

Integrating EMDR Into Your Practice

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*This book is dedicated to those clients who have
shared their stories with us. Their courage is
inspiring and many have left footprints on our hearts.*



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Foreword

Thirty-five years ago, I started out as both a researcher and a “radical behaviorist” who was convinced that if I could not see it and count it then it didn’t have any clinical significance. It was this same investigative process that led me to take trainings in cognitive therapy, hypnotherapy, sex therapy, gestalt therapy, group therapy, and finally in eye movement desensitization and reprocessing (EMDR). Since then, EMDR has become the major focus of my professional career as a practicing clinician as well as in my roles as research adviser and EMDR trainer.

My enthusiasm for training clinicians internationally in the EMDR approach is based primarily on the treatment effects that I have observed over the years when using EMDR clinically. Initially, these were primarily with trauma victims and those suffering from posttraumatic stress disorder (PTSD) and other trauma-related syndromes. Subsequently, it became evident that EMDR often is beneficial for patients suffering from many other types of problems as well.

As a clinician, what initially became most striking for me are the major differences in how patients resolve issues through various forms of psychotherapy. Most evident were the nuanced changes that EMDR patients made as compared to other modalities of treatment I practiced. These changes included rapid shifts in emotional reactions, shifts in perspective with regard to what had happened in the past, cognitive shifts in how patients thought about themselves and the previously distressing events in their lives as well as changes in self-esteem and a renewed sense of self. In many cases, patients resolving traumatic memories and the current symptoms with which they had long struggled made changes in ways that seemed to be almost effortless. What patients reported was that they were resolving traumatic or disturbing experiences so that these memories felt neutral and “in the past.” In contrast, when using cognitive behavioral therapy (CBT) techniques, my patients had learned useful, new skills but were still managing or coping with these overwhelming

events from the past. These early impressions have remained over the past two decades and I can say from personal experience that EMDR provides benefits that can offer the practicing clinician a way to provide effective, efficient, and client-centered treatment.

It is most satisfying that EMDR has garnered considerable attention from researchers over the past 21 years. Since Shapiro's seminal randomized controlled trial was published (Shapiro, 1989), more research has been reported that not only demonstrates EMDR's effectiveness in treating PTSD and other trauma-related syndromes, but also shows EMDR to be the most efficient treatment available (Bisson & Andres, 2007; Bradley et al., 2005; Davidson & Parker, 2001; Rodenberg et al., in press; Siedler & Wagner, 2006; Van Etten and Taylor, 1998). This research has corroborated those treatment effects that I have observed clinically.

Further, clinical reports suggest that EMDR is effective with a broader range of clinical issues. Reports from clinicians in many countries around the world seem to corroborate my own clinical observations that the EMDR approach may be useful with a wide range of clinical presentations including affective and anxiety disorders, somatoform disorders, alcohol and substance abuse, relational problems and attachment disorders as well as personality disorders. It also appears to be a very useful adjunct to couples and family therapies. It will be for forthcoming research to validate these additional applications.

Since the earliest published articles on EMDR, there has been some controversy. Initially, critics in the CBT community argued that EMDR "did not work." As research continued demonstrating its effectiveness, the argument morphed into "it works but it is nothing other than exposure therapy." This argument was buttressed with misinterpretations of research data or simply ignoring it entirely (Perkins & Rouanzoin, 2002; Rogers & Silver, 2002). Also, as critics have argued that the eye movements and other forms of bilateral stimulation that are integral components of EMDR treatment are unnecessary, they have ignored research specifically demonstrating the utility of eye movements themselves (Andrade, Kavanagh, & Baddeley, 1997; Christman et al., 2003; Christman, Propper, & Brown, 2006; Kavanagh et al., 2001). Further, the critics continue to ignore issues such as EMDR's greater efficiency in treatment; that EMDR is more easily tolerated as a treatment for psychological trauma by both patients and therapists alike; and lastly, that it requires minimal if any homework from patients. Regarding this latter point, exposure therapy requires hours of weekly homework by patients

and if the patient does not follow through with this homework, the treatment's effectiveness is minimal.

Currently, the EMDR approach is recognized as an effective treatment for trauma by various professional organizations and governmental agencies internationally, e.g., the American Psychiatric Association (2004) and the Department of Defense and the Department of Veterans Affairs (2004) in the United States, and the National Institute for Clinical Excellence (2005) in the United Kingdom. While these determinations are based on more than 20 randomized controlled studies, of particular concern is the issue of procedural fidelity. In their meta-analysis of published treatment outcome studies, Maxfield and Hyer (2002) demonstrate that those EMDR researchers that adhered more closely to the EMDR model in their research obtained better treatment results. This underscores the importance of adherence for clinicians. The closer the therapist adheres to the EMDR procedures and protocols, the better the treatment outcomes that are obtained in clinical settings.

Over the last two decades, EMDR has evolved from a treatment method solely for PTSD and other trauma-related disorders to a comprehensive psychotherapy approach. As a psychotherapy approach, EMDR is guided by the Adaptive Information Processing (AIP) model. AIP places the central focus not on a manipulation of symptoms, such as the dysfunctional behavior, affect, or cognition, but rather on the underlying memories that are actually the source of the pathology. It is through these new lenses that the clinician is able to access the appropriate targets and assist the client in processing the disturbing memories to an adaptive resolution, and then incorporating the positive memory networks necessary for comprehensive treatment. Since a thorough understanding of this model guides the practice of EMDR, one of the key resources most useful to newly trained clinicians is the supervision/consultation process. It is not only helpful in learning the EMDR approach but also is extremely useful in assisting newly trained EMDR therapists to integrate EMDR into their established ways of conducting psychotherapy. Happily, our two authors, Liz Royle and Catherine Kerr, are seasoned psychotherapists in the United Kingdom. Not only are they well versed in providing EMDR treatment for a broad range of clinical presentations but also have years of experience providing supervision/consultation to EMDR-trained clinicians.

This book is an outgrowth of their experience during that supervisory/consultation process. The authors provide the clinician with a clear and concise clinical text with practical strategies and insights to navigate

the “ins and outs” of developing their EMDR skills. The authors have organized this text so that each chapter addresses specific phases of the EMDR model and the AIP model. Chapters follow particular clinical cases and offer suggestions for what may be most effective and cautions for what to avoid. The authors offer insight into some of the basic errors and misunderstandings that new EMDR clinicians make as well as highlighting what can be helpful in making memory-reprocessing sessions go more smoothly. The goal is that newly trained EMDR clinicians can integrate EMDR conceptually and procedurally with the rest of their years of clinical experience and clinical intuition. This book is an excellent complement to formal EMDR training as well as to Shapiro’s clinical text (Shapiro, 2001).

On a closing note, as I discuss EMDR with colleagues, we find that we can each integrate the EMDR/AIP model with our previous theoretical background. However, we may perceive the clinical changes differently. For example, my psychodynamically trained EMDR colleagues frequently describe “an accelerated free association” process, while CBT-trained EMDR clinicians perceive shifts in learned behavior and cognitive restructuring. But we are all considering treatment from the EMDR/AIP model, which explains not only the effects of EMDR treatment, but also the clinical phenomena observable in each of the varied orientations.

During my many years of teaching EMDR, I have observed that as therapists gain greater understanding of the AIP model and develop confidence in their EMDR skills, they find themselves relying on this approach more and more extensively in their clinical work. Further, these therapists appear to find greater satisfaction in their work and are more passionate about it. Their continued enthusiasm is a reflection of the clinical changes they observe on a daily basis with their clients.

This book will be a worthwhile resource for clinicians who are newly trained in EMDR, as well as for those with more EMDR experience who wish to improve their skills and understanding of this remarkable psychotherapeutic approach.

Gerald Puk, PhD
EMDR Europe Approved Trainer
EMDRRIA Approved Trainer

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Preface

Stepping Up to the Plate

Don't learn the tricks of the trade—learn the trade.

—Anon

The idea for this book came through long-standing discussions between the authors about the difficulties faced by therapists fresh from an EMDR training course. As clinical supervisors of novice EMDR therapists, the authors found themselves answering the same questions and problems. A little like passing your driving test, the real learning begins once you have passed the basic training and are attempting to integrate the protocols into your existing practice.

The book is not intended to replace the authoritative text that is required reading for EMDR clinicians—Francine Shapiro's *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*—neither is it a training manual. This is rather a hands-on, helpful guide based on clinical experience of the standard EMDR protocol. It encompasses the common difficulties and challenges that novice EMDR practitioners present in supervision. The book has three main aims. First, there are clear themes that arise in this early learning stage, and the book proposes to address these with a simple, understandable approach. This simplification does not, however, detract from the accuracy of the advice and guidance given. Using case examples, the book illustrates common pitfalls and strategies for preventing many of them.

Second, both authors recognize the lack of confidence that many novices talk about when they first begin. Because EMDR can be such a powerful therapy, and this is quite rightly emphasized within the training, it can discourage therapists from ever using their new skills, or can result in them giving up at the first hurdle. This can mean that clients who would benefit from EMDR are not able to access the support. Accredited

EMDR training courses are intensive and involve many participants from diverse therapeutic backgrounds. New practitioners often feel isolated. Chapters will include frequently asked questions, often the ones that were not asked during training or that have arisen since.

Third, increasing numbers of therapists are simply reading an EMDR-protocols book or seeing descriptions of EMDR on the Internet and are attempting to duplicate this highly effective therapy. As practicing EMDR therapists, the authors hear “horror stories” where EMDR has been used inappropriately or with potential to endanger clients; this is something they are passionate about rectifying. With the assumption that therapists have the right intentions, the authors considered how an “easy read” book could address these difficulties. By including “Whatever you do, don’t do this,” the book proposes to guide those therapists into a safer way of working while encouraging them to access accredited training and consultation for their practice. This book is not intended as a replacement for appropriate clinical supervision. Readers are encouraged to access specific EMDR consultation from a qualified practitioner.

The authors provide many case examples to illustrate key learning points. All these are either composite cases or are here with the permission of the client or supervisee. In the latter cases, identifying details have been changed. The complete eight-phase protocol is illustrated using a composite case study. This demonstrates EMDR in practice from start to finish. The standard EMDR protocol focuses on resolving distressing life events. These may be a major traumatic event such as a natural disaster or a comparatively minor trauma such as parental criticism in childhood. This book includes a number of resources drawn from other areas of therapy that can support the integration of the standard EMDR protocol into readers’ practice.

The scope of the book is limited to EMDR practice with adults, taking into account practitioners’ differing levels of experience and theoretical backgrounds. It is intended to cover office consultation rather than inpatient treatment. Child EMDR is a specialized area within the field of EMDR, and the authors do not attempt to address this. This is not a book about posttraumatic stress disorder (PTSD), but EMDR is one of the psychotherapeutic approaches recommended to treat PTSD. Consequently, this is where the focus of the book lies.

You may pick up this book to deal with a particular issue or read it from start to finish. EMDR is not a linear model—sometimes when things are not going to plan, we need to check our foundations, return to earlier phases, and rethink our EMDR case conceptualization. When

you feel as if you are banging your head against a brick wall, it's usually wise to stop, stand back, and look at the bigger picture.

EMDR is a very powerful evidence-based therapy that can transform an individual when used with due care.

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This book has been a labor of love, hard work, and dedication, and could not have been produced without the support and encouragement of some very special people.

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Liz Royle: The most important people as always are my family. They have provided solid support and tolerance even when I have been grumpy and consumed with “the book.” Special mentions go to my husband Gary and children Simon and Sophie for keeping me grounded. Without your support, I would not be able to do any of this. Thank you.

Catherine Kerr: To my close friends (you know who you are!) thank you for your patience and faith in me, and for always being there to support

me. I would like to thank my family for their love and unwavering belief that I would finish this book, and finally, my partner Rob, who always kept me grounded and provided a constant source of wisdom, love (and home-cooked food!) when frustration and procrastination had set in.

Several clients have contributed their stories to this book. The positive outcomes they have with EMDR make it all worth it. Final thanks go to the therapists who have given permission to bring their challenges and successes to a wider community and who continued to learn and integrate EMDR into their practice even when the going got tough.

1 Who's Sitting Opposite You?

Phase 1 of the standard *eye movement desensitization and reprocessing* (EMDR) protocol is history taking. It is important to determine whether the client is appropriate for EMDR selection. Even when the presenting problem appears to be suitable for this treatment, the client may not be, and a full consideration of cautions must be made. Where EMDR is deemed suitable, the treatment plan needs to be conceptualized by taking a full history to establish the origins of the presenting problems. Many clients will have come specifically for EMDR, for others the appropriateness of EMDR as a primary treatment modality will become apparent during history taking. It can be easy to get caught up in the “technique” of EMDR and plunge straight into desensitization, but EMDR is no different from any other therapeutic approach in needing certain things to be in place before proceeding.

THE THERAPEUTIC RELATIONSHIP—BACK TO BASICS

Many practitioners who are new to EMDR suddenly lose sight of their existing therapeutic skills. This book includes reminders of some of these and provides the familiar, background context for integrating EMDR into our practice. It is important to remember that when we are learning

anything new, we all go through a process, such as the conscious competence model shown in Table 1.1. Supervisees often describe finding themselves in a position of conscious incompetence regarding EMDR and, in supervision, present as disempowered, apprehensive, or downright scared to death of making a start! It may be of some comfort to know that this cautious, conscientious approach is preferable to the supervisee who rushes in and is overly confident. It cannot be overstated that EMDR is a psychotherapeutic approach and issues such as client safety, therapeutic alliance, comprehensive assessment, confidentiality, and boundary issues are paramount.

Therapists should ensure they are

- Offering the core conditions of unconditional positive regard, empathy, and congruence (Rogers, 1995; see Chapter Resource 1.1: Roger’s Core Conditions)
- Creating an environment, through the development of trust and rapport, in which the client is able and willing to be vulnerable

Table 1.1 The Conscious Competence Model

Stage 1: Unconscious Incompetence

Therapists are not aware of the existence or relevance of EMDR to their practice and must become conscious of their incompetence before development of the new skill or learning can begin.

Stage 3: Conscious competence

Therapists achieve “conscious competence” in a skill when they can perform it reliably at will. They still need to concentrate and think to perform the skill because the skill is not yet “second nature” or “automatic.”

Stage 2: Conscious incompetence

Therapists become aware of the existence and relevance of EMDR and of their own deficiency in this area. If you are reading this book then you have made the commitment to learn and practice EMDR and to move to the “conscious competence” stage!

Stage 4: Unconscious competence

Therapists become so practiced in their EMDR skills that they enter the unconscious parts of the brain—it has become instinctual. Do we ever really get there?

This model provides a simple explanation of the process and stages of learning a new skill. The learner or trainee always begins at stage 1, “unconscious incompetence,” and moves through stages 2 and 3 to end at stage 4, “unconscious competence.”

- Being flexible according to the client's needs and that they have a tool box of strategies
- Attending to client safety (see Chapter Resources 1.2: Suicide Ideation and 1.3: Brief Suicide Counseling Model).

All these are necessary before using EMDR, and many of the “failures” that are seen in supervision arise because not enough time has been spent on this foundation. They are particularly important when working with survivors of child sexual abuse and clients with posttraumatic stress disorder (PTSD). However, therapists sometimes put the above skills to one side as they focus on the protocol and their anxieties about getting that right. The practicalities of EMDR sessions should also be borne in mind. Desensitization sessions cannot be rushed, and therapists will need to allow near-double their usual session time. An early consideration therefore is whether this is feasible in the workplace setting, for example, is the therapy room being rented for 50 minutes only? Similar consideration is suggested for time-limited therapy as all the phases of the protocol need sufficient time. Dealing with more complex issues may not be possible where a client can only be seen for four to six sessions and the therapist risks “opening a can of worms” and then having to leave the client with that.

What Does the Client Need?

Clients need to be aware that the process of EMDR treatment can be disturbing and that dissociated material may surface during therapy. Because EMDR has the potential for a rapid uncovering of this unsuspected material, some of which may be extremely distressing (Shapiro, 2001), an assessment needs to be made of the client's ability to handle strong emotions. An important theme running through any theoretical work should always be client safety. Risk factors should be assessed including the following short-term high-risk factors:

- Impairment in daily functioning
- Unstable lifestyle
- Inadequate coping style and resources
- Few available significant others or reliance on one person alone
- Uncooperative in prior psychiatric treatment or unreceptive to help

- Chronic illness
- Parasuicide acts or suicides within the family
- Previous suicide attempts
- Recent losses
- Severe depression or hopelessness
- Chronic abuse of alcohol/drugs
- Unexplained improvement in clinical features.

Although highly effective, EMDR can be very hard work for clients, and both client and therapist need to be prepared to deal with whatever surfaces during therapy. Before commencing the desensitization phase, clients need to be as stable and competently resourced as possible to better buffer any deterioration in symptoms.

Clients will need varying amounts of therapy time to create this resilience. You will need to explore your client's ability to self-soothe, encourage their use of social support, and assess their control over any external stressors both current and likely to occur in the future. Other demands (such as upcoming exams, high workloads) will have an impact on the client's finite resources. Systems issues may need to be addressed, for example, the therapist working with a victim of domestic violence should consider ongoing risks.

Perhaps because EMDR has the reputation of solving problems rapidly, some clients have unrealistically positive expectations for therapy. It is important that the therapist examines these up front. EMDR is neither a panacea nor a magic wand. Where clients expect to "have something done to them" and to be passive in the process, this can have an impact

⊗ ***Whatever You Do, Don't Do This...***

Claire came to therapy for an anxiety disorder. Her therapist introduced the concept of EMDR to her at the third session.

"Oh, I think I've had that when I saw another counselor a couple of years ago. He didn't say what it was though. It was our first meeting and I was talking about my problems when he just said 'stop there a moment,' came and sat right next to me and started waving his fingers in front of me. I don't think it really worked..."

👉 **Common Pitfall** ***The Client Is Not Ready for Therapy***

On occasion, clients may have been “sent” to therapy by an employer, a well-meaning friend, relative, or a professional. Alternatively, they may have heard EMDR being described as a “quick fix” or similar and are expecting the therapist to do all the work.

It is important in such cases to establish in the history-taking phase what brought them to therapy, why now, what are their hopes and expectations, and what are their fears? What do they expect to be different once they have completed therapy and what do they understand the process to be? Eliciting this information early on in the relationship can prevent frustration and disappointment and create a transparency that allows the client to make a choice as to whether to engage. It is also important to carry out regular reviews to ensure the client maintains engagement.

on their willingness to engage and utilize self-help strategies. Informative literature and directed research can help to inform clients of the true nature of EMDR therapy.

Secondary Gain

For some clients there may be ambivalence about recovery from their dysfunction or distress. This may not always be something to which they give a conscious thought, and therapists should explore the possibilities of secondary gain in a sensitive and nonjudgmental manner. Common secondary gains include the loss or reduction of a compensation claim or disability pension. Others include the loss of their identity, particularly for veterans or survivors of abuse, or for clients who identify too closely with their symptoms and struggles with life.

Dissociative Disorders

It is strongly recommended that EMDR is not used with clients who have dissociative disorders (DD) unless therapists are *confident and competent in their EMDR practice as well as in working with this client population*. Because of this, readers of this book are

Case Example Secondary Gain

Henry had reactive depression following serious bullying at work. During the subsequent internal investigation, he had felt unsupported by his managers and had left work to go on sickness absence due to raised levels of anxiety and disturbed sleep. An emerging secondary gain for him was that, if he recovered, he would have to return to the workplace. Additionally, he believed that he would be giving his employers the impression that he had not been that badly affected and they could forget what had happened to him—he needed to be seen to “suffer” for them to care. Recovery was equated with “forgive and forget,” and he was not ready for that to happen.

advised to screen for DD and, where present, refer to appropriate professionals.

See chapter 3 for more information on DD or one of many comprehensive texts available (Dell & O’Neill, 2009; DePrince & Cromer, 2006; DePrince & Freyd, 2007; Forgash & Copeley, 2008; Karjala, 2007; Moskowitz, Schafer, & Dorahy, 2008; Ross, 1989, 1996).

Cautions

EMDR can create a physical strain on the client as high emotions and somatic symptoms are processed. Enquiries should be made about the client’s general health and history of physical conditions. Table 1.2 indicates areas where caution should be exercised.

Legal Issues

There are several legal issues that concern supervisees:

- The use of EMDR during ongoing litigation cases (see Frequently Asked Questions, concluding this chapter)
- Fears that a client may sue the therapist if previously dissociated material surfaces during EMDR therapy
- Fears that a lawyer will attempt to devalue or “rubbish” EMDR or even suggest that the therapist has done harm.

Table 1.2 Cautions

CONDITION	ACTION
Contact lenses	Client may experience discomfort with eye movements and should remove contact lenses during desensitization
Eye diseases, surgery	Seek advice from ophthalmology consultant; use alternative DAS such as sound and tapping Never continue eye movements when client reports eye pain
Pregnancy	Seek physician advice and consider the appropriateness of avoiding high levels of arousal during the pregnancy
Heart condition Respiratory condition Severe physical impairment Trauma-related memories that involved severe physical sensations, for example, choking, drowning, intense pain/invasion	Seek physician advice and consider whether it is appropriate to treat as an inpatient or in a setting where medical assistance is readily accessible
Epilepsy	There is a very low probability of EMDR treatment triggering a seizure. Consult with client's neurologist as to whether increased affect or repetitive DAS would be of concern
Active drug/alcohol abuse	Consider what other support needs to be put in place. Therapists may work with such clients in partnership with professionals skilled in working with addictions. For nonactive drug/alcohol abuse, therapist and client may agree to a nonabuse contract for the duration of therapy. Clients need to be as stable as possible prior to desensitization and the risk of relapse actively monitored
Schizophrenia	Seek physician advice and assess the need for accessible medical assistance, restraint, and medication

(continued)

Table 1.2 Cautions (Continued)

CONDITION	ACTION
Organic brain damage	Seek physician advice
Prescribed medication	Medication may be needed to stabilize the client during therapy and its efficacy and appropriateness should be monitored as progress is made by a suitably qualified professional. EMDR treatment effects can be expected with most psychotropic medications except for benzodiazepines because these latter medications can prevent the client from experiencing the affect and physical sensations associated with the memory he or she is working on.

If in doubt, always seek advice from an appropriately qualified physician or consultant.

Therapists are less likely to encounter scrutiny of their use of EMDR now that it has gained approval from NICE (National Institute for Clinical Excellence, 2005) for PTSD. However, the importance of gaining the client's informed consent prior to desensitization is crucial. When the therapist introduces the use of EMDR to the client, it should be made explicit that dissociated material can surface during therapy. This information should preferably be provided in written form for clients to take away. It is all too easy for clients to not absorb all the information provided to them verbally in sessions or for therapists to “forget” this part (Chapter Resource 2.3: Example Informed Consent Form) Whether therapists choose to use this type of form or simply mark that the appropriate written information was given to the client, it can provide the much needed reassurance if ever that very rare, but commonly dreaded, lawyer's letter lands on the doormat.

Pre-EMDR Questionnaire

At this point, supervisees are often wondering whether they will ever get a client who passes all the criteria for EMDR as well as feeling rather anxious about remembering to consider all of this. A useful way of checking all the boxes is to use a standard tick-list or questionnaire such as the one in Table 1.3. Therapists who are new to EMDR feel reassured that they have not missed something vital—and removing that particular worry allows them to focus on the task at hand.

Table 1.3 Pre-EMDR Questionnaire

ADDITIONAL PRE-EMDR CHECKLIST FOR ANY CAUTIONS AGAINST USING EMDR	
CHECK	ANY COMMENTS
Has the client got suicidal thoughts or intent? Has he/she previously attempted suicide? Has he/she reported current or previous self-harm?	
Does the client drink excessively, take drugs, gamble, or have any other comorbidity?	
What is the client's score on the Dissociative Experiences Scale? (See chapter 3 for meanings)	
Are there previous critical events in the client's history?	
Does the client know how to self-soothe? Can the client manage high affect? What coping skills are used regularly?	
Have you enhanced a safe place and does the client practice it regularly?	
If there is a current ongoing legal case, has legal advice been sought?	
Does the client have epilepsy?	
Any head injuries?	
Is the client pregnant?	
Any other medical condition? If so, does client need to see physician?	
Any medication? Prescription or otherwise	
Has client been given literature on EMDR to take away, read, and research?	
What is the client's understanding of EMDR?	
What (if any) are the client's expectations?	
What (if any) are the client's fears?	
Informed consent form signed?	
Check out preference for DAS—eye movements (EM)/audio/tapping	First choice: Second choice:
If using eye movements, does the client wear contact lenses/glasses? Has the client got any eye diseases or problems with his or her eyes other than refractory problems?	

CASE STUDY: INTRODUCING EMMA

Throughout this book, we will be illustrating common pitfalls as well as offering techniques and advice on how to avoid them. A variety of case examples will be shown in text boxes but we will also be taking readers through a complete case from start to finish. Emma's is a composite case study, and information relating to her case will be described in text boxes so that readers can more easily follow her progress. A snapshot of Emma's assessment below gives a rough guide as to the kind of information that should be gathered to determine suitability for EMDR.

CASE STUDY: EMMA

Emma was 27 years old; she was of medium build with dark brown shoulder-length hair. Quietly spoken and very nervous on our first meeting, she could hardly look at me and her shoulders were bent forward as she sat on the edge of the seat. Emma was dressed in a grey shapeless jumper and baggy jeans that appeared to swamp her. She took a while to tell me that she had decided to seek therapy following a "bad experience with a boyfriend." She began by telling me how stupid she was being and that she should not have got herself in this situation. She was clearly embarrassed about telling her story and needed reassurance that she would not be judged. It transpired that, 6 months ago, she had been out for the night with a new boyfriend, Duncan. She had seen him a couple of times previously and was enjoying his company. At the end of the night, they had shared a taxi home and she had invited him into her shared apartment for a coffee.

"I suppose I gave him the wrong impression. We were having a lovely evening talking and laughing, and I just wanted it to carry on a little longer."

Emma became increasingly tearful as the story unfolded, and she expressed anger with herself. I just let her talk, focusing on providing a safe relationship for her to do so.

Duncan had followed Emma into the kitchen, and although she had initially welcomed his advances, he became more insistent and had eventually forced her to have sex. Emma was devastated and blamed herself.

"He kept telling me I'd led him on, how he'd spent a fortune on a fancy restaurant, and now I was being selfish. He said I shouldn't wear what I was wearing if I didn't want sex. It was just a pretty summer

dress—I've thrown it away now. Afterward he kissed me goodbye like nothing had ever happened. I must have missed all the warning signs. I thought he was a nice guy. Maybe it is my fault”

Emma was having difficulty with her reaction to what had happened. She explained that since it happened, she had become very withdrawn, would not venture out at night, had mood swings, and had lost her “sense of self.” She had also started to have panic attacks and was blaming herself for what had happened, so she had not reported it to the police.

“They're not going to take it seriously. Let's face it, they'll just think I was stupid asking a man back when I'd had a few drinks. It'll be my word against his and it probably was my fault. I just want to be able to put this behind me and move on.”

She was now complaining of poor concentration and being unable to sleep, and she spent most of her time at her mother's home, not getting dressed all day as she was currently on sickness absence from work.

EMMA'S CASE SHEET

Name and reference number:

Emma Smith—07/ST

Address:

Currently resides at mother's home
123 Rainbow Walk
San Francisco, CA
94111

Telephone No: (915) 555-5555

Occupation:

Human Resources Manager

Contract signed: Yes

Emergency contact—relationship, name, and telephone number:

Mrs. Smith (mother)—as above

Family and significant others:

Parents: mother, Carol, 59 and father, Martin, 60 (lives 23 miles away)
Both of good health and supportive but father unaware of situation
Mother single; father remarried, no children with new wife Wendy
Brother, James, 34, lives 120 miles away and “busy with his family but we speak often.” Good relationship with his daughters, Maisie, 6 and Chloe, 10
Parents divorced 19 years ago
Grandmother, Vera, 83, in nursing home
Good friends, Kate, Susan, and Charlotte (unaware of whole story; Emma has isolated herself).

Psychological well-being prior to the incident (including suicide ideation, alcohol/drug usage, previous counseling):

Good social network, lived happily and independently in an apartment. Works hard.

No previous mental health issues. Social drinking only—none at all since incident.

No previous suicide ideation or intention.

Previously healthy diet and regular exercise. Hobbies included music, holidaying, and dancing.

Previous critical incidents or significant life events:

See lifeline

Postincident history and summary of current situation—last seen GP/medication?

Impact of Events-Revised Scale (Weiss & Marmar, 1996) completed: Yes
Scores: avoidance = 16; intrusion = 21; hyperarousal = 24

Other information:

Emma had been to her physician 1 week ago and had been offered antidepressant medication, which she declined. Now just seeing GP for sickness absence certificates.

Psychoeducation literature and explanation

Given

Leaflet on understanding trauma reactions	Session 1
The body's arousal system, the panic diagram, and dealing with hyperarousal	Session 1
Self-nurturing activities leaflet	Session 2
Fact sheet 1—Managing sleep disturbance	Session 1
Fact sheet 2—Managing symptoms of reexperiencing	Session 2
Fact sheet 3—Managing symptoms of avoidance and numbing	Session 2

Arrangements made with client:

Initial weekly contract for 10 sessions followed by review

Initial reflections:

Emma has good resources but needs to be encouraged to use them. She seemed committed to following the advice given regarding symptom management.

Systems control is reasonable. Her employers are not putting any pressure on her to resume work. However, this may change.

Themes from lifeline and assessment reflect safety, shame, being deserving, and blame (highlighted in bold).

Emma seems to have a need to work hard (school and employment), and I wonder what is driving this?

Does she have suppressed memories around divorce?

IS EMDR SUITABLE FOR THE CLIENT?

It can be tempting for therapists, particularly when they are fresh from basic training and keen to use EMDR, to want to practice desensitization skills at any available opportunity. However, time properly spent on history taking and preparation will pay dividends when they do begin desensitization. It really is a case of “More Haste, Less Speed.”

During history taking, the therapist needs to consider carefully any early memories that may be responsible for setting the groundwork for the current dysfunction, in addition to the present complaints and goals for the future. From the moment the client enters the consulting room, therapists can be listening attentively for negative self-evaluations and paying attention to the client's unspoken communications. Sometimes stabilization work may be needed before getting a detailed history, particularly with more traumatized clients.

Impact of the Past

Because past events can often be responsible for current dysfunction, careful exploration needs to be made of the client's history. It is equally important to be aware of the past because of the potential for these events to surface during desensitization. Never assume face validity. There is a variety of methods for exploring additional past occurrences, and therapists should be flexible in their approach. It is important never to assume anything about the clients' presenting issues, therefore, whatever the therapist's theoretical orientation, a structured in-depth assessment and/or detailed exploration of history and symptomatology is advised. Some clients will find it more difficult to provide a full history to the therapist. Reasons for this can include shame, feelings of overwhelm when they focus on all the negative events in their past, and difficulties articulating or organizing their thoughts.

The Top Ten

Clients can be asked for the “top 10 significant events in their life.” It can be revealing to have the client include good and bad events in this. Some clients will struggle to come up with 10 events and may be better asked “what have been the worst/most challenging things you have experienced/witnessed in your life?”

⊗ ***Whatever You Do, Don't Do This...***

Peter came to therapy because he had been experiencing distressing nightmares in which he was horrifically attacked by a stranger wielding a machete. The nightmares had started around 2 years ago but were increasing in intensity and having a major impact on his waking day. He had become anxious and hypervigilant and was confused as to why he was suffering in this way.

Peter revealed no trigger for the onset of the nightmares. He was a social worker, and he enjoyed his work and had a settled home life. In fact, this was his motivation to sort out his problem as he was concerned that if he continued this downward spiral, then he could lose this.

The EMDR practitioner who saw Peter asked why he had chosen EMDR specifically as a treatment method.

“Oh, my neighbor is a therapist and she had been on an EMDR course. We were at a party and she offered to cure my spider phobia. It worked a bit...”

And when was that...?

“Ooh, around 2 years ago...”

Sure enough, detailed history-taking sessions revealed that his neighbor’s “party trick” had uncovered traumatic material from his early childhood that, fortunately once reprocessed with EMDR, led to the cessation of his nightmares and their resulting effects.

Creative Exploration

Clients and therapists may be more comfortable with creative exploratory exercises such as creating a lifeline. Using paper and pen, the client is encouraged to “plot” his or her lifeline. Starting at birth and ending with the present day, the client will mark significant markers along the way.

A similar exercise asks clients to depict their life on paper, as a corridor with doors on either side. Behind the doors are significant events and memories. The client does not need to open the door at this stage but can give each door a label. This serves to highlight to the therapist

👉 **Common Pitfall** ***The Client Talks Too Much or Too Little***

One of the common complaints from supervisees is that “it’s like pulling teeth!” Some clients find it very hard to actually be in therapy and open up to a complete stranger. Some lack the ability to articulate their emotions or experiences. With many traumatic events there is an element of shame or fear of being judged.

It’s strange that, fresh from training, supervisees often forget or dismiss how they would usually handle this in their practice and get caught up in EMDR being somehow different. This is particularly common where the client has come specifically for EMDR and just wants to get on with the desensitization! If the groundwork, in terms of relationship building and history taking, is rushed, then there is a much greater probability that problems will surface later on. Being consciously incompetent, it is very easy to give in to the pressure to do this and ignore your therapeutic instinct and experience.

Always ensure that the client is able to be open and vulnerable with you *before* tackling traumatic material in desensitization. Otherwise you will probably find that they somehow block their processing and you will both feel like failures.

Conversely, supervisees often bring the concern that the client is talking too much during the history taking, going off on tangents and overwhelming the therapist with fine detail. Things to remember here are:

- This may be the first time that the client has ever been listened to—never underestimate the power of letting clients tell their various stories
- Visual techniques such as lifelines and spider diagrams can be helpful to allow the client to focus
- While clients are talking, they are offering up clues to the therapist about how they view themselves and others. For example, Harry could be awarded a gold medal for talking and the therapist was anxious to focus on the protocol. However, during this time Harry was feeling “heard” for the first time ever, thus building trust and rapport. His conversation was regularly dotted with phrases such as “they changed the goalposts,” “I never get what I need,” and “I’m on a treadmill.” Picking up on these themes helped later with the thorny subject of identifying negative cognitions.

(continued)

👉 **Common Pitfall**
The Client Talks Too Much Or Too Little (continued)

- Where the “verbal torrent” appears to be a defense mechanism, pushing the therapist away, this needs to be gently challenged.

In both the above cases, think “If I hadn’t done my EMDR training, how would I handle this?”

the existence of an event while keeping the client safe from its content until such time as sufficient trust and resources are present.

Maureen Kitchur’s Strategic Development Model for EMDR (Shapiro, 2005) builds on genogram mapping formats to explore key events, family systems, and dynamics.

An example of a mapping exercise is shown below for Emma.

CASE STUDY: EMMA’S LIFELINE

AGE	EVENT	CLIENT’S COMMENTS
0–5	Happy childhood	We lived in a nice town and I’ve got lots of happy memories, stuff like picnics and having friends round to the house.
5–11	Loved school, “my haven”	My teacher, Mrs. Jones, was really kind, and I remember she always used to put my artwork up on the wall. I think my parents were going through a bit of a hard time then so school was my haven . I always looked forward to it. I don’t remember any friction at home, but my brother James tells me there was a lot.
9	Parents divorced Went to stay with aunt for a while with two older cousins	I don’t remember much about the divorce other than that my mum lost her temper with me and James once. It must have been hard for her, and we were probably being a nuisance .

(continued)

AGE	EVENT	CLIENT'S COMMENTS
11	Friend of her cousin molests her during summer holiday	He was a lot older I think—about 17—he grabbed me and touched my breasts. I was an early developer, and I was ashamed and scared . My cousin came in the room, and I ran back to my aunt's house. My aunt went mad when I told her. She said I shouldn't have been hanging around with the older boys.
11	Moved to new area and starts secondary school	We moved to the town where we live now, and I started a new school. I didn't really like it much, being the new girl, and it was very different from my old school. I worked hard though and did well.
11–16	Settling into new school	I was the quiet one , but I got a good circle of friends and didn't have any problems with bullying or anything like that.
18–21	Went to college studying	I loved college. I felt grown up at last and I enjoyed my course.
21– to date	Got taken on by current employer	I was lucky to get the job. I think they decided to take a chance on me.
25	Promoted	I've been very lucky.
26	Minor road traffic accident	Just glad it wasn't my fault and no one was hurt
27	Index event	

Assessment Tools

There are various diagnostic tools that have been devised to identify PTSD as defined in *DSM IV* (American Psychiatric Association, 1994), including the Structured Clinical Interview for *DSM-IV-PTSD* (First, Spitzer, Gibbon, & Williams, 1997). In addition, there are a range of psychometric tests that determine the level of severity once the diagnosis has been made, such as the PTSD Symptom Scale and the Clinician-

Common Pitfall***Clients Are Overwhelmed by Negative Experiences and Unable to Find Anything Positive About Their Lives***

Occasionally clients can present in therapy with such an overwhelming history of negative events that it can be difficult to draw on anything positive that has happened in their lives. In such cases, it is important during the first phase to be aware and to focus and highlight the clients strengths and resources, what they put in place to survive these events, how the events ended (did their actions contribute to this?), and whether they protected other people. Emphasize the courage it takes to come to therapy and face their fears. Check out how they might view someone else who had come through similar experiences and was, for example, holding down a job, raising a family, and living day to day.

Administered PTSD Scale (Blake et al., 1995). Also, the Impact of Events Scale—Revised (Weiss & Marmar, 1996) is the primary psychological test to identify a client's reactions to a specific traumatic event.

These tests can be helpful in determining various features of post-traumatic stress and can also have the added advantage of validating a client's symptoms. However, if clients are ill-prepared prior to completing the appropriate questionnaires, they can be left feeling more helpless and/or hopeless. It is important therefore to be sensitive to preparation for, and timing of, the test as well as to normalize the client's current experiencing of reactions. Some of the questions may be open to different interpretations by both the client and the therapist, and, depending on the levels of trust and rapport, the client may not be ready to be totally honest with the therapist. Conversely, some clients may find it easier to disclose a past traumatic event in writing rather than verbally. Flexibility is the key.

Because the effects of a traumatic incident can be wide ranging, it can be argued that some tests can be deficient and may omit certain idiosyncrasies. Thus, an individual may fall "under the radar" of the diagnostic tests by not falling neatly into the DSM IV diagnostic categories. As such Briere and Spinazzola (2005) suggest the concept of "multidimensional spectrum level phenomenon" to prevent oversimplification. Blanchard and Hickling (as cited by Scott & Stradling, 2001) highlight that, to meet the DSM IV criteria for PTSD, the individual must meet

a certain number and type of criteria. However, because the client who does not quite meet those measures is unlikely to be clinically different, they propose the idea of a “subsyndromal” level of trauma, which still warrants therapeutic intervention.

There is a danger that by using one trauma-specific diagnostic tool, other diagnoses could be overlooked. It is important that such tools are not used in isolation but rather used as part of a comprehensive approach.

Presenting Problems

It may seem obvious to state that the therapist needs to know what has brought the client to therapy, yet occasionally supervisees will neglect to spend sufficient time on this clarification as they focus on the event(s) that is “crying out” for desensitization.

Clients may describe their problems in a variety of ways including their symptoms of distress, dysfunctional behaviors, negative emotions, or feeling held back from a fulfilled life. The therapist needs to explore with the client the latter's perception of the initial cause and duration of symptoms along with the frequency and intensity. Current triggers for distress should be identified. It is important to ask about other complaints that the client may or may not feel to be related so as to ensure as complete an understanding as possible of the whole picture (Chapter Resources 1.5: Mapping Exercise and 1.6: Identifying Symptomatology Using the Film Script).

At this point, it may be appropriate to offer psychoeducation and normalization of symptoms, and this in itself can prove of great relief to a client.

Goals for the Future

It is important to elicit the client's desired future state and goals for therapy. A simple question such as “If you had a magic wand and you could use it to change your life tonight, how would you know this had happened when you woke up the next day?” Although this may seem obvious, in cases of bereavement the therapist may need to acknowledge the reality that the person who died cannot come back before asking the question.

Defining goals using the SMART acronym below helps to focus the client and inspires thoughts of the possibility of a different life.

For example, the client who states “I just want to be happy ...”

Case Example Symptom Clarification

Jane complained of not sleeping very well. The therapist explored this with her.

Therapist: So could you perhaps describe a typical night, in terms of what time you go to bed, how long it takes to get to sleep . . .

Jane: Well, I generally go to bed around 10:30 P.M., but it takes me a couple of hours to get to sleep.

Therapist: What's happening in those 2 hours?

Jane: I tend to toss and turn, I'm very fidgety and my mind then starts obsessing about things.

Therapist: Like?

Jane: Well, it can be things that happened during the day, or thinking about (the incident), worrying about what I've got to do next week.

Therapist: How much time is thinking about general worries and how much about (the incident)?

Jane: I suppose about 60% general stuff and 40% (the incident). It tends to be a spiral—I start worrying about the day-to-day stuff and move on to the incident.

Therapist: And then what happens?

Jane: Well, sometimes I get up and make a cup of coffee and other times I'm just so tired I eventually fall asleep.

Therapist: And what happens next?

Jane: Most nights I have bad dreams where I'm being chased or someone's in the house. Usually this wakes me up, and I have to get up and put the lights on.

Therapist: How often?

Jane: Well, this week I've had dreams every night, last night was bad because I knew we had this session . . . I'd say I get up four nights out of the week.

(continued)

Case Example Symptom Clarification (continued)

Therapist: When you do get up, what do you do after you've put the lights on?

Jane: Usually read some of my books or watch TV until I've calmed down. Quite often I can fall asleep when it starts getting light outside. Then I sleep in until about 10 A.M., if I can.

Therapist: Does this have an impact on your daily functioning?

Jane: Oh yes! I've got in trouble at work for being late or I'm bad tempered all day because I'm tired and then I feel bad. Sometimes I get on the couch for an hour when I get home and just have a cat nap.

Therapist: What time is that generally?

Jane: About 5 P.M. I only work short days thank goodness, 11 A.M. until 4:30, otherwise I don't know how I'd cope.

Therapist: Can you tell me a bit about your bedtime routine? What time do you eat your evening meal?

Jane: About 8 P.M. I go to the gym most nights as I've heard that exercise helps so I eat quite late. Then I watch TV and have a hot bath around 10 before I go to bed with my book.

Therapist: What do you have to drink in the evening?

Jane: I have to admit to a couple of glasses of wine—they help me sleep, but I have a pint of water before my bath so I'm not dehydrated. I'm really trying to do the right things...

Following this clarification, primary therapeutic goals included teaching the client basic sleep hygiene and techniques for managing nightmares. Without clarifying the symptom, these may have been missed as necessary. Jane was trying hard to do the right things but unfortunately many of her efforts were counterproductive. Providing psychoeducation gave her choices and empowered her to make positive changes that would underpin her further treatment.

Specific

What does happy mean to you? What are happy people like? Whom do you know who are happy (role model)?

Measurable

What would be different if you were happy? What would you see, do, feel? Who would be the first to notice and what would they see differently?

Achievable

Avoid goals where happiness depends on external influences that are out of the client's control or dependent on other's reactions, for example, if my parent no longer criticized me. Equally, the goal of being a 75-year-old ballerina may need some gentle challenging.

Realistic

Requests to win the lottery or to be happy 100% for the rest of their lives are perhaps not realistic.

Time Framed

This will give an indication of the client's willingness to participate actively in the therapy, offer a reality check, and inspire hope.

Although this can be an empowering process for most clients, some may find it hard to imagine things being improved ever. A balance is needed between inspiring hope for recovery and making false promises. As with any other psychotherapeutic approach, goals should be set collaboratively and neither too low nor too high.

Particularly in cases of complex trauma, it is helpful to review these goals regularly as they may change as the client does.

Treatment Plan

By this stage, the therapist should have as complete a picture as possible and, only when this is done is it possible to begin conceptualizing the treatment plan.

The treatment plan identifies specific targets for reprocessing. These include the past memories that appeared to have set the pathology in process, the present situations that exacerbate this dysfunction, and the desired future response. Where clients have identified groups of memories with parallel cues (e.g. similar negative cognitions, emotional or physical reactions) these may be clustered to maximize the generalization effect.

This can be a complex area, yet is fundamental to the effectiveness of EMDR, later chapters elaborate on treatment planning.

FREQUENTLY ASKED QUESTIONS

Q: My client is a police officer involved with a major court case in which he is to be called as a witness to a serious assault on a child. Because he wasn't the victim, is it okay to use EMDR around his intrusive images of the incident?

A: Providing EMDR may be construed as rehearsing the client or changing his perception of the incident therefore calling into question his evidence. It may also fade his images of the event and have an impact on his ability to recall vital detail of those images. This could have serious consequences for his testimony and the victim. For any client involved in litigation, advice on using EMDR should be sought. Clients may still wish to proceed but you should ensure they are giving informed consent (Chapter Resource 2.3).

Q: My client only wants to deal with a later trauma but she was abused as a child. She says she's dealt with that. Is it OK to proceed?

A: This raises several questions. Firstly, there is no way of preventing dissociated or unresolved material from surfacing during desensitization. For this reason, the client needs to be fully informed that her earlier abuse may come up. Additionally, it may be helpful to gently challenge the client about any reluctance to discuss all past trauma. This could indicate that the therapeutic relationship needs strengthening or that the client is using avoidance techniques. Finally, links to earlier trauma may not always be apparent but it may not be possible to fully address later trauma if its foundation lies in these earlier issues.

Q: Do I need to take a full history for every client? One of my clients has come for EMDR for a phobia and doesn't wish to discuss her past.

A: Yes. In the authors' opinion, this is probably the most important phase and is the foundation for later work. Get this wrong and you will most certainly encounter problems later. This also avoids a "fishing expedition" and allows the client some control and understanding of his or her current reactions. Using a gardening metaphor, it is helpful to explain to the client that the presenting problem is rather like an insidious weed. The roots need to be completely removed in order to prevent its return. It is strongly urged that the therapist

does not assume that the presenting problem, for example flying phobia, has only face validity. The memory network may contain other earlier experiences besides those involving flying, possibly associations to feeling out of control or unsafe.

Q: How do we know if we've got all the information from the history taking? I'm worried that my client may not disclose something relevant or may not even be aware of dissociated material.

A: It is important to explain the rationale for taking the client's history so that the client can take responsibility for what he or she discloses. At some point we have to trust that the clients are doing this and we have given them sufficient opportunity to build a safe relationship in which he/she can do this. However, some memories may be preverbal or dissociated. The therapist needs to remain alert to new material and have ensured that the client is fully prepared for this eventuality. The informed consent form will help with this awareness, but the preparation phase is crucial. As we know from experience, many clients will identify additional memories as treatment progresses.

Q: Is EMDR going to work with conditions other than PTSD?

A: EMDR was originally developed to treat traumatic memories and its efficacy for PTSD is well documented (Chemtob, Tolin, van der Kolk, & Pitman, 2000; Clinical Outcomes Efficiency Support Team [CREST], 2003; Department of Veterans Affairs & Department of Defense, 2004) with many randomized studies supporting its efficacy (Carlson et al., 1998; Ironson, Freund, Stauss, & Williams, 2002; Power et al., 2002; Soberman, Greenwald, & Rule, 2002). EMDR has also been reported as being effective in the treatment of other psychological problems, for example, Body Dysmorphic Disorder (Brown, McGoldrick, & Buchanan, 1997), Non-Psychotic Morbid Jealousy (Keenan & Farrell, 2000), Phantom Limb Pain (Tinker & Wilson, 2005), Vicarious Trauma (Keenan & Royle, 2008), Anxiety Disorders (Shapiro, 2005), and Chronic Fatigue Syndrome (Royle, 2008). EMDR is not, however, a panacea, and no psychotherapeutic approach is 100% successful.

Some of the indications that EMDR may be an effective therapy include:

- Intrusive imagery or other “stuck” sensory material such as smells or sounds

- Repetitive dreams and nightmares
- Where the client rationally knows that something is untrue (e.g., I'm safe) but emotionally/behaviorally disagrees with this
- A strong negative self-evaluation that is unjustified
- Unexplained somatic symptoms

It is equally important to be aware of the appropriateness of education, marital therapy, assertiveness, anger management training, and problem solving when a client enters therapy.

LEARNING SUMMARY

You should feel confident that you are able to:

- Begin to build the therapeutic relationship
- Assess whether the client is ready for therapy and, in particular, to consider the following:
 - A risk assessment of client safety
 - Any potential secondary gain issues
 - Screening for DD (see chapter 2)
 - Any physical contraindications
 - Legal issues
 - Client's ability to self-soothe and access social support
 - The existence (or likelihood) of external stressors and their potential to have a negative impact on the client
- Take a full history from the client including:
 - Past events that may be unresolved or contributing to the current presenting problems
 - Present dysfunction
 - Their goals for the future.

RESOURCES

1.1: Carl Roger's Core Conditions

Carl Rogers (1995) said that there are three core conditions: respect (also known as unconditional positive regard), genuineness, and empathy. He suggested that the three conditions are “core” because they are necessary for development to take place.

Respect is about valuing the other person as a human being. This does not involve approving of all of the other person's behavior, but appreciating the other as a person. Each person is unique, and therefore has something to contribute to the experiences of others. Whether this contribution is regarded as positive or negative, it stems from the values of the perceiver. Being nonjudgmental is an important characteristic of therapy. Although the therapist will have his or her own values, it is not part of therapy to make judgments about the client. Acceptance is another term that is sometimes used for this core condition.

Genuineness is a characteristic of the therapist in the relationship. Rogers said that he aims to be "transparent" in this relationship. In other words, there is nothing that he is feeling or thinking that he wished to hide from the client. If, for example, there is some aspect of the client's behavior that Rogers finds difficult or disagreeable, then he would aim to find a way to share this with the client. It is arguable that if these perceptions are not shared, then they will still be present and influence the therapist's behavior in his or her relationship with the client. Openness is preferable, and in the long run, more therapeutic for the client.

Empathy is a characteristic that the therapist brings to the relationship. It involves being able to perceive a situation as the client perceives it. This is sometimes referred to as being within the client's "frame of reference." The therapist is able to see things as the client does. It is very different from sympathy. Sympathy is concerned with appreciating how someone else feels because that is the way you would feel in that situation. Because we are unique, this cannot precisely be the case; we can only approximately know how someone else feels in or about a particular situation. Often we may think that we know, but fall wide of the mark.

1.2: Suicide Ideation and Intent

It is not true that most people who complete suicide do not tell anyone. Eighty percent of the people who kill themselves have communicated their intention. Probably the biggest indicator of suicide is hopelessness. Other indicators can include stating goodbyes and putting affairs in order. The suicidal person's ambivalence can lead to vague references to suicide and an expectation that the helper will inevitably understand these communications.

Therapists should always explore throwaway comments such as "I've had enough, they'd be better off without me, I can't stand this."

It is not true that if you mention it you may put the idea into his mind. If the idea isn't there you will get told that he has no intention of doing that. If it is there, he will feel able to be more open about thoughts that he may have felt ashamed to admit. The opportunity to discuss suicidal thoughts can give relief and enable a person to put thought between impulse and action. The greater risk is that the idea becomes shameful and increases a sense of low worth and isolation.

It is not true that people who make suicidal gestures never do kill themselves. Some of them do kill themselves. Even if they may have half-hoped that they would be found, if they are very unlucky they still end up dead.

If the means of completing suicide are removed, then suicide rates will drop. As more cars are fitted with catalytic converters, asphyxiations by car fumes will drop. The suicide rate dropped significantly in the 1960s when British homes switched to natural gas. A government initiative in the 1990s made buying large quantities of paracetamol more difficult in an attempt to reduce overdoses. Where there is suicide ideation, the therapist should explore the extent of plans to carry this out.

	LOW RISK	MODERATE RISK	HIGH RISK
Method	Undecided	Decided	Decided
Availability of method	No	Yes	Yes
Time and place	Not specific	Not specific	Specific
Lethality	Low	Moderate	High
Final arrangements	None	Some planning	Written notes, wills, possessions given away

It is untrue that people who really want to die will find a way or that it would not help to try and stop them. The impulse to commit suicide is generally an acute, transient experience that often passes if delayed. Most suicidal people are highly ambivalent about suicide—often simultaneously desiring death, while desperately wishing to be rescued.

It is not true that if someone survives a suicide attempt it must have been a manipulative act. People usually have complex reasons for attempting suicide, and manipulation by itself is usually insufficient reason.

1.3: Brief Suicide Counseling Process

Recognize the risk

- Listen actively
- Look out for hints and desperate words
- Look at the whole person; body language, demeanor, self-care

Explore the risk

- Important to maintain Roger's Core Conditions
- Use explicit language
- Accept depth of feelings. The current crisis may be caused by something that seems almost trivial, but in reality this may be the final straw, often a culmination of events.

Assess the level of risk

- Assess short-term and historical risk factors

Interrupt the process

- Gently challenge cognitive distortions
- Instill hope
- Build relationship
- Delay action on impulses
- Help with problem solving
- Establish reasons for living/not dying
- Mobilize internal resources

Close session

- Mobilize external resources
- Refer on
- Help with time structuring and contract setting

Look After Yourself

Self-care and supervision: Take a few minutes after dealing with the situation to calm down. It is very normal to feel anxious, sad, or “fired up” after this kind of intervention. If you can, get some fresh air, speak to a colleague or your supervisor, have a cup of tea, or move away from the environment you were in. Do not throw yourself headlong into another intensive piece of work until you feel calmer.

Consider self-use of EMDR, that is, using sets of dual attention stimulus (DAS) to reprocess your reaction to this emotionally intense session. See Shapiro (2001) or your EMDR Part 1 training manual.

1.4: Mapping Exercise

In their model of posttraumatic stress counseling, Bourne and Oliver (1999) described the importance of helping the client to survey the full effects of the traumatic incident. The client is encouraged to “map out” these effects in visual terms, for example, using paper and pen, and to think about what has changed, what remains the same, what has been lost, and what has been introduced since the incident?

Case Example

Mary was involved in an armed attack at the superstore where she worked. She has been off work with high anxiety for the last 2 months. Her completed mapping exercise is shown below:

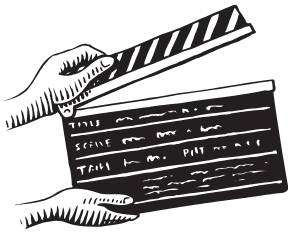
EMPLOYMENT	HOME LIFE
No longer going to work	Children have been a continuous strength, and I enjoy spending time with them
Occupational health nurse ringing weekly	Doing the school run is unchanged
Visiting GP for sick notes	I'm doing more housework
Lost my good sickness record	Relationship with grandmother is unchanged
Colleagues are ringing me for progress reports	Feel let down by husband and defensive when he talks about work
Still getting paid	Parents are fussing, and my mum doesn't talk about her own problems any more
No focus/structure to week/day	I like being at home (but not alone)
I miss the lunch breaks and camaraderie	
Feel panic at the thought of returning	

(continued)

EMPLOYMENT	HOME LIFE
<p>See work as risky now, particularly thoughts of being around money or stock-taking when store is closed</p> <p>I worry about my capability for managing conflict like customer complaints</p> <p>Supervisors/culture changes seem threatening</p> <p>No longer feel valued by work</p>	<p>Don't watch TV now</p> <p>Would like to go away for a holiday but scared</p> <p>Don't want sex but want lots of cuddles—hubby doesn't know the difference so this causes conflict</p> <p>Okay about driving with kids but must put music on and lock the doors</p>
SOCIAL LIFE	TIME ALONE
<p>Friends are sympathetic but awkward</p> <p>Not as much face-to-face contact with work friends</p> <p>Strangers appear threatening</p> <p>People at school gossip—feel labeled</p> <p>No longer going to the gym</p> <p>Feel okay about having people round to the house so long as they don't want to go over the robbery</p> <p>Feel okay in crowds—never used to but I seek company out (so long as they don't ask questions about why I'm not at work)</p> <p>Am only able to go shopping with a companion</p>	<p>Don't like open spaces</p> <p>Taking pills and have panic attacks</p> <p>I flit from one job to another, sometimes I clean like mad as a distraction</p> <p>Still like spending time with my children</p> <p>Jumpy at front door bell/telephone</p> <p>Don't like being alone—used to</p> <p>Uncomfortable about coming back to house especially after dropping kids at school</p> <p>Comfort eating—put on 1 stone</p> <p>Unhappy with self-image</p> <p>Nightmares</p>

1.5: Identifying Symptomatology Using the Film Script

Using the metaphor of writing a film script, the client is asked to consider how life was before, during, and since the incident. This will include symptomatology, lifestyle, and any ways that his or her life has changed—the exercise should help provide a detailed narrative of life in the client's shoes, past and present.



BEFORE

DURING

AFTER