

EMDR Level 1 – preworkshop recording one

Transcript

Origins of EMDR – The Beginnings

My name is Chris Lee. This first recording covers the history of EMDR, my introduction to EMDR, understanding EMDR using information processing models and key aspects of client assessment. The second recording concerns more procedural aspects of the therapy.

How did EMDR begin? Shapiro writes that while walking in a park in 1987, she was troubled by some personal issues. At the time she was in the process of writing a Doctoral thesis and was suffering cancer. During this walk she noticed that the distress of some of the more disturbing aspects of her life at that time were diminishing. At the same time, she became aware that her eyes were moving rapidly from side to side and began to wonder if there was a possible association between the decrease in distress and her eye movements. Or were these just chance associations.

Over the next two years she experimented with inducing eye movements in others by having them follow back and forth movements of her fingers. She began noticing that eye movements did commonly reduce the distress of an upsetting memory. Through the assessment of some 70 or so individuals over the subsequent 12 months she made observations of how best to facilitate this reduction. What type of eye movements produce the best effects? What should the client be thinking of when engaging in eye movements? She documented her observations and thoughts and in 1989 published an article describing 22 participants who she treated and the ways to elicit the maximum effect from the eye movement task.

She initially described the procedure as Eye Movement Desensitisation. Later, she began to consider that desensitisation was not the best description of this therapy. People appeared to not only lose their distress associated with the experience, but also have a different view of the event and appeared to link the past upsetting events to other phenomena in their lives. Therefore, in 1991 she described the procedure as Eye Movement Desensitisation and Reprocessing.

Twenty two years later, after two decades of independent research, it was clear that eye movements reduce the distress associated with upsetting memories. Pim Cuijpers and I published a meta-analysis that proved this in the Journal of behaviour therapy and experimental psychiatry in 2013. Furthermore we found that eye movements reduces the vividness of distressing memories. After eye movements clients report that distressing memories feel more distant.

Most of the methods of EMDR that we use today are based on those initial observations and experiments that Francine described. We have, over time, a greater understanding of the conditions that optimise the treatment, and these will be presented to you through this pre-workshop reading and at your two day face-to-face training. At the conclusion of your face-to-face training we will also provide you with a Dropbox link to further EMDR resources. The resources include; client handouts,

protocols for clinicians to follow and research articles, including the latest evidence based practice reviews.

So given the above history its obvious that EMDR did not evolve from a particular therapeutic orientation. Since its first publication, researchers and clinicians have attempted to account for the curative elements of the therapy and this has led to revisions of existing theories and in turn improvements in EMDR practise. I will describe the relevant theories shortly but first I'd like to describe how I became interested in EMDR.

My initial interest in EMDR

My use and study of EMDR began with a man named Don Heggie. Don was a multi-millionaire who ran a trucking company in Sydney, Australia. Don was also a WWII bomber pilot. During WWII his plane was shot down over Germany. He was the only survivor of the crash. He lost his entire crew and spent the rest of WWII in a POW camp. Given the allies policy at the time of bombing civilian populations, bomber pilots were given a particularly difficult time in POW camps. Despite years of therapy, Don had symptoms of PTSD from WWII all the way up to 1989. At that time he came across EMDR. He thought it had to be worth a go. So he flew himself over to America and had two weeks of EMDR treatment with Francine Shapiro. He told me that after this treatment he never had a nightmare about WWII again and rarely experienced flashbacks.

Don told me that he wanted to make sure as many people as possible could experience the relief that he had from EMDR. He offered to finance a psychologist from each State of Australia to fly to America and to pay their accommodation and training fees under the small provisio that when they come back to Australia that they would tell other therapists about what they thought of EMDR. Don offered me this opportunity and so it is thanks to him that I have had the chance to develop my ideas on EMDR. It is also thanks to Don that so many practitioners in Australia have received EMDR training and been able to use this in helping their clients.

Returning to the therapy. The first thing to be clear about is that EMDR is not eye movements. EMDR involves an 8 stage or phase model. The 8 stages are Stage 1 which is called client assessment, Stage 2, procedural preparation, Stage 3, target assessment, Stage 4, desensitisation, Stage 5, integration, Stage 6, body scan, Stage 7, closure, & Stage 8, re-evaluation.

Before explaining these stages in more detail I want to focus on phase 3 target assessment and make links between this phase and crucial aspects of information processing theory so that you understand what we need to obtain from our clients in order to do EMDR.

In Phase 3 we first identify possible target memories for EMDR and assess the key component of a central target. This includes memories of the image of the event, associated negative beliefs, emotions and physical sensations and a positive belief that represents the desired goal for change.

Suitable EMDR targets

In phase 3 target assessment phase begins with determining the picture that best represents a traumatic event for the individual. For someone who has been sexually assaulted the intrusive recollection of the rapist's knife might be the image that best represents the event to that person. For someone else who has been involved in a motor vehicle accident, the car colliding with the other vehicle, and the bonnet of their own car being concertinaed into the oncoming car may be the best visual representation of that event.

In EMDR we do not only target traumatic events of this type. That is those that are of sufficient severity to meet category A diagnostic criteria for Post-Traumatic Stress Disorder. EMDR targets don't have to be life threatening events, or ones that involved serious injury or a sexual assault. Everyday noxious events can be legitimate targets for EMDR. For example someone who is presenting for treatment with a social phobia may have a memory of being humiliated when they were in year 7 or 8. You may decide to use EMDR to target that early humiliation memory. In this case the picture that best represents the target could be a smirking look on the teacher's face after your client spoke to the class.

These events that were not serious injuries, life threatening moments or something that resulted in a sexual assault, can be crucial in the etiology of someone's psychological disorder.

Shapiro described these more every day events as little T of traumas to distinguish them from the traumas that are part of a PTSD presentation. However, given this, one can conceive that where upsetting the emotional experiences are relevant to the development of a disorder, then EMDR can have a place in the treatment of this disorder. Early memories of being humiliated, bullied, picked on or embarrassed are legitimate targets, although not of course not resulting in a PTSD diagnosis. At the workshop I will present recent literature on where EMDR has been extended to treat other disorders that have a trauma focus.

After determining the event details of a memory, the next step in target assessment is to determine a negative cognition that goes with that picture. Ideally we're looking for a negative self-referencing statement. Examples include, "I'm stupid, I'm a goner, I'm helpless, it was my fault, I'm dirty". We try to ascertain what is the underlying threat about this event for the person.

Having obtained the negative cognition, the next step is to obtain a positive cognition. This is the belief that the person would like to have about themselves when they are over the event. Examples of a suitable positive cognition are "I'm OK, I'm safe, I'm worthwhile, it's over, it's in the past". Ideally we try and obtain a positive cognition that is the opposite of the negative cognition. In the second recording I will give you some more clues on how to elicit appropriate negative and positive cognitions and will also provide additional material on this during your face-to-face training.

The final step in target assessment is to determine the associated emotion. Is it fear, shame, anger or something else? Then you assess the location in the person's body where they notice this distress or discomfort as they think about the event. The client

might say, stomach, shoulders or some other part of the body.

So how do these procedural steps in phase 3 relate to Information processing models of trauma?

In 1996 I wrote a paper with Helen Gavriel and Jeff Richards. A brief extract of this paper is available from our website. In that paper we pointed out some similarities between what Foa and colleagues described as critical to their information processing model of trauma and what Shapiro described as critical to the target assessment phase. This model of understanding trauma process has been further developed by Graham Taylor and me. We have constructed a visual model of these principles and our most recent version of this diagram is attached to the back of this 1996 extract.

In the centre of that diagram is a circle that represents the memory of a traumatic event. Both Foa and Shapiro would consider that the event is stored in memory via three channels. The first channel is sensory stimuli information, the second channel is the meaning the stimuli has for the person or the negative cognition associated with the stimuli. The third channel is the somatic or affective response. This not only includes the emotional label given to the affective experience, but also the physical location of that experience in the body.

The memory of a traumatic event can be activated by any of these three channels, so a picture, a sound or a smell that was the same or similar as the stimuli that occurred at the time of the trauma can cause the person to remember the event. In activating the memory they will also recall the threat or meaning of the event and the affective or somatic response. Hence, sounds such as a car back firing can remind the combat veteran of an ambush experience during Vietnam, or for a sexual assault survivor, the noise of a party may cause her to remember scenes of her date rape.

Our experience is that prior to the resolution of a traumatic memory these stimuli are often associated with strong dysphoria and vivid recollection of the event. However similar stimuli are not the only triggers for the reactivation of a trauma memory. The memory can also be re-activated by an entirely different event that may carry the same personal meaning. For example, I worked with a client in my private practice, who came for assistance to deal with a motor vehicle accident. She reported that she was driving along the road, she approached a traffic intersection, and at the time the lights were green, but as she crossed the intersection she could see that another car was going to run a red light and collide into the side of her car. She was aware that this was going to occur, but because of the way the traffic was situated, there was no way she could do anything to prevent this event. At this time she experienced the thoughts "I'm powerless, I've got no control". After the collision she regained consciousness and realised that she was lying at the side of the road. She looked up and saw that her car was still in the middle of the intersection and with that fact came the awful realisation that her 6 year old son who was still in the car in the middle of the intersection and therefore still in danger. So naturally she tried to get up to rescue her son, however, a bystander at the time held her down and said "You can't move, you've been in an accident. You've sustained serious injuries, I can't let you leave this spot". So for her this was a double whammy on the feelings of powerlessness, of having no control.

Initially her EMDR treatment focussed on material related to the accident. After 10 minutes she recalled a memory of when she was 6 and was in the kitchen of her family home. Now this is where EMDR significantly departs from standard desensitisation procedures. If I was just doing desensitisation with this woman I would've encouraged her to focus back on the motor vehicle accident, as this was obviously the material that we needed to desensitise. However, in EMDR this material is considered likely to be associated material in her memory network and therefore the client was encouraged to stay with this new memory. After another set of eye movements, she went on to report that this scene was related to an experience of domestic violence. Her father had been an alcoholic, who'd frequently beat her mother. My client had considered her role in the family to be the protector and rescuer of the mother. It had been her experience that if she could just keep the father amused, keep his wishes satisfied, that he would stay in a good mood and that domestic violence wouldn't occur. However, on this particular occasion, no matter what she tried to do to distract or amuse her father, it was unsuccessful and he continued to physically assault her mother. So the meaning of this event was also "I'm powerless, I've got no control". In EMDR we're often working with material that is associated to the individual's trauma. In my client's case it was necessary to deal with these early events, find a healthier perspective on this childhood material, reprocess this, before the recent trauma could be resolved.

The third channel that can re-activate a traumatic memory is a similar affective or somatic state to that experienced during the original trauma. For example, whilst working at a hospital I was asked to see a woman who had become very distressed after a surgical intervention. It appeared that she began gagging during a medical investigation and at that time re-experienced memories of having been forced by her uncle to have oral sex.

The phenomena that mood affects our memory recall has been well demonstrated in the laboratory. This has been termed mood-dependent learning, or state-dependent learning. For example, university students are shown a depressing film. At the conclusion of the film they are asked to remember a list of words. The next day the students return to the laboratory, half of the group are shown an equally depressing film, the other half are shown a film with a happy content. At the end of the second film the students are asked to try and recall as many of the words that they learnt on the first day. Contrary to what a Pollyanna might predict, it's the students that watched the second depressing film that remember more of the words. The experiment demonstrates the importance of affect in assisting recall of memory.

Returning now to other implications of the Foa model for EMDR therapy? Firstly it underscores the importance of activating all of the network before doing the desensitisation. Therefore you need to pay particular attention to target assessment. You need to understand what are the relevant stimuli for a person, the negative cognition and their affective response. In our 1996 paper we've been very critical of studies allegedly purporting to investigate the efficiency of EMDR, but have neglected to include this phase of the procedure.

Shapiro wrote that it is important to understand that a target memory node may represent many trials of different events with similar responses. For example, I saw

a woman who was injured in an industrial accident at work. She had always been nervous around chainsaws, but it was a requirement of the workplace that she was competent with this tool, and so she was forced to attend a day's training in chainsaw use. However, there was an accident during this training. The chain bit into the tree. The chain then broke off from the tool and careered into my client's face, knocking out practically all of her teeth.

Her interpretation of this event included that "I'm defective", and "that there is something wrong with me". There were previous times in her life when she had similar experiences. These beliefs were also associated with memories of incest experience perpetrated by her father. She was also physically abused by her mother, and a combination of these events had led to her removal from parental care. She had an image of being at a swimming carnival and two welfare officers removing her from the pool. They took her away in front of the whole school whilst she was wearing only her bathers and a towel. Her response to this incident, to her incest memories and to the chainsaw event, was in each case shame and humiliation. Therefore, it's important to take a thorough history before doing desensitisation phase of EMDR as these associated events may emerge during reprocessing, and it is important that you and your clients not feel ambushed by these events.

The third implication from the information processing model for EMDR is that it's important to try and facilitate the clustering of these events, so during the exploration of the problem and history taking, you may find that there are 10 or even 20 traumatic experiences that are connected in the network through similar interpretation and emotional responses. Discussing similarities between such events prior to desensitisation assists generalisation of your treatment. It is our experience that in EMDR that reprocessing of a particular trauma is more likely to lead to generalisation than with any other therapy.

The final implication of information processing models that I'd like you to consider is to realise that the same event may need to be processed through different channels. Recently I saw an inpatient who was diagnosed with major depression. One of the striking features of his presentation was a tendency, when extremely distressed, to punch himself in the head and call himself useless and a failure. In conducting a history, there were several times in his life where he reported having similar feelings and self-critical thoughts. For example, he reported when he was about 9 or 10 years old, recalling his next door neighbour saying to his mother "there's something wrong with Peter, he's not quite right in the head". He also remembered an earlier incident when he first went to school. He became involved in a fight with some Aboriginal children and as a result, his mother sent him away to live on an Aunt's farm until things blew over.

I decided to use EMDR with Peter. After taking the history we elected to focus on the earliest incident that he could remember of thinking that he was useless. Hence, we targeted the experience in primary school. This event appeared to be desensitised after about 20 minutes, however, when we returned to the target memory of that school experience, Peter reported that although his SUDS score had gone down, from 8 to 5, the fact that it was still 5 implied the trauma needed to be desensitised further. When I asked him to talk about that early experience, he stated that when he focuses on it now he thinks "people will always abandon me, I'm not loveable".

So we then proceeded to focus on that thought content, and during the EMDR session Peter related a number of experiences where people had abandoned him, where he had felt rejected, where he had felt that he wasn't loveable. Once it appeared that this channel had been desensitised we went back to the target material and his SUDS level was at a 4. When I asked him to talk about his association to that original event, he recalled a sense of being socially isolated of not fitting in, of not belonging. We then needed to process through a number of incidents in his life where he had had similar feelings. It was only after information was processed through each of these 3 different meaning channels that we were able to return to the original target incident, and obtain a 0 SUDS.

In the first session of your training I will explore this information processing model in more detail and also cover critical points on what resolution should look like for people who have experienced trauma.

Now I want to return to the other 8 stages of EMDR treatment. The first phase is client assessment. In this phase we conduct a basic psychological assessment; this includes understanding the symptoms that brought the client to treatment, current supports, assessing their strengths and capacity to self-soothe. From the history we need to identify significant past events and their response to previous therapies. Finally we need to understand their therapy goals.

EMDR Level 1

Phase 1 – Client Assessment and History

EMDR is not a cure all. Client problems may be remedied by education, problem solving, stress management techniques, and skills training etc. EMDR is not suitable for every client and the results of the technique are improved the better the client assessment and case formulation. Therefore, therapist needs to obtain a detailed client history.

Single incident PTSD problems can be treated by targeting the traumatic memory, but a good history is still required.

Description of Presenting Problems

In EMDR the assessment of appropriate target begins with understanding the reasons why the client attended the therapy and the goals that they have for the therapy. We need to ask the client to describe the nature of their main problem, the degree of its severity and the impact on their current life. This includes; understanding the behaviours that the client wants to change, how traumatic experiences affected their life, what things would they like to be doing more of, what things would they like to be doing less, what factors make these behaviours worse or better. In assessing these behaviours, we are beginning to understand what psychological themes are relevant to the client's distress. Do the problem behaviours relate to; issues of connectedness, that is the client doesn't feel loved or liked, are the problem behaviours related to autonomy, does the client feel that they are not capable or competent. Alternatively do the issues relate to safety? Is the client, therefore hypervigilant to threat? Do the issues relate to the client's sense of responsibility? Do they feel guilty for events that have occurred where they are clearly not responsible? And finally, do the behaviours and feelings that the client is plagued

by relate to themes of helplessness and/or choice?

Determine the Experiences that Gave Rise to these Themes

For example, what events first led to the person thinking that they cannot trust others, or that they are not lovable, or when did they first learn that the world is not safe? In a single incident trauma the recent event may be the only experience related to this distress, however in more chronic PTSD presentations there will be multiple events that led to this negative self-view or negative world view.

Understanding the Client's Goals

It is important to obtain a shared understanding of the client's goals for treatment. What would they like to be doing more of? What feelings would they like to experience more? How do they imagine the therapy will change their life? Understanding the behaviours and feelings associated with these goals are also important in targeting events and psychological themes for EMDR.

Other Aspects of the Client History

For each client, the amount of history detail required depends upon the complexity of their clinical presentation. Typical things that would be important to investigate would be; the extent and type of trauma history of the past, the nature of current attachments, both romantic/intimate, and the peer or friendship-based relationships. Also of interest are major attachments through childhood including relationship to principal carers, methods of discipline, things the client was rewarded for when growing up, ability to confide in carers, previous therapy, current drug and alcohol use and other escape behaviours. Finally current activities that provide pleasure and a sense of satisfaction.

Imagery

It is important that imagery is part of the initial assessment as the client is asked to comment on this during EMDR treatment. Imagery could include; describing memories of experiences or attachments to major carers. Images that intrude into the client's thinking currently that are associated with distress and images of previous occasions where the client reports positive feelings such as memories of being happy, succeeding, being competent being capable or being loved and liked and being safe.

Stability Factors

As therapists we need to be sensitive to the sorts of experiences that a person has during the EMDR treatment, and the possible manifestation of post session information processing. Information processing typically continues after an EMDR session, although generally at a slower rate, the client may therefore experience a variety of memories and emotions that are distressing to some degree. This is common in the 24 hours after a session and may also occur up to 48 hours post an EMDR session. In order that the client is not re-traumatised by this emerging information they need to have the resources to deal with whatever emotions are associated with this processing.

Later in this talk I'll address specifically some issues of history taking. First however I wish to consider some general factors pertaining to client's safety. The first issue is the level of rapport. Clients must be able to tell their therapist whatever is going on during the experience. It's not necessary they give the full sensory and image details of their EMDR processing, but they must be willing to experience the emotions associated with such a memory and report the nature and intensity of these to the therapist. The potential for post session processing also underscores the need for a strong therapeutic alliance. The therapist needs to elicit a truth telling agreements and to convey a message of safety and flexibility and unconditional positive regard. Clients with more severe abuse backgrounds may have attachment difficulties and therefore more likely to have difficulties around issues of safety and trust.

The next issue is that of emotional stability and a capacity to self-soothe. Clients need to be able to withstand and deal with a potentially high level of emotional distress that may arise during or between EMDR sessions. Thus it's important to find out during history taking what self-soothing skills the client has and how effective these are. You would continue with the EMDR only if the client has shown a capacity to successfully cope with moderate levels of emotional distress. If the client does not have such skills then the EMDR should begin with the teaching and coaching in emotional regulation skills. A client who in dealing with every day stressors is acutely suicidal will need significant other work before attempting trauma processing with EMDR.

The third issue is related to that of environmental stability. If the client is in the midst of major life pressures, it may be prudent to postpone the EMDR until these have passed. Emotional supports also need to be considered. Who is available to support the client between sessions? What's the nature of that support? What level of support is the therapist willing or indeed able to provide?

We need to consider issues of general physical health as well. EMDR can generate brief periods of high emotional and physiological arousal. Does the client have the capacity to tolerate this? In focusing on trauma memories, people with PTSD elevated heart rates. However, it's rare for this to be more than 120 beats per minute. Therefore, someone who cannot tolerate a modest increase in heart rate would not be suitable for EMDR. Therefore, I confidently treated the trauma memories of an 89 year old woman who was fit and healthy and walks on the beach every day. However, another elderly patient who had been advised against doing exercise as it would exacerbate her heart condition was someone I choose not to treat. Shapiro originally cautioned against treating women in their third trimester of pregnancy. She suggested that given there can be an increase in arousal during EMDR that the treatment might pose a risk. However, therapists working in this domain have not reported any issues in treating women in this stage of pregnancy but restrict the treatment to those who do not have medical complications.

The role of inpatient treatments.

Treating a person through outpatient consultations may not always be safe and therefore an inpatient treatment can be considered. Can this material be processed in an outpatient setting with safety, or is the additional support of an inpatient treatment facility required? If there is a question of clients becoming a danger to themselves then an inpatient setting is strongly recommended.

Neurological impairment. EMDR has been successfully used with clients evidencing a full range of neurological complaints, although depending on the nature of the neurological impairment some caution may be needed and adaptations to the standard protocol are often necessary. Clients with epilepsy have been successfully treated but there has been a couple reports of clients experiencing seizure during an EMDR session. Other than this there have been no reports of adverse events from clients being treated with EMDR who suffer neurological impairment. There are no contraindications for the use of EMDR in clients who suffer Attention Deficit Disorder.

Eye problems. There has been one reported incident where a clinician untrained in EMDR persisted with eye movements in spite of client reports of eye pain. That client suffered a detached retina and blindness resulted. Under no circumstances should the eye movement variant of EMDR be considered or continued if the client reports eye pain. There are alternatives to providing bilateral stimulation, such as tapping tasks. These permit processing to occur and they don't involve eye movement. This will be explained further during the workshop.

Clients who wear contact lenses typically have no problems with the eye movement task. However, the occasional client may report dryness or irritation and therefore will want to remove the lenses in order to proceed with the task.

In the past bifocal lenses were sometimes problematic but with the advent of improved multifocal technology this is now rare.

Borderline and Dissociative Patients. Unless you've had considerable experience and level II training, EMDR should not be used on clients with a Dissociative Disorder. Similarly with conditions of extreme emotional vulnerability such as Borderline Personality Disorder. Further considerations on working with emotionally vulnerable clients will be offered during the workshop. During the workshop we'll discuss the use of the Dissociative Experience Scale as a screening tool. We will also provide this measure to you in a drop box link after your workshop. The Dissociative Experience Scale or DES is a brief self-report measure of the frequency of dissociative experiences. It enquires about the frequency of these experiences in daily life and was developed to provide a reliable, valid and convenient way to quantify dissociative experience. The DES was not intended as a diagnostic instrument. High DES scores should not be construed as an indicator of a Dissociative Disorder diagnosis, but simply to alert you to the possibility that such a condition exists.

There have been numerous studies published using the DES on a wide range of clinical and non-clinical populations. Excellent test, re-test reliability and internal consistency has been demonstrated. No significant effects of sex, income level, employment status, education or religious affiliation have been demonstrated in large clinical samples. In terms of using it as a screening tool a cut off score of 30 has been identified. A score above this level does not imply that the person has a dissociative disorder, merely puts them in a category of risk for this diagnosis. Given that it is a screening tool, this level creates a high false positive, it is unlikely that a person scoring less than 30 will, in fact, have a dissociative disorder, but many people will score above 30 and not meet a criteria for a dissociative disorder.

The DES takes the client about 5 minutes to complete on average and can be scored within 2 minutes by the therapist. If a person has a score above 30, you as a therapist will want to know more about the experiences that contribute to that score and one approach would be to ask the client to describe in more detail some of the experiences that they have rated as quite frequent. Another approach would be to use one of the available structured interview schedules for Dissociative Disorders and references to these will be provided during the training.

Drug and Alcohol Abuse. Clients who have substance abuse or dependence diagnosis may experience increased urges for their drug of choice after EMDR processing. Presumably this is because of the stimulation of disturbing psychological material during the session. Thus it is important that clients with a substance abuse history have in place appropriate supports before commencing the EMDR treatment and if dependent have a sufficient abstinent period such as 4 months. This is not to say that EMDR cannot be used for such populations. Indeed there have been specific EMDR protocols developed to deal with craving even immediately following detox. However these should only be attempted after an EMDR level II training.

Legal Requirements. After successful EMDR therapy, a client may not be able to give a vivid report of a traumatic event or they may be able to recount that event but without significant emotion. Both these effects may cause difficulties in a court setting. The implications of successful treatment and resolution need to be thoroughly discussed with both the client and all relevant legal parties. If a decision is made to proceed with EMDR before a case goes to trial, detailed accounts of the incident need to be made before treatment commences. The clinician also needs to detail the client's symptoms and the ways that the trauma has impacted on the person's life. This should include standardized assessment instruments. More information on this will be provided during the training and additional resources will be sent to you after the training via a drop box link.

Systems Issues. Treatment of one aspect of a client's problem with EMDR may open up other issues which require intervention. As a client starts to think in new ways it opens up new choices. To build on these new choices skills training may be indicated. For example a client who after treatment starts to feel that their needs are just as important as anyone else may need assertiveness training to communicate her wishes. Client changes can destabilise the client's close relationships eg marriage/family. Using the same client example if he or she was to start behaving more assertively, this could have consequences for the family who are used to your client subjugating their needs. Thus the implications of successfully achieving the therapeutic goals need to be explored with the client.

Secondary Gains. Symptoms often serve a purpose and we need to be mindful of possible positive consequences of the symptoms for the client. Do the symptoms impact positively on the identity of the client, or satisfying a need for revenge, and/or provide a financial compensation. Some clients need to be aware of what they will need to confront or give up, if treatment succeeds.

Timing of Treatment. The emotional responses of clients and the intensity of the between session emotions are highly variable and therefore it's important to assess the client's current life situation in order to avoid potential problems. If the client is

involved in important work issues, or other life stressors eg they need to attend a hearing pertaining to court orders on their parenting, then treatment may be better postponed until such deadlines are past. This is consistent with what I said earlier to remember that post session processing can be up to 48 hours after a session and therefore reprocessing sessions need to be scheduled being mindful of acute major events.

Similarly, if the therapist is about to become unavailable, reprocessing of a major trauma should not be started. I make it a personal rule not to use EMDR within 7 days of leaving Perth to run workshops. Clients need to be aware that EMDR may involve emotionally intense work, and they may need to plan their subsequent time after the session accordingly. It's recommended that an EMDR processing session should be scheduled for 1.5 hours or at least 1.25hour. If shorter sessions are used, there's the increased likelihood that the client will be at a high level of distress at the conclusion of the session, and this will markedly increase the likelihood of post session abreactions. Shorter sessions probably disproportionately lengthen treatment time. In my private practice I handle this problem by scheduling the EMDR for the last of my morning appointments and for the end of the day appointment. Then if I need the extra time, I have it without encroaching on other client's time.

Medication. Some medications have been demonstrated to block or at least inhibit EMDR processing. Benzodiazepines have been reported to reduce treatment efficacy. Sometimes therapists who have treated clients on benzodiazepines have noticed that once they've come off the medication the EMDR has to be repeated in order to consolidate the treatment gains. There appears to be no such state-dependent effects for patients on anti-depressants such as SSRIs.

Summary Phase one

So once we have completed a basic psychological assessment. Determined that the client is suitable for EMDR. Understood the symptoms that brought the client to treatment, their current supports, assessed the client's strengths and capacity to self-soothe. Identified their significant past events, their response to previous therapies and clearly understand their therapy goals, then we are ready to begin phase 2 which we've called procedural preparation. The details of this are described in the second recording. In Phase 2 we need to orientate the person to the EMDR therapy, including; giving clear instructions on what is required of them, provide metaphors to encourage mindful noticing of the reprocessing and to provide a basis for cheerleading. We also may need to teach self-control strategies, and to strengthen the therapeutic alliance.

After describing the details of this phase, the second recording concludes with more details on Phase 3, Target Assessment.

End of recording one.

EMDR Level 1 Pre-Workshop Preparation

Second Recording

Phase 2 – Procedural Preparation and a brief overview of Phase 3 – Target Assessment

Phase 2 – Procedural Preparation.

This stage involves securing a therapeutic relationship with the client, explaining to the client of what to expect from EMDR, and addressing the client's concerns and setting up the basic mechanics of the eye movement task. EMDR is a highly interactive client driven process. It requires considerable flexibility on the part of the clinician. It's the clinician's job to facilitate the client's self-healing process, and as with many treatment modalities, EMDR involves considerable general clinical skills.

The most important aspect of this phase is forming a good bond with the client. This includes a solid therapeutic alliance, a sense of collaborating towards common goals, and an understanding of the need for honest communication. EMDR should not be employed until a sufficient level of safety and trust has been established. For some clients this will be straight forward and can occur within a session, for others, particularly those with significant personality disorders or borderline conditions, this may take months. Regardless of how long it takes to establish a good therapeutic relationship, EMDR should not be attempted without it, otherwise there are risks that the client may prematurely terminate treatment during an abreaction or perhaps terminate therapy altogether in a worse state than they were to begin with. It's important that the client understands the need for direct and open feedback of what it is they are experiencing. If a client tells you they're feeling better when they're not, there's a good chance they'll experience emotional distress between sessions and thus could become vulnerable without adequate support.

One part of procedural preparation is to explain a theory of EMDR. We need to provide our clients with a general understanding of EMDR in language they can understand. There are numerous ways to do this.

Shapiro suggests an explanation such as the following: "often when something happens it seems to get locked in the nervous system so that when you are triggered you experience the original picture, sound, thoughts and feelings. Thus when you are triggered you experience a lot of discomfort and sometimes negative emotions, such as fear and helplessness. These experiences feel out of our control. The eye movements that we use in EMDR somehow seem to unlock the nervous system and allow the brain to process the experience so that it is no longer stuck. It's important to remember that in these sessions it's your own brain that's doing the healing and you're the one in control".

For some clients I may in fact share the diagram that is provided with the extract from our 1996 paper. This diagram depicts an information processing model of trauma and we have found that it can help some clients to see the model in picture form to better understand their symptoms and how EMDR may change the nature of their memory. Most typically, my explanation of EMDR is based on this information processing model and the Stickgold paper provided for you on the website.

Typically, I would adjust the explanation to link the client's individual symptoms to the model but it often sounds something like this:

"Initially any experience that we have through the day is encoded in our brains, rich in the sensory detail of the moment. So take for example this conversation that we are having now, if you were to recall it on the way home, you would remember that I was wearing a purple shirt and I have purple glasses, however, by the next day we don't tend to remember that level of vivid detail about a previous event. You probably won't remember the colour of my shirt, instead you will probably mostly recall the gist of our conversation that is 4 or 5 things that were important to you.

At this stage I would ask the client if they have ever heard of rapid eye movement sleep and invite them to say something about what they know and link this to dreams. Then returning to the explanation I would offer, "So during this REM stage of sleep our brain naturally changes what information is stored, from something that is rich in details to just remembering the importance bits. This happens to nearly everything that we experience. The exception to this is trauma. If the memory is traumatic then we experience a lot of arousal during this dream, and this arousal wakes us up. People with PTSD frequently recall experiencing nightmares. Therefore the brain is left stuck with the trauma experience frozen in its original form so that when we recall that memory it appears very vivid and we can think and feel that it is still happening to us."

"A woman in the US discovered that by focusing on such memories, even in an awake state, and moving your eyes rapidly from side to side, appears to restart the natural healing that should have occurred."

We then need to establish the mechanics of the eye movement. We need to determine the position of our hand that is the most comfortable distance for the client to focus on our fingers. This is known as the optimal focal distance. It is usually achieved by sitting adjacent to the client with our hand typically level with the client's knees. Following establishing this distance, we trial a couple of side to side movements and reinforce the client for tracking.

The next part of procedural preparation would be to check if the client has a self-soothing image or technique to use if they need it. If they already have such a skill you only need to establish a cue phrase word for this. If they don't you need to help create a safe place. The main uses of the safe place are as an aid to closing down an incomplete session and as a way of dealing with distress between sessions.

Shapiro describes the establishment of the safe place as follows:

The first step is to identify an image of a safe place. This may be based on an actual experience or from their imagination or a combination of the 2.

The second step is to enhance the imagery and the associated responses. This can be done by having the client focus on what he or she is able to see, hear, smell, taste and the physical sensations of the experience. The therapist should use open-ended probes rather than suggest particular imagery which may not mesh with the client's internal experience. Therapists with training and familiarity in hypnotic processes may enhance the link between the internalised

experience and feelings of safety and security with appropriate indirect suggestion.

The third step is to associate a cue word or phrase with the image. A client will be asked to link the two in the following way. For example, my safe place is triggered by the cue phrase Cable Beach which just happens to evoke for me pleasant sensations and memories associated with that part of Western Australia. So my therapist might say to me, “just take a deep breath now, picture Cable Beach, and just be there, notice what you can see, hear, feel, smell and taste”. After the client learns this technique its good to have them practice the procedure between sessions.

In subsequent sessions it can be really helpful to have the client practice the safe place after deliberately triggering some mild level of emotional disturbance. This might be evoked in the session by asking the client to think of some frustrating or annoying situation. The therapist would then guide the client through the use of the safe place exercise to reduce negative feelings.

Addressing motivation and fears.

Clients with PTSD may have fears about receiving treatment. These may include fears that they are not able to handle the treatment experience and perhaps go crazy or that they're not going to get over their difficulties. If this occurs we discuss that in EMDR the emotions that emerge can feel scary but are not dangerous, as discussed in recording one. We also talk about a sense like it won't work for me is part of that stuck process that occurs with trauma experiences. Another issue is that a client might be unwilling to proceed because of issues of shame or guilt associated with their particular memories. They can be reassured that, unlike other therapies, once target set up is complete, it's not necessary to report or describe in detail everything that is happening in the session. During an EMDR session they simply need to report some aspect of the experience at the end of each set of eye movements.

As part of procedural preparation we need to communicate two very important aspects to this treatment. The first is that there are no set rules as to how their brain will process information during EMDR and that they need to keep an open mind. They don't have to make anything happen and only have to notice what occurs during the eye movement task. The second thing to communicate is that whatever happens its best to just keep tracking and keep noticing. Shapiro has a couple of metaphors to encourage this stance by the client. The first is the notion that EMDR is like a car driving through a dimly lit tunnel, in order to get to the other end the driver needs to keep their foot on the accelerator, easing off on the accelerator will cause the vehicle to slow down or even stop and that's not what you'd want to do in the darkest part of the tunnel. In EMDR terms the eye movements act as the accelerator and when peaks of emotion or somatic sensation are experienced we need to keep driving on through that dark spot in the tunnel, towards resolution.

The second common metaphor is likening EMDR to a journey on a train. It encourages the client to just notice their experience from a distance.

“When you travel on a train you can see scenery out the window through the glass, but typical of train journeys you often don't feel as if you are in the scenery, it is more like you're able to look at it from some kind of distance. Also, similar to train journeys,

a lot of scenery will pass by. It is your job to simply to notice the scenery and we will stop the train every now and again and I will ask you to comment. All you have to do is tell me what you just noticed, without trying to judge what you have experienced.

Shapiro recommends other more detailed metaphors for clients that are high in emotional vulnerability. These will be discussed in the workshop. One of the most common designed to decrease the fear of fear is to discuss that “just because you feel fear does not mean there’s a tiger in the room”.

Setting expectations.

An important part of the procedural preparation phase is to set appropriate expectations. Material that can be covered include discussing that during EMDR information is processed and as a result traumatic memories often become more distant and historical. It is very important to cover that during processing associated memories may come into awareness, and new thoughts and ideas about the self or the world may come to mind. The client may also experience shifting emotions or physical sensations. Negative emotions may occasionally peak before they subside. It’s important to impress upon clients that they do not have to and indeed should not try to do anything with the memories, thoughts or emotions that surface during the EMDR treatment. The basic idea is just notice and let whatever happens, happen. Although the client begins by focusing on a memory, thought, emotions and physical sensations, once the eye movement starts it’s impossible to stay on this. Other experiences will emerge.

Whatever information the client reports after a set of eye movements typically becomes the focus for the next set of eye movements. For this reason it’s important that the therapeutic relationship be sufficiently safe and trusting for the client to report whatever it is they do experience whether this is an increase in negative emotions, or new and disturbing memories, or associations that they don’t understand.

A typical way to introduce this to a client is to say

“Although we have spent some time focusing on this particular memory, you may find that once we start the eye movements that you may not be able to think of that memory anymore. In fact, other memories may come up, and these other memories may seem relevant to the memory that we start with, or they may not, and either way is fine. Also, other experiences may come up, and these experiences may seem relevant to you or they may not and either way is fine. All you have to do is just notice whatever it is you are experiencing and report it back to me when I ask. The other thing that might happen is that the feelings about your memories may change, sometimes they can get more intense and upsetting, or alternatively sometimes people just feel calmer as we begin the eye movement process. Again, with this method, there is not right or wrong way. There are no shoulds. All you have to do is just notice your experiences. From time to time, I will check in and ask you what is happening and you just have to tell me this without judging what you are experiencing.”

Procedure preparation concludes with setting up a stop signal. You inform the client that if distressing memories do come up during EMDR you will tend to keep going with the eye movements so that the brain can get past the point where the processing

is stuck. However if it ever gets too much they can stop the process by simply using a prearranged signal, such as holding up their hand like a policeman stopping traffic. Although with less disturbed clients a stop signal is seldom utilised, its inclusion in the procedural preparation is important because it gives the client a sense of control and contributes to their sense of safety. During the workshop we'll do an exercise which focuses on this aspect of the procedural preparation.

Once this phase is complete, you are ready to proceed to the 3rd phase of the EMDR, which Shapiro simply calls 'assessment' but which we call 'target assessment' to differentiate it from the broader issues of assessment and history taking that we've already considered in phases 1 and 2.

Target assessment

During this 3rd phase, the therapist determines the elements of the target memory that'll be the starting point for processing. The therapist also establishes baseline measures of the client's level of distress, and the degree to which they hold beliefs associated with resolution. There are several aspects to target assessment and in this recording I'm going to introduce each of them. We'll be spending more time on each in the face-to-face component of the workshop. So don't feel you have to memorise them now.

In brief, target assessment begins by selecting the most relevant memory to target. Then we focus the client on the most salient scene within that event.

We then identify the negative cognition or belief associated with that memory.

Then we get the opposite to this negative belief, that the client associates with a resolution of their trauma experiences.

Next we get them to rate how believable or valid this positive cognition is. We then return to the target memory, link it to the negative cognition, and then identify the emotion that this process evokes. The strength of this emotion is then measured on a SUDS scale, 0 – 10. Finally we ask that they identify the location of any bodily sensations associated with the memory and this emotion. At this point target assessment is complete.

I'll now examine these steps in a little bit more detail.

Event details

Most clients who have experienced trauma have faced an event that involved many moments over a period of time. The moments relevant to target may be before anything happened at the point they first realised that something was about to go wrong. Alternatively there are moments within the trauma per se, or it might be a post trauma events. When assessing the target event, it is firstly important to identify what the memory is. However, subsequently it is important to know which aspect of that memory is the most blocked. This can be determined by asking the person to focus on the scene within the memory that is either the most vivid or the most emotional. Another clue as to which aspect of the memory needs to be targeted is to find out the first thing that comes to mind when the person thinks of the event, that is, when the person has an intrusive recollection of the event, what is the scene that comes to mind. Most typically in EMDR it is an image, although for some clients it can be a smell or a sound.

The next step is to elicit the negative cognition associated with that particular scene. This is one of the most technically difficult aspects of EMDR for the clinician. We will discuss what constitutes a negative cognition in more detail on the first day of your training and practice eliciting negative cognitions using real client vignettes in small group exercises.

To begin the process of eliciting a negative cognition you might ask the client what does this event mean to you? Or what words best go with the image that expresses something about you? A negative cognition is a negative self-referencing belief. Further, it's presently held, and has affective resonance, in other words, it has a painful bite. Finally, it should be congruent with the client's behaviours in session and their presenting symptoms.

For example, a client who has been sexually assaulted and reported feeling ashamed described having difficulty with relationships. She stated that she doesn't feel worthwhile and tends to keep things to herself. Then these symptoms would be consistent with ideas such as there is something wrong with me, I am worthless. A person, presenting in this way, is less likely to have cognition of I am not safe associated with their target incident. Whereas someone with whom this cognition is relevant is more likely to present in session as hypervigilant and describe considerable anxiety as they currently try and negotiate their way in the world.

The next stage of target assessment is to develop a positive cognition. This is a positive self-referencing belief which is realistically adaptive for the client now and for the future. It accurately focuses on the client's desired direction of change. It's in the same theme as the negative cognition but moving the client in a positive direction. Examples include I am worthwhile, I am competent, I am safe now, I have choices now, I was not responsible.

Positive cognitions must be believable to some extent. We assess this by asking the client to think of the targeted memory and the belief and ask "how true does this feel to you on a scale from 1-7 where 1's completely false, 7's completely true?" We need to distinguish here between a truth in the head and a truth in the heart. Sometimes we might explain that we can know something in our head is true but it feels quite differently in our heart. What we're looking for is the gut level feeling of how believable this idea is. Notice that we're looking for the validity of this positive belief or cognition in relationship to the incident or memory not as an abstract idea in its own right.

Having established the positive cognition we then return to complete target assessment by assessing and activating the client's emotional response. So we would ask our client "when you concentrate on the image of ... (describe the image) and the belief (repeat the negative belief) what emotion do you get now?"

You then assess the subjective degree of this disturbance. We would ask "on a scale of 0-10, where 0 is neutral and 10 is the strongest that an emotion can be, how distressing does it feel now?" and the final step of target assessment would be to ask "and where do you feel that in your body?" Once we have this response we have fully activated the dysfunctional stored memory. That is we have the image, we have the negative cognition and the resultant emotions with its associated somatic sensation.

Therefore, from here we can move seamlessly into the 4th stage of EMDR, Desensitisation, and that's where you get to move your hand and the eye movement occurs.

Now I can't stress enough how important the procedural preparation and a good assessment is to the successful outcome of EMDR. During the face-to-face component of the workshop you will engage in two extended practicums where you'll be invited to be client, therapist or observer. Everyone will get an opportunity to play each of those roles at least once and some roles twice. We invite you to bring to the workshop some old memory or incident which upon recall still generates some distress. Now the practicums are not designed to provide therapy, remember your therapist will be just as new to EMDR as you are. Thus you should not bring to the practicum experiences memories which still have some present reference to current issues or relate to things that you're working through in therapy, or issues related to long standing core beliefs such as defectiveness, incompetence or abuse. What we're looking for initially is an old memory that has a SUDS of no more than 6. If you've got any concerns about what sort of material you might like to work on in the practicum you'll have plenty of opportunity beforehand to raise this privately or with one or other of the trainers or the facilitators. Your workbook also provides space for you to reflect on suitable memories to choose for the extended practicum.

We will proceed in the workshop on the assumption that you have worked through this pre-workshop material thoroughly so you may wish to review some of the sections of this recording or your readings again. If you've got any questions about this material, please, please jot them down and we'll cover those questions early on in the workshop. Please feel free to share the information which you have received as pre-workshop preparation with colleagues who are not yet enrolled in the workshop and who may consider doing so. All that we ask is that you don't make copies of this recording for your own commercial gain.

Thank you, and I look forward to meeting you at the training. This is the end of the second recording.