ironson et al. (2002) reported that both treatments produced significant reductions in PTSD and depression symptoms. This is the only research on the comparison of EMDR and exposure therapy in which *in vivo* homework (e.g., returning to the location where the traumatic event had occurred) was included in the EMDR condition. The study found that 70% of EMDR participants

achieved good outcomes in three active treatment sessions as compared to 17% of those in the PE condition. The EMDR condition also experienced fewer dropouts (0 vs. 30%).

Two RCTs compared the effects of EMDR and composite CBT conditions. Lee, Gavriel, Drummond, Richards, and Greenwald (2002) reported that both EMDR and stress inoculation therapy plus PE (SITPE) produced significant improvements. EMDR was significantly superior on all measures at 3-month follow-up. The EMDR condition used 3 hours of homework, compared to 28 hours for SITPE. Power et al. (2002) compared EMDR to imaginal exposure and *in vivo* exposure therapy plus cognitive restructuring (with daily homework) and reported that both treatments produced significant improvement. EMDR was more beneficial for depression and social functioning, and required fewer treatment sessions. Subsequent reevaluation of the data (Karatzias et al., 2007) indicated additional superiority for EMDR on the trauma measure. In an RCT, Nijdam, Gersons, Reitsma, de Jongh, and Olff (2012) evaluated the response pattern and efficacy of EMDR as compared to brief eclectic psychotherapy (BEP). They reported that both treatments were effective but that EMDR resulted in faster recovery, with a 92.2% elimination of PTSD in the EMDR group versus 47.7% in the BEP group at the first assessment (at approximately six sessions).

Two studies have reported superior effects for CBT. One RCT (Taylor et al., 2003) compared an EMDR therapy condition of eight processing sessions and no homework (except for the use of the Safe Place exercise if needed) with a CBT treatment condition. The investigators used a protocol based on Marks et al. (1998) consisting of four sessions of imaginal exposure and four sessions of therapist-assisted *in vivo* exposure, together with approximately 50 hours of imaginal exposure and *in vivo* exposure homework. The only other study with a superior CBT outcome was conducted by the developer of the control condition who also acted as the primary therapist (Devilly & Spence, 1999). This study is often excluded from treatment evaluations due to poor randomization (e.g., International Society for Traumatic Stress Studies [ISTSS] 2000 Practice Guideline; Chemtob et al., 2000) and demonstrated other deficiencies (e.g., inadequate fidelity; see Table 12.1).

In summary, six out of eight studies, using participants from a variety of trauma populations, have reported that EMDR therapy produces effects comparable to various CBT treatments while using no homework and/or fewer sessions. Future studies should investigate these differences to ascertain potential effects on treatment motivation, retention, and recovery patterns. As indicated in the WHO practice guidelines (2013), although trauma-focused CBT and EMDR are the only psychotherapies recommended for children, adolescents, and adults with PTSD, there are distinct procedural differences. According to these guidelines, "Like CBT with a trauma focus, EMDR aims to reduce subjective distress and strengthen

adaptive cognitions related to the traumatic event. Unlike CBT with a trauma focus, EMDR does not involve (a) detailed descriptions of the event, (b) direct challenging of beliefs, (c) extended exposure, or (d) homework" (p. 1). These differences have important clinical implications, since all exposure to the trauma takes place within the affect-regulating presence of the therapists. In addition, the differences have important implications for potential mechanisms of action. For instance, an RCT comparing single-session treatments with EMDR and exposure therapy using combat veterans (Rogers et al., 1999) reported a different response pattern involving a substantially greater reduction of distress in the EMDR condition. Another first-session RCT analysis (Ironson et al., 2002) comparing EMDR and PE reported similar differences, with greater reductions in distress for the EMDR condition.

These two studies indicate different mechanisms of action (i.e., reconsolidation and extinction, as discussed earlier) and the possibility of encouraging client retention because of the rapid treatment effects. The low dropout rates for EMDR therapy RCTs also suggest the presence of strong treatment efficacy. For example, in a study that entailed 12 sessions with multiply traumatized Vietnam veterans, Carlson et al. (1998) reported a dropout rate of zero (and a remission rate of 78%). These results differ dramatically from the approximately 35% elimination of the PTSD diagnosis and approximately 25% dropout rate reported with CBT military treatments (Steenkamp, Litt, Hoge, & Marmar, 2015; see also the section "Treatment of Military Personnel" later in this chapter).

RCTs of the treatment of PTSD evaluated in a meta-analysis (Bradley et al., 2005) reveal a median EMDR therapy completion rate of 92%. However, two "outlier" studies (Devilly & Spence, 1999; Devilly et al., 1998) reported only an average retention rate of 66.5%. When these two studies are eliminated, the mean completion rate for the remaining studies is 94.3%. These two RCTs were also evaluated as having inadequate fidelity in a meta-analysis (Maxfield & Hyer, 2002) that reported a positive correlation between treatment fidelity and therapeutic efficacy (see Table 12.1 and the ISTSS practice guidelines; Chemtob et al., 2000). In addition, despite the compromised means mentioned earlier, a meta-analysis by Swift and Greenberg (2014) reported that EMDR therapy has a lower rate of premature discontinuation than any of the other trauma-focused therapies evaluated (i.e., full CBT, cognitive processing therapy [CPT], exposure). Nevertheless, these findings indicate the need for expert fidelity evaluations in future RCTs, which should rigorously investigate additional parameters of treatment, including the comparative efficacy of daily and weekly treatment regimens, as well as applications with a variety of specialty populations (see the following sections). Research should also specifically address the new DSM-5 PTSD criteria, including the amelioration of affects such as anger, guilt and shame, as well as behavioral reactivity (i.e., destructive or risky behavior).

Other noteworthy research involves the treatment of complicated mourning in a multisite study (Sprang, 2001) in which EMDR therapy was found to reduce symptoms significantly more than did CBT treatment ("Guided Mourning") on behavioral measures and four out of five psychosocial measures. EMDR therapy was also more efficient, producing change at an earlier stage and requiring fewer sessions (6 vs. 11). Of particular interest was that positive recall of the deceased was substantially greater for the EMDR condition at both posttreatment and follow-up. These outcomes have important implications for the treatment of those dealing with the loss of loved ones, including specialized populations such as the survivors of natural disasters and combat veterans. The finding that positive recall of the deceased increases subsequent to treatment should be further investigated with RCTs that make use of the protocol for excessive grief described in Chapter 9. And, as discussed previously, this observation may also implicate different mechanisms of action (i.e., reconsolidation and extinction). It is posited here that EMDR therapy functions by means of reconsolidation, which has the effect of altering the targeted memory. However, the original memory of the traumatic event in the kind of exposure therapy used in the Sprang (2001) study is posited to leave the trauma memory intact, with the result that it may continue to inhibit positive recall.

Another important area of investigation involves the treatment of sleep disturbance, a prominent symptom of PTSD that has been reported to be resistant to treatment (Spoormaker & Montgomery, 2008). EMDR therapy includes directly targeting both the trauma and the nightmare image itself. Clinical reports indicate the rapid amelioration of nightmares (e.g., Pellicer, 1993; Woo, 2014), and studies have revealed improved quality of sleep as measured by questionnaires, polysomnographic recordings (Raboni, Tufik, & Suchecki, 2006; Raboni et al., 2014), and the reduction of nightmares (Silver, Brooks, & Obenchain, 1995). RCTs are needed in which EMDR therapy is compared to other standard treatments such as imagery rehearsal (Casement & Swanson, 2012).

Treatment of Military Personnel

As is the case with any multiply traumatized population, ensuring sufficient treatment time when dealing with military populations is also vital. Although, as previously reported, single-trauma victims can be adequately treated within three 90-minute sessions, this is not always the case with combat veterans who have suffered numerous traumatic experiences. While EMDR RCT research with military populations has been severely hampered by inadequate treatment doses and fidelity, clear contrasts are observable when using a 12-session RCT (Carlson et al., 1998) as a benchmark. This treatment dose resulted in a 78% PTSD remission rate and zero dropouts as compared to the limited outcomes obtained when only two sessions are used (e.g., Devilly et al., 1998; Jensen, 1994) or in component

analyses in which only one memory is treated (e.g., Boudewyns & Hyer, 1996; see also Table 12.1).

As noted in the WHO (2013) guidelines and the American Psychiatric Association Practice Guidelines (2004, p. 18), in EMDR therapy, "traumatic material need not be verbalized; instead, patients are directed to think about their traumatic experiences without having to discuss them." Given the reluctance of many combat veterans to divulge the details of their experience (Rogers & Silver, 2002), this fact is relevant to their willingness to initiate treatment, retention of diagnosis, and therapeutic gains. It may also be one of the causes of the low remission (60–72% retain their PTSD diagnosis posttreatment) and high dropout rates (approximately 25%) reported in a review of military RCTs by Steenkamp et al. (2015) when CBT procedures (PE or CPT) are used. In contrast, as described previously, in an RCT, Carlson et al. (1998) found that after 12 EMDR therapy sessions, 77.7% of the combat veteran participants no longer met the criteria for PTSD. There were no dropouts, and effects were maintained at 3- and 9-month follow-up. All other RCTs of veterans have used insufficient treatment doses to assess PTSD outcomes (e.g., two sessions and/or treated only one memory; see ISTSS Practice Guidelines, Chemtob et al., 2000; DVA/DoD, 2004). As mentioned previously, there must be adequate treatment time for multiply traumatized veterans (e.g., Russell, Silver, Rogers, & Darnell, 2007). However, of interest here is a process analysis (Rogers et al., 1999) using inpatient veterans, which compared a session of EMDR therapy to one of exposure therapy. The result was a difference in recovery pattern for the two treatments, in which the EMDR group evidenced a decline in self-reported distress (i.e., SUD levels), whereas exposure led to an increase. Future RCTs should further investigate both process differences and treatment outcomes by directly comparing EMDR and CBT during a full course of treatment.

Positive effects have been reported in uncontrolled studies of DVA and DoD programs and deserve further evaluation. An analysis of an inpatient veterans PTSD program (n = 100) found EMDR to be superior to biofeedback and relaxation training on seven of eight measures (Silver et al., 1995). Russell et al. (2007) evaluated 72 active-duty military personnel, 48 of whom were diagnosed with combat PTSD, and reported that positive pre–post changes were significant on all measures. A recent program evaluation of active duty military (McLay et al., 2016) compared various forms of treatment and reported: "Results indicated that patients receiving EMDR had significantly fewer therapy sessions over 10 weeks but had significantly greater gains in their PCL-M [PTSD Checklist–Military] scores than did individuals not receiving EMDR" (p. 702). Therefore, rigorous controlled research of veterans and active duty personnel comparing EMDR with other treatments in inpatient and outpatient programs is highly recommended with military populations in a variety of contexts. For instance, since EMDR therapy utilizes no homework to achieve its effects, it may be particularly suited for frontline treatment, as indicated in the rapid

alleviation of symptoms in consecutive 1- to 4-day sessions with veterans of the Iraqi War (Russell, 2006; Wesson & Gould, 2009). Furthermore, the prevalent somatic and chronic pain problems experienced by combat veterans indicate the need for additional research regarding the reported amelioration of medically unexplained symptoms (see Russell, 2008a) and the elimination of phantom limb pain (Russell, 2008b; Shapiro, 2014a; see the section "Diverse Somatic Conditions").

The ability of EMDR to simultaneously address PTSD, depression, anger, shame, guilt, and pain can have distinct benefits for military treatment providers and should be investigated further. In addition, given the positive treatment effects with those suffering from moral injury (Hurley, 2016a; Russell & Figley, 2013) research should investigate potential differences in treatment when comparing military personnel with and without this condition. Another area that deserves attention and rigorous RCTs is the further investigation of the positive treatment outcomes reported with those suffering from military sexual trauma (Hurley, 2016b). Current observations regarding the use of daily sessions with military personnel indicate that therapy can be completed within 1 to 2 weeks, depending on the number of deployments (Hurley, in press-b). Further, a direct comparison of daily and weekly treatment regimens (Hurley, in press-a) reported comparable substantial decreases on the IES (pre—53, post—17) that were maintained at 1-year follow-up. RCTs are needed to further investigate all these areas of interest.

Given the difficulties discussed previously in the context of the early military studies on EMDR therapy, it should be emphasized that rigorous RCTs with proper attention to treatment fidelity and sufficient treatment dose are of vital concern. Future RCTs with military populations should conform to the 12-session standard generally used in CBT research (see Steenkamp et al., 2015). Although substantial reductions of distress can be obtained from processing one memory within one to three sessions, comprehensive treatment effects discernible by means of standardized PTSD measures generally necessitate a longer course of treatment in this multiple-trauma population. Adequate treatment fidelity should be assessed by EMDR experts experienced in the treatment of military trauma (see Russell & Figley, 2013). Given the potentially severe emotional and physical consequences of unhealed trauma and research indicating that veterans with PTSD are twice as likely to develop dementia as those without this diagnosis (Yaffe et al., 2010), it is vital that the most effective and efficient treatments are disseminated to treat this population.

Complex PTSD

There is current debate about the treatment of complex PTSD, which is not designated as a separate category in DSM-5, but has been proposed in the WHO ICD-11 (Maercker et al., 2013). In addition to symptoms of

PTSD in the four delineated DSM-5 clusters (reexperiencing, avoidance, negative cognitions and mood, and arousal), complex PTSD highlights the existence of pronounced disturbances in three areas: (1) affect regulation, (2) self-concept, and (3) relational domains. Research involving 20 WHO population surveys of 51,295 individuals reported that "a risk threshold was observed in this large-scale cross-national database wherein cases who associated their PTSD with four or more [traumatic events] presented a more 'complex' clinical picture with substantially greater functional impairment and greater morbidity [e.g., higher comorbidity with mood and anxiety disorders, elevated hyper-arousal symptoms] than other cases of PTSD" (Karam et al., 2014, p. 130). Other research has supported these findings, and an ISTSS expert clinician survey (Cloitre et al., 2011) recommended a phase-based approach with preparation before engaging in trauma processing. However, the guidelines have recently been disputed (De Jongh et al., 2016) based on the claim of inadequate research. The authors maintain that evidence currently fails to support the contention that a history of interpersonal childhood trauma or the presence of symptoms belonging to complex PTSD are contraindications for traditional PTSD treatment, and need to be preceded by a Stabilization Phase. They argue that deviating from the existing general recommendations of individual trauma-focused treatments as first-line interventions for PTSD is neither necessary nor expedient. Arguments include the comparable effects obtained in RCTs comparing CBT and controls such as present-centered therapy. It is clear that more research must be conducted to settle this dispute. (For overviews and suggested research on both sides of the argument, see Cloitre, 2015, 2016; De Jongh et al., 2016).

Meanwhile, given the potentially long delay before the matter is resolved, it is useful to look at absolute numbers. For instance, an RCT (McDonagh et al., 2005) that is often cited as support for the efficacy of CBT with complex PTSD and argues in favor of no preparation reported an intention-to-treat analysis with only a 27.6% remission rate and a 41% dropout rate. Clearly, the former is low and the latter high compared to what one would like to see in clinical practice. Additionally, a meta-analysis of CBT RCTs with child abuse victims (Dorrepaal et al., 2014) demonstrated the need for affect management procedures, as exposure alone resulted in low remission rates and a mean dropout rate of 32%.

The standardized procedures of EMDR therapy include a Preparation Phase that is customized to the individual needs of the client. A meta-analysis (Ehring et al., 2014) of three EMDR RCTs of adult survivors of child abuse that involved two to eight treatment sessions and 0–17% dropouts (Edmonds & Rubin, 2004; Scheck, Schaeffer, & Gillette, 1998; van der Kolk et al., 2007) reported that the effect sizes ranged from 1.24 to 2.75. All three studies used the standardized EMDR therapy procedures during the Preparation Phase that included a Safe Place exercise. However, it will be important in future research to use a wide range of measures

with participants diagnosed with Complex PTSD. These measures should comprehensively evaluate psychosocial functioning and include assessment measures that are designed specifically for this population (see Briere & Spinazzola, 2005).

A recent study (Bongaerts, De Jongh & van Minnen, 2017) evaluated the safety and effectiveness of intensive EMDR therapy in patients with complex PTSD. The study entailed a case series of seven (three males, four females) patients suffering from PTSD and high levels of comorbidity as a result of multiple childhood sexual abuse, physical abuse, and work- or combat-related trauma. Treatment was not preceded by a Preparation Phase and consisted of two EMDR therapy treatment periods on 4 consecutive days for 2 consecutive weeks. It was administered to participants at the treatment center in 90-minute morning and afternoon sessions, interspersed with psychoeducation and intensive physical activity (totaling 11 hours per day). Participants slept at the center during the two treatment periods and returned home on the intervening weekend. During treatment no personal adverse events or dropouts were reported. At follow-up, four of the seven patients revealed a loss of diagnosis, with two in full remission (loss of diagnosis plus a CAPS severity score < 20). The remaining patients demonstrated a Clinician-Administered PTSD Scale (CAPS) score reduction of 10 points or more. The results of this study suggest that intensive EMDR therapy under the conditions described has the potential to be a safe and effective treatment alternative for those with complex PTSD. Future RCTs should rigorously investigate these and other, similar programs. However, given the combination of modalities, 11 hours of daily contact, and sleeping arrangements, these conditions most resemble inpatient treatment, which provides containment and stabilization factors not found in typical outpatient therapy. Future research with participants with complex PTSD should evaluate the level of stability and distress experienced between sessions, both in protected inpatient environments using consecutive-day treatment and in general clinical practice, where clients regularly return to home environments with an array of potentially triggering situations.

Future EMDR therapy studies should investigate procedures best suited to enhance retention and affect regulation, as well as establish benchmarks to determine the optimal length of preparation with respect to specific clinical indicators. The goal of the Preparation Phase is to enable clients to maintain stability during processing and between sessions. Therefore, future studies should evaluate various strategies to see how rapidly these results can be obtained. As indicated in Chapter 11, clients with complex PTSD demonstrate greater instability than those in the general trauma population. However, it is preferable to begin memory processing as soon as it can safely proceed, since according to the AIP model, the affect dysregulation is being caused by the unprocessed memories. Research should identify outcomes that are currently attainable with the Safe/Calm Place exercise and with RDI (Korn & Leeds, 2002) during the Preparation Phase, both

with and without BLS, and in comparison to other forms of stabilization procedures using appropriate measures (e.g., Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006; Gratz & Roemer, 2004). It would also be useful to determine the affects and behaviors that are most beneficial to incorporate during initial phases of treatment with this population as compared to those with simple PTSD. Procedural variations, such as initial targeting of adult memories in a symptom-based approach versus using a chronological approach that first addresses childhood trauma (see Korn, 2009), should be investigated in relation to both treatment outcomes and retention. Research should also investigate clinical indicators to determine when it is best to incorporate more complex stabilization programs such as Skills Training in Affective and Interpersonal Regulation (STAIR; Cloitre et al., 2002) or dialectical behavior therapy (DBT; Linehan, Tutek, Heard, & Armstrong, 1994). It is also vital to employ fidelity checks in this population. Further, it is important that adequate treatment time be used in RCTs aimed at comprehensively assessing outcomes of overall treatment, and/or the contributions of the Preparation and Processing Phases. The allotted time must be sufficient to take into account clinical realities of this multiply traumatized population, rather than implementing short-term studies that offer little hope of revealing significant clinically relevant differences.

Elderly Adults

The successful use of EMDR therapy with children is mirrored by its effectiveness with those on the other end of the lifespan. Elderly individuals, defined here as those 65 years of age and older, have been reported to experience PTSD symptom remission after two to three sessions using standard EMDR procedures and protocols. These results have been reported for elderly adults suffering from the trauma of warfare (Thomas & Gafner, 1993), sexual abuse (Hyer, 1995), and automobile accidents (Burgmer & Heuft, 2004) and are comparable to those achieved with patients under 65 year of age (e.g., Wilson et al., 1997). Additionally, a case study (Hyer, 1995) reported the elimination of PTSD symptoms and improved cognitive function in a 72-year-old rape survivor who suffered from dementia. He speculated that older clients might be well suited to benefit from EMDR therapy "because it is a more active form of reminiscence [which] allows the client to participate in the past as currently real *and* to evaluate the unfolding of the process from an observer perspective" (p. 73). Burgmer and Heuft (2004) reported the elimination of PTSD, depression, chronic neck pain, and severe headaches experienced for 2 years by a 71-year-old woman who had been involved in an auto accident. They concluded that although "elderly patients may be less 'psychologically minded' and therefore less amenable to psychological treatment . . . EMDR proves to be an effective and efficient trauma-specific treatment method in older patients, also helping to reestablish psychosocial functioning of the affected elderly person" (p. 187).

An interesting speculation that emerges from the preceding clinical observations is the possibility that chronic pain and dementia in elderly adults entail unresolved traumas and can thus be ameliorated by focused EMDR processing. In this vein, an important case series conducted in a nursing home (Amano & Toichi, 2014) reported the successful treatment of behavioral and psychological symptoms of dementia (BPSD) in three patients with moderate-to-severe dementia caused by cerebrovascular disease or Alzheimer's disease. They conjectured that pronounced symptoms (e.g., screaming, wandering, physical aggression) were evidence of previous trauma and related to PTSD symptoms. The eight phases of EMDR therapy were modified because of the patients' severe disabilities, and since patients with dementia cannot control their recollections, an "on-the-spot EMDR method" was used when psychological or behavioral disturbance emerged. The investigators administered two to four sessions of a modified EMDR protocol that is similar to those that have been used with children (e.g., employing simple words and tapping as BLS). This treatment "led to a marked improvement of BPSD in two patients and possibly had a strong influence in the relief of symptoms in a third patient" (p. 63). These effects were maintained at 6-month follow-up. Rigorous RCTs are needed to investigate further the application of this protocol with the older adult population. Given that PTSD has been shown to be a risk factor in dementia (e.g., Yaffe et al., 2010), this area of investigation has important implications for the aging population worldwide.

Disaster Response Research

Despite the difficulties in conducting research during this chaotic and vulnerable time, there is a growing body of literature investigating the use of the standard EMDR protocol and EMDR early interventions (EEIs) following both natural and man-made disasters. Given the wide range of protocols, this section will evaluate the current research on each. Detailed descriptions of most of the interventions can be found in Chapter 9, and clinical suggestions for disaster relief projects are presented in Chapter 11.

INDIVIDUAL PROTOCOLS

EMDR Standard Protocol

The effectiveness of the EMDR standard protocol for postdisaster relief has been validated in three RCTs, one partially controlled study, and one uncontrolled field trial. An RCT by Chemtob, Nakashima, Hamada, and Carlson (2002) administered three EMDR sessions to 32 children who met the criteria for PTSD 3½ years after experiencing a hurricane, despite having received another (unspecified) form of therapy the previous year that had been effective for a large majority of the treated children. EMDR therapy resulted in substantial decreases in PTSD symptoms, as well as more

modest reductions in anxiety and depression, which were maintained at 6-month follow-up. Fifty-six percent of the children no longer met criteria for PTSD at follow-up. In addition, reported visits to the school health nurse decreased after treatment. Another RCT (de Roos et al., 2011) randomly assigned 52 children (ages 4–18) 6 months after an explosion at a firework factory to either EMDR therapy or CBT. Equivalent significant reductions were demonstrated on measures of PTSD, depression, anxiety, and behavioral problems, with results maintained at 3-month follow-up. EMDR treatment ranged from two to five sessions and was found to be more efficient than CBT in that its treatment gains were reached with fewer sessions. In another RCT (Grainger, Levin, Allen-Byrd, Doctor, & Lee, 1997), 40 adult victims were treated 2 to 3 months after a hurricane with one EMDR session. Compared to a wait-list control group, the treatment group showed significant improvement on the Impact of Event Scale (IES) and fewer negative reactions to experiences that were reminiscent of the hurricane. Means on these measures declined from severe clinical to subclinical levels at posttest, and gains were maintained at 1- and 3-month follow-ups. The standard EMDR protocol was also used 17 months after a large earthquake in Turkey to treat an estimated 1,500 victims with PTSD still residing in tent cities (Konuk et al., 2006). In a partially controlled field study evaluating a representative sample of 41 participants from this population, symptoms were eliminated in 92.7% of those treated after an average of five 90-minute sessions. The remaining survivors experienced a reduction in symptoms. Treatment effects were maintained at the 6-month follow-up. In another humanitarian program, Fernandez (2007) treated 32 children with six EMDR sessions following a building collapse as a result of an earthquake in Italy. PTSD symptoms rated on a PTSD checklist prepared by the National Institute of Health dropped from an initial 61 to 29% after treatment, then to 9% at 6-month follow-up.

Recent Traumatic Events Protocol

The Recent Traumatic Events Protocol (REP; Shapiro, 1995a, 2001) was evaluated following the terrorist attacks on the World Trade Center on September 11, 2001 (Silver, Rogers, Knipe, & Colelli, 2005). Using an analogue wait-list design, 65 adults who requested treatment for trauma symptoms directly related to the event (e.g., lost loved ones, witnessed the event, served as a rescue worker) were provided with a mean of four EMDR REP sessions. Three groups were evaluated separately, with treatment ranging from 2 to 48 weeks following the attack. Equally substantial treatment effects were reported in all three groups, as measured by the Impact of Event Scale—Revised (IES-R), the Beck Depression Inventory (BDI), and the Beck Anxiety Inventory (BAI), all of which decreased to mild or subclinical levels. The last of the three groups, which received treatment 30–48 weeks after the attack, initially presented as more disturbed than did the two earlier treatment groups, suggesting that the longer treatment is delayed, the greater the

level of disturbance experienced. However, comparable treatment effects were demonstrated in all three groups. An RCT with 60 victims of workplace violence (Tarquinio et al., 2016) compared single 1.5- to 2-hour sessions of immediate REP, delayed REP, and Critical Incident Stress Debriefing (CISD; Mitchell & Everly, 1997). The immediate REP and CISD sessions were administered 48 hours after the incident and the delayed REP after an additional 48 hours. At posttest and 3-month follow-up the EMDR conditions proved significantly superior to CISD as measured by the Posttraumatic Stress Disorder Checklist Scale (PCLS) and SUD scores. At follow-up none (0 out of 37), of the EMDR-treated participants had PTSD compared to no change (18 out of 23) in the CISD condition. Additional RCTs are needed to evaluate effectiveness and optimal treatment times.

EMDR Protocol for Recent Critical Incidents

The EMDR Protocol for Recent Critical Incidents (EMDR-PRECI; Jarero et al., 2011) can be used for an extended post-disaster period and addresses situations in which there is ongoing trauma and therefore no subsequent period of safety. In an RCT by Jarero et al. (2011), 18 adults were treated 15–30 days following an earthquake by means of a single (80- to 130-minute) session of EMDR-PRECI. Despite frequently occurring aftershocks, both an immediate-treatment group and a delayed-treatment control group showed substantial (30 points) reductions of trauma symptoms on the IES, effects that were maintained at a 12-week follow-up. Following a lethal factory explosion, Jarero, Uribe, Artigas, and Givaudan (2015) administered EMDR therapy to 25 survivors in an RCT using a delayed treatment control design. Treatment was provided in two 60-minute sessions on consecutive days and within 34 days of the explosion. Initial scores for both groups were in the severe range for trauma symptoms, as measured by the Short PTSD Rating Interview (SPRINT), and declined to low levels after treatment (from 22 to 2) that were maintained at follow-up. A nonrandomized delayed treatment control design (Jarero & Uribe, 2011) evaluated the treatment of 32 forensic personnel working with the bodies evacuated after a large-scale massacre. Individuals who scored above the cutoff for PTSD on the SPRINT (> 14) were assigned to two groups: immediate treatment (severe scores) and wait-list/delayed treatment (moderate scores). Treatment with one session (90–120 minutes) of EMDR-PRECI produced significant improvement for both groups, with 3- and 5-month follow-up scores indicating a further significant reduction of symptoms despite continued exposure to extremely difficult conditions. The 5-month follow-up evaluation (Jarero & Uribe, 2012) indicated that no participants remained above the designated cutoff score for PTSD, indicating the potential utility of early treatment to prevent the development of chronic PTSD. Rigorous RCTs by independent research groups are needed to evaluate the efficacy of the protocol, the optimal time for intervention, and the long-term impact on the prevention of mental health issues postdisaster.

Recent Traumatic Episode Protocol

The Recent Traumatic Episode Protocol (R-TEP; E. Shapiro & Laub, 2008) is an individual early intervention for critical episodes with traumatic aftermath. The R-TEP usually requires two-to-four sessions and can be optionally conducted on consecutive days. A wait-list controlled pilot RCT (Acarturk et al., 2015) evaluated the effects of four sessions of R-TEP with 29 adult refugees living in camps at the Syrian–Turkish border and reported significant decreases in trauma symptoms and depression at posttest. An RCT was conducted with another group of 70 refugees from the same camp (Acarturk et al., 2016). All participants met the criteria for PTSD on assessment and demonstrated a significant reduction of PTSD and depression symptoms at posttreatment and at the 5-week follow-up. At follow-up, 49% were no longer diagnosed with PTSD. E. Shapiro and Laub (2015) tested the efficacy of R-TEP 6 weeks after a community crisis in which a missile fell in a crowded area. Using an RCT/delayed treatment control, 17 survivors were treated with two sessions of R-TEP on consecutive days. Both groups demonstrated substantial improvement posttreatment on the IES-R (20-point decline), which was maintained and continued to improve at a 3-month follow-up. A significant decrease in depression was demonstrated at follow-up only. Additional RCTs are needed to examine further the efficacy of this intervention and to determine the optimal length of treatment.

Group Protocols

EMDR Integrative Group Treatment Protocol

The EMDR Integrative Group Treatment Protocol (EMDR-IGTP) (Jarero et al., 2006) uses a group therapy format to combine the drawings of the processing targets, and the Butterfly Hug (Jarero & Artigas, 2009) as a form of a self-administered BLS. The protocol was originally designed to be used with children (Artigas, Jarero, Alcalá & López Cano, 2014) and later modified for adults (Jarero & Artigas, 2014). The effectiveness of the EMDR-IGTP has been evaluated with large and small groups of adult and child participants in multiple case reports, nine pilot field studies in Latin America (Jarero, Artigas, Uribe, & Miranda, 2014), and uncontrolled field studies conducted in Latin America, Europe, and the Middle East.

Following a flood in Argentina, 124 children with postdisaster PTSD were treated with one session of EMDR-IGTP (Aduriz et al., 2009). A statistically significant reduction in symptoms at posttreatment was obtained, and persisted at the 3-month follow-up. Fernandez et al. (2004) treated 236 children in Italy exhibiting PTSD symptoms 30 days after witnessing the Pirelli Building airplane crash adjacent to their school. One 90-minute session of EMDR-IGTP was provided to children in their classrooms. Teachers and parents reported that all but two children returned to normal

functioning after treatment, which was maintained at the 4-month follow up. A study of 44 children treated with a group protocol after a flood in Mexico (Jarero et al., 2006) reported that one session reduced trauma symptoms from severe to low (subclinical) levels of distress post-treatment and at one-month follow-up. In another field study, IGTP was provided to 16 children five months after their fathers had been killed in a mine explosion in Mexico (Jarero et al., 2008). Following one session of EMDR-IGTP, there was a substantial drop in trauma symptoms from high to low range on the Child's Reaction to Traumatic Events Scale, which was maintained at 3-month follow-up. The results of three consecutive-day sessions with a group of 20 adults during a geopolitical crisis (Jarero & Artigas, 2010) revealed significant decreases in IES scores posttreatment (from 49 to 22) that were maintained at 14-week follow-up despite exposure to ongoing turmoil. The protocol has also been used successfully with children in an area of ongoing violence (Zaghrout-Hodali et al., 2008) in which, after witnessing a shooting, seven children were referred for treatment because of high levels of physiological and physical distress. Four of the children had also been wounded in the attack. Substantial decreases in their distress were demonstrated after 2 consecutive-day sessions and maintained despite the occurrence of an additional violent attack at their residence. Two additional sessions addressed both incidents and resulted in SUD levels of 0–1 for both. At posttreatment and at 4- to 5-month follow-up, consultations with parents confirmed that the children were no longer disturbed and had resumed normal lives despite ongoing potentially disturbing events. The results of these studies clearly indicate that this group protocol can efficiently reduce symptoms and build resilience to ongoing trauma. Rigorous RCTs are needed to substantiate effectiveness in both of these areas, an outcome that would have major implications worldwide. Situations of mass disaster and/or ongoing crises often lend themselves to RCT/delayed treatment designs to study both treatment efficacy and optimal timing given that the demand for therapeutic services is often greater than available personnel can handle immediately.

Group Traumatic Episode Protocol

The Group Traumatic Episode Protocol (G-TEP) was presented by E. Shapiro in 2013 (Konuk & Zat, 2015) for use with groups of adults, adolescents, and older children who have experienced trauma with ongoing consequences. The G-TEP is a simplified adaptation of the R-TEP, in which BLS is provided by having the participant follow his own hand as it moves back and forth from one spot on his worksheet to another. It follows an eight-phase protocol while working with the fragmented nature of memories.

In an RCT (Yurtsever et al., submitted) 47 Syrian refugees were treated with two 2-hour sessions of G-TEP. Reported results include decreased

symptoms of trauma on the IES. Evaluation with the Mini International Neuropsychiatric Interview indicated a 55.6% elimination of PTSD diagnosis at posttest and 61% at follow-up, results that were significantly superior to those of the control group. Although depression scores decreased, as measured with the BDI, results were not significantly better than the control. A pilot study (Lehnung, Shapiro, Schreiber, & Hofmann, 2017) treated 18 Syrian refugees in a wait-list control design using two 2-hour sessions each on consecutive days. Declines in symptoms of PTSD as measured on the IES and of depression measured on the BDI are reported. However, the study is marred by a low sample size and lack of follow-up and partial randomization. The protocol was also evaluated with a sample of 529 symptomatic survivors of an earthquake, using a retrospective analysis of medical records (Saltini, Rebecchi, Callerame, Fernande Bergonzini, & Starace, 2017). The IES-R was administered and revealed that at posttest 65.8% of those treated within 1 month of the traumatic event fell below the clinical cutoff of 33. This compared to 64.02% of those treated more than a month after the incident. Unfortunately, this study is marred by the lack of (1) randomization, (2) independent assessors, and (3) follow-up. Rigorous research is needed to further evaluate this protocol.

Protocols for Disaster-Response Teams

A primary concern in a disaster response is the emotional state of the trauma-response team. Although these people may be as traumatized as the survivors, there is little research on the use of EMDR protocols to treat them. In one of the very few RCT studies on this issue, an individual protocol for paraprofessionals (EMDR-PROPARA) in post-acute trauma situations was used by Jarero, Amaya, Givaudan, and Miranda (2013) to treat 39 traumatized first responders. Team members were assigned to either EMDR-PROPARA or supportive counseling. Participants in the PROPARA group demonstrated decreased scores on PTSD measures immediately posttreatment and further decreases at 3-month follow-up, while those receiving supportive counseling demonstrated a nonsignificant decrease on PTSD measures following treatment and an increase at 3-month follow-up. While these results reveal preliminary support for EMDR-PROPARA, RCTs are recommended to evaluate the efficacy of this intervention.

FUTURE RESEARCH

These studies provide evidence for the effectiveness of EEIs in decreasing distress in disaster survivors. Although most studies focus on the reduction of PTSD symptoms, other effects reported include statistically and clinically significant reductions in depression and health issues (e.g., Acarturk et al., 2016; Chemtob et al., 2002; Silver et al., 2005). Some of these studies

have demonstrated positive results with child survivors as well, indicating effectiveness across the age range. However, rigorous research is needed to compare these EEIs to one another and to other trauma treatment interventions, as well as to determine which interventions can be most effective at various points in recovery. Studies utilizing early interventions should include sufficient follow-up to determine whether treatment has prevented the development of PTSD. It is also important to establish the optimal length of treatment for various postdisaster settings. Specifically, RCTs should be considered when ethically possible, without preventing needed treatment. The randomized wait-list (delayed treatment) controlled interventions can often be utilized, since the need for services often outstrips the availability of service providers. RCTs are also needed to determine which EEIs can be safely and effectively delivered by adjunct or paraprofessionals as part of a trained disaster response team.

Given widespread disasters and resulting population dislocations, additional research, including rigorous RCTs with refugees, is highly recommended. However, it is vital that sufficient treatment time be used to evaluate clinical outcomes. For instance, an RCT (ter Heide et al., 2016) comparing EMDR therapy to stabilization was conducted with asylum seekers at an institute in the Netherlands with patients who were considered "relatively difficult to treat [due to] the complexity of their traumatic experiences (i.e. multiple, prolonged, interpersonal traumatic events often involving intentional and extreme cruelty) as well as the complexity of their present-day lives (such as being threatened with expulsion, having no financial means, being socially isolated, fearing the effects of ongoing conflict in the country of origin)" (p. 6). One goal of the study was to determine whether EMDR therapy could be safely implemented with this population. No adverse effects were reported, and there was no difference in treatment outcome between the two conditions in terms of global psychometrics measures (e.g., CAPS, Harvard Trauma Questionnaire). However, the evaluation of the efficacy of EMDR is problematic in this study because the mean number of traumas for each participant was 14, but only six reprocessing sessions were used. As indicated in previous discussions, clinically relevant research must allocate adequate treatment for multiply traumatized victims, particularly when global psychometrics are used. Future studies with refugees should take these factors into account.

Another area in need of research is the EMDR Emergency Response Procedure (ERP), which has been proposed as a stabilization technique to be used within minutes to hours following a trauma, particularly for those survivors or witnesses who are highly agitated or experiencing disorientation, depersonalization, or peritraumatic dissociation. To stabilize the individual, the ERP utilizes BLS in conjunction with cognitive interweaves focused on orientation to time, place, and current safety (Quinn, Elkins, Zucker, & Smith, submitted). It is typically described as a one-time intervention that can be used again if survivors experience additional episodes

of high levels of emotional arousal. While case reports show promise, controlled studies are needed to assess the safety and effectiveness of the ERP, the conditions under which it should be used, and the optimal form of BLS.

DIVERSE CLINICAL APPLICATIONS

Since research has clearly shown that many presenting psychological complaints are based on or greatly influenced by earlier adverse life events, it is not surprising that EMDR therapy has found widespread use beyond PTSD. As indicated in numerous studies (e.g., Gold et al., 2005; Mol et al., 2005; Robinson & Larson, 2010), adverse life experiences that do not rise to the level of a Criterion A event can result in similar and even more PTSD symptoms than a major trauma. According to the AIP model that guides EMDR practice, these memories, like those identified as pivotal for the PTSD sufferer, are stored in state-specific form; that is, they contain the affective, physiological, and cognitive elements experienced at the time of the original event (see Chapter 2). The following sections provide an overview of research for a variety of clinical applications, emphasizing published controlled studies and specific areas in need of further investigation. Rigorous RCTs are recommended for all clinical applications involving the experientially based disorders delineated in the DSM. In designing the appropriate controlled research, however, it is important to evaluate the entire EMDR therapy protocol within the context of the potential special needs of the particular population. It is imperative, for example, to specify the degree to which the standard PTSD protocol is effective with the clinical application and whether or not special adjustment of targeting and procedures is needed. Furthermore, all procedural alterations of the standard EMDR protocols should be clearly delineated and rigorously evaluated. A comprehensive list of published cases with a wide range of clinical applications may be found in Appendix D.

Anxiety Disorders

Phobias

Five RCTs have evaluated the treatment of phobias. Unfortunately, three of them (Muris & Merckelbach, 1997; Muris, Merckelbach, van Haaften, & Nayer, 1997; Muris, Merkelbach, Holdrinet, & Sijsenaar, 1998) have been seriously compromised by the use of only one session and a failure to use the complete EMDR therapy phobia protocol (see Shapiro, 1999; De Jongh Ten Broeke, & Renssen, 1999). Although these studies found reductions in distress, the effects on avoidance were limited. These findings may be attributed to the failure to use the last three steps of the phobia protocol, which incorporate templates for appropriate future action (see Chapter 9). These steps are necessary for the treatment of phobias and any

research that involves the Behavioral Avoidance Test. One RCT using the full protocol evaluated the effects of three sessions with participants suffering from dental phobia (Doering, Ohlmeier, Jongh, Hofmann, & Bisping, 2013). Substantial treatment effects were reported on measures of fear and anxiety, and PTSD symptoms. Avoidance was overcome, as indicated by the fact that 83% of the participants were in a regular dental treatment program at 1-year follow-up. In an RCT that examined the treatment of flying phobias, Triscari, Faraci, D'Angelo, Urso, and Catalisano (2011) reported positive effects but combined EMDR with a variety of CBT techniques. Rigorous RCTs are needed in which the full EMDR phobia protocol alone (see Chapter 9) is compared to other treatments.

Panic Disorder

Two RCTs (Feske & Goldstein, 1997; Goldstein et al., 2000) have offered only limited support for EMDR as a treatment for panic disorder. Furthermore, these studies were marred by protocol restrictions and a lack of sufficient treatment time (see also Fernandez & Faretta, 2007). A pilot study (Faretta, 2013) compared 12 sessions of EMDR with CBT in the treatment of panic disorder with or without accompanying agoraphobia. The processing of etiological events, triggers, and memory templates was accomplished in session without the use of treatment-specific homework. In contrast, the CBT group utilized in-session breathing and relaxation exercises plus imaginal exposure, and was assigned both relaxation and exposure homework. Both treatments demonstrated a substantial decrease in anxiety symptoms, intensity, and frequency of panic attacks. EMDR resulted in significantly fewer panic attacks than CBT at posttest and at follow-up. Results indicate that in addition to the standard phobia protocol (see Chapter 9), childhood experiences that may contribute to a "fear of fear" or feelings of powerlessness (e.g., due to humiliations, assault, abuse, or unmet needs) should also be assessed and processed. Rigorous RCTs using larger samples, sufficient treatment time, and expert fidelity checks should evaluate the efficacy of the protocol used in this study. A recent RCT (Horst, Oudsten, Zijlstra, Jongh, Lobbestael, & De Vries, 2017) comparing EMDR therapy and CBT reported equivalent treatment effects on a broad range of measures, despite the addition of daily in vivo exposure homework in the CBT condition. More RCT are needed. However, in all cases, it is vital to utilize the standard three-pronged approach to directly process past memories, current triggers, and future templates to ensure changes in both emotional responses and avoidance behaviors.

Obsessive–Compulsive Disorder

In an RCT, Nazari et al. (2011) evaluated the effects of EMDR therapy and citalopram with 90 diagnosed patients with obsessive–compulsive

disorder (OCD). An unspecified number of sessions over a 12-week period was administered. Results indicated that EMDR resulted in approximately twice the positive treatment effects as did citalopram, as measured by the Yale–Brown Obsessive Compulsive Scale. However, this study is marred by a variety of problems, including a lack of fidelity checks and an unclear description of the protocol administered. Rigorous RCTs with this population are needed that compare EMDR to other psychological and pharmaceutical treatments.

Mood Disorders

Numerous RCT have demonstrated positive outcomes on depression measures secondary to the evaluations of PTSD treatment (Chen et al., 2014). Additionally, two RCT have directly evaluated the effects of EMDR therapy with a diagnosis of depression. An RCT (Gauhar, 2016) of 26 participants diagnosed with major depressive disorder were treated with six to eight 1-hour sessions. Reported outcomes included substantial effects on depression, trauma, and quality-of-life measures, with the effects maintained at 3-month follow-up. A range of stressful adverse life events related to the depression was targeted. The study also reported a substantial generalizing of positive treatment effects in relation to the participants' negative cognitions. Negative beliefs that were identified at the beginning of treatment were automatically neutralized as processing proceeded. As stated by the researchers, "The shift in the validity of the targeted cognition seemed to generalize to other untreated negative cognitions" (p. 66). In another RCT (Behnam Moghadam, Behnam Moghadam, & Salehian, 2015), the effects of three 45- to 90-minute sessions administered during a 1-week period targeting a cardiac incident were evaluated with patients using the BDI. The mean depression level in the EMDR group was substantially decreased at posttest and was significantly improved at 12-month follow-up (Behnam Moghadam et al., 2015). In addition, an uncontrolled study of 42 participants diagnosed with unipolar depression (Hofmann et al., 2014) compared the effects of CBT alone (mean of 47 sessions) to CBT (mean of 46 sessions) plus a mean of seven adjunctive EMDR sessions. Results indicated that with 21 participants in each condition, "the number of remissions at posttreatment, as measured by a symptom level below a BDI-II score of 12, was significantly better in the adjunctive EMDR group, the group showing more remissions (n = 18) than the control group (n = 8; p = .001)" (p. 103). Another uncontrolled study (Hase et al., 2015) reported a 68% remission after a mean of five EMDR sessions targeting adverse experiences related to the onset and course of the depression in addition to TAU group therapy. The EMDR group demonstrated significantly superior effects in terms of depressive symptoms, and relapse rates at posttest and long-term follow-up compared to a matched control receiving individual and group TAU alone. The results of these studies underscore the need for additional rigorous RCT

with diagnosed depression compared to other psychological treatments and using long-term follow-up. Additionally, a randomized pilot study (Novo et al., 2014) of 20 subsyndromal bipolar patients with a history of trauma reported significantly greater effects in the EMDR condition than the TAU condition at posttest on symptoms of depression, hypomania, trauma and trauma impact, but only on trauma impact at 24-week follow-up. Findings indicate the potential utility of EMDR with this population, but more rigorous trials are needed with a larger sample and the identification of additional targets related to the specific symptoms. Given the apparent relationship between early adverse experiences and depression (e.g., Heim et al., 2004; Williams, Debattista, Duchemin, Schatzberg, & Nemeroff, 2016) future studies should investigate the impact on the disorder of processing a range of adverse life experiences in addition to major trauma. As indicated in DSM-5, "Adverse childhood experiences, particularly when there are multiple experiences of diverse types, constitute a set of potent risk factors for major depressive disorder" (American Psychiatric Association, 2013, p. 166). Longitudinal studies should investigate the potential of EMDR therapy as both a remediation and preventative treatment.

Addictions

A relatively small but growing body of literature indicates that EMDR therapy may be an effective adjunctive treatment for substance abuse, especially in the presence of a trauma history. Without large-scale controlled studies, best practices for the use of EMDR therapy with addicted clients are currently based on uncontrolled studies, case reports, a sound theoretical framework, and consensus among practicing clinicians within this area of dual expertise. There is now a solid body of research supporting the strong correlations among trauma, substance abuse, and other compulsive, maladaptive behaviors (Anda et al., 2006; Brady, Back & Coffey, 2004; Dube et al., 2003; Felitti, 2004; Felitti et al., 1998; Ouimette, Brown, & Najavits, 1998; Petry, Stinson, & Grant, 2005), indicating that further controlled research with EMDR therapy is warranted. The following section summarizes some of the existing studies to date. Additional reports of the application of EMDR therapy to the treatment of substance addictions and other compulsive behaviors can be found in Appendix D.

Trauma and co-occurring substance use disorders (SUDs) are disproportionately prevalent in individuals involved in the criminal justice system (Grant et al., 2004). A meta-analysis (Latimer, Morgon-Bourgon, & Chretien, 2006) determined that although drug courts can reduce recidivism, the attrition rate from 66 programs averaged a poor 45%. One reason participants fail to complete drug court programs is the presence of comorbid mental health problems that have been left unidentified and untreated in such programs (Marlowe & Meyer, 2011). Given the known correlation between trauma and SUDs, it is proposed that providing trauma-specific

treatment could lead to increased program retention and graduation rates, as well as a greater reduction in recidivism. A quasi-experimental study conducted over a 5-year period by Brown et al. (2015) offered an Integrated Trauma Treatment Program (ITTP) combining EMDR therapy and Seeking Safety (SS; Najavits, 2002) to 68% of participants (n = 150) in the Thurston County Drug Court Program who endorsed a Criterion A trauma history. Seeking Safety (SS) is a manualized, cognitive-behavioral, integrated PTSD and substance abuse program, is generally conducted in groups by trained paraprofessionals and focuses on present safety and stabilization. Brown at al. (2015) recommended that it be integrated into the preparation phase of EMDR therapy. Completion of selected SS groups was required before participants could voluntarily receive up to 30 individual EMDR sessions. The average number of EMDR sessions for those completing the program was 12. One hundred twelve ITTP participants completed SS. The following graduation rates were reported: 91% of those who selected EMDR therapy in Phase Three of the Drug Court Program (n = 65); 57% of those who declined EMDR but completed SS (n = 47); and 60% of those in the Program as Usual without reported trauma. These outcomes are noteworthy, since research has demonstrated that Drug Court Program graduates reoffend considerably less often than those who do not complete the program (Belenko, 2001; U.S. Government Accountability Office, 2005). These program outcomes suggest that EMDR therapy may be an important trauma-specific adjunct in Drug Court Programs. RCTs comparing EMDR therapy to other trauma therapies are recommended within a drug court setting measuring symptom reduction, relapse rates, and recidivism.

It is suggested here that comprehensive EMDR treatment of individuals with co-occurring addiction and trauma utilize the standard eight-phase, three-pronged protocol. A number of case series have reported positive effects for the standard protocol in reducing alcohol and/or substance use. Kullack and Laugharne (2016) reported on four patients meeting pretreatment criteria for PTSD, three with co-occurring alcohol dependence and one with substance dependence. Treatment with EMDR resulted in three out of four participants no longer meeting the criteria for PTSD, alcohol dependence, or substance dependence by the end of therapy, and at 12-month follow-up, without targeting the substance use behavior directly or using any of the modified addiction-specific protocols described below. This leads to the question of what types of targets need to be addressed in substance use treatment to maximize recovery, and what type of clients will most benefit. In this study, the four participants were noted to have increased substance abuse soon after a traumatic event in adulthood, which was processed. Two participants reported childhood traumas, which were also targeted in the EMDR treatment. The resolution of the substance dependence as a combined outcome with resolution of PTSD supports the self-medication hypothesis as a major contributor in addictive disorders (Hien et al., 2010; Khantzian, 1985; see Chapter 11). The current addiction

literature suggests other pertinent memory elements worth targeting in future research with EMDR therapy, such as episodic and other addiction-specific memories associated with substance abuse (Müller, 2013; Torregrossa, Corlett, & Taylor, 2011).

An RCT (Hase, Schallmayer, & Sack, 2008) used a modified application of EMDR procedures to target addiction memories, including drug effects, relapse, and craving, instead of a trauma memory. The term "addiction memory" was originally defined as a nonconscious, implicit memory, with craving as its conscious manifestation (Boening, 2001). Implicit memories related to addiction can be highly resistant to alteration or extinction, which limits the usefulness of exposure therapies outside of laboratory conditions (Torregrossa et al., 2011). In the Hase et al. (2008) study, 34 alcohol-dependent patients were randomly assigned to TAU, including detoxification, motivational interviewing and addiction-focused group therapy, or TAU plus two sessions of modified EMDR procedures, as noted earlier. After two sessions targeting addiction memories reported by participants, craving for alcohol, as measured by the Obsessive–Compulsive Drinking Scale (Anton, Moak, & Latham, 1995), dropped significantly in the TAU + EMDR group, but not in the TAU group. The study indicates the potential utility of targeting craving and other memories of addictive behavior to reduce the risk of relapse.

Two studies (Little et al., 2016; Markus et al., 2016) investigated whether EMs in isolation could reduce addiction imagery and associated food or smoking craving. Results suggest that EMs focused on addiction-related targets may reduce the vividness and emotionality associated with these experiences, suggesting potential usefulness in relapse prevention. A modified addiction-specific protocol called "desensitization of triggers and urge reprocessing" (DeTUR; Popky, 2005; Vogelmann-Sine, Sine, Smyth, & Popky, 1998) has also been investigated in multiple case studies (e.g., Bae & Kim, 2012, 2015). Sets of EMs are focused first on urges and cravings, usually revealing the underlying distress that almost always accompanies addiction and compulsive behaviors. In clinical practice, the underlying disturbances, when they emerge, are treated with standard EMDR therapy. Reports have indicated that therapeutic gains noted with DeTUR are maintained at 6- and 12-month follow-up, suggesting that it may be a useful adjunct within the standard EMDR therapy protocol in the treatment of SUDs and other maladaptive behaviors. However, RCTs are needed to confirm both of these protocols and identify the different treatment elements needed for comprehensive recovery.

The three-pronged EMDR treatment of addiction issues includes (1) reprocessing past disturbing experiences fueling addictive behavior, (2) neutralizing current triggers (including craving), and (3) developing templates that incorporate desired future adaptive actions to live a healthy, meaningful life, without the use of substances or maladaptive behaviors to cope. Controlled research is needed to compare standard EMDR therapy

with other empirically supported treatment models for co-occurring trauma and SUDs. In the Drug Court Program described earlier, it was recommended that future research include a randomized comparison between SS (Najavits, 2001) alone and SS plus EMDR therapy to help determine the added significance of processing past trauma for overall treatment outcomes. Other potential comparison groups for EMDR therapy include an exposure-based model (e.g., Brady, Dansky, Back, Foa, & Carroll, 2001) in addition to other CBT-based protocols specific to co-occurring trauma and addiction (Ford & Russo, 2006). All comparisons should include the assessment of client acceptance of the treatment approach, which is usually reflected in treatment retention rates. In addition, future comparative research should track long-term relapse rates (abstinence) and include a quality-of-life measure, which would be the best measures of treatment success.

Further research is needed to determine which targets should be processed for the most robust, long-term outcomes in EMDR treatment of addictions. For example, RCTs should investigate a condition in which participants are treated with standard trauma targets only compared to a condition incorporating standard trauma targets plus positive (rewarding) addiction-associated targets. Also in need of study is the timing of the reprocessing phases of EMDR therapy. Examples include (1) comparison of clinical and sobriety outcomes when initiating trauma work begins prior to complete sobriety versus initiating trauma work after a "wait period" of 30 days sobriety; (2) comparison between processing triggers, urges, and positive "reward" states prior to trauma work versus initiating trauma work first; (3) comparison between the integrating processing of both disturbing and rewarding memories within early processing versus processing sequentially (either trauma or rewarding addiction memories first); and (4) comparison between once-weekly treatment sessions and intensive successive-day treatment, which would include establishing an expected dosing range (number of treatment sessions likely to offer positive, lasting treatment outcomes). Future research should include long-term follow-up to evaluate relapse rates, as well as a quality-of-life assessment, since treatment of addiction is about more than just abstinence. The ultimate goal is the creation of a life that makes abstinence worthwhile.

Pain Conditions

Research has demonstrated beneficial results of EMDR therapy for patients suffering from a wide range of debilitating physical conditions. Rigorous EMDR RCTs are recommended to investigate several areas of interest, including the alleviation of chronic pain (see Tefft & Jordan, 2016; Tesarz et al., 2014; Gerhardt et al., 2016). The first such study to be published involved a burn victim who had been severely debilitated for almost 10 years (McCann, 1992) and found that the patient's PTSD and somatic symptoms

were eliminated after one session of EMDR therapy. Burn victims are only one example of patients suffering from chronic pain, and the possibility that unremitting pain can be alleviated by processing the memories of the traumatic event, as demonstrated in case studies with numerous pain patients (see Appendix D), has obvious implications. The AIP model, which posits that chronic pain includes the storage of somatic elements of the traumatic event, appears consistent with current neurobiological research (Rome & Rome, 2000). Suggested EMDR treatment includes processing both antecedent events, future concerns, and pain sensations (see Chapter 9). In one RCT (Gerhard et al., 2016), 40 chronic back pain patients received 10 sessions of EMDR plus TAU, which was compared to a condition of TAU alone. Fifty percent of the EMDR participants reported clinically satisfactory improvement as compared to zero in the control condition. Another RCT (Maroufi et al., 2016) reported on the treatment of 56 patients experiencing moderate-to-severe postoperative pain who received one 60-minute session of EMDR that resulted in a significant decline in pain as compared to a control condition. Positive results were also obtained for a variety of pain conditions in an open trial of 38 patients (Mazzola et al., 2009). Patients were treated with 12 sessions and reported substantial decreases in pain, anxiety, and depression, and an increase in a sense of emotional and physical health. Although these extant studies reported positive effects with both acute and chronic pain, further RCTs to assess the effects of a full course of treatment with long-term follow-up are recommended.

Another important area of investigation involves the treatment of phantom limb pain. To date, there have been six published case studies or series evaluating the efficacy of EMDR with this syndrome (Amano, Seiyama, & Toichi, 2013; de Roos et al., 2010; Russell, 2008a; Schneider et al., 2008; Sinici, 2016; Wilensky, 2006). Success, defined as complete or substantial reduction of experienced pain, was obtained on average with 80% of the cases after 2-to-9 sessions. A recent RCT (Rostaminejad, Behnammoghadam, Rostaminejad, Behnammoghadam, & Bashti, 2017) described the results of the treatment of 30 phantom limb patients with 12 one-hour sessions of EMDR within a 1-month period compared to a standard care condition. All participants in the EMDR group experienced a reduction of pain at posttest. At 24-month follow-up, the treatment effects were maintained or increased, with 93% experiencing a substantial effect, including 47% with complete elimination of pain. The control group participants were worse at posttest and at follow-up.

The effectiveness of EMDR treatment is congruent with the AIP model, which posits that phantom limb pain is the result of unprocessed memories of the event (together with its physical sensations) that necessitated the amputation. It is proposed that processing the memory of the traumatic event causes a simultaneous shift in emotions, physical sensations, and beliefs associated with the occurrence through memory integration and reconsolidation. The result in the case of phantom limb pain is

to eliminate or greatly reduce those pain sensations that are not caused by actual nerve damage. Such an outcome, if further confirmed by RCTs, is of great importance given the large number of victims of accidents and combat veterans who suffer from this debilitating and psychologically disturbing condition. Rigorous RCTs comparing the pain protocol described in Chapter 9 with other extant treatments are strongly recommended.

Another recommended area for further research is the use of EMDR as a treatment for migraine headache pain. A pilot study (Konuk et al., 2011) reported decreases in the frequency and duration of migraine attacks after a mean of eight EMDR sessions targeting events related to the headaches. Consumption of painkillers and emergency room visits also declined. Effects were maintained at 3-month follow-up. Other studies of pain conditions, including fibromyalgia, musculoskeletal pain, trigeminal neuralgia, neuropathy, and chronic fatigue syndrome, are listed in Appendix D. These encouraging results indicate the need for rigorous RCTs to determine the optimal clinical applications and treatment duration, given the potentially severe psychological consequences of unremitting chronic pain and modest effect sizes reported in research trials of extant treatments (see Eccleston, Morley, & Williams, 2013).

Diverse Somatic Conditions

EMDR therapy has also been evaluated in relation to patients with other somatic conditions. An RTC (Arabia, Manca, & Solomon, 2011) compared EMDR with imaginal exposure (repeatedly describing the memory in detail during the session) as used in PE (Foa & Rothbaum, 1998) in the treatment of patients traumatized by heart attacks or heart surgery. Homework (imaginal and *in vivo* exposure) traditionally used in PE was not incorporated due to concerns about safety and debilitation. It was found that three to five sessions of EMDR administered over a 4-week period produced greater positive effects, as measured by substantial decreases in depression, trauma symptoms, and anxiety at posttest, and of trauma symptoms and anxiety at 6-month follow-up. Another RCT (Moradi, Zeighami, Moghadam, Javadi, & Alipor, 2016) evaluated the effects of two sessions of EMDR therapy compared to a wait-list control with myocardial infarction patients hospitalized in an intensive care unit and suffering from anxiety. Treatment was administered using two 45- to 90-minute sessions over a 3-day period. Anxiety was measured using the BAI, which indicated substantial reductions in the EMDR condition that were maintained at 12-month follow-up (pretreatment: 48.86; posttreatment: 7.36; follow-up: 6.73). The effects of three 45- to 90-minute sessions targeting the cardiac incident administered during a 1-week period were evaluated in an RCT (Behnam Moghadam, Alamdari, Behnam Moghadam, & Darban, 2015) of 60 patients using the BDI. The mean depression level for the EMDR group decreased substantially at posttest (from 27 to 12) and was significantly better than that

of the no-treatment control group. The positive treatment effects in the EMDR condition were further significantly improved at 12-month follow-up (Behnam Moghadam, Behynam Moghadam, et al., 2015).

Given the serious mortality risks of anxiety, depression, and PTSD symptoms that are associated with cardiac conditions (Dew et al., 2000; Ladwig et al., 2008; Moser, 2007), rigorous RCTs evaluating long-term outcomes, including effects on quality of life, physical health, and mortality, are strongly recommended. Research comparing the effects of weekly and consecutive-day treatment are also recommended to ascertain the advisability of rehabilitative treatment during the hospital stay, as suggested by Moradi and colleagues (2016).

Cancer treatment is, not surprisingly, associated with psychological traumatization (Kangas, Henry, & Bryant, 2007; Pérez et al., 2014) and therefore worthy of further investigation. A combined open trial and RCT (Capezzani et al., 2013) evaluated the effects of eight sessions of EMDR therapy with cancer patients who had a (DSM-IV) diagnosis of PTSD. Ten patients who were in the active phase of the disease were treated exclusively with EMDR. Twenty-one patients in the follow-up stage of the disease were randomly assigned to EMDR or CBT conditions and evaluated in terms of anxiety, depression and PTSD symptoms. EMDR treatment resulted in reductions on all measures, with significantly greater elimination of PTSD than occurred with CBT. EMDR was equally effective for patients in the active or follow-up stages of cancer, and all but one of the 21 patients treated with EMDR lost their PTSD diagnosis by the end of treatment. While the results are promising, limitations of this study include the lack of expert fidelity checks and that treatment to all participants was provided by only one therapist. A nonrandomized multicenter study of 57 cancer patients with symptoms of either anxiety or depressive disorder (Faretta, Borsato, Civilotti, Fernandez, & Pagani, 2016) measured the effects of 12 sessions of EMDR therapy focused on memories directly related to the disease (see Faretta & Borsato, 2016) compared to 12 CBT sessions employing different techniques. A present-based treatment (i.e., focusing on memories directly related to the current disease) is recommended by the authors for hospital settings because of time limitations on the potential number of sessions that can realistically be administered. EMDR was found to be significantly superior on 11 out of 17 measured variables. Rigorous RCTs are recommended to further evaluate this protocol. Effective and timely treatment is needed for clients with trauma symptoms as a result of their diagnosis given the negative effects of stress on immune system function (e.g., Lutgendorf & Andersen, 2015). In addition, RCTs using the comprehensive EMDR therapy cancer protocol are recommended for patients in traditional clinical settings (see Chapter 9). With this population, RCTs that include long-term follow-up can help to determine the most effective treatment by evaluating effects on symptoms, as well as recovery and longevity.

Positive treatment effects have also been reported with a group protocol (Jarero Artigas, Uribe, & Garcia, 2016) which utilizes pictures of the processing targets, and the Butterfly Hug as BLS (see Chapter 9). In an open trial (Jarero et al., 2015), 24 adult women with various forms of cancer were administered group sessions twice daily on 3 consecutive days. The group protocol was reported to produce marked reductions in trauma symptoms for patients in the active phase of cancer treatment and likewise during the follow-up phase. Furthermore, with three exceptions, all proved to be subclinical at a 3-month follow-up.

Rigorous RCTs of all the extant protocols are needed to evaluate immediate and long-term outcomes, and to compare the effects of individual and group therapy. Because the protocols can be administered on consecutive days, they may be particularly suited for timely application in rehabilitation programs. The fact that the symptoms of PTSD can be reduced or eliminated in patients with cancer and other life-threatening diseases has clear implications for immune system functioning, recovery, and prevention of relapse. Similarly, an RCT of multiple sclerosis patients diagnosed with PTSD (Carletto et al., 2016) reported that after ten 60-minute sessions, 100% of those in the EMDR condition lost the diagnosis, compared to 77% in the control condition. Given research indicating the relationship between stress and future relapse (Mitsonis, Potagas, Zervas, & Sfagos, 2009), further studies are needed with large samples and long-term follow-up to evaluate outcomes in terms of symptoms, quality of life, enhanced resilience, and immune function.

Although much is known about EMDR therapy and its treatment efficacy for a wide range of psychological and physical problems, there is much left to discover. Future research evaluating EMDR with somatic conditions could find no better model than the ACE Study (Felitti et al., 1998) conducted at a Kaiser Permanente hospital. This investigation revealed that adverse childhood experiences are associated with a variety of physical conditions, including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease. Rigorous longitudinal studies are recommended to evaluate whether EMDR processing of the adverse experiences can prevent the development of these conditions. Such studies would have important implications for social policy and optimizing medical care.

Clearly, all future studies of the EMDR procedures must meet criteria for treatment validity. Furthermore, successful treatment requires that practitioners identify an adequate number of salient adverse events in the patient's history and allocate a commensurate amount of treatment time. According to the ACE Study, there is a "strong graded relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults" (p. 245). A variety of somatic conditions, as well as associated psychological issues, can be successfully treated through a short course of EMDR therapy. However, in the case of multiple abusive events throughout

childhood, more extensive treatment is necessary (see Chapter 11). Fortunately, because the positive effects of EMDR processing of a given traumatic memory have been shown to generalize to other, similar ones, it may be unnecessary to process each memory separately. However, each category of memory identified in the ACE Questionnaire (see Appendix A) must be adequately assessed, and the amount of treatment time necessary to process the salient memories in each cluster must be allocated for optimal therapeutic change to occur. It is also recommended that any proposed future study of this issue include procedures for identifying potential posttreatment epigenetic and neurophysiological changes. Efficient and cost-effective research opportunities are available in outpatient and residential settings, since EMDR therapy can be successfully administered on consecutive days rather than the weeks or months typically required by other therapies.

TREATMENT-RESISTANT POPULATIONS

Additional areas of investigation in need of rigorous research include traditionally resistant treatment populations. For instance, as reported in a recent review (Harrison, de la Cruz, Enander, Radua, & Mataix-Cols, 2016), body dysmorphic disorder (BDD) is generally considered to be difficult to treat. Studies of CBT have generally used eight to 14 sessions and reported a 40–54% success rate, defined as a change of at least 30%. However, a small consecutive case series using EMDR therapy (Brown, McGoldrick, & Buchanan, 1997) reported that five of seven patients experienced a complete remission of BDD symptoms within one to three processing sessions, an improvement that was maintained at 1-year follow-up. Similar outcomes were reported with four consecutive patients with olfactory reference syndrome (McGoldrick et al., 2008), all of whom lost their diagnosis after one to three treatment sessions and maintained that status at follow-up (6 months to 10 years). As predicted by the AIP model, both diagnoses were successfully treated through the EMDR processing of the apparent etiological event involving shame and humiliation. These findings merit future investigation with rigorous RCTs using large samples and long-term follow-up. It is also recommended that longer treatment be incorporated to assess and treat other potentially contributing events, given that two of the patients with full remission of BDD were assessed with other symptoms (i.e., delusions of reference, and OCD) at 1-year follow-up.

Another traditionally resistant diagnosis involving delusional symptoms for which EMDR therapy may prove useful is psychosis. An initial uncontrolled pilot study (van den Berg & van den Gaag, 2012) reported that the EMDR treatment of PTSD in psychotic patients resulted in a decrease of trauma and depression symptoms as well as a reduction in auditory hallucinations and delusions. Since the publication of that study, two RCTs (De Bont, van Minnen, & de Jongh, 2013; van den Berg et al.,

2015) evaluated EMDR and PE in the treatment of PTSD with this population and reported reductions in trauma symptoms, indicating that the two therapies are both safe and effective. Secondary analyses also revealed decreases in some psychotic symptoms (de Bont et al., 2016). However, future research should evaluate a longer course of EMDR therapy, one that targets the full range of adverse life experiences that may be contributing to this disorder. Research (Bentall, Wickham, Shevlin, & Varese, 2012; Read et al., 2014; Varese et al., 2012) has clearly revealed the association between childhood adversity (e.g., bullying, loss, sexual trauma, institutional care) and psychosis. It is possible that the etiological events associated with the pronounced psychotic delusions and hallucinations can be identified through direct questioning and the use of the "Floatback" technique and, if so, these should be processed directly. Initial pilot studies evaluating a comprehensive and naturalistic course of treatment are recommended first to determine specific parameters of EMDR application with this complex population before initiating more rigorous short-term RCTs with long-term follow-up to evaluate the possibility of attaining full and stable remission.

Another historically intransient condition for which EMDR therapy has shown promise is the treatment of child molesters. A recent study (Levenson, Willis, & Prescott, 2014) has revealed the high incidence of adverse life experiences characteristic of this population, including three times greater likelihood of sexual abuse and 19 times greater likelihood of verbal abuse compared to the general population. An uncontrolled study (Ricci, Clayton, & Shapiro, 2006) of 10 treatment-resistant participants in an offender program, evaluated the effects of six sessions of EMDR therapy that processed the molesters' memories of their own childhood sexual abuse. Significant positive effects were demonstrated on the Sex Offender Treatment Rating Scale, with the participants taking appropriate responsibility for their actions and gaining empathy for the plight of their victims. Furthermore, the treatment significantly reduced or eliminated deviant sexual arousal in 90% of the participants, as measured by a penile plethysmograph. The longevity of these psychological and physiological effects was demonstrated by their maintenance when measured at 1-year follow-up. A comparison to a matched sample of participants in the program that did not receive EMDR confirmed the substantial improvements. Given the lack of definitively effective treatments for this population (Marques, Wiederanders, Day, Nelson, & Van Ommeren, 2005; Schmucker, & Lösel, 2008), the importance of these results and the need to confirm these findings in rigorous RCTs with measures of recidivism and long-term follow-up are self-evident. A recent case study by the same researchers (Ricci & Clayton, 2016) built on their original research and advocated the use of EMDR therapy as an adjunct to standard sex offender treatment programs. It highlighted the utility of more comprehensive memory processing to address a range of negative beliefs and behaviors in this population. The article offers considerable guidance for those interested in further exploring this important area of investigation.

As in the treatment of addictions, it is recommended that research regarding any sexually deviant behavior evaluate the utilization of the entire EMDR therapy three-pronged protocol and include the comprehensive processing of memories, triggers, and templates to incorporate adaptive future functioning. In addition, urges should be targeted along with the positive states they provide. An excerpt of a processing session with an exhibitionist illustrates (Ten Hoor, 2015) the potential value of such targeting. On a 0- to 10-point positive feeling scale, the client reported feeling "Exciting, thrilling, enjoyable" at a level of 9 when asked to think of a recent time that he exposed himself. Below are his responses after each set of EMs:

- "Well, it's getting somewhat less."
- "That I am now doing something that is actually not right."
- "I am getting sad, because I am hurting people."
- "That indeed I am hurting a lot of people" *(crying voice)*.
- "That my marriage was at stake, everything" *(crying voice)*.

Targeting the positive state induced by visualizing the behavior can help to elicit insights that break through denial and help to increase treatment motivation. However, in order to obtain lasting change, it appears necessary to process the adverse life experiences that are the foundation of the deviant behavior. Rigorous RCTs with long-term follow-up are needed on this important topic.

SUGGESTED CRITERIA FOR CLINICAL OUTCOME RESEARCH

This section delineates some basic research criteria that appear both judicious and necessary for a valid test of any therapy. Of course, the evaluation of therapeutic procedures should adhere to the highest standards of controlled clinical research. The standards enumerated in the following discussion are the basic guidelines for adequate testing. The remainder of the section expands on principles reasonably needed to establish clinical validity factors, which may be overlooked by researchers insufficiently versed in the exigencies of standard clinical practice. It is hoped that the guidelines in this section will also assist clinicians to adequately evaluate research reports. Suggestions and clinical aids for both single-case and controlled research are included in Appendix C.

The seven "gold standards" for research design articulated by Foa and Meadows (1997) include (1) "clearly defined target symptoms," so that appropriate measures can be employed to assess improvement, with specifications of inclusion and exclusion criteria; (2) "reliable and valid measures," with good psychometric properties; (3) "use of blind evaluators," other than the treatment provider, to collect assessment measures; (4)

"assessor training," with demonstrated interrater reliability; (5) "manualized, replicable, specific treatment programs," to ensure consistent and replicable treatment delivery; (6) "unbiased assignment to treatment," either random assignment to conditions or stratified sampling, with treatment delivered by at least two therapists; and (7) "treatment adherence," evaluated by treatment fidelity ratings.

Three additional standards were identified by Maxfield and Hyer (2002): (1) "no concurrent treatment," to ensure that the treatment condition is not confounded; (2) "use of multimodal measures," to assess a wide range of pathology and outcome with interview, behavioral, and physiological measures; and (3) "adequate course of treatment," to ensure that participants receive the number of sessions necessary to eliminate the disorder in most persons. This combination of the 10 standards was designated the Revised Gold Standard Scale and was used to assess the first decade of EMDR research (see Table 12.1). It is strongly advocated for the evaluation of current studies and the planning of future research.

The following section explores in more detail some of the principles I consider especially meaningful in the evaluation of any therapy. To elucidate what I consider to be imperatives to establish clinical validity factors in controlled research, EMDR therapy as it is applied to the treatment of trauma is used as an example. However, the standards should be applied in the evaluation of the EMDR therapy with any clinical population.

Method Validity

Researchers should be trained in the entire approach being evaluated and should implement the protocols actually used in clinical practice. Fidelity checks are included in the gold standards of psychotherapy research (Foa & Meadows, 1997) and are, of course, necessary to assess the value of any approach. Fidelity checks should be performed by competent instructors or clinicians to assess the validity of the researcher's use of the therapy. Any designated fidelity checker should be assessed prior to the treatment as competent in the tested therapy, and should have established reliability in the fidelity assessment measure being used. The researcher's competence with the approach should be assessed on the basis of an agreed-upon standard.

Clearly, methods used incorrectly or incompetently by researchers contribute little or nothing to the knowledge base for these therapies and, indeed, can lead to false conclusions.

Before any therapy is evaluated in a research study, training during adequately supervised practice sessions is a minimal expectation. However, training alone does not ensure competency, and this is especially true for students or researchers who have not yet perfected their general clinical skills through extensive practice and clinical experience. Ideally, researchers should observe the use of therapeutic procedures as practiced by fully

trained, thoroughly experienced clinicians who are comfortable with and have been assessed as competent in the use of the therapy. When this is not possible, they should receive formal training in the methodology, practice it sufficiently on participants in a pilot study to obtain consistently positive fidelity checks (assisted by appropriate consultation and supervision, if necessary), and feel comfortable in using it before systematically examining it in controlled research. It appears especially important that these precautions be taken with any therapeutic approach. Indeed, this is the format used by researchers in the so-called "hard sciences" (e.g., physics, chemistry, biology) when conducting formal studies, and it should be an established part of general research practice in clinical psychology, as should continued supervision and checks of procedural fidelity and protocol maintenance. It should be noted further that two meta-analyses of EMDR research have indicated that practice fidelity is positively correlated with treatment outcomes (Maxfield & Hyer, 2002; Shapiro, 1999).

Equally critical to ensuring that therapists are competent in EMDR therapy, or any other therapeutic approach, is the task of assessing their continued compliance with the protocol throughout the course of a research study, as it has long been recognized that even fully trained therapists tend to drift away from a protocol over time (McHugh & Barlow, 2010; Moncher & Prinz, 1991; Prowse & Nagel, 2015; Walz, Addis, Koerner, & Jacobson, 1993). It is for this reason that, ideally, independent ratings of therapist adherence to the treatment manual should be conducted on randomly selected sessions over the course of the study, with the raters blind to treatment outcome.

Selection of Psychometrics

The psychometrics used in evaluating a therapy should be appropriate to the clinical population and the parameters of that treatment. For instance, when testing the application of a therapy to a single traumatic memory, researchers should use measurement tools that are capable of assessing change when a single memory has been successfully processed. An example of such a tool is the IES-R. For instance, if only one disturbing memory (or a small number of memories) is being treated in subjects who are suffering from multiple-event trauma (e.g., molestation or military combat), global psychometrics such the CAPS and/or Structured Clinical Interview for DSM-5 (SCID-5), Trauma Symptom Inventory (TSI), and PTSD Checklist (PCL) are unlikely to detect changes. Furthermore, clinical observation indicates that if global measurements are used with multiple-event trauma, subjects should receive no fewer than 12 sessions of EMDR processing on a sufficient number of memories to represent all of the major symptom clusters. Even more sessions may be needed to address the issue of secondary gains, as discussed below. This caveat applies equally to any treatment approach and any diagnosis caused by multiple adverse events.

Participant Selection

Research participants should meet reasonable criteria for the possibility of clinical change. For example, adequate clinical work with clients cannot be done without first addressing potential secondary gains. Clearly, participants who are in danger of losing their disability checks or insurance settlements when they are cured may be less responsive to a therapeutic procedure than those who are not. Just as dual diagnoses and active drug abuse are frequently employed as exclusion criteria, so too should secondary gains issues such as financial compensation disqualify prospective participants. The exception is any long-term experiment that targets these factors first. However, the establishment of new clinical methodologies should not depend on obtaining substantial treatment effects with chronically impaired combat veterans presently receiving disability compensation.

Comparative Research

Controlled comparative clinical outcome research with clinical populations should use the most established available methods. Consequently, in the treatment of PTSD, EMDR therapy has been tested against standard treatments that include prolonged exposure, stress inoculation therapy, and other cognitive-behavioral therapies, as well as selective serotonin reuptake inhibitors (SSRIs), which has been judged the most effective pharmaceuticals for the treatment of PTSD. The treatments should be compared with a nontreatment control, when ethically possible (Kazdin, 2013). Evaluations should be done on comparative efficacy, length of treatment, attrition, status of diagnosis, intent-to-treat analyses, maintenance, generalization of effects, and long-term effects—issues that are of vital concern to clinicians in standard clinical practice.

Recommended Clinical Parameters for Comparative Outcome Studies

1. Research should adhere to the "gold standards" advocated by Foa and Meadows (1997) and expanded by Maxfield and Hyer (2002). It is especially important that experiments include fidelity assessment to verify that the protocol being examined in the study is actually the one currently advocated for and used by practicing clinicians. Otherwise, the results from the laboratory may have little or no bearing on clinical practice. It is also necessary that researchers are knowledgeable about the principles, procedures, and protocols that apply to the specific population being evaluated.

2. Investigators should pay special attention to efficacy, effectiveness, efficiency, and attrition, as well as clinician and client preference (e.g., tolerance and comfort) for the type of therapy being used.

3. Studies should include follow-up tests of therapeutic effectiveness (preferably at more than one postexperiment interval) to determine the longevity of effects.

4. When possible, the research team should include practicing clinicians in actual field settings to maximize the external/ecological validity of the study.

5. Studies should employ the number of treatment sessions that is appropriate for the clinical population being tested. For example, for multiply traumatized subjects (e.g., combat veterans) the use of 12 ninety-minute sessions would be much more likely lead to success than the use of three to six sessions, the dose that has been recommended for single-trauma victims (see Maxfield & Hyer, 2002).

6. Research should evaluate outcomes with respect to robust substantial clinical change, not simply statistically significant differences. Outcomes should include diagnosis at posttest and follow-up, as well as the percentage of clients who attained full remission.

7. Studies should include tests of the clinical effects of their procedures, not only on the overt clinical symptoms but also on a variety of the more global personal characteristics. Examples of the latter are self-attribution, self-efficacy, behavioral shifts that affect family, social and employment domains, and overall life goal attainment.

8. Ideally, investigators should attempt to collect neurophysiological and neurobiological data in order to illuminate the underlying mechanisms on which the effects of trauma and alternative paths to healing are based.

9. Studies should entail a sufficient number of subjects to conduct internal analyses that will identify the characteristics of the subjects who respond differentially to the comparison conditions (see Beutler, & Forrester, 2014; Norcross, & Wampold, 2011). It is important to establish parameters to determine which of the various possible treatments can best be offered to individual clients seeking therapy.

ADDITIONAL FUTURE RESEARCH

The Adaptive Information Processing Model

The AIP model was formulated to explain the clinical phenomena observed during EMDR therapy processing sessions and to guide practicing clinicians in effective applications. One tenet of the model is that a major source of present pathology is insufficiently processed etiological experiences stored with the affects and physical sensations attendant to the event. Research and clinical observation indicate that processing the experience

eliminates these elements as the memory is transmuted into an adaptive form (see also Chapters 1 and 2). Clinicians are therefore guided to identify these dysfunctionally stored experiences and treat them within the standard three-pronged approach.

The utility of the AIP model is demonstrated by the fact that it accurately predicted the successful treatment of phantom limb pain (e.g., De Roos et al., 2010; see the section "Pain Conditions") by processing the etiological memory. This also provides a good illustration of the distinction between the AIP model and standard conditioning models, in that the somatic elements of the traumatizing experience involving the missing limb itself appear to be physically stored in the brain. The effective treatment of phantom limb pain also underscores the separation of the AIP paradigm from the model of ego states (Watkins & Watkins, 1997), since there are no attendant personality characteristics in the stored somatic memory, and from the traditional concepts of repression and dissociation, since the pivotal experiences can be either conscious or unconscious. Consequently, the further predictive value of AIP for the application of EMDR therapy to other complaints, including a variety of health issues, should be explored. Such evaluations should also investigate the clinical failures in order to delineate the boundaries of EMDR applications and, hopefully, ways in which the AIP model can be refined to increase its explanatory and predictive value.

Research topics that may shed light on the utility of the AIP model can also be explored through single-subject designs and process analysis. Of interest is the manner in which the cognitive–emotional–somatic elements interact during processing. Clinical observations indicate that all elements shift simultaneously as processing occurs. However, careful process investigations are needed to determine the ordering of effects and the specific patterns of emotional healing for a variety of memory categories (see Chapters 3 and 10). It is also important to evaluate (1) how symptoms and personality characteristics shift as the etiological events are being processed, (2) the degree to which this shift increases the efficacy and/or efficiency of both subsequent defusing of triggers and the education processes, and (3) the degree to which behavioral and interpersonal improvement accrue during the various phases of treatment.

BROADER CLINICAL AND PROFESSIONAL CONCERNS

The question of how well clinical treatment outcome studies are conducted and reviewed is no longer primarily an academic issue but one that directly relates to the practicing clinician. If clinicians are to be directed toward or away from a specific treatment method for their clients, such guidance should come from the results of peer-reviewed published experimental tests of the method, used in a way that is consistent with clinical practice, by

means of subjects who are clinically appropriate, and evaluated according to applicable psychometrics.

Clinical Responsibility

In addition to the issues of research validity and judicious review, there are also those of personal responsibility and treatment fidelity (Shapiro, 1995b). Any positive treatment effect is the result of an interaction among clinician, method, and client. Clearly, the clinician must evaluate a prospective client to assess readiness and appropriateness for a given intervention. A treatment may fail if the client is inappropriately assessed, and the clinician must make consideration of this possibility a part of any treatment evaluation process.

Of course, a particular therapeutic method may simply be ineffective. In the case of EMDR therapy, however, the preponderance of controlled research has revealed positive treatment effects. Therefore, if the clinician using EMDR is failing to achieve positive effects with a high percentage of clients, he should at least consider the possibility that the problem lies in the way he is using it. For instance, multiple controlled studies have reported substantial clinical effects with trauma victims in three to five treatment sessions. The purpose of this research is to guide the practicing clinician. Clinicians who fail to achieve positive treatment effects with EMDR therapy may simply be those who cannot incorporate it into their therapeutic styles. Any of its procedural factors may be disturbing to some clinicians. For example, some therapists may find it difficult to follow the injunction "Stay out of the way of the client during successful processing," whereas others may find the cognitive interweave too directive. Thus, some otherwise excellent clinicians may never become skilled in EMDR therapy simply because they are uncomfortable with it. This is one of the hazards of attempting to learn any new methodology midway or late in one's clinical career.

Clinicians who find EMDR principles and practices appealing will still find it to be a challenging modality and will need to work to upgrade their skill levels. In my formal EMDR training sessions, it is continually stressed that EMDR therapy is not a "cookie cutter" approach but must be tailored to each client. It is also emphasized that EMDR training does not ensure EMDR competency; it is merely the beginning of an ongoing learning experience. This book can assist the learning and retention process by serving as a training guide and clinical handbook. However, each clinician (and researcher) will have specific weaknesses that can be addressed only with training, supervision, and consultation with other trained clinicians.

Clinical observation suggests that therapists trained formally or through supervision by experienced EMDR clinicians can expect a high success rate for appropriately selected clients. If this level of success is not being achieved, the clinician should take responsibility for becoming more

skilled in the approach. Assessment and application are equally important: Education in the appropriate use of a therapy includes not only *how* but also *when* (and *with whom*) to use it. A valid opportunity for informed consent cannot be given to clients contemplating therapy unless the clinician is sufficiently educated and practiced in it.

At the time of this writing, there are approximately 200,000 clinicians worldwide who have been trained in EMDR therapy. Some are more skilled and experienced than others. Among the most highly proficient are those certified by the various nonprofit professional organizations dedicated to ongoing education and development of therapist resources (see Appendix F). Membership in these national and international organizations is open to clinicians, researchers, and students who have been formally educated through approved trainings and university courses. Interested readers should review the information in Appendix E. An independent EMDR Professional Issues Committee was previously established to oversee training policies and professional activities. Although this function is now part of the EMDR International Association, the original set of recommended guidelines for formal training is retained.

The skill level of each clinician has a profound effect on individual clients and on those with whom these clients come in contact. The successful treatment of one client can inspire others to seek assistance, while a failure can discourage many others. The joy of good clinical work is the ability to participate in a client's personal healing. Successful therapy causes a ripple effect through the population and through succeeding generations. But along with the potential for great impact comes a tremendous responsibility. If we do not take sufficient care to learn our methods well, we fail in our responsibility as therapists. The first rule is "Do no harm," yet we harm when we do not prepare enough to do our best. Our clients place their lives and their psyches (from the Greek word for "soul") in our care. Only our highest integrity, our most educated level of skill, and our most profound compassion should answer their need.

Global Responsibility

In the last two decades there has been a significant increase in trauma treatment research. This is a welcome development when one considers the wide range of suffering currently experienced worldwide. With this sobering thought in mind, it is advocated here that the field of scientific clinical psychology make an even greater effort to test therapeutic methods that can be implemented in those parts of the world that are in greatest need. Research should be implemented in all of the clinical and societal domains described in this section to evaluate the potential for both remediation and prevention through timely treatment.

The occurrence of profound psychological disturbance as the outcome of high stress (e.g., rape, combat, natural disaster) is well documented (e.g.,

Charlson et al., 2016; Fink & Galea, 2015; McLaughlin et al., 2013; Scott et al., 2014). Such disturbance, in turn, can lead to a cascade of deleterious effects. For example, it is generally recognized that people who have been exposed to high-stress events are likely to exhibit a variety of physical symptoms (e.g., unexplained illnesses) that may require extended hospital stays and result in increased medical costs and work absences (Afari et al., 2014; Boscarino, 2011; Boscarino, Forsberg, & Goldberg, 2010; Eslick, Koloski, & Talley, 2011; McFarlane, 2010; Millegan et al., 2015; Subica, Claypoole, & Wylie, 2012; Tursich et al., 2014).

Sometimes the root of the problem is not a specific and dramatic traumatic event; rather, it is the accumulation of stressors such as those generally experienced, directly or indirectly, in the inner cities, developing nations, and/or war-torn countries (Anakwenze & Zuberi, 2013; Bunting, Ferry, Murphy, O'Neill, & Bolton, 2013; Donley et al., 2012; Miller & Rasmussen, 2010; van der Kolk, McFarlane, & Weisaeth, 1996). Stressors, whether specific or accumulated, can also impair the individual's sense of well-being, and her level of job performance (Barrett, Green, Morris, Giles, & Croft, 1996; Bremner et al., 1993; McFarlane, 2010; Scott et al., 2015; Wrocklage et al., 2016; van der Kolk, 2014). Also of serious concern are the findings that, if left untreated, trauma and associated stress conditions can impair the physical and mental development of children and contribute to a generational cycle of violence and psychological disturbance (Allen, Hauser, & Borman-Spurrell, 1996; Bücker et al., 2012; Carr, Martins, Stingel, Lemgruber, & Jurena, 2013; D'Andrea, Ford, Stolbach, Spinazzola, & van der Kolk, 2012; Elklit, Karstoft, Armour, Feddern, & Christoffersen, 2013; Ellason, Ross, Sainton, & Lawrence, 1996; Ford et al., 2013; Levenson & Grady, 2016; Perry, 1997; Perry, Pollard, Blakley, Baker, & Vigilante, 1995; Read et al., 2014; Sansone, Lam, & Wiederman, 2013).

There can be no doubt that many citizens of developing countries are seriously handicapped by the psychological and physical problems directly associated with stress reactions. Although the most obvious effects of exposure to traumatic events include the intrusive thoughts and exaggerated startle responses that characterize PTSD, other consequences are not so easily recognized, including mood volatility (e.g., hostile, passive, or depressed reactions), which, if left untreated, can lead to substance abuse, somatic illnesses, and accelerated aging (Bennett & Kerig, 2014; Miller & Sadeh, 2014, van der Kolk, 2015; van der Kolk & McFarlane, 1996; Wolf et al., 2016), as well as memory and concentration problems that can seriously disrupt job and academic performance (Adler et al., 2011; Kira, Lewandowski, Somers, Yoon, & Chiodo, 2012; Millegan et al., 2015; Perfect, Turley, Carlson, Yohanna, & Saint Gilles, 2016; Scott et al., 2015; Wrocklage et al., 2016).

Whether individuals are suffering from traumata engendered in developing countries or within the inner cities of developed nations, there is evidence that violence begets violence, and that some of our most prevalent

social problems are correlated with trauma histories (Folette, Polusny, Bechtle, & Naugle, 1996; Brignone et al., 2016; Donley et al., 2012; Ford, Chapman, Connor, & Cruise, 2012; Gillikin et al., 2016; Honorato, Caltabiano, & Clough, 2016; Levenson & Grady, 2016; Stimmel, Cruise, Ford, & Weiss, 2014; Weiss, Dixon-Gordon, Duke, & Sullivan, 2015).

Specific research is needed to explore the degree to which successful treatment of trauma decreases the amount of high-risk and/or perpetrator behavior and deters further victimization. Additional research is also needed to explore the degree to which neurobiological changes correlated with traumatization, cognitive deficits, affect dysregulation, and perpetrator behavior (Erickson, Hurley, & Taber, 2014; Perry, 1997; Perry et al., 1995; Schore, 20001; Siegel, 2012) can be reversed with the judicious application of EMDR, or any other treatment (Barsaglini, Sartori, Benetti, Pettersson-Yeo, & Mechelli, 2014; Quidé, Witteveen, El-Hage, Veltman, & Olff, 2012; Schore, Siegel, Shapiro, & van der Kolk, 1998; Thomaes et al., 2014). It seems self-evident that the ideal way to address pressing societal needs, on both local and global levels, is by the integration of science and practice.

A final area of proposed future research with important global implications is the examination of the efficacy of EMDR in treating traumatization from direct, natural, structural, and cultural causes (e.g., Carriere, 2014). Untreated traumas can have profound interpersonal and intergenerational consequences, as clearly indicated by research reporting that mothers suffering from PTSD have an increased likelihood of mistreating their children (Chemtob, Gudiño, & Laraque, 2013). Similarly, Afifi et al. (2012) reported, "Harsh physical punishment [i.e., pushing, grabbing, shoving, slapping, hitting] in the absence of [more severe] child maltreatment is associated with mood disorders, anxiety disorders, substance abuse/dependence, and personality disorders in a general population sample" (p. 184). These findings clearly indicate the need to make effective trauma treatments available worldwide.

Internationally, it is vital to devote resources to the investigation of treatment options with individuals living in underdeveloped areas in the world in which mental health professionals and facilities are scarce. Research should be designed to determine which protocols and procedures can be safely provided by paraprofessionals as psychological first aid. Also of concern in these regions is determining the best ways to remove the stigma about mental health treatment, so that it will be accepted in the same way that offers of physical treatment are embraced. This research has potentially important consequences for peaceful coexistence, as attempts at reconciliation of people beset by ethnopolitical violence are often hampered by unprocessed memories of trauma. Research has identified a negative attentional bias in people with PTSD (Pineles, Shipherd, Mostoufi, Abramovitz, & Yovel, 2009) that hampers their ability to disengage from threatening cues. Clearly, this can have a detrimental effect when

attempting to forge agreement and understanding, since the very sight of individuals long viewed as the enemy can disrupt any attempt at reconciliation. Fortunately, preliminary research indicates that EMDR therapy can restore normal cognitive processing and eliminate the attentional bias (El Khoury-Malhame et al., 2011). More research is needed, however, and this should include a direct examination of the effects of EMDR on the process of mediation and reconciliation, as well as attempts to counter the effects of negative historical memories handed down from adults to children that maintain and reinforce cultural antagonisms (e.g., Bombay, Matheson, & Anisman, 2014). The outcomes of such research will have important implications for reallocating resources and influencing both national and international social policies.

Nonprofit EMDR therapy associations that exist in North and South America, Europe, the Mideast, and Asia set training standards and provide clinical and research resources internationally (see Appendix F). In addition, the nonprofit EMDR humanitarian assistance programs (also listed in Appendix F) offer pro bono training worldwide after natural and man-made disasters to teach local clinicians how to administer EMDR therapy to those in need. These pro bono humanitarian efforts were initiated in response to the Oklahoma City bombing in 1995. An FBI agent on site requested assistance to deal with the traumatized populations in the city. A total of 186 EMDR clinicians from around the country volunteered their services to aid in the recovery process by providing direct services and conducting pro bono trainings. The clinical results of this project were consistent with the research published the same year in the *Journal of Clinical and Consulting Psychology* (Wilson et al., 1995, 1997), which reported an 84% elimination of PTSD within three sessions. The nonprofit Trauma Recovery/EMDR Humanitarian Assistance Programs was incorporated later that year and has been providing pro bono services after natural and man-made disasters both domestically and internationally ever since (Gelbach, 2014). Trauma Response Networks mobilize after local disasters such as after the September 11, 2001 terrorist attack to provide treatment, with clinical evaluations indicating substantial positive treatment effects and a return to normal functioning in the survivors (Silver et al., 2005; see also Alter-Reid, Colelli, & Simons, 2014). These efforts have been mirrored by national EMDR organizations worldwide (see Shapiro, 2014b) that provided pro bono training and treatment after disasters in Africa (Zimmermann, 2014), Asia (Farrell, 2014; Konuk & Zat, 2015; Mehrotra, 2014), Europe (Fernandez, Callerame, Maslovaric, & Wheeler, 2014; Matthess & Sodemann, 2014), Latin America (Jarero, Artigas, Uribe, & Miranda, 2014), and the Middle East (Zaghrout-Hodali, 2014). Participating clinicians throughout the world have extended their help, regardless of boundaries and borders, to assist in the alleviation of suffering. It is hoped that through such elimination of suffering we can also help to eliminate the cycle of violence worldwide.

As a helping profession, we must take help to where it is most needed. As a global network of committed clinicians and researchers, we must integrate our therapeutic practices and our scientific rigor in the service of humanity. To this end, the knowledge and practices of all the therapeutic disciplines are needed. I hope that the message of this book has been clear throughout: Clinicians must utilize everything they have ever learned to best serve their clients. EMDR therapy is offered as a tool in that integration process. Likewise, an integration of science and practice is needed to best guide us. The standards of scrutiny should be high, rigorous, and appropriate to the real-world concerns of clinicians. The clinicians are those who directly help to alleviate the world's suffering. The alleviation of that suffering is the duty of our profession.

SUMMARY AND CONCLUSIONS

The clinical effects of EMDR therapy in the treatment of trauma have been demonstrated in numerous RCTs, and EMDR therapy is now considered an empirically validated frontline treatment for PTSD in international guidelines. Research has also demonstrated positive effects with a wide range of other disorders, and additional rigorous RCTs are needed to strengthen and expand this effort. Several theories have been proposed to explain EMDR's therapeutic effects. These theories involve the procedural elements, as well as specific hypotheses about the bilateral stimulation component. The dominant theories involving the therapeutic effect of the EMs that have received research support include working memory, the orienting response, REM processes, and the activation of cortical functions that induce integrative processing.

Much more scientific investigation must be conducted on all of our psychotherapeutic approaches, and issues such as treatment fidelity, the use of appropriate standardized psychometrics and treatment comparisons, and the identification of suitable populations must be directly addressed in order to test methods sufficiently and inform research reviews so as to adequately guide the practicing clinician. Rigorous evaluation must assess both new applications and proposed alterations to the published protocols and procedures.

This book has been written to supplement supervised practice conducted by trained, experienced EMDR therapy instructors. Whether EMDR education takes place in formal, dedicated training sessions, within mental health agencies, or as part of graduate school curricula, it is only the beginning of the learning process. Once formal training is complete, it becomes the responsibility of all therapists and researchers using EMDR therapy, or any other treatment approach, to continue to upgrade their skills through ongoing practice, supervision, and consultation with more experienced practitioners. EMDR therapy has already helped to relieve

suffering for millions of people and has affected many more through their association with friends and family. Nevertheless, there are millions more who are suffering worldwide. Consider reaching out to participate in the humanitarian efforts. Seeing life and happiness return to those in need is its own reward. We join together in a commitment to do our best to ensure that no one is left behind.

> Just as the wave cannot exist for itself, but is ever a part of the heaving surface of the ocean, so must I never live my life for itself, but always in the experience which is going on around me.
>
> —ALBERT SCHWEITZER

APPENDIX A

Clinical Aids

Permission to photocopy the clinical aids in Appendix A of *Eye Movement Desensitization and Reprocessing (EMDR) Therapy, Third Edition,* is granted to purchasers of this book for personal use or use with clients (see copyright page for details). Purchasers can download enlarged versions of this material (see the box at the end of the table of contents). Copyright © 2018 Francine Shapiro. Published by The Guilford Press.

ADVERSE CHILDHOOD EXPERIENCES QUESTIONNAIRE

The Adverse Childhood Experiences (ACE) Study (Felitti et al., 1998) is the most influential epidemiological study of our time, conducted collaboratively by Kaiser Permanente San Diego and the Centers for Disease Control and Prevention (CDC). The study examined the impact of 10 categories of adverse experiences on over 17,000 individuals before the age of 18 with regard to future mental and physical health and well-being. The 10 categories included five personal experiences: physical, verbal, and sexual abuse; physical, and emotional neglect. Five are related to family members: an alcoholic or domestically abused parent; an incarcerated family member; a mentally ill family member; and the loss of a parent through divorce, death, or abandonment. Each endorsed category of trauma counts as a score of 1, regardless of the number of times it was experienced. Therefore, a person who experiences 10 episodes of sexual molestation would score a 1 for that category. A person who has a mentally ill parent, experienced divorce, and had a substance-abusing parent would score a 3, equal to the number of reported categories.

The study's authors reported a total ACE categories score to determine a person's risk for future health and mental health disorders. The higher one's ACE score, the higher the risk of disease, social disorders, and emotional disorders. An ACE score of 4 begins to increase risk significantly. For example, an ACE score of 4 or more increases the risk of adult alcoholism by 500%. A child with a score of 6 or more ACEs increases the likelihood of becoming an adult smoker by 250% and of experiencing chronic pulmonary disease by 390% (no coincidence). A male child with an ACE score of 6 has a 4,600% increased likelihood of becoming an intravenous (IV) drug user, and 78% of IV drug use in women is attributable to

intravenous (IV) drug user, and 78% of IV drug use in women is attributable to ACEs. Depression increases 460% and suicide 1,200% with ACE scores of 4 or more. These are staggering statistics for a study of this magnitude.

This 10-question abbreviated version of the ACE Questionnaire can be used in EMDR therapy during Phase One (history taking and treatment planning) to determine targets for reprocessing. For example, Jane endorsed seven categories of ACEs. Representative incidents from each of the eight categories were identified and assessed. Physical, emotional, and sexual abuse accounted for three ACES, generating the following negative cognitions: "I'm worthless," "I'm disgusting," and "I'm unlovable." Parental substance abuse and divorce accounted for two more ACEs, leading Jane to believe "I'm not safe," "I'm disposable," and "I have no control." Her mother's mental illness added another ACE, leaving her with the negative belief that she was "defective." The last ACE involved her mother's emotional neglect, from which Jane concluded, "I am not worth love or care," "I am invisible," "I am different," and "I can't express my emotions." The wide range of Jane's negative cognitions covers the three plateaus of self-worth, safety, and power, and presents a complex clinical picture. However, the ACE Questionnaire allowed the clinician to rapidly determine the contributors to dysfunction and identify the memories to be targeted for processing through the use of direct questioning, as well as the Floatback and Affect Scan techniques.

WHAT'S MY ACE SCORE?

Prior to your 18th birthday:

1. Did a parent or other adult in the household **often or very often** . . .

   Swear at you, insult you, put you down, or humiliate you?

   or

   Act in a way that made you afraid that you might be physically hurt?

   Yes No If yes, enter 1 _____

2. Did a parent or other adult in the household **often or very often** . . .

   Push, grab, slap, or throw something at you?

   or

   Ever hit you so hard that you had marks or were injured?

   Yes No If yes, enter 1 _____

3. Did an adult or person at least 5 years older than you **ever** . . .

   Touch or fondle you or have you touch their body in a sexual way?

   or

   Attempt or actually have oral, anal, or vaginal intercourse with you?

   Yes No If yes, enter 1 _____

4. Did you **often or very often** feel that . . .

   No one in your family loved you or thought you were important or special?

   or

   Your family didn't look out for each other, feel close to each other, or support each other?

   Yes No If yes, enter 1 _____

5. Did you **often or very often** feel that . . .

   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?

   or

   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

   Yes No If yes, enter 1 _____

6. Was a biological parent **ever** lost to you through divorce, abandonment, or other reason?

   Yes No If yes, enter 1 _____

7. Was your mother or stepmother:

   Often or very often pushed, grabbed, slapped, or had something thrown at her?

   or

   Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?

   or

   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

   Yes No If yes, enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic, or who used street drugs?

   Yes No If yes, enter 1 _____

9. Was a household member depressed or mentally ill, or did a household member attempt suicide?

   Yes No If yes, enter 1 _____

10. Did a household member go to prison?

    Yes No If yes, enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score.

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EMDR THERAPY SCREENING AND DATA CHECKLIST

The following sample checklist may be helpful to record pertinent data and dates of important communications to the client. Additional space or sheets will be necessary for actual use.

Name: _____ Date: _____

Type and amount of previous counseling: _____

_____

Present medications: _____

☐ Results of objective tests _____

☐ Mental status exam plus dissociative disorder screening

☐ Sufficient rapport (feeling of safety, degree of truth telling)

☐ Ability to use self-control techniques tested positive with _____

_____

☐ Personal and environmental stability: Factors needing attention are _____

_____

☐ Life supports: _____

_____

☐ Physical health (areas of concern include neurological impairment; pregnancy; cardiac, respiratory, and geriatric issues; seizures, and eye problems): _____

_____

_____

☐ Inpatient treatment (medical needs; nature of the traumatic memory; is client a danger to self or others?): _____

_____

☐ Medication needs: _____

☐ Drug or alcohol abuse (supports; program; was briefing given of potential exacerbation?): _____

_____

☐ Legal restraints (processing effects/forensic issues): _____

_____

☐ Systems control: _____

☐ Secondary gains (action planned): _____

☐ Timing considerations: _____

☐ Reporting requirements: _____

- ☐ Terms in which theory was explained: information stored in brain, blocked learning, REM, hemispheres, or other? _____
- ☐ Informed consent: Mention possibilities that distressing, unresolved memories may surface; that unanticipated reactions may include disturbing emotions or sensations; and that between-session disturbance, such as nightmares or other memories, may occur.
- ☐ Test eye movement (client's preferences? which movements to avoid? alternative stimuli to be used?): _____
- ☐ Metaphors (train, tiger, tunnel, other?): _____
- ☐ Safe/Calm Place (specify place and word): _____
- ☐ Stop signal: _____
- ☐ Other: _____

_____

_____

CLIENT HISTORY FORM

These questions can be incorporated into the History-Taking Phase in order to aid case conceptualization and client management. Questions about substance abuse, mental status exam, and standard psychometrics are all part of generic history taking and are not covered below. The following questions are meant as guides in a checklist format. Initial rapport building and general "get acquainted" conversation is assumed. From the very beginning, look for earlier events that set the groundwork for the pathology, the present situations and people that trigger disturbance, as well as what skills and deficits need to be addressed for the future.

Name: _____ Date: _____

1. What are the reasons the client came for therapy?

2. What are the client's goals?

3. What are the client's symptoms?

4. When did the symptoms start?

5. What else was happening at that time? *(contributing events)*

6. Have the symptoms changed? If so—how/when?

7. Why did the client decide to come in now?

8. What other situations may be contributing at this time?

9. Is there any crisis or situation needing an action plan? *(e.g., danger, family reunions, tests)*

10. Present medications *(plus effects of and feelings about them)*

11. Previous therapy:
    - Reason and focus
    - What kinds? *(descriptions of memorable interactions)*
    - Length of therapy
    - Quality of relationship with therapist *(any problems?)*
    - What characteristics does client look for in a therapist?
    - Why did the client stop treatment?
    - Results of therapy including:
    - What did s/he learn that was useful? How was it disappointing?
    - Was there anything s/he never addressed? *(events/situations/symptoms/issues)*
    - What did client like and not like in previous therapy?

12. Present relationships—spouse/partner/significant other/children *(include quality of these relationships)*

13. Other current caring friends and relatives

14. Current and previous work/school situations and relationships *(bosses/colleagues)*

15. Successes/Strengths/Feeling protective of anyone? *(useful for Cognitive Interweaves)*

16. How would client know if therapy is successful?

17. What would happen if therapy is successful? Would there be a downside? Would anyone in the client's life have a problem with this?

18. Attachment issues?

19. Issues related to race, ethnicity, culture, and nationality?

20. Religious influences/issues

21. Issues related to gender identity and sexual preference

22. Relationships with parents—past and present *(use pictures from childhood to discuss, if possible)*

23. Quality/examples of relationship between parents—past and present

24. Quality/examples of relationships with siblings—past and present

25. Friends/mentors in childhood and adolescence *("Who really cared about you? How did that feel?" Subsequent disappointments.)*

26. School experience/teachers/peers—positive and negative

27. "Is there anything I haven't asked that you feel is important for me to know?"

28. Use of various self-control techniques in order to increase access to resources *(positive memories and projective experiences)*

29. How does client presently self-soothe? *(including exercise, yoga, meditation, drugs, drinking, shopping, etc.)*

30. Hobbies and fun activities:

31. Additions:
    - Safe/Calm Place(s): image, emotions, sensations, cue word/phrase
    - Resource Enhancement (e.g., RDI): image, emotions, sensations, cue word/phrase
    - Additional: Light Stream, Breath, Hypnosis, Other *(specify)* _____
    - Therapeutic relationship experiences/exercises (for stability within and between sessions)

32. Time line. Ask for 10 most disturbing memories and place them on a chronological time line. Explain 0–10 SUD scale and indicate level of disturbance as a baseline. Do the same for 10 most positive memories.
    - Sometimes it is useful to ask: "On this time line, what are the most important events—good and bad—that formed the person you are today?" Or "When are the times that things changed?" Specifically ask for deaths/losses (including animals) and humiliations.

33. Negative Cognition checklist: Ask clients to check off the ones that give them a feeling in their body and/or "feels like them" when they are disturbed. These can be used to identify the earliest memories that set the groundwork for them. These events are also placed on the time line.

34. People and present situations that cause disturbance. These triggers are used to access specific memories of present events that will be targeted with an Affect Scan or Floatback to identify the pertinent Touchstone Memories. These Touchstone Memories will be processed in the first stage of the Three-Pronged Protocol. Then the triggers will be targeted and processed. Each triggering situation will also be the basis for the processing of a future template.

35. Observations of therapeutic, family, and other systemic interactions that indicate automatic responses and deficits that will need to be addressed.

36. List kinds of skills and experiences necessary to bring the client to a full level of mental health and adaptive functioning (happiness, confidence, bonding, contributing). For instance, what relationship skills or experiences are needed? Most needs will be further revealed as therapy progresses. What types of experiences are needed to maintain the client's motivation to continue therapy?

37. Personal feelings about client. To foster self-awareness, evaluate as if from a third-person perspective: What sensations arise in the therapist's body? How comfortable is the therapist with the way the client demonstrates affect? What personal issues may arise from client's problems? These involve the therapist's own memory networks that are stimulated. What may need to be processed? How comfortable does the therapist feel about disclosure/honesty.

RECOMMENDED FORMAT FOR WEEKLY LOG (TICES) REPORT

Client compliance with homework assignments asking for reports can be assisted by supplying the following log. It offers the client a specific format that limits the amount of work necessary. The client writes only a short description in each column when an experience comes up that needs to be reported. The first column designates the date. The rest of the columns ask for a few words regarding the experience: (1) the triggering event, (2) the image that arose, (3) the cognition/belief that emerged, (4) the emotion, (5) the sensations and SUD score/disturbance level. Placing the description in this order is a duplication of what is needed to target the event in a subsequent session. It reminds the client to break the disturbance into the attendant parts. It also notes just the information necessary to remember what happened and convey it to the clinician. Once the description is filled in, the client uses a self-control technique to dissipate the disturbance.

WEEKLY LOG (TICES) REPORT

Date	Trigger	Image	Cognition	Emotion	Sensation/SUD

NEGATIVE AND POSITIVE COGNITIONS

Clinicians may find it useful to offer clients the list of sample negative and positive cognitions on this page. Generally, clients can make an appropriate selection or use the examples as a starting point to construct choices more suitable to their particular problems. The grouping into Responsibility/Defectiveness, Responsibility: Action, Safety/Vulnerability, and Power/Control/Choice may be helpful for the initial selection. However, there are nuances to many of the cognitions, whereby they overlap or are a combination of two or more categories. The selection should be one that resonates most for the individual, one that articulates the dysfunctional affect that pervades the person when he or she thinks of the event.

EXAMPLES OF NEGATIVE AND POSITIVE COGNITIONS

Negative Cognitions	Positive Cognitions
Responsibility/Defectiveness	
I'm not good enough	I am good enough/fine as I am
I don't deserve love	I deserve love; I can have love
I am a bad person	I am a good (loving) person
I am incompetent	I am competent
I am worthless/inadequate	I am worthy; I am worthwhile
I am shameful	I am honorable
I am not lovable	I am lovable
I deserve only bad things	I deserve good things
I am permanently damaged	I am/can be healthy
I am ugly/my body is hateful	I am fine/attractive/lovable
I do not deserve . . .	I can have/deserve . . .
I am stupid/not smart enough	I am intelligent/able to learn
I am insignificant/unimportant	I am significant/important
I am a disappointment	I am OK just the way I am
I deserve to die	I deserve to live
I deserve to be miserable	I deserve to be happy
I am different/don't belong	I am OK as I am
I have to be perfect (out of inadequacy)	I am fine the way I am
Responsibility: Action	
I should have done something*	I did the best I could
I did something wrong*	I learned/can learn from it
I should have known better*	I do the best I can/I can learn
*What does this say about you? (e.g., I am shameful/I am stupid/I am a bad person)	I'm fine as I am
I am inadequate/weak	I am adequate/strong

Negative Cognitions	Positive Cognitions
Safety/Vulnerability	
I cannot trust anyone	I can choose whom to trust
I cannot protect myself	I can learn to protect myself
I am in danger	It's over; I am safe now
I am not safe	I am safe now
I am going to die	I am safe now
It's not OK (safe) to feel/show my emotions	I can safely feel/show my emotions
Power/Control/Choice	
I am not in control	I am now in control
I am powerless/helpless	I now have choices
I cannot get what I want	I can get what I want
I cannot stand up for myself	I can make my needs known
I cannot let it out	I can choose to let it out
I cannot be trusted	I can be trusted
I cannot trust myself	I can/learn to trust myself
I cannot trust my judgment	I can trust my judgment
I cannot succeed	I can succeed
I have to be perfect	I can be myself/make mistakes
I can't handle it	I can handle it

FORM AND SEQUENCE FOR TECHNIQUES TO IDENTIFY PAST EVENT

Earlier memories setting the groundwork for dysfunction should be processed before current events. These procedures may be used when the client is unable to easily identify an earlier target for processing.

Affect Scan (Shapiro, 1995)

The Affect Scan is particularly useful when earlier memories are not readily accessible, when they took place at an extremely young age, or when clients have difficulty putting into words negative thoughts or feelings about themselves. It can also be used during reprocessing when the client gets stuck in an emotional state and it doesn't shift on its own with bilateral stimulation. The client is asked to focus on the experience, emotions, and sensations. Instruct him:

> "Hold the experience in mind, notice the emotions you're having right now and notice what you're feeling in your body. Now let your mind scan back to an earlier time when you may have felt this way before and just notice what comes to mind"

Floatback Technique (Young, Zangwill, & Behary, 2002)

Can be used to identify a childhood memory potentially causing current dysfunction that is not accessible through direct questioning. Ask the client to bring to mind the recent disturbing experience, identify the negative cognition, and notice the associated physical sensations. Then instruct him: **"Now hold the image and negative belief in mind, and notice the sensations in your body, and just let your mind float back to an earlier time and tell me the first scene that comes to mind where you felt this way before."**

EMDR THERAPY PROCEDURAL OUTLINE

Explanation of EMDR

Wording of the explanation of the EMDR therapy depends on the age, background, experience, and sophistication of the client.

> "When a trauma occurs it seems to get locked in the brain with the original picture, sounds, thoughts, and feelings. The eye movements we use in EMDR seem to unlock the system and allow the brain to process the experience. That may be what is happening in REM or dream sleep—the eye movements may help to process the unconscious material. It is important to remember that it is your own brain that will be doing the healing and that you are the one in control."

Specific Instructions

"What we will be doing often is a simple check on what you are experiencing. I need to know from you exactly what is going on, with feedback that is as clear as possible. Sometimes things will change and sometimes they won't. I'll ask you how you feel from 0 to 10; sometimes it will change and sometimes it won't. I may ask if something else comes up; sometimes it will and sometimes it won't. There are no 'supposed to's' in this process. So just give feedback as accurately as you can as to what is happening, without judging whether it should be happening or not. Let whatever happens, happen. We'll do the eye movements for a while, and then we'll talk about it."

- *Stop signal:* "If at any time you feel you need to stop for any reason, raise your hand."
- *Establishing appropriate distance:* "Is this a comfortable distance and speed?"
- *Presenting issue:* "The issue we have agreed to address is _____."
- *Target memory (or trigger):* "What incident would you like to work on today?" or "The incident we have agreed to work on today is _____."
- *Image:* "What picture best represents the experience to you?" or "What picture represents the **worst part** of the experience as you think about it now?"
- *Negative cognition (NC):* "What words go best with that picture that express your negative belief about yourself now?" or "What negative belief about yourself comes up as you think of that picture now?" (Have client make the statement in the form of an I-statement in the present tense. This must be a presently held negative self-referencing belief.)
- *Positive cognition (PC):* "When you bring up that picture (or experience), what would you prefer to believe about yourself instead?" (This must be a presently desired self-referencing belief.)

- *VOC* (for PC only): "When you think of the memory, how true do the words *(repeat the PC above)* feel to you now on a scale from 1 to 7, where 1 feels completely false and 7 feels completely true?"

- *Emotions/feelings:* "When you think of the memory and the words *(repeat the NC),* what emotions do you feel now?"

- *SUD scale:* "On a scale of 0 to 10, where 0 is no disturbance or neutral and 10 is the highest disturbance you can imagine, how disturbing does it **feel** to you **now**?"

- *Location of body sensation:* "Where do you feel it [the disturbance] in your body?"

- *Desensitization:* "[I'd like you to] bring up that picture, those negative words *(repeat the NC),* notice where you are feeling it in your body, and follow my fingers."

1. Begin the eye movements slowly. Increase the speed as long as the client can comfortably tolerate the movement.
2. Approximately every 12 movements, or when there is an apparent change, comment to the client, **"That's it. Good. That's it."**
3. It is helpful to make the following comment to the client (especially if the client is abreacting): **"That's it. It's old stuff. Just notice it."** (Also use the speeding train metaphor.)
4. After a set of eye movements, instruct the client to **"Blank it out"** or **"Let it go and take a deep breath."**
5. Ask: **"What do you get now?"** or **"What are you noticing now?"**
6. If the client reports movement, say, **"Go with that"** or **"Notice that"** (without repeating the client's words).

The client should be reporting a 0 or 1 (or otherwise ecologically valid) on the SUD scale score before doing the installation.

- *Installation of positive cognition* (linking the desired positive cognition with the original memory or image):

1. "Do the words [*repeat the positive cognition*] still fit, or is there another positive statement you feel would be more suitable?"
2. "Think about the original incident and those words [*selected positive cognition*]. From 1, completely false, to 7, completely true, how true do they feel?"
3. "Hold them together." Lead the client in an eye movement set. "On a scale of 1 to 7, how true does that [*positive statement*] feel to you now when you think of the original incident?"
4. VOC scale: Measure the VOC score after each set. Even if the client reports a 6 or a 7, do eye movements again to strengthen, and continue until validity no longer strengthens. Go on to the body scan.
5. If the client reports a 6 or less, check appropriateness and address blocking belief (if necessary) with additional reprocessing.

- *Body scan:* "Close your eyes; concentrate on the incident and the PC, and mentally scan your body. Tell me where you feel anything." If any sensation is reported, do BLS. If a positive/comfortable sensation, do BLS to strengthen the positive feeling. If a sensation of discomfort is reported, reprocess until discomfort subsides.

- *Closure (debriefing the experience):* "The processing we have done today may continue after the session. You may or may not notice new insights, thoughts, memories, or dreams. If you do, just notice what you are experiencing. Take a snapshot of it (what you are seeing, feeling, thinking, and the trigger), and keep a log. We can work on this new material next time. If you feel it is necessary, call me."

After the target memory and trigger(s) are processed, a Future Template is installed using the following sequence. BLS is used to process any distress that arises and then strengthen the adaptive movie and PC.

> "We have worked on past experiences relating to your issue, as well as current situations that have triggered you. I'd like to suggest that we now work on how you will respond in the future to the same or similar situations."

- *Scene:* "I'd like you to imagine yourself dealing with the same or similar situation in the future, responding in an adaptive way, while thinking of your positive belief (PC)."

- *Movie:* "Now I'd like you to run a movie dealing effectively with this situation, holding in mind the positive belief you have about yourself."

- *Challenges(s):* "I'd like you to think of a challenge situation that could occur."

APPENDIX B

Client Transcripts

These two client transcripts illustrate the EMDR therapy reprocessing procedures described throughout the text. The first transcript involves the treatment of a combat veteran and guides the reader through the eight phases and the three-pronged protocol described in Chapter 8. The second transcript involves the treatment of a molestation survivor and guides the reader through the application of the cognitive interweave described in Chapter 10.

THREE-PRONGED PROTOCOL WITH A COMBAT VETERAN

Identify Current Symptoms

THERAPIST: All right, so what would you like to work on? What's the biggest problem for you that's going on, that you'd like to work on?

CLIENT: My anxiety. When I'm in certain situations, I guess.

THERAPIST: Uh huh.

CLIENT: The biggest thing for me is just . . . I have shortness of breath and tightening in the chest, and I start shaking and I would like not to do that, at least as much, or, as severe, as it can get sometimes.

THERAPIST: Okay. Now when does that happen?

CLIENT: In social situations, when I'm around a lot of people; whether it be going out to dinner or walking down the street. If there's a crowd. Like when I go with my wife to a restaurant or store I feel that anxiety, like I want her protected kind-of-a-thing and that really builds up my anxiety, huge, when I'm out with *her*.

THERAPIST: Okay, can you think of a specific example when this happened?

CLIENT: Yeah, when we were walking through the supermarket and a couple of younger guys had walked up. She was looking at some food items and they

walked up and they were reaching over her and trying to get stuff off the shelf. I was standing behind the cart and just a little ways from her and I started to really get agitated. I ended up telling her, "Let's just go look at something else. These guys are being jerks," and walked away because I was getting really agitated and very nervous for her.

THERAPIST: All right, so, when you're thinking of that incident now, what moment stands out for you right now; the image that would represent the worst part of that experience?

CLIENT: Those guys being so close to her, I guess.

THERAPIST: Okay.

CLIENT: Hovering over her.

THERAPIST: And now, let's talk about that negative belief you have about yourself when you're thinking about it. It sounds like it's a sense of "I'm not safe, or we're not safe."

CLIENT: (*nodding*) Yeah.

THERAPIST: Any other words that you would use to describe what your mind frame is?

CLIENT: Yeah, lack of control, because I'm not in control of the situation.

THERAPIST: Okay, so "I'm not in control."

CLIENT: Yeah.

THERAPIST: And as you think of that situation, and the words "I'm not in control," what are the emotions that you experience right now?

CLIENT: Anxiety, a feeling of I just want to be in control.

THERAPIST: Okay and where do you feel this in your body?

CLIENT: In my chest and in my arms.

Floatback

THERAPIST: Okay. Now, one of the things that we can do is find what this might be connected to. I'm just going to ask you to think of this situation. Notice your feelings, sensations; just kind of see where we can take you back to.

CLIENT: Okay.

THERAPIST: Okay, so I'd like you to just close your eyes and think of that situation at the supermarket and those words "I'm not in control." Notice the emotions and sensations that are coming up and just let your mind float back to a time when you may have felt this way before, and just notice what comes to mind. Just let whatever happens, happen. *(Client closes his eyes.)* Okay. You can open your eyes and tell me what came up for you.

CLIENT: Couple things did. There was a time when I was the team leader on a convoy and I was in the rear vehicle, and a guy on a motorcycle came up and tried to get in between my vehicle and the vehicle in front of us, and there was a lot of yelling going on, on the radio, "Take him out," and I had to have my driver go up and hit his motorcycle and run over him. Later we found out that he did have a bomb on his motorcycle and he was trying to get into our convoy. That

lack of control, right there, because I didn't know how best to handle it and I didn't want to kill the guy, but it was a what we had to do kind of a thing.

THERAPIST: Can you tell me more?

CLIENT: I was the team leader on that mission. I just think of all the guys around me being so much younger than me, and I'm the old man that keeps everybody safe. It's just not having control over the situation. I thought about it a lot, after it happened, because I tried to think about everything I could have done differently. I suppose it is just part of the job, and I guess I just did what I had to do. I don't know how big the bomb was or if it would actually have hurt us in the armored vehicles, or not, but I couldn't take that chance.

Assessment

THERAPIST: Okay. So the image that comes to you now, the image that represents the worst part is?

CLIENT: It's the image of his face just looking at me in anger.

THERAPIST: And the words that go with this image that describe your negative belief about yourself now? "I'm . . ."

CLIENT: Powerless.

THERAPIST: "I'm powerless." Okay. So you bring up this moment and the words, "I'm powerless." So let's talk about a goal now. What words would you rather have, instead of "I'm powerless"?

CLIENT: Well, I would like to know that it wasn't my fault; that I did everything right; that I did what I had to do.

THERAPIST: All right. So "I did what I needed to do."

CLIENT: Yeah. That gives me a sense of control. I did what I needed to do, and I was justified, I was right.

THERAPIST: Got it. What you would like to believe about yourself is "I did what I needed to do, and I was right." *(Note: Given that the client's words resonate a sense of control for him, the negative and positive cognitions are on the same dimension.)*

THERAPIST: Okay, when you bring up the image of this man's face, how true do the words "I did what I needed to do, and I was right" feel to you? On a scale from 1 to 7: 1 = false, 7 = true. Now your head knows it's a 7. Now what would your gut say? How true does it feel?

CLIENT: Probably a 1 or a 2.

THERAPIST: Okay. Now, when you bring up this guy's face, and those words "I'm powerless," what are the emotions that you have right now?

CLIENT: Sadness.

THERAPIST: How disturbing is this memory right now, 0 to 10? If 0 were calm and 10 were the worst it could be?

CLIENT: Seven, 8.

THERAPIST: Where do you feel that in your body?

CLIENT: In my gut and my chest.

Desensitization

THERAPIST: Okay. So, bring up that image, those words "I'm powerless." Notice those sensations that are in your body, and just follow. *(EM)*

THERAPIST: Good. Take a breath.

CLIENT: My mind feels calmer about it. It's not as intense a feeling. It's still there. I feel it in here. It's just not as intense.

THERAPIST: Just notice that. *(EM)*

THERAPIST: And now?

CLIENT: More relaxed. When I picture his face, in my mind, it's there but it's not as intense. I guess that's the only way I can really explain it.

THERAPIST: Uh hmm. Just notice that. *(EM)*

THERAPIST: Now?

CLIENT: Much calmer.

THERAPIST: Okay.

CLIENT: In my mind, it isn't racing around.

THERAPIST: Okay. So now, when you go back to this incident, what comes up for you? What do you notice?

CLIENT: I notice I'm not jumping around thinking about all the different scenarios in my head.

THERAPIST: Uh hmm.

CLIENT: It feels like it happened. It was the only thing that could happen and I came out okay and my team's okay. It's not as intense, at all.

THERAPIST: Well, let's just notice that. *(EM)*

CLIENT: I don't feel anything in my gut anymore.

THERAPIST: Okay. 0 would be calm and 10, the worst.

CLIENT: Maybe a 1, probably a 0.

THERAPIST: Let's just go with that. *(EM)*

CLIENT: I'd say it's a 0. It's kind of interesting. I feel like it's in the past almost; like I'm not living it right now. I'm not there.

Installation

THERAPIST: Okay. Now do the words "I did what I needed to do and I was right" still fit? Or are there some other words that maybe now might be more suitable or appropriate?

CLIENT: No, I feel more confident in those words, that I was right. I feel like that was my only option. I don't have any doubt, as I did before. I had a lot of doubts when I'd think about that situation.

THERAPIST: So the words "I'm right" really fit for you.

CLIENT: Yeah.

THERAPIST: Okay. Now when you bring up that memory, how true do those words, "I'm right; I did what I had to do" feel? If 1 = false, 7 = true, how true do they feel now?

CLIENT: Oh, I'd say a 6 to a 7.

THERAPIST: Okay, so, again, think of that situation, think of that moment, bring it up together with those words, "I'm right." Hold them together and follow. *(EM)*

CLIENT: Yeah. I definitely feel . . . I feel more relaxed about the whole thing and that I am justified in what I did.

THERAPIST: Okay. How true, when you bring up the memory of those words "I am justified." How true do they feel when you say them?

CLIENT: Oh, it's a 7.

THERAPIST: Okay, let's just go with that. *(EM)*

THERAPIST: And 1 to 7, the words, "I'm justified," how true do they feel now?

CLIENT: 7.

Body Scan

THERAPIST: So, if I can ask you to close your eyes and bring up the memory and the words "I am justified," and scan your body as you're thinking that, and starting from the top of your head and going downward, let me know if there's any tightness or tension or any unusual sensation.

CLIENT: Nothing.

THERAPIST: Okay, good. Let's just notice that. *(EM)*

THERAPIST: And now.

CLIENT: No, no tightness in my chest. I don't feel the tingly sensation in my arms or anything. I don't feel like I'm ready to move.

THERAPIST: Okay, good.

CLIENT: I feel relaxed.

Closure

THERAPIST: So let's just reflect on what happened now and what's different for you, when you think of this memory.

CLIENT: It's hard to explain, but it feels like it's in the past.

THERAPIST: Uh hmm.

CLIENT: It all happened before now. I feel relaxed and comfortable and solid now and like I'm living in the now.

THERAPIST: Okay.

CLIENT: And not going over in my head, different things about that situation: different scenarios, what could have happened or didn't happen. It's just complete, final.

THERAPIST: Okay, great. Any other thoughts or reflection on this process?

CLIENT: I continue to be amazed. I don't understand why, but it worked and it's just amazing to me.

THERAPIST: So, again, the processing may continue after this session. Other thoughts, other memories. Things may continue to come up; there may be dreams about it. Be mindful of what's happening. Remember to keep a log,

and you might want to even take a few notes about anything that comes up just so we can talk about it next time and go on from there.

CLIENT: Good.

Reevaluation

THERAPIST: All right, so how did the night go?

CLIENT: It went really well. I was amazed at how exhausted I felt. My wife called me on the way home and she asked me how it went. I said, "It went well but I'm just really tired." I went home and fell right to sleep and didn't wake until this morning when my alarm went off. I usually have trouble sleeping so it was really, really nice to be able to do that.

THERAPIST: Great. So have you noticed any changes in how you respond to the issues that we've been working on, in terms of startle response and feelings like safety?

CLIENT: Yeah, when I think back to Afghanistan now, since last night, I don't get as tight as I did before. My chest doesn't get that sinking feeling as I did before. It really helped overall. I still have hesitation when it comes to thinking about going to the store. My wife was telling me last night that we have to go to the store because we don't have any food in the house. I don't feel as nervous about it. I'm not going through my head what we're going to get, where we're going to go exactly, so we can get in and get out as quickly as possible. But I still feel like I'm going to be upset and, if possible, I want to just get past that last step and be as done with it as I can.

THERAPIST: Okay. So just to see how we're doing with the memory we worked on. If you think of the memory of the incident what comes up?

CLIENT: I still see the face but it just doesn't bring up the hard feelings that I had about it before. I feel like I've processed it in my mind. It's behind me. It is a past thing. It's not something I'm going to have to go through again.

THERAPIST: Any other insights or thoughts about it?

CLIENT: I thought about it last night and I was wondering why that one was so big in my mind. I think it's because that face was right there. I was looking at that face and I remember the look in his eyes, and I could tell the feelings that he was having. We were that close. The other instances weren't maybe as personal to me. I could stand back. This one was really personal with me.

THERAPIST: That eye contact.

CLIENT: Yeah. I think that was it.

THERAPIST: When you think about that incident now, anything else come up, any other connections?

CLIENT: No, even right now, I feel apart from it. I feel apart from him, personally.

THERAPIST: Zero to 10, now?

CLIENT: Oh, I'd say 0.

THERAPIST: Zero? Okay. Now there were some other incidents you talked about relevant to Afghanistan. There was the helicopter crash, and where the truck was coming head-on.

Identify New Target

CLIENT: Yeah. I don't know if my mind is dealing with them differently, as a whole, but it just doesn't seem to bother me as much as it did before. I go through the helicopter incident in my mind, but it just doesn't make me tight and anxious. I don't know why, can't explain it, but it just doesn't. I don't feel like it's a problem for me anymore.

THERAPIST: Okay. We've used that 0 to 10 scale. As you go back to that helicopter, how does that resonate for you, now from zero to 10?

CLIENT: I would say a 1. Yeah, a 1, just because of a tinge of feeling I get in my chest when I think about it, versus the guy on the motorcycle.

THERAPIST: Okay. Let's just go through this one and we'll just do the same thing we did before. When you think of the helicopter crash, what's the moment, the image that stands out for you?

CLIENT: When I heard over the radio that we'd taken fire and that we had to land. "Right now" is what the pilot said. And looking at the other guys in the back of the helicopter with me and thinking, "Oh shit." There was that "Oh shit" moment again, because at that point, it was all up to the guy flying the helicopter. It was at night. I didn't know where we were going to land, didn't know *how* we were going to land, didn't know how hard of a landing it was going to be.

THERAPIST: When you bring up that moment now, let's talk about the words that would go with that moment; that would express the negative belief or sentiment that you have about yourself. Now, not then. Right now. What still resonates; that "I am . . . " statement?

CLIENT: I am powerless.

THERAPIST: Okay, and what words would you rather have? What would you rather believe about yourself? What's our goal instead of "I'm powerless"?

CLIENT: I can persevere through it.

THERAPIST: I can persevere. Does that fit?

CLIENT: Yes.

THERAPIST: And right now when you bring up this moment with the helicopter, this image, how true do the words "I can persevere" feel to you now, on a 1 to 7 scale, where 1 is false and 7 is true, right now?

CLIENT: Three.

THERAPIST: Okay and when you bring up this moment, the helicopter, and "I'm powerless, helpless," what are the emotions right now?

CLIENT: Scared.

THERAPIST: And 0 to 10, how disturbing is it right now? Zero would be calm, 10 the worst, right now.

CLIENT: Right now, 5.

THERAPIST: And where do you feel that in your body?

CLIENT: Right here in my chest.

Process Event

THERAPIST: So bring up the image, those words, "I'm powerless, helpless." Notice those sensations in your body, and follow. *(EM)*

CLIENT: My chest isn't as tight. It's not fluttering as much when I think about it, but it's still there.

THERAPIST: Okay. Just notice that. *(EM)*

CLIENT: When I think about that feeling and that picture in my head, it doesn't feel as bad here. (*Pointing to chest.*) I feel like it's more in the past, right now. It doesn't feel like it happened yesterday. It feels like it happened a long time ago.

THERAPIST: Just notice that. *(EM)*

CLIENT: It feels like it's in the past.

THERAPIST: Okay, so when you go back and you think about this helicopter incident now, what comes up for you?

CLIENT: Not really any feeling at all.

THERAPIST: Okay. Zero to 10, how disturbing does it feel now? Again, zero's not the absence of emotion. Zero means it's calm, neutral. Ten's the worst it can be.

CLIENT: Zero.

THERAPIST: Okay. Let's just go with that. *(EM)*

CLIENT: Completely calm about it.

THERAPIST: Do the words "I can persevere" come to mind. . . ? Are there other words that may be more suitable?

CLIENT: "I made it; I can persevere."

THERAPIST: Okay. Now when you bring up this helicopter incident, how true do those words "I made it; I can persevere" feel? With 1 totally false, 7 totally true, right now?

CLIENT: Seven.

THERAPIST: So, think of that memory of the helicopter incident and those words "I'm alive" together and follow. *(EM)*

CLIENT: Yeah, it's in the past.

THERAPIST: How true do the words "I made it; I can persevere" feel, 1 to 7?

CLIENT: Seven.

THERAPIST: Okay. So if I can ask you to close your eyes and think of the helicopter incident and the words "I'm alive," and scan your body starting at the top of your head and going downward, let me know if there's any tightness, tension, or unusual sensation.

CLIENT: No.

THERAPIST: All right, great. Just notice that and follow my fingers. *(EM)*

CLIENT: Really relaxed.

THERAPIST: All right, great. How's the truck incident you mentioned?

CLIENT: I thought about that last night and this morning on the way to school, and I just don't feel anything to do with that at all. It feels okay.

THERAPIST: Any other memories of Afghanistan?

CLIENT: No, and there's a lot of instances I talked to you a little bit about. After engagements, seeing dead bodies and stuff like that, but now I don't feel any constriction in my chest about it. I feel very relaxed and good about the whole thing.

Target Current Trigger

THERAPIST: Let's process some of the more recent experiences you had.

CLIENT: Okay.

THERAPIST: You were telling me about that incident at Safeway, with your wife.

CLIENT: Yeah, the guys were kind of crowding her.

THERAPIST: Right.

CLIENT: It was hard, because I wanted to get myself and her out of the situation. Sometimes I feel like I try to avoid confrontational situations like that because I just don't want to be in them. You have to act really differently here than you do there. Not that I am afraid of what I'm going to do necessarily, but I'm just trying to avoid them. It feels better for me.

THERAPIST: Okay. So let's process this one, okay?

CLIENT: Okay.

Assessment

THERAPIST: When you go back to that incident in Safeway, what image, what moment represents the worst part?

CLIENT: Seeing my wife's face as she turned to me and looked at me and kind of rolled her eyes like a "What are these guys doing?" type of thing. That was the most intense moment for me.

THERAPIST: And the words that would go with this moment, that would express your negative belief about yourself, now?

CLIENT: I don't know. That's a hard one. I don't know.

THERAPIST: Okay, well, what still bothers you?

CLIENT: I guess what bothers me is I want to protect my family. It made me feel like if something happened, what would I do? The most important thing to me is my family, undoubtedly, and even over my own life. It just upset me about myself.

THERAPIST: So the emotional belief was "I can't protect my family."

CLIENT: Yep.

THERAPIST: What words? "I can't protect my family? I'm not safe? My family's not safe?"

CLIENT: I'm not adequate enough; not brave enough. It's like I can't protect my family.

THERAPIST: "I can't protect my family." Does that fit?

CLIENT: *(Nods in agreement.)*

THERAPIST: What words would you rather have?

CLIENT: That I am my family's rock and I am the one that protects them.

THERAPIST: I can protect them. I am the rock. What words?

CLIENT: I'm strong enough.

THERAPIST: "I'm strong enough." Now you bring up this moment with these teenagers in the supermarket. How true do the words "I'm strong enough" feel on a 1 to 7 scale, with 1 false, 7 true, now, as you hold that memory?

CLIENT: Three.

THERAPIST: And when you bring up that moment and the words "I can't protect my family," what emotions resonate right now?

CLIENT: Sadness and frustration.

THERAPIST: Zero to 10 right now?

CLIENT: Ten. Totally frustrated with myself.

THERAPIST: Where do you feel that in your body?

CLIENT: In my throat and in my arms.

Processing

THERAPIST: Okay, so bring up that image, and the words "I'm not brave enough." Notice those sensations there in your body and follow. *(EM)*

CLIENT: I feel calmer about it, but I still feel very emotional about it all.

THERAPIST: That's okay. Let's just keep going, all right? *(EM)*

CLIENT: It's definitely a lot calmer. I don't feel nearly as emotional as I did. I feel a lot more relaxed about it.

THERAPIST: Just notice that. *(EM)*

CLIENT: Yeah, much calmer.

THERAPIST: So now when you go back to this incident at the supermarket, what do you notice now?

CLIENT: It's almost like it doesn't bother me as much. It doesn't seem like it's as big of a deal as it was at the time. Yeah, much more relaxed.

THERAPIST: So when you think of this incident now, how disturbing is it, 0 to 10?

CLIENT: Zero.

THERAPIST: Okay, let's just notice that. *(EM)*

CLIENT: Yeah, 0.

THERAPIST: Okay. Do the words "I'm brave enough" fit or are there other words now that may be more suitable or appropriate?

CLIENT: Adequate, able and that it will be okay. I feel like I can handle it. It doesn't make me nervous like it did before.

THERAPIST: So, it would be okay. "I can handle it."

CLIENT: Yeah. Within myself, I can handle it.

THERAPIST: When you bring up that incident now, how true do those words "I can handle it" feel, 1 to 7?

CLIENT: Seven.

THERAPIST: Put them together. *(EM)*

CLIENT: Seven.

THERAPIST: Okay.

CLIENT: It's amazing.

THERAPIST: Now, if I can ask you to just close your eyes for the body scan. Just bring up that incident in the supermarket and the words "I can handle it." You're starting at the top of your head, going downward. Let me know if there's any tightness, tension, or unusual sensation.

CLIENT: No, relaxed.

THERAPIST: All right. Just notice that. *(EM)*

CLIENT: Yeah. Nothing, relaxed.

THERAPIST: All right.

Future Template

THERAPIST: There's another step that I think we could take now and we call it a Future Template. I'd like you to imagine yourself coping effectively with a similar situation in the future.

CLIENT: Okay.

THERAPIST: Now, let's imagine that tomorrow you and your wife go to a supermarket and the same thing happens: She gets crowded by a bunch of noisy teenagers.

CLIENT: Okay.

THERAPIST: How would you like to respond?

CLIENT: I would like to be able to let her handle the situation herself and not feel like I have to get involved in it. I don't like to feel like she's a team member that I'm pulling out of the fire. She's an adult, and I can stand back and let her do her thing.

THERAPIST: Can you tell me more how you would like to be feeling, believing, and behaving?

CLIENT: I can step back and watch calmly, and let her handle it, knowing I can handle it if more is needed.

Future Scene

THERAPIST: So, imagine the scene at the supermarket with the noisy teenagers around your wife and you are just watching her deal with it, while feeling calm, and holding in mind your belief, "I can handle it." Notice what you are thinking and feeling, and experiencing in your body. How is it?

CLIENT: *(After about 10 seconds)* Good, it was good. I just felt it a little in my chest. I was still a little nervous watching it, still a little shaky.

Process

THERAPIST: Just notice those sensations. *(set of EM)*

CLIENT: It feels better, much more calm.

THERAPIST: Notice that. *(set of EM)*

CLIENT: It feels calm.

THERAPIST: Go with that. *(EM)*

CLIENT: Feels calm, no tension in my chest. I feel I can step back and let her handle it.

THERAPIST: How true do those words "I can handle it" feel when you imagine that situation, 1 to 7, with 1 totally false, and 7 totally true?

CLIENT: Seven.

Run Movie

THERAPIST: Good, now I'd like you to close your eyes and run the movie of your wife handling the situation, holding in mind your positive belief, "I can handle it," and noticing the sense of calmness you have.

CLIENT: *(Closes his eyes and after a few seconds begins to nod his head.)* I didn't feel like I needed to reach out. I just let her do her thing.

Process

THERAPIST: Okay. Notice that. *(EM)*

CLIENT: Yep. She handled herself, and I felt calm watching it.

THERAPIST: Good, just go with that. *(EM)*

CLIENT: Yeah. I think "positive" is the word.

THERAPIST: Do the words" I can handle it" still fit?

CLIENT: Yes, I can handle it.

THERAPIST: Now how true do those words, "I can handle it," feel when you imagine that situation happening again, 1 to 7?

CLIENT: Seven.

THERAPIST: Good. So, again, I want you to run that scenario and the words "I can handle it" together. *(EM)*

CLIENT: Okay. Yep.

THERAPIST: Now, how true do the words "I can handle it" feel when you imagine that situation happening again, 1 to 7?

CLIENT: Seven.

Challenge

THERAPIST: All right. Now let's put a challenge to it. For example, what can go wrong? What's the monkey wrench that can be thrown into it?

CLIENT: They say something to her and then I react. That would be the biggest monkey wrench, I guess.

THERAPIST: And how would you see yourself reacting?

CLIENT: Starting to say something back and getting into a confrontation, I guess. That would be the worst-case scenario.

THERAPIST: So it would start with them saying something back and you responding?

CLIENT: Yeah, getting into a verbal argument and then, worst-case scenario, it would escalate from there.

THERAPIST: Okay, but right now, just handling it verbally. So let's imagine that happening. They say something to your wife and then you step in . . .

CLIENT: And say something.

THERAPIST: And say something like?

CLIENT: "Please leave us alone."

THERAPIST: Okay, imagine the scene when the teenagers start saying things to your wife, and you calmly say, "Please leave us alone," along with your positive belief, "I can handle it," and notice what you are thinking and feeling, and experiencing in your body.

CLIENT: I feel calm and able, and even confident.

THERAPIST: Can you close your eyes and run the movie of them saying something, and you saying, "Please leave us alone"? Hold it in mind with your positive belief, "I can handle it," and notice feelings.

CLIENT: *(Closes eyes and opens them after about 10 seconds.)*

THERAPIST: How was that?

CLIENT: I could picture it, and I don't feel the tension that I would think I would feel.

THERAPIST: How did you feel?

CLIENT: Just relaxed and the confidence is still there.

THERAPIST: Okay. Run that movie again, feeling that. *(EM)*

CLIENT: Yeah, just relaxed, and I feel like I can handle the situation better.

THERAPIST: So, do the words still work for you, "I can handle it"?

CLIENT: Yeah.

THERAPIST: So as you run the movie again and think of it, how true do those words, "I can handle it," feel—1 false, 7 true?

CLIENT: Oh, true. Seven, true.

THERAPIST: Okay, so run the movie while thinking, "I can handle it." *(EM)*

CLIENT: Yeah. I can handle it. It's under control.

THERAPIST: How true are the words "I can handle it" as you run the movie, 1 to 7?

CLIENT: Seven.

Closure

THERAPIST: Great. You've done some amazing work today. Let's just reflect on the experience you've just had.

CLIENT: It's very emotional. It just amazes me that doing something so simple can change your whole way of thinking and feeling that much. It's just amazing to me. My head has a hard time wrapping around what's actually happening. It wants to figure out why but it's just amazing.

THERAPIST: Okay, great. So, again, processing will continue and you can just notice what it is that's coming up and you have your safe place, and your resource, too, that you can rely on. Remember to keep a log that we can review next time.

CLIENT: Okay.

COGNITIVE INTERWEAVE CASE SESSION WITH A MOLESTATION SURVIVOR

Maintain Contact

THERAPIST: Let the feelings be there [during BLS]. Let whatever comes up, come up. It's okay. Let it peel. Let whatever comes out, come out. Let it peel off. Follow—good. *(in cadence)* That's it. Come on, follow. *(changes direction and speed)* Blank it out—Deep breath. What do you get now? Take another deep breath. Take another deep breath. Take another deep breath. That's good. What do you get now?

KAREN: He just wouldn't let me go and I know that he knows that I want to go. He keeps talking to me.

Address Responsibility

THERAPIST: So whose fault is it? Whose responsibility is it?

KAREN: His.

THERAPIST: Right. Stay with that and follow [BLS]. What do you get now?

KAREN: He's bad. He's bad and I've got to get away.

THERAPIST: Stay with that now [BLS]. What do you get now?

KAREN: I just feel really light.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: All I can picture is him. All I can picture is him. *(shows fear)*

Address Safety

THERAPIST: Where is he now?

KAREN: In the basement.

THERAPIST: Where is he today?

KAREN: He lives in Texas.

THERAPIST: . . . And how is he now?

KAREN: I don't know—haven't seen him in a long time.

THERAPIST: How dangerous is he now?

KAREN: Not at all.

THERAPIST: Think of that [BLS]. What do you get now?

KAREN: I just get angry and disgusted at him.

THERAPIST: Stay with that [BLS].

KAREN: I feel that I want to tell him that I know what he did.

Discharge Fearful Withheld Statement

THERAPIST: Tell him.

KAREN: "Uncle Larry, I know what you did to me. And it was wrong and you hurt

me. And you scared me. And you did not even care about me. And it was wrong."

THERAPIST: Stay with that. Tell him it was his responsibility [BLS]. What do you get now?

KAREN: "Uncle Larry, what you did to me was wrong. And I had no control over it. You were the adult and you abused me. And it was your fault."

THERAPIST: Stay with that [BLS].

KAREN: I'm okay.

Reinforce the Positive

THERAPIST: That's right. That's right. Stay with that [BLS]. What do you get now?

KAREN: I didn't cause it.

THERAPIST: That's right. Stay with that [BLS]. What do you get now?

KAREN: It's okay now. I just wanted to let him know that I knew.

THERAPIST: Stay with that. *(pause)* What do you get now?

Note Spontaneous Emergence of New Affect

KAREN: I don't feel so lonely anymore.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: Relief. I feel relieved.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: I feel like it's okay. It won't happen again.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: I feel safer.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: I'm just more calm—relaxed.

Address Choices, Summarize, and Reinforce

THERAPIST: So you know you can act on what you know is right and you're now in control.

KAREN: I really feel okay and not to blame.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: I feel happier.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: More connected—I feel more whole.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: I feel like I'm in control. Like an adult . . . like more in control.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: Peace. Just a real calmness. Really relaxed.

Reprobe, Make Sure All Channels Are Processed

THERAPIST: What happens when you think of Larry again?

KAREN: It's a memory.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: I sort of feel sorry for him—a sadness.

Check for New Associations

THERAPIST: What do you feel sorry for him about?

KAREN: I'm not quite sure. Why he would do that. What would make him want to do that.

THERAPIST: Stay with that [BLS]. What do you get now?

KAREN: Not much of anything. I feel really removed from him—not connected. I do not get much of anything.

Reprobe

THERAPIST: And how do you feel about yourself?

KAREN: A lot better—I feel really relieved. I don't know—all of this tension that was built up inside—and I can finally release it. It feels really good.

THERAPIST: Great—good. It's in the past. Great. So it's over.

Debrief, Prepare for Future Processing

THERAPIST: During the next week things can continue to process even more. Because basically what we've done is we've taken something that is frozen in time—that was locked in the nervous system the way it originally happened and that's why you continued to cycle through it—the same feelings that were coming up at the time—actually almost reliving the experience. We've opened up the barrier to what was locked up. That's why it's been able to process out.

Reprobe

THERAPIST: So now we are in present time. So again, when you think of it how does it come up? How does it feel?

KAREN: I'm still feeling this residue of sadness and I'm not sure where it's connected.

THERAPIST: Stay with that [BLS].

KAREN: I know what it is!

THERAPIST: What's that?

KAREN: I'm feeling sadness for my little girl.

THERAPIST: What about your little girl?

KAREN: The little girl that experiences things. And me as a mother nurturing her, and holding her, and saying it's okay.

Reinforce Spontaneous "Inner Child Work"

THERAPIST: Stay with that. Let it all come out [BLS].

KAREN: I feel so much love. I really do. It's like now I can love this little person inside me and say it's okay.

THERAPIST: Stay with that [BLS].

KAREN: You want me to tell my little girl?

THERAPIST: Yes.

KAREN: I understand. I know the pain, the fear you must have felt. You aren't to blame. You did not cause it. You could not make him stop. It's okay.

THERAPIST: Stay with that [BLS].

KAREN: I'm here now. And I'm here to protect you. And I love you.

THERAPIST: How does it feel?

KAREN: It feels really good.

Final Debriefing

THERAPIST: So whatever comes up during the week, observe—write it down. Other memories, thoughts, dreams, whatever comes up, it's only feedback. Bring it in so that we can work with it next week. Only observation, without judging whether it should or shouldn't. Just write it down.

Stay Available

THERAPIST: And you can call me anytime. Okay?

APPENDIX C

Clinical and Outcome Assessments

This appendix is composed of two sections: The EMDR Fidelity Rating Scale (EFRS), which is used to evaluate EMDR therapy procedures, and Empirically Evaluating EMDR without a Control Group: A Step-by-Step Guide for EMDR Therapists.

EMDR FIDELITY RATING SCALE (EFRS)

Deborah L. Korn, PsyD, Louise Maxfield, PhD,
Nancy J. Smyth, PhD, and Robert Stickgold, PhD

The EMDR Fidelity Rating Scale (EFRS; Korn, Maxfield, Smyth, & Stickgold, 2017) evaluates adherence to EMDR therapy's standard eight-phase treatment approach and three-pronged protocol (Shapiro, 2001). Originally developed for use in a study by van der Kolk et al. (2007), the scale was revised in 2016 after receiving feedback from researchers and raters who had used the scale. The EFRS is a comprehensive rating instrument designed to assess treatment integrity in a single EMDR session and across multiple sessions. The scale provides a breakdown of treatment components, with indicators for "acceptable" adherence, a rating system, and an easy-to-use scoring calculator. Fidelity ratings range from 0 ("no adherence") to 3 ("very good adherence"), with a cutoff score of 2.0 for acceptable fidelity.

The EFRS is reprinted by permission from Korn, D. L., Maxfield, L., Smyth, N. J., & Stickgold, R. (2017). EMDR Fidelity Rating Scale (EFRS). Copyright © 2017 Deborah L. Korn, Louise Maxfield, Nancy J. Smyth, and Robert Stickgold. Published through a Creative Commons Attribution-NonCommercial-NoDerivatives License and available at *http://emdrresearchfoundation.org/emdr-fidelity-rating-scale*. Permission to photocopy this material is granted to purchasers of this book for personal use or use with clients. Purchasers can download enlarged versions of this material (see the box at the end of the table of contents).

The EFRS was designed as an observer-rated research scale to be used in reviewing recordings of actual treatment sessions. However, it may similarly be used by an individual clinician to monitor fidelity in his/her own treatment sessions. EMDR consultants may also find the scale helpful when assisting therapists in the development of their EMDR therapy skills.

The EFRS can be used in the evaluation of EMDR treatment sessions for any disorder or presenting problem with which standard EMDR procedural steps and the three-pronged protocol are used in addressing memories of adverse life experiences or current triggers eliciting distress. In addition to being established as an efficacious treatment for PTSD (Watts et al., 2013; WHO, 2013), EMDR standard procedures have been successfully used for symptoms of depression (Gauhar, 2016), panic disorder (Faretta, 2013), chronic pain (De Roos et al., 2010), relational stresses (Reicherzer, 2011), performance anxiety (Maxfield & Melnyk, 2000), and many other problems.

The EFRS is designed to evaluate a therapist's adherence to EMDR therapy's standard eight-phase treatment approach during a single session. It also examines whether a therapist is adequately adhering to the three-pronged protocol, that is, whether the therapist is appropriately addressing relevant past events, present triggers and symptoms, and future behavioral goals. The scale is divided into five subscales, some of which have multiple sections. The five subscales (and sections within each subscale) are as follows:

I. **Introductory Subscale**
   - Phase 1—History-Taking and Treatment Planning Section
   - Phase 2—Preparation Section
   - Safe/Calm Place Exercise Section

II. **Resource Development and Installation Subscale** (optional)

III. **Adverse Life Experiences Processing Subscale**
   - Phase 3—Assessment Section
   - Phase 4—Desensitization Section
   - Phase 5—Installation Section
   - Phase 6—Body Scan Section
   - Phase 7—Closure Section
   - Phase 8—Reevaluation Section

IV. **Future Template Subscale**

V. **Three-Pronged Protocol Subscale**

The EFRS follows. Items and sections identified as "critical elements" are marked with an asterisk. The concept of critical items and their relevance to scoring is addressed in the EFRS manual. The complete EFRS (formatted for use in research), the EFRS manual (containing relevant information about the scale, with instructions for clinicians, raters, and researchers), essential forms, EFRS Excel workbooks with embedded scoring calculators, and a sample scoring workbook may be found and downloaded at *http://emdrresearchfoundation.org/emdr-fidelity-rating-scale*. These materials are available through a Creative Commons Attribution-NonCommercial-NoDerivatives License (*https://creativecommons.org/licenses/by-nc-nd/4.0*).

EMDR FIDELITY RATING SCALE

I. Introductory (Intro) Subscale (History-Taking and Treatment Planning, Preparation, Safe/Calm Place Exercise)

0	1	2	3
No Adherence	**Some Adherence But Inadequate**	**Adherence Acceptable**	**Adherence Very Good**

☐ **History-Taking and Treatment Planning (HTP)**

1. Gathers relevant history (according to framework provided in treatment manual).

   0 1 2 3 NA

*2. Identifies possible EMDR processing targets (past, present, and future).

   0 1 2 3 NA

3. Appropriately uses the "affect scan/floatback technique," if information is not obtained from direct questioning, to identify past events related to current disturbance.

   0 1 2 3 NA

4. Proposes and discusses treatment plan (focused on past adverse life experiences (ALE), current triggers, and future goals) with client.

   0 1 2 3 NA

☐ **Preparation**

(In addition to this subscale, also use Resource Development and Installation [RDI] subscale if RDI is used in a Preparation session)

1. Offers a coherent explanation/rationale for EMDR.

   0 1 2 3 NA

2. Offers clear instructions to client about his/her role.

   0 1 2 3 NA

3. Provides appropriate physical preparation.
   a. Arranges chairs for "ships in the night" position. + –
   b. Introduces and explains use of other bilateral stimulation (BLS) and associated technology if relevant. + –
   c. Establishes comfortable distance/speed for facilitation of eye movements (EMs) and/or BLS. + –

   0 1 2 3 NA

4. Establishes stop signal.

   0 1 2 3 NA

5. Establishes metaphor.

   0 1 2 3 NA

☐ **Safe/Calm Place Exercise**

1. Offers a coherent explanation/rationale for the Safe/Calm Place exercise.

   0 1 2 3 NA

2. Helps client identify an appropriate Safe/Calm Place.

   0 1 2 3 NA

3. Asks client to describe a Safe/Calm Place image and identify the emotions and positive sensations experienced in the body. Helps client enhance his/her imagery/experience.

   0 1 2 3 NA

4. Asks client to bring to mind the image, encouraging him/her to concentrate on the positive sensations while following the EMs/BLS.

   0 1 2 3 NA

5. Introduces one or more short sets of slow EMs/BLS (sets of four to eight back-and-forth or left/right movements) and checks in with client about what he/she is noticing at the end of each set.

   0 1 2 3 NA

6. Asks client to identify a cue word or phrase associated with the Safe/Calm Place. Then, asks client to notice the positive feelings and sensations he/she has when focusing on the cue word, encouraging him/her to concentrate on the positive sensations while following the EMs/BLS.

   0 1 2 3 NA

7. Instructs client to repeat the procedure on his/her own, bringing up the image and the cue word, and experiencing the positive feelings without EMs/BLS.

   0 1 2 3 NA

8. Asks client to bring up a minor disturbing thought, issue, or incident and notice the negative feelings. Then, guides him/her through the Safe/Calm Place Exercise.

   0 1 2 3 NA

9. Asks client to bring up a disturbing thought, issue, or incident and do the Safe/Calm Place exercise, this time without assistance.

   0 1 2 3 NA

10. If client experiences difficulties with exercise (unable to identify a safe place; dissociative or avoidant response; emergence of negative pictures, emotions, sensations, thoughts), offers appropriate suggestions or interventions.
    a. Assists client in exploration of possible other Safe/Calm Place images. + –
    b. Redirects client back to positive aspects of the Safe/Calm Place image. + –
    c. Introduces container imagery to manage negative material, or shifts to mindfulness or breathing exercise. + –
    d. Uses shorter sets of EMs/BLS or decreases speed of EMs/BLS. + –

    0 1 2 3 NA

II. Resource Development and Installation (RDI) Subscale (optional part of the Preparation Phase)

0	1	2	3
No Adherence	**Some Adherence But Inadequate**	**Adherence Acceptable**	**Adherence Very Good**

☐ **Resource Development and Installation (RDI)**

1. Offers a coherent explanation/rationale for resource development and installation work.

   0 1 2 3 NA

2. Asks client to focus on a challenging current life situation (including EMDR treatment itself).

   0 1 2 3 NA

3. Asks client to identify what qualities (capacities, strengths, feelings, beliefs, etc.) he/she needs to manage this situation.

   0 1 2 3 NA

4. Asks client to identify an image that captures or enhances the desired quality, capacity, feeling and/or strength.
    a. Prompts client to consider previous mastery experiences or images, relational resources, and/or relevant symbolic resources or metaphors. + –
    b. Facilitates the search for resource images if client has difficulty. + –

    0 1 2 3 NA

5. Asks client to describe the resource image and identify the emotions and positive sensations experienced in the body. Helps client enhance his/her imagery/experience.

   0 1 2 3 NA

6. Asks client to bring to mind the resource image, encouraging him/her to concentrate on the positive sensations while following the EMs/BLS.

   0 1 2 3 NA

7. Introduces one or more short sets of slow EMs/BLS (sets of eight to ten back-and-forth or left/right movements) and checks in with client about what he/she is noticing at the end of each set.

   0 1 2 3 NA

8. Asks client to identify a cue word or phrase associated with the resource image. Then, asks client to notice the positive feelings and sensations he/she has when focusing on the cue word, encouraging him/her to concentrate on the positive sensations while following the EMs/BLS.

   0 1 2 3 NA

9. Continues with sets of EMs/BLS as positive feelings and associations get stronger, and/or stops when the resource is appropriately strengthened.

   0 1 2 3 NA

10. Instructs client to repeat the procedure on his/her own, bringing up the image and the cue word and experiencing the positive feelings without EMs/BLS.

    0 1 2 3 NA

11. Instructs client to imagine the situation that he/she would like to manage more effectively. Then, asks client to run a movie of his/her desired response, using his/her resource to enhance coping or performance.

    0 1 2 3 NA

12. Asks client for feedback and once movie feels positive and strong, introduces several sets of slow EMs/BLS until client feels comfortable and secure with his/her future movie.

    0 1 2 3 NA

13. If appropriate, instructs client to imagine a particular challenge that might arise in a future situation. Then, asks client to run a movie of his/her desired response, using his/her resource to enhance coping or performance. Introduces EMs/BLS as in #12.

    0 1 2 3 NA

14. Asks client to practice using his/her resource(s) in the actual challenging life situation identified in #2.

    0 1 2 3 NA

15. If client experiences difficulties with exercise (unable to identify resource; dissociative or avoidant response; emergence of negative pictures, emotions, sensations, thoughts), offers appropriate suggestions or interventions.
    a. Assists client in exploration of possible other resource associations/images. + –
    b. Redirects client back to positive aspects of resource image. + –
    c. Introduces container imagery to manage negative material, or shifts to mindfulness or breathing exercise. + –
    d. Uses shorter sets of EMs/BLS or omits EMs/BLS. + –

    0 1 2 3 NA

III. Adverse Life Experiences (ALE) Processing Subscale (Assessment, Desensitization, Installation, Body Scan, Closure, Reevaluation)

0	1	2	3
No Adherence	**Some Adherence But Inadequate**	**Adherence Acceptable**	**Adherence Very Good**

☐ **Reevaluation (N/A if first reprocessing session)**

1. Obtains feedback on experience since last session (e.g., symptoms; behaviors; reactions to present triggers; new thoughts, insights, or information; dreams; and any new or associated material that may have emerged). Reviews log with client if available.

   0 1 2 3 NA

2. Assesses the previous target by asking the client to bring up the memory, incident, or trigger addressed in the previous session (appropriate only if client has had a previous processing session). Asks client what he/she notices and, more specifically, elicits information about the following elements, as appropriate:
   a. Image + –
   b. Emotions + –
   c. SUD (0–10) + –
   d. Body Sensations/Locations + –
   e. Positive Cognition and VOC (1–7) + –
   (If positive cognition or future template previously addressed)

   0 1 2 3 NA

3. Works with client to select appropriate target for current session.
   a. If work with previous target remains incomplete (i.e., elevated SUD, low VOC, or body scan not clear), continues with previous target (i.e., proceeding with Phase 4, 5, or 6, as apporpriate). + –
   b. If processing of previous target appears complete (i.e., SUD = 0/1, VOC = 6/7, or ecologically valid ratings; clear body scan), does one of the following, as appropriate: + –
      i. Shifts to focus on another memory identified in the treatment plan or a feeder memory.
      ii. Shifts to focus on current trigger or symptom.
      iii. Shifts to focus on future template.
   c. If current life crisis or clinical symptoms are significantly destabilizing and it is determined that further processing would not be useful, shifts to Preparation Phase interventions. + –

0 1 2 3 NA

☐ ***Assessment (N/A if starting with reevaluation and not assessing a new target)**

1. Helps client to select appropriate target (may be past adverse life experience or present trigger).

   0 1 2 3 NA

2. Obtains picture representing the worst aspect of memory or target issue; if unable to obtain a picture, asks client to just think of it and identify the worst part of the experience (e.g., smells, sonds, taste, touch).

   0 1 2 3 NA

3. Helps client identify appropriate negative cognition, seeking one that is present tense, generalizable, irrational, and a self-referencing I-statement.

   0 1 2 3 NA

4. Helps client identify appropriate positive cognition, seeking one that is possible, generalizable, a self-referencing I-statement, and matching in focus with the negative cognition.

   0 1 2 3 NA

5. Obtains accurate VOC (Links positive cognition with picture or issue. Stresses rating of VOC in the PRESENT).

   0 1 2 3 NA

6. Helps client identify emotions linked to picture and negative cognition; explores for additional emotion(s) if warranted.

   0 1 2 3 NA

7. Obtains SUD level.

   0 1 2 3 NA

8. Helps client identify body sensations.

   0 1 2 3 NA

9. Follows the standard Assessment sequence, as presented in this subscale.

   0 1 2 3 NA

☐ ***Desensitization**

1. Before beginning EMs/BLS, instructs client to bring up picture, negative cognition, and body sensations.

   0 1 2 3 NA

2. If resuming processing of an incomplete target memory from previous session, asks client to bring up the image (that represents the worst part of the memory upon reevaluation), identify emotions, rate disturbance (SUD 0–10), and identify location of body sensations. Then, begins EMs/BLS. (Note: The negative cognition is not included when restarting an incomplete target memory.)

   0 1 2 3 NA

3. Effectively introduces EMs/BLS and makes sure that client tracks adequately.

   0 1 2 3 NA

4. If client's eyes don't follow, clinician makes appropriate response. (If an alternative form of BLS is used, circle NA for this item.)
   a. Verbally cues client. + –
   b. Slows speed. + –
   c. Makes additional finger motions. + –

   0 1 2 3 NA

5. Performs initial set of at least 24 back-and-forth or left/right movements (unless client has difficulty tolerating set of 24). If appropriate, subsequently adjusts length of set in response to client need.

   0 1 2 3 NA

6. Gives appropriate verbal support during EMs/BLS.

   0 1 2 3 NA

7. Stops EMs/BLS gently and instructs client appropriately (some version of "Take a breath. Let it go." and "What comes up for you now?").

   0 1 2 3 NA

8. Restarts EMs/BLS at appropriate time without digression, inappropriate discussion, or repetition of client's words. Provides sets of BLS, not continuous BLS, during processing.

   0 1 2 3 NA

9. Continues down the same channel with multiple sets until there is apparent resolution. If new material is emerging and/or change is observed, continues to facilitate processing. Does not return to the original incident prematurely.

   0 1 2 3 NA

10. When client appears to be at the end of the channel, asks client to "think of the original incident" (not "original picture") and to describe what he/she notices. Resumes processing with sets of EMs/BLS until client appears to be at the end of the next channel.

    0 1 2 3 NA

*11. Handles abreactions (strong emotions, high arousal) appropriately.
    a. Keeps eyes moving (or continues alternative form of BLS). + –
    b. Provides additional support to maintain dual attention and expresses compassion. + –
    c. Does longer sets of EMs/BLS. + –

    0 1 2 3 NA

*12. If material is stuck or looping, therapist intervenes appropriately, using one or more of the following strategies:
    a. Increases rate and duration of EMs/BLS. + –
    b. Asks client to focus on body sensations. + –
    c. Changes directions of EMs. + –
    d. Returns to initial incident or memory. + –
    e. Changes modalities (e.g., to taps). + –
    f. Checks for blocking beliefs or feeder memories. + –
    g. Introduces cognitive interweave. + –

    0 1 2 3 NA

*13. Appropriate timing and application of cognitive interweaves (including sensitivity to possible issues of responsibility, safety, and choices).

    0 1 2 3 NA

14. Checks SUD score with original incident when appropriate and makes sure SUD = 0 or 1 (or is as low as it can ecologically go) PRIOR to moving on to Installation of Positive Cognition (continues EMs/BLS if SUD is >1 and not deemed ecologically valid).

    0 1 2 3 NA

☐ ***Installation**

1. Checks for the possibility of a better positive cognition and revises positive cognition if more appropriate one is identified.

   0 1 2 3 NA

2. Asks client to think about the incident and the selected positive cognition and checks VOC (1 = completely false and 7 = completely true).

   0 1 2 3 NA

3. Does one set of EMs/BLS while client focuses on both positive cognition and incident and then, rechecks VOC.

   0 1 2 3 NA

4. Continues with sets of EMs/BLS, checking the VOC as needed until VOC = 7, no longer increases, or is evaluated to be ecologically valid.

   0 1 2 3 NA

5. If VOC is not increasing, checks for blocks (i.e., "What prevents it from being a 7?").

   0 1 2 3 NA

6. If blocks are identified, addresses them with additional sets of EMs/BLS until VOC = 7 or is evaluated to be ecologically valid. If needed, uses cognitive interweaves to address blocks and/or returns to processing to address emerging associations.

   0 1 2 3 NA

7. Once VOC = 7, continues with an additional set or sets of EMs/BLS to further strengthen PC, until its validity and sense of appropriateness appear to reach a maximum level.

   0 1 2 3 NA

☐ **Body Scan**

1. Upon completion of Installation Phase, facilitates a body scan. Asks client to hold in mind the original incident/experience and the positive cognition while bringing attention to different parts of the body, starting with the head and working downward. Asks client to report on what he/she notices.

   0 1 2 3 NA

2. If positive sensations are reported, strengthens and reinforces these sensations with additional set or sets of EMs/BLS.

   0 1 2 3 NA

3. If disturbing material, feelings, or sensations emerge during body scan, returns to processing with sets of EMs/BLS. Continues until body scan is clear and no negative sensations are being reported. Note: If clear body scan is not achieved by end of session, contains material or assists with any discomfort.

   0 1 2 3 NA

☐ **Closure**

1. Provides appropriate closure.
   a. Chooses appropriate termination point. + –
   b. Provides support/normalizes experience. + –
   c. Adequately debriefs. + –
   d. Predicts possibility of continued processing between sessions. + –
   e. Encourages client to call if having difficulties. + –

   0 1 2 3 NA

2. If material not completely processed, uses procedure for closing incomplete session (relaxation, visual healing, containment).

   0 1 2 3 NA

3. Requests that client journal or maintain a log between sessions.

   0 1 2 3 NA

IV. Future Template (FT) Subscale

0	1	2	3
No Adherence	**Some Adherence But Inadequate**	**Adherence Acceptable**	**Adherence Very Good**

☐ **Future Template**

1. Helps client identify a future behavioral goal (related to a challenging recent experience, present trigger, or potential new situation).

   0 1 2 3 NA

2. Asks client to imagine coping effectively in a future scene while focusing on a positive cognition (initially without BLS to make sure that client can visualize it).

   0 1 2 3 NA

3. Asks client about blocks, anxieties, or fears that arise while imagining the future scene.

   0 1 2 3 NA

4. If client encounters blocks, anxieties, or fears, intervenes appropriately.
   a. Focuses client's attention on disturbance/body sensation and facilitates EMs/BLS. + –
   b. Problem-solves with client to increase sense of mastery with future template scene; introduces relevant skills, information, or resources. + –
   c. Introduces cognitive interweave. + –
   d. Redirects client to past or present targets that may need additional attention and processing. + –

   0 1 2 3 NA

5. If there are no apparent blocks and client is able to visualize the future scene with confidence and clarity, asks client to focus on the image, positive belief, and sensations associated with scene and introduces EMs/BLS.

   0 1 2 3 NA

6. Facilitates several sets of EMs/BLS until the future template is sufficiently strengthened (check with body scan and VOC).

   0 1 2 3 NA

7. Asks client to move from imagining a "scene" to imagining a "movie" of coping in the future, with a beginning, middle, and end.

   0 1 2 3 NA

8. If the client encounters blocks, anxieties, or fears, intervenes appropriately (as above in #4).
   a. Focuses client's attention on disturbance/body sensation and facilitates EMs/BLS. + –
   b. Problem-solves with client to increase sense of mastery with future template movie; introduces relevant skills, information, or resources. + –
   c. Introduces cognitive interweave. + –
   d. Redirects client to past or present targets that may need additional attention and processing. + –

   0 1 2 3 NA

9. When the client is able to play the movie from start to finish with a sense of confidence, asks client to play the movie one more time while focusing on the positive cognition; facilitates EMs/BLS while playing entire movie.

   0 1 2 3 NA

10. Helps client generate one or more potential challenge situations (unanticipated or undesirable triggers/outcomes). Asks client to run a movie of effectively responding to each challenge situation. Intervenes if client has difficulty (as in #8). Otherwise, installs the positive movie with BLS/EMs (as in #9).

    0 1 2 3 NA

V. Three-Pronged Protocol (TPP) Subscale
(Ratings based on review of data from Treatment Plan Tracking [TPT] form available in online manual. Evaluates whether clinician did or did not appropriately identify and process relevant past adverse life experiences, present triggers/symptoms, and future templates associated with a given presenting issue. Completed by rater at end of treatment/research study.)

No	**Yes**
No Adherence	**Adherence Acceptable**

☐ **Three-Pronged Protocol**

1. For a specific presenting issue, appropriately identifies target(s) related to past adverse life experiences.

   No Yes NA

2. For the same presenting issue, appropriately identifies target(s) related to current triggers or symptoms.

   No Yes NA

3. For the same presenting issue, appropriately identifies target(s) related to future behaviors and goals.

   No Yes NA

4. For the same presenting issue, processes relevant past adverse life experience(s), using the standard EMDR protocol.

   No Yes NA

5. For the same presenting issue, processes relevant associated present trigger(s)/symptom(s), using the standard EMDR protocol.

   No Yes NA

6. For the same presenting issue, installs future template(s) relevant to client's desired behaviors and goals.

   No Yes NA

EMPIRICALLY EVALUATING EMDR WITHOUT A CONTROL GROUP: A STEP-BY-STEP GUIDE FOR EMDR THERAPISTS

Allen Rubin, PhD

Purpose of This Guide

Although EMDR is recognized as an effective therapy in the treatment of trauma, this does not guarantee that all therapists who provide EMDR will be adequately effective with every client to whom they provide it. This guide explains two empirical methods that therapists can employ to evaluate their effectiveness when providing EMDR to an individual or to multiple clients. Those two methods involve the use of single-case designs with each client or calculating an average effect size across multiple clients, then comparing that average to published benchmarks. The first section of the guide covers single-case designs; the second covers effect sizes and benchmarks.

Part I: Single-Case Designs

Overview and Logic of Single-Case Evaluation

Empirically validating your effectiveness when providing EMDR therapy requires going beyond your clinical judgments or your routine clinical observations about how your clients are responding to EMDR. Just noting remarkable in-session improvements in client SUD or VOC scores won't suffice. Empirically validating that EMDR is the most plausible *cause* of client improvement requires ruling out plausible alternative explanations for the improvement. For example, we seek to show that it is very unlikely that other events coinciding with the EMDR intervention could have caused the improvement, or that normal maturation processes or just the passage of time could have caused it.

Imagine, for example, someone who has just survived a natural disaster and has trauma symptoms connected to the disaster. Regardless of whether the client receives EMDR treatment, and no matter how effective EMDR may be in treating her trauma symptoms, we may expect the severity of the symptoms to lessen to some degree merely due to the passage of time or as the client experiences other sources of support. Consequently, if all we show is that the client's distress is less after EMDR treatment than before it, scientifically oriented skeptics will remain unimpressed, noting that the improvement may be a function of other factors.

To rule out other factors as plausible explanations, and to support the effectiveness of a particular treatment as the most plausible explanation for the improvement, clinical researchers and scientific practitioners conduct experiments. The word "experiment" typically connotes random assignment of a large number of clients to experimental and control groups, with the experimental group receiving the treatment being evaluated and the control group not receiving it. If the group receiving the treatment improves significantly more than the control group, the treatment is deemed effective, because both groups are equivalent regarding other factors, such as the passage of time or the experience of contemporaneous events, and the only plausible difference between the groups is whether the tested treatment was provided.

For obvious reasons that I won't delve into in this brief guide, clinical practitioners—no matter how scientifically oriented they may be—typically do not have the resources to conduct such group experiments. However, there is another type of experimentation that is geared for use by clinicians and is feasible for them to conduct. That type of experimentation, which is often called "single-case evaluation," utilizes designs that may be called single-subject or single-case designs.

Rather than employ a control group to isolate the effects of a particular intervention, these designs attempt to rule out alternative plausible explanations through many repeated measures of the targeted outcome at regular intervals before and after the tested intervention commences. How does this differ from just a simple before–after test that, as I noted earlier, does not rule out these other possibilities? To answer this question, suppose that a recent trauma survivor's symptoms are improving just due to the passage of time. If all we do is measure her symptoms once before and once after EMDR is provided, we'll have no way of distinguishing between treatment effects and passage of time effects. However, if we measure her symptoms at the start of each weekly appointment for 4 or more weeks before our first EMDR processing session with her, we will learn whether—and to what degree—her symptoms appear to be improving just due to the passage of time.

Suppose we continue to measure those symptoms at the start of each appointment after the EMDR intervention commences (whether preparation or processing phases), and we find a sustained pattern of improvement in them that began only after we began providing the EMDR intervention. Having conducted numerous repeated measures, we can now rule out the passage of time as the explanation. But can we rule out other extraneous events that may have coincided with the onset of the EMDR treatment? Although such a coincidence is not impossible, it becomes less plausible as we accumulate more measurement points, or more replications with other clients, indicating that sustained patterns of improvement repeatedly coincide with the provision of EMDR treatment, and not at other times. The more repeated measures of the targeted outcome both before and after treatment, the greater the unlikeliness that improvement due to other factors will coincide only with the provision of EMDR. Likewise, the more we can replicate the coinciding of improvement with EMDR treatment across individual clients—or across different targeted outcomes within the same client—the less plausible the alternative explanations become.

Although numerous practice guidelines recognize that EMDR therapy has strong research support for being effective in the treatment of PTSD, this does not remove the need for individual therapists to evaluate their effectiveness when providing EMDR to their clients. There are two reasons why they should do so. One is that the strong research support for the effectiveness of EMDR, as established in research studies, does not guarantee that all therapists who provide EMDR will implement the EMDR protocol with adequate fidelity or that it will be effective with all of their clients. A second reason involves the need to strengthen empirical support for the effectiveness of EMDR with other disorders. By conducting single-case evaluations when using EMDR to treat another disorder, then submitting your results for publication, you can make a significant contribution toward the recognition of EMDR therapy as an empirically validated treatment for that disorder. A different series of single-case evaluations is needed for each disorder to which EMDR may be applied. Thus, if one series documents the efficacy of EMDR with depression, another series would be needed to document its efficacy with a different disorder.

Step-by-Step Guide

STEP 1. SPECIFY THE TARGET

The targeted outcome of EMDR intervention varies from case to case. For some cases, it may be specified in positive terms, such as improving self-esteem or the performance of some desired behavior. For others, it may be specified as reducing something that is undesired, such as anxiety, depression, intrusive thoughts, sleep disturbances, or other symptoms. In many (perhaps most) of your cases, there will be multiple targets, and it may be possible to evaluate the effectiveness of EMDR with all of them simultaneously, or perhaps sequentially. For example, a single-case evaluation supporting EMDR's efficacy in alleviating a student's depression symptoms might be followed by another evaluation of its efficacy in helping the same client overcome performance anxiety connected with taking exams.

The chosen target should be something that occurs frequently enough to be measured on a regular basis and can reasonably be expected to vary during the course of brief treatment. Thus, if working with a severely depressed client, rather than selecting a reduction in rarely occurring suicidal gestures as the targeted outcome to be evaluated, you might choose to monitor sleep disturbances on a daily basis, frequency of positive and negative self-cognitions each day, and/or weekly scores on a brief self-report depression scale.

STEP 2. OPERATIONALLY DEFINE THE TARGET

Specify the measurement procedure(s) that will be used to objectively quantify the target(s) over time. Quantification may be in regard to the frequency, duration, or intensity of the target. It might involve clients in self-monitoring their own cognitions or behaviors. Another option would be to have a significant other (parent, spouse, etc.) monitor targeted behaviors. It might involve the use of brief standardized assessment instruments, such as the Beck Depression Inventory, the State–Trait Anxiety Inventory, or the Impact of Event Scale.

STEP 3. DEVISE A DATA COLLECTION PLAN

A. *Who Should Measure?* One important question in devising your data collection strategy is: Who should measure? If you conduct the measurement yourself as the clinician, you might be biased, since it is only human to want to obtain findings that support your effectiveness and indicate that your treatment is benefiting clients. Also risky is relying exclusively on clients to do the measuring themselves. Clients, too, may be biased to perceive or report positive results to please you or to reassure themselves that they are not wasting their efforts in treatment. Significant others (teachers, cottage parents, etc.) might be asked to monitor certain behaviors in the hope that they have less invested than you or the client in seeing a positive outcome. But their objectivity or commitment to the study cannot be guaranteed. Since there is no foolproof answer to the question of who should measure, you might want to gather data from more than one source. To the extent that different data sources agree in their measures, our concerns about bias may diminish.

B. *With What Instrument(s)?* Another important decision that pertains to the instruments used in measurement of particular values here may be the use of existing scales. Self-report scales can be very convenient; repeated measures can

be expedited by simply having clients complete a brief self-report scale at specified intervals where they live or each time you see them. Self-report scales also ensure that the repeated measures are being administered and scored in a uniform fashion.

In selecting self-report instruments, you should attempt to choose instruments with established reliability and validity. Also, your chosen instruments should have been shown in prior studies to be applicable to clients like yours—as well as to the outcome being targeted for that client—and sensitive to modest changes in targeted outcomes with similar clients. In addition, you want an instrument that is fairly brief, easy to administer and score, and one that can be administered repeatedly, without long time lapses between administrations. Here is a list of some of the instruments and other measures that have been used in EMDR single-case experiments and might work well for your use:

- Anxiety Disorders Interview Schedule—Revised
- Generalized Anxiety Disorder Questionnaire Self-Report version (at *www.psycho-oncology.info/anxietyscale.htm*)
- Beck Anxiety Inventory (BAI)
- Beck Depression Inventory (BDI)
- Behavioral Avoidance Test
- Impact of Event Scale (IES)—Revised
- PTSD Checklist (PCL) (a civilian version and a military version)
- Mississippi Scale for Combat-Related PTSD (MISS)
- State–Trait Anxiety Inventory (State subscale)
- Client monitoring of instances of intrusive thoughts, flashbacks, and sleep disturbances
- Physiological measures of the following:
  - Blood pressure
  - Heart rate
  - Pulse
  - Skin conductance
  - Temperature

If none of the previous measures fit your situation, or if your client has a disorder other than one of those mentioned previously, you can do an online search using terms for that disorder coupled with the term "randomized clinical trial" (RCT). Then you can examine the latest RTCs that appear and see if they used a measure that is a better fit for you.

The previous measures are by no means the only possibilities for you to use. Corcoran and Fischer (2013a, 2013b), for example, describe and reproduce over 300 rapid assessment measures that clinicians can use in practice evaluation. Studies have also commonly used the SUD and VOC scores. However, if you use the SUD and VOC scores, you should supplement them with standardized measures.

C. *When, Where, and How Often?* When, where and how often to collect data will be influenced by what is being measured, who is doing the measuring and with what instruments. If the client is self-monitoring his own cognitions, feelings, or behaviors (e.g., perhaps the client is monitoring instances of intrusive thoughts), the data ideally should be recorded by the client when and where the cognition or thought occurs. In order to minimize distortions influenced by memory, the delay

between the occurrence of the phenomenon and its recording should be as short as possible. However, the severity of problems stemming from a delay in recording will depend on what type of behavior, feeling, or cognition is being monitored. Waiting until close to bedtime to record whether one had a panic attack during the day may be less problematic than waiting until then to try to recall how many negative cognitions one had that day.

You should be attentive to whether any particular setting or time may bias the data and make them unrepresentative. For example, if a client tends to feel particularly lonely at night, you would not want to have her record only at night how lonely she felt each day. Instead, you should have her record the information at different times, to attain a representative sample of the occurrence of the target being monitored (Bloom, Fischer, & Orme, 2006). For another example, suppose you are using the SUD score as an outcome measure. If so, it can make a difference whether you use an SUD score derived before rather than after a session. Critics of some EMDR studies, for example, have argued that clients experience considerable internal pressure to report low SUD scores and high VOC scores to their EMDR therapists after receiving EMDR, because they feel they are expected to do so and not to do so might disappoint their therapist or make the clients look like failures. This underscores the necessity of supplementing the SUD and VOC scores with independent, standardized measures.

The need to vary the time and place for gathering data depends on what is being measured and how. Whereas you may want to vary the time and place for client self-monitoring of some behaviors and cognitions, you may want to keep time and place constant for client completion of SUD and other self-report scales so as to *minimize* situational forces that create unstable fluctuations in the data that are very difficult to interpret. It would be particularly important *not* to administer the SUD to a client at a different time or place during the processing phase than you did during a different phase (e.g., the pretreatment, or baseline, phase). When using client self-report scales, one important decision is whether to have the client complete the scale at home or in your office. By choosing to administer it in your office (perhaps before or at the start of each session), you ensure that the client won't forget to complete it, that you will be able to assist with any questions the client has about how to complete it (without, of course, giving any biasing responses as to what answers the client should give!), and that the time and setting of the completion will be held constant. These advantages, however, should be weighed against the potential for the client to feel watched by completing the scale in your presence, which could bias the data. Having the client complete the scale in the waiting room prior to treatment sessions may be a good option.

As to how often data should be recorded, the answer is, as often as possible without becoming onerous to the data provider. Self-report scales (other than the SUD and VOC scales) should probably be completed about once per week. This will require having about four or more weeks of scale completions before EMDR processing commences (for reasons to be discussed shortly). With self-monitoring of cognitions or behaviors, however, data can be recorded much more often, and conceivably you may obtain a sufficient number of pre-EMDR treatment measures in 1 week. The more repetitions in measurement, the more likely the data are to accurately represent the phenomenon being measured. Perhaps more importantly, the more repeated measures you have, the more able you are to assess the plausibility of contemporaneous events or the passage of time as causes of changes in the

targeted outcome. As noted earlier, having many repeated measures is the essence of the logic of single-case experimental designs.

STEP 4. THE BASELINE PHASE

The first phase in implementing the study you have designed in Steps 1 to 3 is called the Baseline Phase. The baseline is the series of repeated measures you collect before introducing the specific intervention you seek to evaluate. Exactly when and where these measures are administered depends on what is being measured and pragmatic considerations. When clients monitor their own cognitions or behaviors on a daily basis, for example, the baseline can be taken at home over several days or perhaps 1 or 2 weeks before their first EMDR session (or before beginning the treatment to which EMDR is being compared). When clients are completing a self-report scale on a weekly basis, you might choose to have the baseline consist of three scale completions in the waiting room before or after their first contact, their first history-taking appointment, and their first preparation appointment. A fourth baseline measure might be taken in the waiting room before their first reprocessing session.

A common misconception is that you cannot take a baseline with a client who is already receiving treatment from you. This is incorrect. If you seek to evaluate the effects of EMDR processing, it is OK to take a baseline while the client is already in therapy with you, as long as that baseline is taken for each clinical disorder before that client receives any EMDR processing for that disorder. This is an important thing to remember, because clinicians often express ethical reservations about delaying treatment several weeks in order to gather a sufficient number of baseline measures.

The logic of single-case designs requires taking enough repeated measures to make it unlikely that extraneous factors (e.g., the passage of time or changes in the client's environment) would account for improvements that take place in the target problem upon the onset of intervention. Therefore, the baseline period should have enough measurement points to show a stable trend in the target problem and enough points to establish the unlikelihood that extraneous events affecting the target problem will coincide only with the onset of intervention.

A stable trend is one that shows the target problem is occurring in a predictable and orderly fashion. The trend is identified by plotting the data points chronologically on a graph, drawing a line between each data point, then observing whether the overall pattern is clearly increasing (Figure C.1A), decreasing (Figure C.1B), relatively flat (Figure C.1C), or cyclical (Figure C.1D). By contrast, Figure C.1E provides an illustration of an unstable baseline in which no clear trend is obvious.

The ideal number of baseline measurement points needed will vary depending on how soon a stable trend appears. You may want to plan for between four and 10 baseline measures. With some very stable baselines, one can begin to see trends with as few as three to five data points. But the more data points we have, the more confidence we can have in the stability of the observed trend and in the unlikelihood that events will coincide only with the onset of intervention.

The realities of practice do not always permit us to take an ideal number of baseline measures, however. For example, the client's problem might be too urgent to delay intervention any longer, even though the baseline trend appears unstable or is unclear. When an ideal baseline length is not feasible, we simply come as close to the ideal as the clinical realities permit. The minimum recommended number

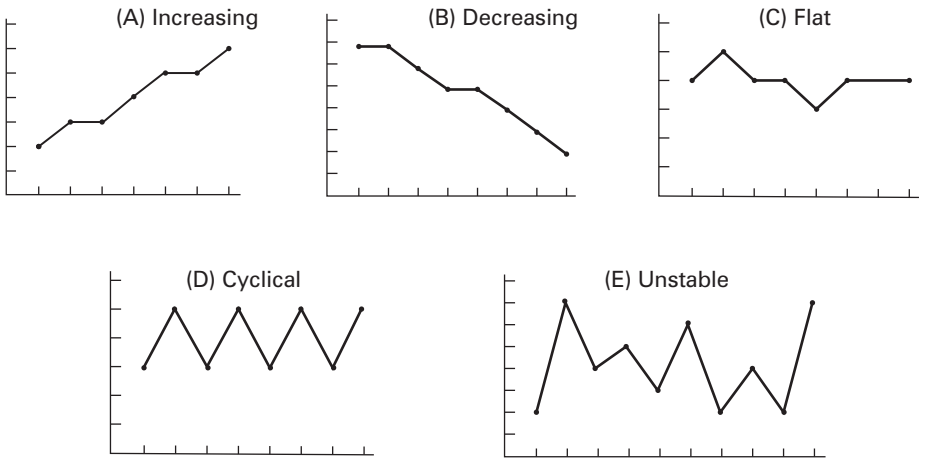


FIGURE C.1. Alternative baseline patterns. From Rubin/Babbie. Empowerment Series: Research Methods for Social Work, 9E. © 2017 South-Western, a part of Cengage Learning, Inc. Reproduced by permission. *www.cengage.com/permissions*

of data points during baseline, as well as other phases, is four (Barlow, Hayes, & Nelson, 1984).

The meaning of increasing or decreasing baselines depends on the operational definition of the target problem. If it involves undesirable phenomena such as intrusive thoughts, then an increasing baseline trend would mean the problem is worsening, and a decreasing baseline would indicate improvement. If the operational definition involves desirable indicators such as VOC ratings, then an increasing baseline would signify improvement and a decreasing baseline would signify deterioration.

When the baseline trend signifies improvement, even if it is stable, it may be advisable to continue collecting baseline measures until the improving trend levels off, as illustrated in Figure C.2. If the intervention is introduced before a baseline trend levels off, it may be difficult to achieve a dramatic improvement in the trend; that is, the baseline trend would mean that the client was improving so steadily

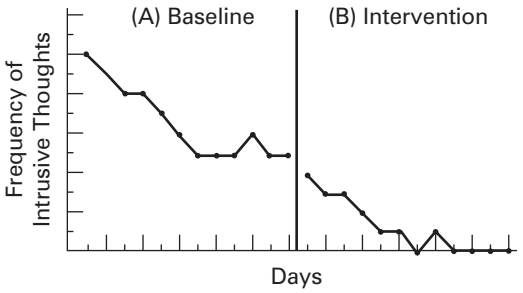


FIGURE C.2. Design with extended baseline after an improving trend. From Rubin/Babbie. Empowerment Series: Research Methods for Social Work, 9E. © 2017 South-Western, a part of Cengage Learning, Inc. Reproduced by permission. *www.cengage.com/permissions*

without any intervention that (1) even an effective intervention might not affect the rate of improvement and (2) perhaps no intervention on that particular indicator was needed in the first place. In other words, introducing an intervention on the heels of an improving baseline introduces the risk of erroneously concluding that an intervention made no difference simply because the ongoing improvement process was already so steady.

We would also want to extend baseline measures beyond the point at which we initially planned to introduce the intervention if the baseline data collected up to that point were unstable (i.e., if they failed to yield a predictable trend). As noted earlier, when we observe an unstable baseline, we ideally would extend the baseline measures until a stable pattern appears. However, it has also been noted that the constraints of practice do not always permit us to extend the baseline until a desirable trend is obtained. Other priorities, such as client suffering or endangerment, may take precedence over the internal validity of the research design. If so, then we simply do the best we can with what we have. Perhaps the intervention is so effective that even an unstable or improving baseline pattern will prove to be clearly worse than the intervention data pattern. Figure C.3 shows an unstable baseline juxtaposed with two alternative intervention data patterns. One pattern illustrates the difficulty of interpreting outcome with an unstable baseline; the other illustrates that it is not necessarily impossible to do so.

STEP 5. THE BASIC SINGLE-CASE DESIGN

There are various single-case designs, most of which are difficult for clinicians to employ in their EMDR practice. The design that best fits the realities of clinical practice is the AB design, which includes one baseline phase (A) and one intervention phase (B), as illustrated in Figures C.2 and C.3. Despite its relative simplicity, the AB design can provide some empirical evidence concerning the effectiveness of EMDR. Also, AB designs can be replicated, and if the results of various AB studies on EMDR with the same type of target are consistent, then the evidence about the effectiveness of EMDR is strengthened. For example, suppose several AB studies at different times and with comparable survivors of sexual abuse all find that trauma

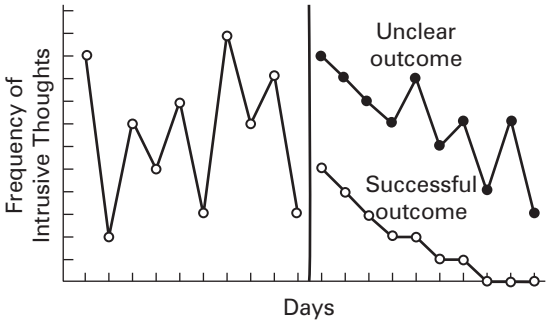


FIGURE C.3. AB design illustrating successful and unclear outcomes after an unstable baseline..From Rubin/Babbie. Empowerment Series: Research Methods for Social Work, 9E. © 2017 South-Western, a part of Cengage Learning, Inc. Reproduced by permission. *www.cengage.com/permissions*

symptoms only begin to improve shortly after EMDR processing is introduced. How credible is the argument that with every client a contemporaneous event could have coincided only with the onset of EMDR processing and caused the improvement?

STEP 6. DATA ANALYSIS

In analyzing the results of single-case experiments, the emphasis is on whether there is a visual pattern in the graph(s) depicting a series of coincidences in which the level or trend of the target problem changes only after the intervention is introduced or withdrawn. This refers to the "visual significance" of the findings. We also consider whether the *amount* of change is important from a clinical standpoint. This refers to the "clinical significance" of the findings.

Visual significance, which is ascertained by "eyeballing" the graphed data pattern, is achieved by looking for shifts in the target problem that occur only when the tested intervention is introduced. Sometimes our single-case design experiments yield ambiguous results that are difficult to interpret. Ambiguity may come in various forms. Perhaps the baseline data are so unstable that it is hard to tell visually whether the intervention data do or do not seem to represent a marked shift in level or slope. Sometimes dramatic improvement begins not at the start of the intervention phase, but so far into it that it is unclear whether improvement represents delayed intervention effects or the influence of an extraneous event. On the other hand, sometimes improvement in the target problem coincides nicely with the onset of the intervention phase but then reverses toward the end of that phase. If the intervention and monitoring cannot be continued, it may be difficult to determine whether the intervention was effective. Perhaps the undesirable data points at the end of the intervention phase indicate that the temporary improvement earlier was due merely to a honeymoon period or to contemporaneous events that coincided with the onset of the intervention. On the other hand, perhaps the undesirable data points at the end of the intervention phase are themselves merely a result of extraneous forces causing a temporary blip in the context of meaningful, sustainable improvement. To read more about data analysis in single-case studies you can obtain the monograph *Empirically Evaluating EMDR Without A Control Group,* published by the Trauma Recovery/EMDR Humanitarian Assistance Programs (*www.emdrhap.org*).

STEP 7. REPLICATION

One way to try to interpret ambiguous data patterns is through replication. If, for example, improvement consistently occurs roughly at about the same time late in the Intervention Phase across studies, then it seems more plausible to argue that the intervention takes a while before showing desired effects than to argue that extraneous events are causing the observed improvements across different clients who begin intervention at different times.

Part II. Within-Group Effect Size Benchmarks

When using an unbiased measurement procedure, EMDR clinicians who want to assess how appropriately or effectively they are implementing the EMDR therapy

protocol can compare the average improvement their clients make to benchmarks that represent the average amount of improvement made by participants in the research studies that have supported the effectiveness of EMDR. The measures and benchmarks below refer to the EMDR treatment of PTSD, anxiety, and depression. Doing so involves the following steps:

1. Administer one of the measures listed later before the EMDR processing begins with each client and again (in an unbiased fashion) at the conclusion of the EMDR treatment protocol.
2. Enter all of your clients' pretest scores for a given measure in an online calculator (e.g., one of those listed later) to obtain the pretest mean and standard deviation.
3. Enter all of your clients' posttest scores for the measure in the same way to obtain the mean posttest score. (The posttest standard deviation is *not* needed).
4. Divide the difference between the two means by the pretest standard deviation. This gives you a statistic called the "effect size." The larger the effect size, the better.
5. Compare your effect size to the benchmarks in the table below that correspond to the measure you used. If your effect size is much closer to the EMDR average effect size than it is to the control group effect size, this indicates that you are implementing the EMDR protocol appropriately and perhaps as effectively as it was implemented in the research studies.

For example, suppose you have treated 10 depressed clients with EMDR and measure outcome using the BDI. You would ask your clients to complete the BDI just before the onset of EMDR treatment. That is the pretest. At the conclusion of EMDR treatment, you would ask them to complete the BDI again. That is the posttest. (Ideally, the posttest should *not* be completed in your presence, so that clients feel comfortable responding in an accurate, unbiased fashion, even if their symptoms have not improved.)

Suppose further that the following 10 clients have the following sets of pretest and posttest scores:

Client	Pretest BDI score	Posttest BDI score
Ann	21	5
Dan	25	7
Fran	29	9
Hans	34	12
Ian	38	15
Jan	43	18
Nan	47	20
Pam	52	22
Sam	55	24
Tammy	60	26

When the 10 pretest scores are entered (each separated by a comma) in one of the online calculators, the mean will be 40.4, and the standard deviation will be 13.2. Entering the 10 posttest scores in the same manner finds a mean of 15.8. The difference when subtracting 15.8 from 40.4 is 24.6. Dividing by the standard deviation of 13.2 results in an effect size of 1.86. That effect size compares quite favorably with the benchmarks for self-reported depression in the table below. It would indicate that your result is just as good as the average effect size (1.31) for EMDR treatment found in the research studies that in aggregate have supported the effectiveness of EMDR. Since the mean EMDR therapy effect sizes have been compromised by some studies using inadequate fidelity and/or treatment duration (see Table 12.1), obtaining somewhat higher outcomes in your practice is preferable.

	Measure used			
Group	Interview[a]	Trauma Symptom Self-Report Scale[b]	Depression Self-Report Scale[c]	Anxiety Self-Report Scale[d]
EMDR	2.43	1.64	1.31	1.33
Control	0.37	0.43	0.24	0.31

Note. Online calculators: *www.easycalculation.com/statistics/standard-deviation.php*; *www.miniwebtool.com/standard-deviation-calculator*; *www.alcula.com/calculators/statistics/standard-deviation.*

[a]Clinician-Administered PTSD Scale (CAPS); [b]IES and PCL; [c]BDI; [d]State–Trait Anxiety Inventory.

For additional information see Rubin, Parrish, and Washburn (2016).

APPENDIX D

Research Lists

An annotated list of the psychophysiological and neurobiological research reviewed in Chapter 12 appears in this appendix.

EMDR therapy has a substantial research base and more than three dozen randomized controlled studies have evaluated the therapy for the treatment of trauma. In addition, more than two dozen randomized controlled trials have tested various hypotheses with respect to the eye movement component. Annotated lists of these studies are available for download at *http://emdrresearchfoundation.org/research-lists,* a dedicated webpage of the EMDR Research Foundation. To date, while numerous randomized controlled studies have supported the effectiveness of EMDR therapy for the treatment of trauma and PTSD across the lifespan, other clinical applications are generally evaluated in case studies or open trials and are thus in need of further, more controlled investigation. In addition to the studies reviewed in Chapter 12, the website mentioned provides an overview of a range of published clinical cases. Due to the rapidly expanding empirical base, the following research lists will be updated periodically and are available for download as PDFs on the webpage:

Adult PTSD and Trauma RCTs
Child PTSD and Trauma RCTs
Component Analyses RCTs
Randomized Studies of Hypotheses Regarding Eye Movements
Evaluated Clinical Applications

PSYCHOPHYSIOLOGICAL AND NEUROBIOLOGICAL EVALUATIONS

All psychophysiological studies have indicated significant de-arousal. Neurobiological studies have indicated significant effects, including changes in cortical and limbic activation patterns, and increase in hippocampal volume.

- Amano, T., & Toichi, M. (2016a). The role of alternating bilateral stimulation in establishing positive cognition in EMDR therapy: A multi-channel near-infrared spectroscopy study. *PLOS ONE, 11*(10), e0162735.

Near-infrared spectroscopy (NIRS). Fifteen healthy volunteers. Tactile bilateral stimulation upon recall of pleasant memories. Accessibility was increased and subjects were more relaxed under BLS conditions. BLS favored an increased activation as compared to no-BLS of the superior temporal sulcus, a structure implicated in memory processing.

- Amano, T., & Toichi, M. (2016b). Possible neural mechanisms of psychotherapy for trauma-related symptoms: Cerebral responses to the neuropsychological treatment of post-traumatic stress disorder model individuals. *Scientific Reports, 6,* Article 34610.

NIRS. Seven healthy volunteers recalling traumatic memories during EMs. EMs reduced the increase in activation elicited by unpleasant memories in the superior temporal sulcus.

- Andrade, J., Kavanagh, D., & Baddeley, A. (1997). Eye movements and visual imagery: A working memory approach to the treatment of post-traumatic stress disorder. *British Journal of Clinical Psychology, 36*(2), 209–223.

Forty-six healthy controls (HCs). Fixed eyes condition. Tapping condition versus no dual task. EMDR reduced vividness and emotiveness of trauma. Effects mediated by the visuospatial sketchpad of working memory.

- Aubert-Khalfa, S., Roques, J., & Blin, O. (2008). Evidence of a decrease in heart rate and skin conductance responses in PTSD patients after a single EMDR session. *Journal of EMDR Practice and Research, 2,* 51–56.

Six HCs. Impedance cardiography (heart rate variability, HRV). Pre–post treatment: within-subject design. Reductions of clinical scores and psychophysiological response. Successful EMDR diminished psychophysiological arousal associated with trauma.

- Bossini, L., Santarnecchi, E., Casolaro, I., Koukouna, D., Caterini, C., Cecchini, F., et al. (2017). Morphovolumetric changes after EMDR treatment in drug-naive PTSD patients. *Rivista di Psichiatria, 52*(1), 24–31.

Magnetic resonance imaging (MRI). Nineteen HCs and 19 individuals with PTSD. Pre–post treatment: within-subject design. Grey matter volume (GMV) analysis before and after 12 EMDR sessions. Relative increase in GMV in left parahippocampal gyrus and diminished GMV in left thalamus of PTSD individuals associated with disappearance of symptoms in 16 of them. EMDR causes changes in the morphology of some brain structures.

- Bossini, L., Tavanti, M., Calossi, S., Polizzotto, N. R., Vatti, G., Marino, D., et al. (2011). EMDR treatment for posttraumatic stress disorder, with focus on hippocampal volumes: A pilot study. *Journal of Neuropsychiatry and Clinical Neurosciences, 23,* E1–E2.

MRI. Nine individuals with PTSD. Within-subject study before and after 12 sessions of EMDR. Bilateral increase of hippocampal volume posttherapy along with improvement of PTSD symptoms.

- Christman, S. D., Garvey, K. J., Propper, R. E., & Phaneuf, K. A. (2003). Bilateral eye movements enhance the retrieval of episodic memories. *Neuropsychology, 17*(2), 221–229.

  Two hundred eighty HCs. Saccadic and smooth pursuit EM. Horizontal versus vertical EM versus no EM. Saccadic vertical EM enhanced interhemispheric interaction facilitating retrieval of episodic memories.

- Christman, S. D., Propper, R. E., & Brown, T. J. (2006). Increased interhemispheric interaction is associated with earlier offset of childhood amnesia. *Neuropsychology, 20*(3), 336–345.

  Eighty-six HCs. Saccadic and smooth pursuit EMs. Horizontal versus vertical EM versus no-EM saccadic. EMs led to recall of earlier childhood events and enhanced interhemispheric interaction facilitating retrieval of episodic memories.

- Farina, B., Imperatori, C., Quintiliani, M. I., Castelli Gattinara, P., Onofri, A., Lepore, M., et al. (2015). Neurophysiological correlates of eye movement desensitization and reprocessing sessions: Preliminary evidence for traumatic memories integration. *Clinical Physiology and Functional Imaging, 35*(6), 460–468.

  EEG. Six individuals with PTSD. EEG coherence pre- and post-EMDR sessions. Increased coherence in beta band between parietal and temporal cortex. Coherence negatively correlated to SUD and positively to parasympathetic activity.

- Frustaci, A., Lanza, G. A., Fernandez, I., di Giannantonio, M., & Pozzi, G. (2010). Changes in psychological symptoms and heart rate variability during EMDR treatment: A case series of subthreshold PTSD. *Journal of EMDR Practice and Research, 4,* 3–11.

  Seven HCs. Pre–post treatment within-subject design. Decreased symptom scores and increased in parasympathetic tone. Results in subsyndromal PTSD are compatible with accumulated evidence in full-blown PTSD.

- Harper, M. L., Rasolkhani-Kalhorn, T., & Drozd, J. F. (2009). On the neural basis of EMDR therapy: Insights from EEG studies. *Traumatology, 15,* 81–95.

  EEG. Six individuals with PTSD. Bilateral tactile stimulation within-group analysis. Symptoms of PTSD were reduced along with brain electrical activity compatible with depotentiation of fear memory synapses, as shown in animals. The desensitization indicated by the delta waves in EMDR results from depotentiation of fear memory synapses.

- Herkt, D., Tumani, V., Grön, G., Kammer, T., Hofmann, A., & Abler, B. (2014). Facilitating access to emotions: Neural signature of EMDR stimulation. *PLOS ONE, 9*(8), e106350.

  Functional MRI (fMRI). Twenty-two HCs. Within-subject design auditory stimulation upon viewing disgusting versus neutral picture stimuli. Specific increase in activation of the right amygdala and decreased activation in dorsolateral prefrontal cortex for the bilateral alternating auditory stimulation. Activation changes in line with theoretical models of how bilateral alternating stimulation could help with therapeutic reintegration of information.

- Jung, W. H., Chang, K. J., & Kim, N. H. (2016). Disrupted topological organization in the whole-brain functional network of trauma-exposed firefighters: A preliminary study. *Psychiatry Research, 250,* 15–23.

fMRI. Nine individuals with PTSD, 9 without PTSD, and 11 HCs. Pre–post treatment: within-subject design. Individuals with PTSD exhibited altered global brain network properties that ameliorated after treatment. Disruption in the optimal balance in the functional brain networks can be ameliorated by psychotherapy.

- Kavanagh, D. J., Freese, S., Andrade, J., & May, J. (2001). Effects of visuospatial tasks on desensitization to emotive memories. *British Journal of Clinical Psychology, 40*(Pt. 3), 267–280.

Eighteen HCs. Visual noise versus exposure alone. EMDR reduced vividness and emotiveness of trauma. Visuospatial task offers a temporary response aid for imaginal exposure without affecting desensitization.

- Landin-Romero, R., Novo, P., Vicens, V., McKenna, P. J., Santed, A., Pomarol-Clotet, E., et al. (2013). EMDR therapy modulates the default mode network in a subsyndromal, traumatized bipolar patient. *Neuropsychobiology, 67,* 181–184.

Resting-state fMRI. One patient with bipolar disorder and 30 HCs. Pre–post treatment: within-subject design. Failure of deactivation in the medial frontal cortex partially normalizing after treatment. Possible neurobiological mechanism of action: normalization of default mode network dysfunction.

- Lansing, K., Amen, D. G., Hanks, C., & Rudy, L. (2005). High resolution brain SPECT imaging and EMDR in police officers with PTSD. *Journal of Neuropsychiatry and Clinical Neurosciences, 17,* 526–532.

Single-photon-emission computed tomography (SPECT). Six individuals with PTSD. Pre–post treatment: within-subject design. Decreases in left and right occipital lobe, left parietal lobe, and right precentral frontal lobe, as well as significant increased perfusion in the left inferior frontal gyrus. EMDR was effective treatment for individuals with PTSD, who showed both clinical and brain imaging changes.

- Laugharne, J., Kullack, C., Lee, C. W., McGuire, T., Brockman, S., Drummond, P. D., et al. (2016). Amygdala volumetric change following psychotherapy for posttraumatic stress disorder. *Journal of Neuropsychiatry and Clinical Neuroscience, 28*(4), 312–318.

MRI. Twenty individuals with PTSD. EMDR versus prolonged exposure. Pre–post treatment: within-subject design. Left amygdala mean volume increased significantly following EMDR treatment only. Differential effect on amygdala volumes, related to neuronal remodeling, underpinning these two established therapies.

- Levin, P., Lazrove, S., & van der Kolk, B. A. (1999). What psychological testing and neuroimaging tell us about the treatment of posttraumatic stress disorder (PTSD) by eye movement desensitization and reprocessing (EMDR). *Journal of Anxiety Disorders, 13,* 159–172.

SPECT. Case report PTSD. Pre–post treatment: within-subject design. Increased activation posttreatment in anterior cingulate gyrus and in the left frontal lobe. Successful treatment of PTSD enhances the ability to differentiate real from imagined threat.

- Nardo, D., Högberg, G., Looi, J. C., Larsson, S., Hällström, T., & Pagani, M. (2010). Gray matter density in limbic and paralimbic cortices is associated with trauma load and EMDR outcome in PTSD patients. *Journal of Psychiatric Research, 44,* 477–485.

MRI. Twenty-one individuals with PTSD and 22 without PTSD; 10 EMDR responders and five EMDR nonresponders. Nonresponders showed a significantly lower gray-matter (GM) density as compared to responders in bilateral posterior cingulate, as well as anterior insula, anterior parahippocampal gyrus, and amygdala in the right hemisphere. Lower GM density in limbic and paralimbic cortices was associated with PTSD diagnosis, trauma load, and EMDR treatment outcome.

- Oh, D.-H., & Choi, J. (2004). Changes in the regional cerebral perfusion after eye movement desensitization and reprocessing: A SPECT study of two cases. *Journal of EMDR Practice and Research, 1,* 24–30.

SPECT. Two individuals with PTSD and 10 HCs. Pre–post treatment: within-subject design. Increased perfusion posttreatment in dorsolateral prefrontal cortex and decreased in temporal association cortex. EMDR treatment appears to reverse the functional imbalance between the limbic area and the prefrontal cortex.

- Ohtani, T., Matsuo, K., Kasai, K., Kato, T., & Kato, N. (2009). Hemodynamic responses of eye movement desensitization and reprocessing in posttraumatic stress disorder. *Neuroscience Research, 65,* 375–383.

NIRS. Thirteen individuals with PTSD. Pre–post treatment: within-subject design. Decreased activity in prefrontal cortex during recall with EMs. Performing EMs during recall reduces the overactivity of the lateral PFC, which may be part of the biological basis for the efficacy of EMDR in PTSD.

- Pagani, M., Di Lorenzo, G., Monaco, L., Daverio, A., Giannoudas, I., & La Porta, P., (2015). Neurobiological response to EMDR therapy in clients with different psychological traumas. *Frontiers in Psychology, 6,* Article 1614.

EEG. Forty individuals with PTSD, 20 HCs. Pre–post treatment: within- and between-subject design in earthquake victims. Significantly increased activation in orbitofrontal cortex pretreatment shifting toward posterior associative regions posttreatment. Clients with chronic exposure had activations closer to that of controls, suggesting an association between social and environmental contexts with the neurobiological response to trauma exposure and psychotherapy.

- Pagani, M., Di Lorenzo, G., Monaco, L., Niolu, C., Siracusano, A., Verardo, A. R., et al. (2011). Pre-treatment, intra-treatment, and post-treatment EEG imaging of EMDR: Methodology and preliminary results from a single case. *Journal of EMDR Practice and Research, 5,* 42–56.

EEG. PTSD case report. Pre–post treatment: within-subject design. Pilot study EEG monitoring. Activations shift from limbic to parietal regions.

- Pagani, M., Di Lorenzo, G., Verardo, A. R., Nicolais, G., Monaco, L., Lauretti, G., et al. (2012). Neurobiological correlates of EMDR monitoring—An EEG study. *PLOS ONE, 7*(9), e45753.

EEG. Ten individuals with PTSD and 10 HCs. Pre–post treatment: within-subject design during EMDR sessions. Activations shift from frontal and limbic to temporo-parietal-occipital regions. Traumatic events are processed at cognitive level following successful EMDR therapy, thus supporting the evidence of distinct neurobiological patterns of brain activations during bilateral stimulation (BLS) associated with a significant relief from negative emotional experiences. No significant interhemispheric correlation. During BLS, decreased connectivity in patients as compared to controls between posterior cingulate and prefrontal and anterior cingulate cortices.

- Pagani, M., Högberg, G., Salmaso, D., Nardo, D., Sundin, O., Jonsson, C., et al. (2007). Effects of EMDR psychotherapy on 99mTc-HMPAO distribution in occupation-related post-traumatic stress disorder. *Nuclear Medicine Communications, 28,* 757–765.

SPECT. Fifteen individuals with PTSD and 22 HCs. Pre–post treatment: within- and between-subject design. Reduction toward normalization in EMDR responders in prelimbic cortices and increases in prefrontal cortex. Findings consistent with previously described effects of psychotherapy on anxiety disorders neurobiology and symptoms.

- Parker, A., Buckley, S., & Dagnall, N. (2009). Reduced misinformation effects following saccadic bilateral eye movements. *Brain and Cognition, 69*(1), 89–97.

Seventy-two HCs. Horizontal versus vertical EM versus no EM. Horizontal EM increased true memories for the event and recollection, and decreased the magnitude of the misinformation effect. Horizontal EM enhanced the monitoring and dual processing of source memories.

- Raboni, M. R., Alonso, F. F., Tufik, S., & Suchecki, D. (2014). Improvement of mood and sleep alterations in posttraumatic stress disorder patients by eye movement desensitization and reprocessing. *Frontiers in Behavioral Neuroscience, 8,* 209.

Thirteen individuals with PTSD and 11 HCs. Pre–post treatment: within-subject design. PTSD patients showed decreased levels of depression and anxiety after therapy and sleep amelioration. Reduced sympathetic activation may explain the improvements observed after EMDR.

- Sack, M., Lempa, W., Steinmetz, A., Lamprecht, F., & Hofmann, A. (2008). Alterations in autonomic tone during trauma exposure using eye movement desensitization and reprocessing (EMDR)—results of a preliminary investigation. *Joural of Anxiety Disorders, 22*(7), 1264–1271.

Impedance cardiography (HRV). Ten individuals with PTSD. EMDR provoked at stimulation onsets an increase of psychophysiological response. During ongoing stimulation autonomic response indicated stress-related arousal. EMDR is associated with patterns of autonomic activity related to de-arousal over time.

- Samara, Z., Elzinga, B. M., Slagter, H. A., & Nieuwenhuis, S. (2011). Do horizontal saccadic eye movements increase interhemispheric coherence?: Investigation of a hypothesized neural mechanism underlying EMDR. *Frontiers in Psychiatry, 2*, 4.

  EEG. Fourteen HCs. EMs versus eye fixation. Interhemispheric phase and amplitude EEG coherence were not affected by the EMs. There were no associations between changes in EM-related interhemispheric connectivity and memory performance. The findings do not support the interhemispheric interaction hypothesis.

- Trentini, C., Pagani, M., Fania, P., Speranza, A. M., Nicolais, G., Sibilia, A., et al. (2015). Neural processing of emotions in traumatized children treated with eye movement desensitization and reprocessing therapy: A hdEEG study. *Frontiers in Psychology, 6*, Article 1662.

  EEG. Ten children with PTSD. Pre–post treatment: within-subject design, passive view of angry, afraid, happy, and neutral faces. In all four conditions, higher activity on the right medial prefrontal and frontotemporal limbic regions pretreatment, shifting toward the left medial and superior temporal after treatment. Increased activity in areas implicated in higher-order cognitive processing and improvement of emotional–adaptive functioning.

- van den Hout, M. A., Eidhof, M. B., Verboom, J., Littel, M., & Engelhard, I. M. (2014). Blurring of emotional and non-emotional memories by taxing working memory during recall. *Cognition and Emotion, 28*(4), 717–727.

  Forty HCs. Recall only versus recall + EM. Negative memories are rated as less vivid after "recall + EM" but not after "recall only." This was not found for neutral memories. Emotional memories are more taxing than neutral memories, which may explain the findings. Alternatively, transient arousal induced by recall of aversive memories may promote reconsolidation of the blurred memory image that is provoked by EMs.

- van den Hout, M., Muris, P., Salemink, E., & Kindt, M. (2001). Autobiographical memories become less vivid and emotional after eye movements. *British Journal of Clinical Psychology, 40*(Pt. 2), 121–130.

  Sixty HCs. EM, finger tapping versus no dual task. Recollections after EMs were less vivid both for positive and negative recollections. Effect of EMs is mediated by visuospatial sketchpad taxation.

- Wilson, D. L., Silver, S. M., Covi, W. G., & Foster, S. (1996). Eye movement desensitization and reprocessing: Effectiveness and autonomic correlates. *Journal of Behavior Therapy and Experimental Psychiatry, 27*(3), 219–229.

  Autonomic measures. Eighteen HCs. Full EMDR protocol versus tapping only. EMDR group showed desensitization. Autonomic changes during EMDR compatible with a relaxation response. Therapeutic effect paired distress with an unlearned relaxation response.

APPENDIX E

Client Safety

Although now considered a standard form of therapy, EMDR was introduced as an experimental procedure during trainings that began in 1990. To disseminate this new psychotherapeutic approach responsibly, the training practices and client safety factors were overseen by independent committees of experienced senior clinicians. Their recommendations have stood the test of time and form the core of the guidelines provided here, so that readers can review the primary areas of concern regarding client safety.

The first section of this appendix consists of the original EMDR Dissociative Disorders Task Force recommended guidelines, which contain a general guide to the use of EMDR therapy with the dissociative disorders and an updated suggested reading list. Although first published in 1995, these guidelines with updated references are still relevant today.

The second section includes the training policies of the EMDR International Association (EMDRIA), which now provides guidelines for EMDR training and clinical practices in the United States. The goal is to find a way to protect client safety, maintain the integrity of the EMDR methodology, and prevent diluted versions from proliferating in the hands of unlicensed lay practitioners. More comprehensive and updated guidelines are available on the EMDRIA website (*www.emdria.org*). See Shapiro (1998) for a complete review of the history of EMDR training practices and recommendations for dissemination of emerging psychotherapies.

EMDR DISSOCIATIVE DISORDERS TASK FORCE RECOMMENDED GUIDELINES: A GENERAL GUIDE TO EMDR'S USE IN THE DISSOCIATIVE DISORDERS

Purpose

This section offers general guidelines in the application of EMDR to the dissociative disorders, with paramount concern for client safety. The intended audience is the *established* clinician who is new to the diagnosis and treatment of dissociative disorders. This guide is not intended to define standards of care or specific training requirements or certification guidelines. Furthermore, it is not intended to supersede expert clinical judgment or training in dissociative disorders or hypnosis.

Assumptions

The following are some assumptions underlying this guide: (1) EMDR treatment of those with a dissociative disorder is best imbedded within a total psychotherapeutic approach and does not stand alone as a treatment; (2) there is a high prevalence of undiagnosed dissociative disorder in clinical populations; (3) there is a high cost to patient, therapist, and the therapeutic alliance in failing to adequately consider the possibility of dissociative disorders before first using EMDR in a patient's treatment; (4) as our understanding continues to develop, these guidelines may need revision. The following paragraphs are guidelines for therapists in evaluating patients for EMDR and determining whether and at what point EMDR may be safely introduced in a patient's treatment.

Screening

The therapist should screen every patient for the presence of an underlying dissociative disorder regardless of the presenting complaint. Screening approaches include the Dissociative Experience Scale II (Carlson & Putnam, 1993), the Somatoform Dissociation Questionnaire (Nijenhuis, 2004), the Multiscale Dissociation Inventory (Briere, 2002), and the Mental Status Examination for Dissociative Disorders (Loewenstein, 1991). The therapist has not conducted sufficient screening if that screening is limited to in-session monitoring for evidence of "switching." If the index of suspicion for the presence of a dissociative disorder is low after screening, the therapist may proceed with the EMDR protocol, including preparatory steps that are appropriate for the presenting problem.

Clarifying the Diagnosis

If the index of suspicion for a dissociative disorder is high after screening, the therapist should conduct further diagnostic evaluation, using, for example, the Dissociative Disorders Interview Schedule DSM-5 version (DDIS; Ross, *rossinst.com*) or the lengthier Structured Clinical Interview for DSM-IV Dissociative Disorders—Revised by Marlene Sternberg (1999), or the Multidimensional Inventory for Dissociation, v. 6.0 (Dell, 2004), or obtain appropriate consultation.

When a Dissociative Disorder Is Present

If the assessment reveals that a dissociative disorder is present, the decision to proceed with EMDR is best guided by considering both therapist and patient factors, as follows:

1. Therapist factors:
   a. It should be determined whether the therapist is sufficiently trained in the dissociative disorders, as evidenced by the therapist's (1) having taken formal courses in the area and (2) having been supervised in the psychotherapy of dissociative patients.
   b. It should be determined whether the therapist is sufficiently skilled in the treatment of dissociative disorders, as evidenced by such abilities as (1) troubleshooting with hostile alters, child alters, and perpetrator alters; (2) anticipating and accommodating transferences; (3) recognizing and working with hypnotic and dissociative phenomena; (4) managing crises; and (5) determining the need for medical and/or inpatient backup.
   c. The therapist should have considerable experience using EMDR on patients without dissociative disorders before attempting it on highly dissociative patients. The therapist needs skill in the "cognitive interweave" interventions and other active interventions described in the EMDR Institute's Level II training.
   d. Unless the aforementioned skills are present, the therapist should either refer the patient or seek additional training in the fields of dissociative disorders and hypnosis before using EMDR with a dissociative patient (see the section "Additional Training").
   e. If the requisite skills and training are present, the therapist may implement EMDR within the context of a thorough treatment plan only if positive patient factors are present (see next section).
2. Patient factors: Patient factors are important in planning the treatment of patients with dissociative disorder, whether EMDR is used or not. Because of the potential of EMDR for rapid destabilization, however, patient factors directly affect the risks associated with the procedure.
   a. Assess patient suitability for EMDR treatment by ascertaining whether the patient has (1) good affect tolerance; (2) a stable life environment; (3) willingness to undergo temporary discomfort for long-term relief; (4) good ego strength; (5) adequate social support and other resources; and (6) a history of treatment compliance. The following assessment is a necessary element in the evaluation of any dissociative patient for any treatment. With EMDR, however, the risks associated with failing to assess adequately are more serious because of the power of the procedure.
   b. Determine whether the patient exhibits the following signs, which tend to contraindicate the use of EMDR: (1) ongoing self-mutilation; (2) active suicidal or homicidal intent; (3) uncontrolled flashbacks; (4) rapid switching; (5) extreme age or physical frailty; (6) terminal illness; (7) need for concurrent adjustment of medication; (8) ongoing abusive relationships; (9) alter personalities that are strongly opposed

to abreaction; (10) extreme character pathology, especially a severe narcissistic, sociopathic, or borderline disorder; (11) serious dual diagnoses such as schizophrenia or active substance abuse.

The presence of these signs may not constitute absolute contraindications. However, the risks and complexities that accrue if the therapist proceeds with EMDR in the presence of these signs are considerable. The potential benefits must outweigh these risks, and safety precautions must be in place. Only therapists who are highly experienced with managing those complications are prepared to proceed with EMDR for patients evidencing these signs.

Embedding EMDR in the Treatment Plan

If the aforementioned therapist and patient factors are appropriate, EMDR may be one component in a progressive course of treatment. The total treatment plan is best guided by the accumulated knowledge of the field of dissociation and may include hypnosis, EMDR, behavior therapy, cognitive therapy, and other methods.

Preparing for EMDR

The therapist should prepare the patient for EMDR with the intention of minimizing the likelihood and impact of any problems occurring in the middle of EMDR sessions. At the same time, the therapist needs to "expect the unexpected," to use Kluft's phrase. At a minimum, the therapist should carefully explain the procedure to the client with the intent of achieving sufficient informed consent of the entire system, recognizing that this is not a fully attainable goal. To the degree that the system consents, EMDR processing is likely to proceed smoothly. Suggestions for the entire system to observe, even if parts are reluctant, can prevent surprised alters from aborting the processing. The therapist's preparation of the patient for EMDR may be affected by factors such as (1) system complexity; (2) informed consent of the relevant portions of the system; (3) cooperation between parts; (4) permeability of dissociative barriers; and (5) overall system motivation for change. A straightforward, cooperative, and co-conscious system is easier to prepare for EMDR than one that is hostile, complex, and impermeable. Preparation for EMDR processing may proceed in tandem with other therapeutic activities, including the establishment of rapport and the teaching of affect containment and other skills.

Early Treatment Phases

Early in the treatment of a dissociative disorder, therapists should refrain from the use of EMDR processing. Exceptions may exist under extraordinary circumstances, to be defined in consultation.

Caution

The use of BLS too early in treatment risks premature penetration of dissociative barriers, which could produce results such as flooding of the personality system, uncontrolled destabilization, and increased suicidal or homicidal risk. For crisis

intervention, the therapist should attempt BLS only if the risks of failing to intervene are as high without as with the intervention.

Middle Treatment Phases

Throughout the Integration Phase of treatment, the therapist may find various uses for EMDR, including, for example, (1) EMDR's prototypical application, the reprocessing of traumatic memory; (2) facilitation of internal dialogue using ego state therapy (Watkins & Watkins, 1997) during EMDR; (3) restructuring of cognitive distortions used as EMDR targets; (4) building of alternative coping behaviors using EMDR installations; (5) ego strengthening through installations; and (6) fusion.

Final Treatment Phases

In the postintegration and termination stages of treatment, EMDR may have continued application, including (1) additional coping skills development; (2) generalization into new situations; (3) facilitating the patient in making meaning of life's trauma, pain, and healing; (4) resolving remaining obstacles to the achievement of life goals.

Task Force Members

The following, in alphabetical order, are the original EMDR Dissociative Disorder Task Force members:

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Additional Training

Clinicians who seek additional training in the diagnosis and treatment of dissociative disorders should contact the International Society for the Study of Trauma and Dissociation (ISSTD), 8201 Greensboro Drive, Suite 300, McLean, VA 22102; phone: (703) 610-9037; website: *www.isst-d.org*.

Suggested Reading

The following are a few of the resources available for the study of dissociation:

Boon, S., Steele, K., & van der Hart, O. (2011). *Coping with trauma-related dissociation: Skills training for patients and their therapists*. New York: Norton.
Braun, B. G. (1988). The BASK model of dissociation. *Dissociation, 1*(1), 4–23.
Chu, J. A. (1998). *Rebuilding shattered lives*. New York: Wiley.

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Loewenstein, R. J. (2006). DID 101: A hands-on clinical guide to the stabilization phase of dissociative identity disorder treatment. *Psychiatric Clinics of North America, 29*(1), 305–332.
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Schwartz, R. C. (1995). *Internal family systems*. New York: Guilford Press.
van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). *The haunted self: Structural dissociation and the treatment of chronic traumatization*. New York: Norton.
Watkins, J. G., & Watkins, H. H. (1997). *Ego states: Theory and therapy*. New York: Norton.

PROFESSIONAL STANDARDS AND TRAINING COMMITTEE OF THE EMDR INTERNATIONAL ASSOCIATION

EMDRIA, which came into existence in 1995, is an independent, nonprofit, professional organization. One of the first committees developed by the board of directors that year was the Professional Standards and Training Committee. The mission of the committee is to develop, establish, and monitor the standards and criteria for training and education in EMDR. As indicated on the website:

> The purpose of the Standards & Training Committee is to ensure that the highest standards of EMDR are maintained for all EMDRIA Approved Basic EMDR Trainings, advanced programs offering EMDRIA Credits and for those who apply for recognition as EMDRIA Certified Therapists and Approved Consultants in EMDR. Committee members review applications of those seeking to offer an EMDRIA Approved Basic Training or EMDRIA Credits (continuing education in EMDR) for advanced programs.

The committee has developed and established criteria for those who teach EMDR therapy in university/internship/agency settings or as independent/commercial instructors. It also established that only individuals who are licensed/certified in their respective mental health disciplines, or those in a graduate program or process that leads to a mental health license/certification, have the qualifications to be trained in the use and application of EMDR to clinical populations.

In 1999, the Professional Standards and Training Committee, with the full approval of EMDRIA's board of directors, developed and established the standards and criteria for Certification in EMDR and Approved Consultant in EMDR designations. To become Certified in EMDR, the applicant must meet the following criteria: (1) have completed an EMDRIA-approved basic training program

in EMDR (20 hours didactic and 20 hours of practicum experience); (2) hold a license, certification, or registration as a mental health professional independently providing services; (3) provide documentation of experience in the mental health field; (4) document having provided a minimum of 50 EMDR sessions to at least 25 clients; (5) document that he has received 20 hours of EMDR consultation from an EMDRIA Approved Consultant; (6) provide a letter or letters addressing the quality of the applicant's use of EMDR from each EMDRIA Approved Consultant whom the applicant utilized for consultation; (7) provide two letters of recommendation regarding the ethics in practice and professional character of the applicant; and, (8) provide documentation of having completed at least 12 hours of EMDRIA credit approved program participation (continuing education in EMDR), and (9) agree to adhere to the EMDRIA Professional Code of Conduct.

To become an Approved Consultant in EMDR, the applicant must meet the following criteria: (1) have completed an EMDRIA-approved basic training program in EMDR (20 hours of didactic and 20 hours of practicum experience); (2) hold a license, certification, or registration as a mental health professional independently providing services; (3) be certified in EMDR; (4) document at least 3 years' experience, after completing an EMDRIA-approved basic training program in EMDR, in providing a minimum of 300 EMDR sessions to at least 75 clients; (5) provide documentation that she/he has received 20 hours of EMDR "consultation-of-consultation" with an EMDRIA approved consultant in EMDR therapy; (6) provide a letter or letters addressing the quality of the applicant's EMDR consultation with others from each approved consultant in EMDR therapy that the applicant utilized for consultation-of-consultation; (7) provide two letters of recommendation regarding the ethics in practice and professional character of the applicant; and (8) provide documentation of having completed at least 12 hours of EMDRIA credit-approved program participation (continuing education in EMDR therapy).

The Professional Standards and Training Committee also oversees and monitors the quality and current relevance of all workshops, seminars, and conferences that provide EMDRIA continuing education credits for the participants. The committee works cooperatively with other EMDRIA committees to provide educational information to consumers and the general public, as well as other professional organizations and entities as the need arises.

More information about the Professional Standards and Training Committee, or about EMDRIA, can be obtained by visiting the organization's website at *www.emdria.org* or by contacting the organization at EMDR International Association, 5806 Mesa Drive, Suite 360, Austin, TX 78731.

APPENDIX F

EMDR Therapy Training Resources

EMDR therapy training is best obtained through programs certified by the regional EMDR association in your area. The internationally standardized trainings consist of lecture, consultation, and supervised small-group practice. To access an evaluated and certified training in your country, contact the organizations below.

NORTH AND SOUTH AMERICA

EMDR International Association
www.emdria.org

Lists qualified EMDR therapy training providers throughout the United States.

Trauma Recovery/EMDR Humanitarian Assistance Programs
www.emdrhap.org

U.S.-based organization providing low-cost trainings for domestic nonprofit organizations and pro bono training and treatment after natural and man-made disasters domestically and internationally.

EMDR Canada
www.emdrcanada.org

Lists training in various provinces.

EMDR Iberoamerica
www.emdriberoamerica.org

The website links to training in 18 national associations. The Mexican

Association for Mental Health Support in Crisis also coordinates pro bono EMDR training and treatment after disasters throughout Iberoamerica.

www.amamecrisis.com.mx/quienes-somos

EUROPE

EMDR Europe
www.emdr-europe.org

The website links to training in 28 national associations. The national associations also provide pro bono training and treatment after domestic disasters. EMDR Europe Humanitarian Assistance Programmes provide pro bono training and treatment after international disasters.

ASIA

EMDR Asia
www.emdrasia-assoc.org

The website links to training in 12 national associations. National associations help coordinate pro bono training and treatment after disasters.

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