EMDR Therapy and Mindfulness for Trauma-Focused Care

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**Demonstrates how mindfulness can greatly enhance EMDR treatment of trauma**

Mindfulness is a critical component in the delivery of EMDR; this innovative text integrates mindfulness-informed practice with EMDR therapy to create an effective new approach for healing trauma. Based on current evidence-based research, the book demonstrates— with clear, step-by-step guidelines—how clinicians can conceptualize and deliver trauma-focused care in both mental health and addiction treatment. Infused with practical applications, the book offers clearly articulated and effective approaches that provide a concrete beginning, middle, and end of treatment planning.

Following a description of the long history of mindfulness practices, the book offers guidelines for developing one’s own mindfulness practice—emphasizing the use of trauma-focused language—and suggestions for teaching specific techniques to clients. The book describes both classic and creative mindfulness practices, including breath awareness/sensory grounding, breath meditation, body scanning, feeling tone meditation, labeling, standing meditation, walking meditation, and loving-kindness meditation, along with using day-to-day objects as a meditative focus, movement practices, the expressive arts, and other forms of creativity.

**Key Features:**
- Offers a complete framework for healing trauma by integrating mindfulness-informed practice with EMDR therapy
- Provides clearly articulated, step-by-step approaches that are evidence-based
- Authored by noted experts in EMDR and mindfulness-based therapies
- Includes guidelines for developing one’s own mindfulness practice and tools for teaching specific practices to clients
- Describes both classic and creative mindfulness practices
EMDR THERAPY AND MINDFULNESS FOR TRAUMA-FOCUSED CARE
ABOUT THE AUTHORS

Jamie Marich, PhD, LPCC-S, LICDC-CS, REAT, RMT, travels internationally to teach on eye movement desensitization and reprocessing (EMDR) therapy, trauma, addiction, expressive arts therapy, and mindfulness while maintaining a private practice in Warren, Ohio. Dr. Marich is the author of *EMDR Made Simple: 4 Approaches for Using EMDR With Every Client* (2011), *Trauma and the Twelve Steps: A Complete Guide to Enhancing Recovery* (2012), *Trauma Made Simple: Competencies in Assessment, Treatment, and Working With Survivors* (2014), and *Dancing Mindfulness: A Creative Path to Healing and Transformation* (2015). She is the founder of the Dancing Mindfulness practice and expressive-arts community and actively offers EMDR therapy training through her company, Mindful Ohio & The Institute for Creative Mindfulness. Marich began her career in human services as a civilian humanitarian aid worker in Bosnia-Herzegovina (2000–2003). Her award-winning dissertation research on the use of EMDR therapy in the treatment of addiction was published in two APA journals (*Psychology of Addictive Behaviors* and *Journal of Humanistic Psychology*). In 2015 she received the NALGAP President’s Award for her work as an LGBT advocate.

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EMDR THERAPY AND MINDFULNESS FOR TRAUMA-FOCUSED CARE

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With love and gratitude to Joe Long (1980–2016), my friend and my “coach.” You left us much too young and I will do my best, dear buddy, to continue writing from our shared mission of authenticity. Thanks for being my spiritual bouncer in this process!

—Jamie

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—Steve
Contents

List of Meditation Practices and Experiential Exercises  xiii
Foreword by Noah Levine, MA  xv
Preface  xvii
  Jamie’s Journey: EMDR Therapy Offers a New Solution  xvii
  Stephen’s Journey: A Mindful Revelation  xix
Acknowledgments  xxi
Share EMDR Therapy and Mindfulness for Trauma-Focused Care

1. Introduction  1
  Shifting From Trauma-Informed to Trauma-Focused  1
  What to Expect From the Book  4
  References  7

2. Redefining the Paradigm for Trauma-Focused Care  9
  A New Hope  9
  Eye Movement Desensitization and Reprocessing Therapy  10
  Mindfulness  12
  The Fusion of Mindfulness and EMDR Therapy  16
  Tying It All Together  19
  Questions for Reflection and Personal Practice  19
  References  20

3. Developing Buddhist Mindfulness Practice for Trauma-Focused Care  23
  No Correct Path to Mindfulness Practice  23
  Starting a Mindfulness Practice  24
    Mindfulness of Breath/Sensory Grounding  25
    Mindfulness of Feeling Tone  27
    Mindfulness of Mind  29
    Mindfulness of Dharmas/Loving Kindness Meditation  31

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4. **An Introduction to the Creative Mindfulness Practices**  41
   Choice and Possibility in Mindfulness Practice  41
   Yogic Breathing Practices  42
      *Diaphragmatic Breathing (Belly Breathing)*  43
      *Complete Breathing (Three-Part or Dirgha Breathing)*  44
      *Ujjayi Breathing (Ocean-Sounding Victory Breath)*  45
      *Lion Breathing*  47
      *Alternate Nostril Breathing (Nadhi Shodnan Pranayama)*  47
   Clench and Release: A Modified Progressive Muscle Relaxation Experience  49
   Transforming Day-to-Day Activities Into Meditation  51
   Energetic Massage  52
   Noodling: The Art of “Going With” Organic, Expressive Movement  54
   The Expressive Arts as Meditation  55
   Tying It All Together  57
   Questions for Reflection and Personal Practice  57
   Resources for Further Exploration  58

5. **EMDR Phase 1, Client History—Setting the Tone for Trauma-Focused Services**  59
   A Mindful Approach to History  59
       The Purpose of Phase 1: Definitions From Shapiro and the EMDR International Association  60
       Honor Possibilities in Phase 1: Gathering Client History in a Mindful Way  62
       Best Practices for Clinical Interaction  63
   Specific Strategies for Phase 1, Client History  67
      How to Avoid Badgering a Client With Narrative  67
      Sample Case Using Worksheets for History Taking  68
   Tying It All Together  75
   Questions for Reflection and Personal Practice  76
   References  76
6. EMDR Phase 2, Preparation in Trauma-Focused Care  77

   Mindfully Navigating the Preparation Phase  77
   A Trauma-Focused Approach to Preparation  79
   The Broader Context for Healing Trauma  79
   Filling Out the Missing Pieces  80
   Resource Development and Installation  80
   The Relational Imperative in EMDR Therapy  82

   Necessary Skills for Preparation and the Art of Modifying Them  83
   No Such Thing as “One Size Fits All”  83
   Mindfulness and Grounding Strategies  84
   Breathing Strategies  86
   Demonstrating Hyperarousal and Release  86
   Multisensory Soothing  87
   Guided Visualizations  88
   Light Stream Multisensory Visualization Exercise  89
   Tree Grounding Visualization Exercise  89
   Modifications for Creativity  90
   Simple Container Visualization Exercise  90

   Movement, Expressive Arts, and Identification of Other Recovery Capital  90

   Tying It All Together  92
   Questions for Reflection and Personal Practice  93
   Resources for Further Exploration  93
   References  94

7. EMDR Phases 3 to 6: Principles of Mindful Decision Making  97

   Moving on to Phases 3 to 6  97
   Clinical Decision-Making Points  98
   Access of Preparation Skills  99
   Positive Material in the Client’s Life  100
   Nature of the Living Situation  101
   Drug/Alcohol Use and Psychotropic Medication  102
   Secondary Gains and Related Issues  104
   Number of Sessions Available  105
   Willingness to Examine Past Issues and Potential Target Adjustments  106
Facilitating a Client’s Journey Through Phases 3 to 6  
Mindfulness in Phases 3 to 6  
   Phase 3: Assessment  
   Phase 4: Desensitization  
   Phase 5: Installation  
   Phase 6: Body Scan  
Tying It All Together  
Questions for Reflection and Personal Practice  
References  

8. Special Situations in Phases 3 to 6: Mindful Facilitation Through Abreaction, Dissociation, and Resistance  
Potential Frustrations in EMDR Therapy Phases 3 to 6  
   Maintaining the Calming Presence  
   Qualities of a Good EMDR Therapist  
Mindful Skills for the Journey Through Phases 3 to 6  
   Handling Abreaction and Dissociation  
   Interweaves  
   “I Don’t Want to Do EMDR Anymore”  
Tying It All Together  
Questions for Reflection and Personal Practice  
References  

9. EMDR Phases 7 and 8: Mindfully Approaching What We Often Overlook  
The Mindful Practice of Transition  
   Transitions in EMDR Therapy  
   Transition as Mindfulness Practice: An Exploratory Exercise  
Phase 7: Closure  
   Learning From Mistakes  
      Ritual Release Breathing: A Simple Breath Practice for EMDR Closure  
      Flicking: A Simple Energy Practice for EMDR Closure  
Best Practices for Mindful Closure  
   Closing and Debriefing a Session  
   Implementing a Safety Plan for In Between Sessions  
   Extraordinary Circumstances in Closure  
Phase 8: Reevaluation
10. Enhancing Your Efficacy as a Therapist: Developing Your Own Mindfulness Practice and Doing Your Own Trauma Work  149
   Interesting Times  149
   Mindfulness and EMDR Therapy: Intimately Connected  150
   Mindfulness: A Way of Life  154
   Finding Your Teachers and Your Community  158
   A Call to Revolutionary Action  161
   Tying It All Together  162
   Questions for Reflection and Personal Practice  163
   References  164

Appendix: EMDR Clinical Worksheet Templates  167

Index  173
List of Meditation Practices and Experiential Exercises

Chapter 3
- Mindfulness of Breath/Sensory Grounding
- Mindfulness of Feeling Tone
- Mindfulness of Mind
- Mindfulness of Dharmas/Loving Kindness Meditation
- Walking Meditation
- Beginner’s Mind Practice

Chapter 4
- Diaphragmatic Breathing (Belly Breathing)
- Complete Breathing (Three-Part or Dirgha Breathing)
- Ujjayi Breathing (Ocean-Sounding Victory Breath)
- Lion Breathing
- Alternate Nostril Breathing (Nadhi Shodhan Pranayama)
- Clench and Release: A Modified Progressive Muscle Relaxation Experience
- Transforming Day-to-Day Activities into Meditation
- Energetic Massage
- Noodling: The Art of “Going With” Organic, Expressive Movement
- The Expressive Arts as Meditation

Chapter 6
- Demonstrating Hyperarousal and Release
- Light Stream Multisensory Visualization Exercise
- Tree Grounding Visualization Exercise
- Simple Container Visualization Exercise
Chapter 9

Transition as Mindfulness Practice: An Exploratory Exercise
Ritual Release Breathing: A Simple Breath Practice for EMDR Closure
Flicking: A Simple Energy Practice for EMDR Closure
EMDR therapy is the Dharma. Dharma means to see clearly and respond wisely. The Buddha often said that he only taught the truth of suffering and how to end suffering. Buddhism teaches many different techniques in the service of ending suffering, mindfulness being the main meditative technique offered in the core teachings, called the Eightfold Path.

EMDR therapy is mindfulness. Mindfulness is the Dharma.

When I learned that the core philosophy of EMDR is about bringing mindfulness to the held memories and sensations of our past traumas, while practicing bilateral attention, I realized that for the last 30 years, one of the primary practices I have been engaging in as part of my Buddhist training is walking mindfulness meditation. While walking slowly, bringing attention bilaterally, left-right, left-right to the sensations of each footstep. In the silence of retreat the mind often releasing the pain of the past. As I noted, right-left, right left. I believe that much of my early life suffering and trauma was reprocessed and integrated as the mindfulness of what was arising and passing was noted and eventually met with compassion and forgiveness.

When I told my father, Stephen Levine, about being trained in EMDR, he told me that Francine Shapiro had been his student around the time she had created EMDR and that much of it may have come from the mindfulness he was guiding her in as a way to be with grief.

As a Buddhist teacher, I believe that the Dharma (mindfulness being an integral part but not the whole of the Dharma) can alleviate all forms of suffering. Of course the end of suffering does not mean the end of pain or painful memories, it just means that we learn to meet our pain—physical, emotional, and mental—with understanding and compassion.

My training in psychology has shown me that without an embodied mindfulness component, conventional talk therapy has severe limitations. This is why I feel that the work that Dansiger and Marich are doing to move forward the great and skillful work of Shapiro is timely and necessary.
At Refuge Recovery Center, we train all our clinicians in EMDR therapy and the Refuge Recovery Buddhist approach to recovery. We have had great success helping our clients resolve the underlying trauma that led to their addictions, and so many of them have gone on to live happy and successful lives of abstinence and recovery.

I truly believe that the practice and philosophy outlined in this book have the power and potential to end suffering. This is revolutionary wisdom. We are on the front lines. The old guard has become complacent. Now is the time to move forward, to advance, to overthrow the causes of suffering.

Noah Levine, MA
Author of Refuge Recovery,
Against the Stream,
Dharma Punx
Preface

Helping professionals often describe what we do as assisting clients in the process of retraining, or rewiring, their brains. Both mindfulness and eye movement desensitization and reprocessing (EMDR) therapy can assist in this process, ultimately bringing about healthier, more adaptive lives for the people we serve. The benefits of pure mindfulness practice are more likely to be experienced over time, as long as practice is engaged in consistently. Although EMDR therapy is not a quick fix and may not work as quickly for everyone as certain promoters would have you believe, it is a more expeditious process. For people who have positively experienced EMDR (including your authors), a constant reflection is that EMDR facilitates shifts in consciousness both rapidly and quickly. At least once a week, people (clients, students, readers, community members) share with us some variation of the following statement: “EMDR moved in a few sessions what I couldn’t do in years of talk therapy.”

JAMIE’S JOURNEY: EMDR THERAPY OFFERS A NEW SOLUTION

In 2004, I began my master’s level clinical counseling internship at a residential hospital for children and adolescents. My initial intention was to work with young people because serving as an English teacher in postwar Bosnia-Herzegovina from 2001 to 2003 sparked my interest in the helping professions. A very wise American social worker mentored me while I was in Bosnia, helping me to identify how unhealed trauma impacted the lives of my students. Thus, when I became acquainted with standard-model mental health care in the United States during my internship, I was surprised to encounter so many children who carried diagnoses such as attention deficit disorder, operational defiant disorder, conduct disorder, and the ever-popular bipolar disorder.

“Why isn’t anybody looking at trauma?” I asked.

Some variation of, “We’re not set up for that,” was the usual response.
These responses triggered the parts of me naturally inclined toward fairness and justice. I found it very difficult to stay present at my internship site. I also became highly disturbed by how the kids were treated by doctors, staff members, and even many members of child protective agencies who were entrusted to advocate for them.

As my dissociative “checking out” moments intensified, so did the concern of a counselor on the residential unit, a lovely man named Joel. He pointed out my dissociative tendencies and lovingly asked how I planned to address them.

I protested, “I don’t see how more therapy is going to help. I know what the answers are; I know what I should be thinking, I know what I should be doing.”

At that point, I was in a pretty standard talk-therapy course of treatment with the third counselor I’d seen in my lifetime, and I’d been working a 12-step recovery program for the better part of two years. I was also active in a church. I didn’t know what else was left to “do.” Joel suggested that I chat with a professor in my graduate program with whom I was especially close and ask her advice.

When I talked with this professor and explained the essence of my dilemma, she responded, “Go see Janet Thornton over in Boardman. She does all of the weird, outside-the-box stuff.”

For the first time since getting sober I experienced a hopeful sense of relief, simply by hearing that there were other approaches to be tried. Following my assessment session with Janet Thornton, she handed me what I now know to be a standard-issue EMDR International Association (EMDRIA) brochure on EMDR therapy. She directly recommended EMDR as a course of treatment for me, the first time I would ever hear those four letters strung together. At the risk of cliché, the experience literally saved my life and later transformed it. My depressive tendencies were known to come with suicidal ideations, and the EMDR treatment—specifically working on my first target, “I’m not lovable”—finally allowed those ideations to lift. I was able to stay more focused at the internship site and felt sufficiently empowered to ask my program for a new internship site, which I secured for the next semester. Moreover, my sobriety felt stronger than ever.

What amazed me the most about EMDR therapy during this first experience was how insights would just pop out of nowhere. These insights helped me connect so many of the proverbial dots in my life, revealing a complete picture that I was unable to see before. For the first time I was able to accept, at the deepest levels of my heart, my body, and my soul, that I am fundamentally a lovable person full of positive qualities and traits. As a result of being silent and reflective on certain parts of my experiences as the stimulation moved back and forth (in my case, it was the tactile stimulation machine), I noticed how the whole puzzle started to
come together. I experienced what I’ve been fortunate to hear many clients subsequently affirm about EMDR: The process allowed what I knew to be true in my rational mind to finally make sense in my heart.

**STEPHEN’S JOURNEY: A MINDFUL REVELATION**

I received my intern number and found a job at a residential addictions rehab, where the clinical director invited me to go into private practice under her supervision. I knew she had a reputation for working with very difficult cases in which complex trauma was a factor. At one point, when she was working on a particularly difficult case, she told me she would bring in an EMDR consultant to help her in using EMDR with the client. I had been assisting this client to develop Buddhist mindfulness practices, something I had been doing for myself and others for more than 15 years by that time. To help coordinate our care my supervisor invited me to sit in on the weekly phone consultation, and the language and protocols of trauma-informed and trauma-focused treatment were introduced to me. As I heard how difficulties were overcome by both the therapist and the client, I became increasingly convinced that I needed to be trained in this therapy. I also heard the deep connections between my mindfulness work and this strange and seemingly powerful therapy. When I heard that our consultant was going to be providing training through the EMDR Institute, I signed up.

At the training I had a mindfulness-based revelation. During a practicum where I was taking on the role of the client, my partner went through the protocol note for note as we had learned it, and I applied my mindfulness practice to the experience, taking “just notice” very seriously. In very simple steps and in short order, the emotional charge of something that had bothered me for a very long time decreased. When it resolved as a completed and installed target, I tried to gather back my energy to have a dialogue about it. All I could muster was a weak, “What did you just do to me?” We both laughed. My long-standing Buddhist mindfulness practice had been screwed in tightly with bilateral stimulation, and the results were remarkable.

Thus began my ongoing relationship with EMDR therapy. Since that day I have practiced it as my primary mode of therapy, always informed by and channeled through the spirit of my mindfulness training. Francine Shapiro’s original protocol, combined with the mindful presence of the therapist, is a powerful treatment not just for posttraumatic stress disorder (PTSD) but for difficulties that do not become full-blown psychological disorders. It works on single-incident trauma as well as complex trauma when used competently and with necessary modifications or adjustments when the wound is deep and the symptoms are profound. The research is quite robust related to PTSD, and it is growing with other difficulties
and diagnoses. My own anecdotal experience is one of deep respect for the ability of the brain to heal, to figuratively scab and scar, and to become more adaptive in its functioning, when I am willing to stay out of the way as much as possible.

Through EMDR therapy, the client becomes able to live a more adaptive life. The language of the adaptive versus maladaptive that Shapiro prefers is infinitely helpful. EMDR is neither *Eternal Sunshine of the Spotless Mind* nor is it trying to do what many beginning meditators believe is supposed to happen—to end all thinking activity. EMDR therapy and mindfulness both point us toward our true north. All the gunk and junk that was piled on top of us is cleared away, leaving our beautiful shining strength and resilience, our powerful internal resources, our connection to ourselves and others, our birthright as human beings. I have experienced it as a client; I have experienced it as a therapist; and I have witnessed the stories of countless practitioners and sufferers who tell similar tales. Each day that I continue as a mindfulness practitioner and teacher, and as an EMDR therapist, my sense of wonder about the human spirit grows, and I see many people find one or more of the Four Divine Abodes in their lives—loving kindness, compassion, appreciative joy, and equanimity. This, I believe, is the journey of mindfulness and EMDR.

As an aid to practitioners, the clinical worksheets shown in Chapter 5 and the Appendix have been made available as PDFs that can be completed digitally or printed as needed. To download this supplemental material, go to www.springerpub.com/marich.
Acknowledgments

Our clients, consultees, and trainees in EMDR therapy remain our greatest teachers as we develop our teaching voices within the EMDR community. It is to all of them that both of us extend our heartfelt gratitude and appreciation! Throughout the composition of this book, we have seen your faces and heard your voices many times, and we thank you for joining us in our collaborative learning process.

We also wish to collectively thank Dr. Francine Shapiro and her early team of leaders, who steadfastly developed what we now know as EMDR therapy in the face of much adversity and opposition. We both consider EMDR therapy to be a great healing gift of which the Buddha himself would have been a fan, vital to our planet in these times. To these historical pioneers and to those who came before us, we extend our appreciation and gratitude.

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me to reconnect with just how much I love EMDR. This trip inspired my renewed commitment to EMDR teaching and writing. *Obrigada a todos.*

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Share

EMDR Therapy and Mindfulness for Trauma-Focused Care
Redefining the Paradigm for Trauma-Focused Care

A NEW HOPE

In redefining and establishing a new paradigm for services as trauma-focused, this book seeks to offer clinicians a grounded and mindfully present spirit of “both/and” rather than the divisive and limiting “either/or.” This presents a number of hurdles from which many theorists, researchers, and practitioners might ordinarily shy away. The first hurdle is that of the scientific method and the belief that the more variables that are present (i.e., the more elements we are throwing into the kitchen sink), the less likely we are to be able to determine what is working or not working in our attempts to care for people. The second hurdle is that element of human nature that at times, either healthfully or pathologically, needs to take a stand, to plant a flag somewhere very specific, to state a case and have it provide meaning and structure. A third hurdle involves several manifestations of that either/or thinking: my way or the highway; I am right/you are wrong; it is this way/definitely not that way.
EYE MOVEMENT DESENSITIZATION AND REPROCESSING THERAPY

The first solution to catapult over these hurdles exists in the ever-changing, still-growing world of trauma theory. Trauma derives from the Greek word *traumatikos*, meaning “wound.” In a broad, humanitarian sense, we define trauma as any unhealed human wound or series of wounds—physical, emotional, sexual, spiritual/existential, and financial/economic. The first appearance of a clinical diagnosis directly naming trauma—posttraumatic stress disorder (PTSD)—appeared in the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM*) in 1980, long after the clinical world was already wrestling with trauma and its effects on human behavior (American Psychiatric Association, 1980). The definition of trauma stemmed less from the effects on the person than it did from the nature of the event. To be viewed as a trauma victim, an individual needed to experience an event that met criteria for a dedicated traumatic experience: “Criterion A trauma under the PTSD diagnosis.” Many factions within the helping professions have since realized that the internal world of the sufferer has a great impact on how those who seek help need to be treated.

This subjectivity requires the “both/and” lens: Helping professionals need to consider the external events driving the response as well as the response itself. More importantly, we must look at the content and the extent of the internal experience. Dr. Francine Shapiro, the creator of eye movement desensitization and reprocessing (EMDR) therapy, played a visionary role in helping our clinical professions to acknowledge that unhealed trauma is a much broader issue than could be encapsulated by the simple *DSM* definition of PTSD. Her early presentations of “large-T” (i.e., PTSD-qualifying) and “small-t” trauma (i.e., everything else) (Shapiro, 1995) started an important conversation. In her updated presentation of the adaptive information processing (AIP) model, the collection of theoretical underpinnings supporting EMDR therapy, Shapiro posits:

*Trauma can include DSM-5® Criterion A events and/or the experience of neglect or abuse that undermines an individual’s sense of self-worth, safety, ability to assume appropriate responsibility for self or other, or limits one’s sense of control or choices.* (EMDR International Association, 2015)

Whether or not you identify as an EMDR practitioner, adopting this general approach to trauma is critical in the modern era.

With this trauma-focused framework, helping professionals are able to conceptualize cases from a more client-centered perspective. Inherent in this approach is collaboration and the Rogerian notion of entering the client’s world. Armed with knowledge of the complex nature of trauma and its
effects, clinicians can meet clients where they are in their process of understanding and grappling with their difficulties, and more effectively facilitate a process of deeper understanding and integration. That integration comes not from creating a hierarchy of trauma and a list of events that qualify, but instead from a relationally mindful understanding of the impact of the past on the present and future adaptive functioning of the client.

Another helpful framework that has yet to make it into the DSM but has become mainstream in the trauma treatment world is the construct of Complex PTSD (Courtois & Ford, 2009; Herman, 1992). Abuse and neglect of many kinds can be carried out over time. Even single-incident traumas can have ripple effects that may be lost sight of in the assessment and treatment of the original identified trauma. We must be alert to the complications and specific manifestations of difficulties fed by ongoing external events and the internal reinforcement of those events. Now that clinicians are looking to treat as many traumatized people for as many symptoms of traumatization as we can—whether that trauma stems from a single incident or complex and repetitive events—we need to have a more nuanced view of the problem and the solution. These nuances are addressed in the growing literature on Complex PTSD and development of specialized protocols within EMDR therapy. A key to the both/and framework for trauma-focused care is to include the great work of theoreticians, researchers, and practitioners who have given years of attention to these matters.

Evidence of the second hurdle can be found in the history of turf wars within the field of psychology. These wars are by no means over, but significant progress toward settling them has been made by the folding of spiritual psychology, complementary medicine, East-meets-West interventions, and many other integrative strategies into the care of those suffering from mental and emotional difficulties. The literature on spiritual psychology and its role in mental health has grown significantly over the past 20 years (Hill & Pargament, 2008). Complementary medicine, including acupuncture, massage, and yoga, has entered the mainstreams of medicine and mental health treatment. The meeting of East and West has manifested in many quarters, most significantly in the advent of mainstreamed mindfulness therapies (Aich, 2013).

Even with these advances in the world of both/and, many practitioners and other experts continue to plant their flag on one side or the other. Such exclusionary mindsets are not unique to the scientist; those more squarely located on the spiritual side of the fence can become just as attached to their views. These stances are the last vestiges of the long battle between matters of the spirit and of science. Throughout the 20th century, and then amplified by the social media culture of the 21st century, many have claimed to have found “the answer.” They have discovered the magic formula. The cure/fix/panacea can be found in the form of a seven-item checklist in a blog post.
that went viral, with a TED Talk attached. Sometimes there is substance to be found, but the main object is too often the marketing of a brand.

Some of the greatest battles have been between those professing a medical model for treatment and those proposing a more psychosocial and/or spiritual approach. And while there has been great progress in bringing both sides to the negotiating table, there is certainly more work ahead. This book’s emphasis on trauma-focused care hopes to be inclusive and integrative, generating a movement of our healing communities toward holistic solutions.

MINDFULNESS

This brings us to Buddhist mindfulness and EMDR therapy. The historical Buddha did not come up with a number of techniques designed to be helpful in difficult spots and used in a pinch. He devised a comprehensive system of psychology and spiritual practice that was the result of a long-running scientific experiment he performed on himself, 2,600 years ago, without the aid of brain-scanning equipment or randomized controlled studies. The Buddha chose to look inward and, from an objective viewpoint, deeply probe the nature of the mind—his mind. He used the technology of the day, most of which had been created by spiritual seekers and teachers in India, alongside a fully formed system of medicine, Ayurveda.

Siddhartha Gautama’s first experiment came when, as a sheltered prince, he left the palace grounds where he had spent the 30-some years of his life. Outside those walls he found the reality of suffering in the forms of sickness, old age, and death, and was drawn to the monastic life. For the next several years, he traveled throughout India seeking teachers who could impart to him the wisdom and skills to calm the mind and to bring peace to himself and others. By this time he was a renowned ascetic, living in denial of the body with the goal of emboldening the spirit. It was then, as he sat beneath what would become the Bodhi tree, that he had his initial enlightenment experience—the recognition of the need for a Middle Path to healing, or an integration of the mind and the body. He arrived at his answer through a single-case study: through direct experience and direct observation, a scientific application of the mindfulness and concentration he had developed over more than a half-dozen years of inquiry (Batchelor, 2010). The Buddha did not immediately know how to explain this experience, and at first vowed to remain silent about it because he believed no one would understand it. When he finally tasked himself with teaching, he went to the science of the time to explain his system of psychology.

His model will look very familiar to the Western medical practitioner: a diagnosis is presented, the symptoms and causes are revealed, the cure is offered,
and a prescription to enact the cure is designed. In the first of his Four Noble Truths, the Buddha provided a diagnosis of the core problem of life: suffering. The Second Truth speaks of the symptoms and causes of this suffering: Pain is a guarantee in this life, but suffering is caused by craving, clinging, aversion, and unhealthy attachment to material things, people, results, and experiences. Simply put, the problem lies not in the experience of pain but in our interpretation of it. He quickly provides the cure for this in the Third Truth: Get into and through these causes and conditions to end the suffering. And finally, the Fourth Truth lays out the Buddha’s prescription—the Eightfold Path.

This prescription is a complete system that contains all the hallmarks of what modern helping professionals work with our clients to accomplish. We want them to grow in wisdom and self-understanding. We help them identify and deal with blocking beliefs so that they may set healthy intentions. We hope that they can speak, act, and work in ways that lead to continued growth and more skillful, adaptive ways of being (Bodhi, 2006).

The Buddha very clearly informed his adherents that he was not God. As to whether a God existed, he did not offer a definitive position. He was, however, definitive about his teaching: the end of suffering—a concept that could easily fit on the shingle of any psychotherapist’s office or serve as a branded meme on social media. But consider his ultimate goal from a much deeper place: To truly conceptualize and internalize an end of suffering, it is important to understand what this system of healing entailed.

The most remarkable aspect of his approach at the time (and that remains so to this day) is his focus on mindfulness. One could say that the entire Eightfold Path described in the prescriptive Fourth Truth is ultimately about mindfulness. Breaking it down, one could hone in on the fact that the last three elements of the path—effort, mindfulness, and concentration—specifically address mindfulness meditation as central to his solution. What made the Buddha unique was his focus on mindfulness and concentration. Many meditation masters of the time used deep states of concentration to perform great spiritual, physical, and psychological feats. The Buddha, however, believed that these feats were primarily self-serving, and that an objective, mindful awareness of the reality of suffering and other inherent realities of life would provide a deeper, direct experience and result in physical, spiritual, ethical, and psychological wellness (Batchelor, 2010).

In his formulation, Buddha proposed that mindfulness, ethical living, and wisdom are intimately connected. Although the Eightfold Path is laid out as a list so that it may be read and understood, it might better be perceived as a wheel. Certainly, the path does not seem like a straight line most of the time, much like our own lives and the lives of our clients. However, “right understanding,” the first element of the path, speaks to the need for at least enough wisdom to believe that following these steps might be a good idea. The second factor—“wise intention”—brings purpose and completion to wise thoughts (Bodhi, 2006).
Then we step into the three ethical factors of speech, action, and livelihood, where our clients (in their lives) and we (as practitioners) reap further wisdom and take opportunities to apply newfound mindfulness skills. In many modern formulations of mindfulness, the emphasis is on skills training rather than ethical factors. For our purposes, the successful application of mindfulness, as well as the reevaluation and future template work in Phase 8 of EMDR therapy, depends upon these real-world examples of how mindfulness can manifest in everyday life. The Buddha’s conception was that if we are consistently attempting—through speech, action, and livelihood—to live mindfully in the world, we will create infinitely less suffering for ourselves and others. This creates a snowball effect: greater wisdom leads to better day-to-day living, which leads to a growing sense of peaceful and mindful awareness.

So now mindfulness has entered the mainstream of Western psychology. There are debates over its efficacy, its proper use, and the diagnoses for which mindfulness practice is indicated, but these are healthy discussions that bring the importance of mindfulness into clearer view. Mindfulness is a useful component of recovery from any number of ailments and injuries. This becomes evident upon examining the new landscape of mindfulness-based therapies, which include dialectical behavior therapy, mindfulness-based cognitive behavioral therapy, mindfulness-based stress reduction, and many other formulations either proposed, in development, or currently in use. Clinicians are using mindfulness at the center of treatments for such problems as depression, anxiety, PTSD, addiction, and personality disorders.

How does this holistic view of mindfulness synch so elegantly with EMDR therapy? The AIP model, the eight-phase protocol, and the three-pronged protocol (i.e., past–present–future orientation in clearing targets) also represent a complete system of psychology. Embedded within EMDR therapy are several elements addressed by mindfulness, including stabilization, grounding, resourcing, and the ability to toggle between somatic and cognitive experience. Helping the overly cognitive person to discover a somatic experience, or helping someone who cannot connect the body and the mind, are baseline needs for the trauma-focused therapist.

The original Phase 1 and Phase 2 toolkit designed by Shapiro for these needs was incredibly useful, if ultimately incomplete (Dworkin, 2005; Greenwald, 2007; Korn & Leeds, 2002). Many EMDR theorists and practitioners have filled gaps in Shapiro’s work, adding or subtracting as necessary to meet needs of the complex client—those with dissociation or with fearful or dismissive attachment styles. The redefined paradigm for trauma-focused care proposed in this book suggests that Buddhist and other forms of mindfulness represent a complete system within EMDR therapy. Mindfulness allows a client to achieve the level of integration that will empower them to do trauma reprocessing and achieve the desired level of relief from symptoms and the resulting full integration of memories.
The feeling is mutual when the roles are reversed. EMDR therapy provides a missing piece to mindfulness in the context of treating the difficulties that are coming into our office in the 21st century. A story about the Fourteenth Dalai Lama is pertinent here. The Dalai Lama is a lover of science, with an infinite curiosity that has resulted in his creation of the Mind and Life Institute, which has hosted conferences on scientific subjects for more than 25 years. He has also written extensively on scientific topics. At one conference he asked a group of Western psychologists, “What are your most common presenting issues in treatment?” The clinicians got together and gave a group reply: “low self-esteem, even self-hatred.” The Dalai Lama and his translator got into a spirited discussion, after which the Dalai Lama replied: “We don’t have a word for this in Tibetan.”

He went on to discuss some of the Buddhist mindfulness teachings regarding impermanence and the lack of a solid self that one can proclaim as the self at any given moment (Kornfield, 2010). That, and the fact that the ethical factors of the Eightfold Path look outward toward helping others as opposed to building the ego, leads to a lack of this self-hatred dilemma in a Buddhist culture, according to the Dalai Lama and others. The development of care and concern for others and for oneself as part of the larger human community is another element of this culture, a feeling of loving kindness and compassion that acts as a frontloaded antidote to ill will, including ill will toward self.

If a person of the 21st century who is not from a Buddhist upbringing attempts to develop a mindfulness practice without also addressing any attachment, developmental, or event-based traumas, that individual may not be able to easily enter or maintain the Eightfold Path. The Buddhist teaching of not-self does not resonate with or may even result in harm to someone who needs to build some ego strength to move more adaptively through life. EMDR therapy itself is a mindfulness practice for both clinician and client that results in the dedicated reprocessing of material that then allows for a more settled and comprehensive relationship with the classical mindfulness practices. With the advent of EMDR therapy, we have arrived at a place where people can heal from their difficulties in such a way that their wisdom is built, they can set wise intention, and they can live a more adaptive life as described by the Buddha. They can continue to build that life through continued mindfulness practice.

Buddhist mindfulness provides a great deal of the preparation required of the EMDR client, then trauma is reprocessed and future templates are installed using the remainder of the eight-phase protocol. Clients can provide their own aftercare with Buddhist psychology and mindfulness, or another mindfulness path that deepens the direct life experience of the practitioners. Again, Buddha taught suffering and the end of suffering. EMDR therapy has brought the end of a specific and exacerbated grade of suffering to
hundreds of thousands of people over the past 25 years. It seems like it has become part of our Right Understanding, a path to a deeper wisdom, a path to a more adaptive life. This indeed is the framework for the new paradigm for healing.

THE FUSION OF MINDFULNESS AND EMDR THERAPY

Mindfulness can be defined as the practice of coming back to awareness. Defining mindfulness in this way becomes very useful in working with clients, especially those who believe that they can’t meditate. Here is a short list of excuses that you may have heard from clients:

- “I can’t sit still.”
- “Meditating makes me more anxious.”
- “Getting that quiet makes me nervous.”
- “I’m a failure at doing it right.”
- “I’m not really a spiritual person.”
- “Meditating goes against my religion.”

Many clients struggle with beginning to embrace meditation because of stereotypical, religiously charged images of mindfulness that abound, such as the shaven-headed Buddhist monk in robes on retreat. Images of the modern mindfulness movement—like sitting in a perfect cross-legged position beneath a tree on a beach while clad in trendy yoga clothing—are no better because they portray mindfulness as total peace, relaxation, and stillness. The reality of the practice is much more complex and rich: a sea of thoughts, images, emotions, and distractions will come at anyone who seeks to meditate or engage in other activities of daily living. The challenge is in learning how to stay present and aware with whatever life may bring—good, bad, or neutral. By regarding mindfulness as the practice of coming back to awareness, clinicians recognize that attention will drift and wander. Neither this wandering nor these reactions make one any less of a person. They make us human. Highlighting this reality for clients may help them shed some of their preconceived notions about mindfulness and meditation and feel more inspired to give the practice an honest attempt.

The modern world is rife with distractions and expectations that battle for our presence, attention, and focus. Mindful practice is not about making those distractions and triggers go away—they are always going to be there. To be a practitioner of mindfulness, neither client nor clinician...
need strive to be that Buddhist monk or that perfectly still meditator beneath a tree. We need simply to practice paying attention; practice bringing awareness back to the present moment when we notice that awareness is drifting. One of the gifts of mindfulness practice is that we can better recognize when our attention is wandering or when visceral responses are flaring up in the body. It is little wonder that mindfulness teachers explain the practice as exercising our metaphorical awareness muscle. The clinical value of such practices is obvious, particularly as clients prepare for EMDR therapy.

The English word *mindfulness* in the context of Buddhist practice was not coined until the 1800s. “Mindfulness” generally refers to both the Pali word *sati* (*sarati* in the verb form) and the Sanskrit term *smrti*. There are subtle nuances in the translations that can be noted and mined for clinical value. Arriving at an exact definition is not as important as considering some of these translational insights and recognizing those that may resonate with the individual. Clients and clinicians can recognize those resonances and let them enrich a personal practice. In addition to mindfulness as the practice of coming back to awareness, modern Theravadan Buddhist teacher Bhikku Bodhi’s reflections on the limitations with the word *mindfulness* are significant:

The word derives from a verb, *sarati*, meaning “to remember,” and occasionally in Pali *sati* is still explained in a way that connects it with the idea of memory. But when it is used in relation to meditation practice, we have no word in English that precisely captures what it refers to. An early translator cleverly drew upon the word mindfulness, which is not even in my dictionary. This has served its role admirably, but it does not preserve the connection with memory, sometimes needed to make sense of a passage. (Inquiring Mind, 2006)

Bodhi’s observation, excerpted from a larger interview he gave on translating Buddhist teachings, suggests that the translation and what it means to practice can vary among practitioners and traditions. The role of memory in the very meaning of the practice is also of great importance. Consider how memory as an essence of mindfulness practice furnishes a golden link between mindfulness and EMDR therapy.

EMDR therapy allows for some talking and asking of questions, which can be important in human relations. However, the level of silence and introspection that the EMDR approach promotes is a major component of its effectiveness for so many people. This silence, generally experienced during the application of bilateral stimulation, allows clients to go within and simply notice internal experience, a process that allows them to arrive at their own insights and solutions instead of relying on the “expert” therapist to unveil the answers. The underlying assumption of EMDR therapy is that human suffering results from physiologically stored, unprocessed memories.
(Shapiro, 2001; World Health Organization, 2013). The AIP model, which Shapiro presents as a framework for explaining EMDR, gives clinicians a road map for helping individuals alleviate their own suffering by reprocessing these memories. The methods and mechanisms that EMDR therapists learn to apply can facilitate this healing, and they are constantly learning new, more artful ways to use these skills within the context of the therapeutic relationship.

Many clinicians who arrive at EMDR trainings are looking for new ways to help their clients. They’ve learned that talking about traumatic experiences is not enough to bring about lasting change. Many report that they’ve been the trauma champion in their agencies or hospital settings for years, often ridiculed or scorned for wanting to focus on trauma in conceptualizing cases. In the EMDR approach to psychotherapy, such a trauma focus is not looked down upon; it is celebrated. “What role is trauma playing in this clinical presentation?” is the question that defines conceptualizing cases in the EMDR approach. With EMDR therapy, you are empowered with a set of skills to help clients reprocess traumatic memories and essentially heal themselves, reducing the impact of suffering in their own lives and in the lives of others around them.

EMDR therapists use classic phrases like “go with that” or “just notice that” as the bilateral stimulation is applied and the storage of traumatic memories moves and shifts. However, EMDR clinicians and clients may find themselves using these phrases in other aspects of living. EMDR therapists can actively encourage this process as they teach clients to carry the fruits of their therapeutic experiences into the arena of daily life. Consider Alex, a college student in her early 20s who presented for clinical services due to crippling anxiety. Alex noticed immediately through client history, preparation, and the first few sessions of reprocessing that her anxiety was clearly linked to obsessive thoughts about things and situations that would likely never play out. Through the mindfulness skills Alex’s therapist taught in preparation and the practice of “just noticing” that Alex learned in EMDR therapy, she began to notice the first signs of obsession in day-to-day life. This early awareness became evident by noticing subtle distresses in the body. As she learned in the EMDR process, Alex continued to “just notice” the body level distress if it flared up, instead of stewing about it further or engaging in an unhealthy behavior like binge eating. Alex learned to notice it fully, without judgment, as she breathed. No specific use of bilateral stimulation or dual attention stimulus is needed in the context of life. Simply noticing can prove to be a helpful practice, in and of itself, for helping clients learn to deal with the stressors of daily life and build a greater sense of mind–body awareness.
TYING IT ALL TOGETHER

Mindfulness practice, as described in a classic metaphor by Jon Kabat-Zinn, can teach people how to surf when waves of stress and emotion come rolling in. Dr. Bessel van der Kolk (2014), an important figure in advancing scholarship on trauma, explains that mindfulness practice allows the executive brain to inhibit, organize, and modulate the hardwired automatic reactions preprogrammed into the emotional brain. In his landmark work, *The Body Keeps the Score: Memory and the Evolving Psychobiology of Posttraumatic Stress*, he summarizes the following benefits of this process for survivors of trauma:

- Traumatized people are often afraid of feeling—mindfulness practices can help orient them to and ease them into this process by widening sensory experience.
- Practicing mindfulness is calming to the sympathetic nervous system, lessening the destruction of fight/flight responses.
- The practices help to promote distress tolerance as awareness develops that emotional states constantly shift.

There is a treasure trove of information here for EMDR therapists. Why wouldn’t we align these benefits into our practice of EMDR? There are so many natural combinations of these practices that can enhance the flow of EMDR therapy. By weaving mindfulness into the early phases of EMDR, we offer an enhanced experience for our clients, especially by widening their affective windows of tolerance, which is vital in the reprocessing phases of EMDR as we target the trauma. As we bring EMDR therapy to a close, we can discharge our clients with a wide set of mindfulness skills that they can continue to access after therapy formally terminates, skills that are vital for resilience and continual adaptation to the circumstances, stressors, and suffering that is the human experience.

QUESTIONS FOR REFLECTION AND PERSONAL PRACTICE

- What is my personal, working definition of mindfulness?
- How am I already practicing mindfulness in my daily life, even if I don’t have a specific meditation practice?
- What are some of the similarities, links, and points of fusion I’ve already started to notice between mindfulness practice and EMDR therapy?
REFERENCES


EMDR Phase 2, Preparation in Trauma-Focused Care

MINDFULLY NAVIGATING THE PREPARATION PHASE

Consultees in EMDR therapy consistently pose these questions:

- How much preparation is considered sufficient in Phase 2, Preparation?

- How do clinicians know when a client is truly ready to plunge into the deeper work of trauma reprocessing in Phases 3 through 6?

- How stable does a client really have to be in order to manage these trauma-reprocessing components that many see as the heart of EMDR therapy?

If you gathered 10 EMDR consulting therapists around a conference table, it’s very likely you would get 10 different answers to these questions. Many believe, especially in working with complex trauma, that the reprocessing phases of EMDR therapy ought not to commence until a person is adequately stabilized. Others follow Dr. Francine Shapiro’s caution to the letter, as noted in her 2001 work, *Eye Movement Desensitization and Reprocessing: Basic Principles, Protocols, and Procedures*, that preparation is not processing, and believe that the real work of EMDR cannot be achieved until traumatic memories are targeted. A popular literature review conducted by a team that included many EMDR therapists challenged long-held recommendations by the 2012 International Society for Traumatic Stress Studies
expert task force (Cloitre et al., 2012) for the implementation of an extensive stabilization phase with complex posttraumatic stress disorder (PTSD) survivors (De Jongh et al., 2016). This research review concluded that (a) there is no substantive research base for the task force’s recommendations for such an extensive period of stabilization, and (b) complex PTSD survivors are better served by more trauma-focused treatments, even though there is some risk involved. Refined clinical judgment is imperative in managing that risk.

Navigating the intricacies of preparation involves much more finesse than making sure clients can get to a Calm Safe Place. In contrast, Phase 2 does not suggest that a client must achieve a perfect state of stabilization to handle the reprocessing phases of EMDR therapy (Phases 3–6). Many therapists are reluctant to take clients into these post-preparation phases, fearing they are not stable enough to handle them. In stymieing the flow of EMDR therapy out of their own fear and trepidation, clinicians may be preventing their clients from getting the help they need via processing to become more stable. It’s noteworthy that Shapiro chose the word “preparation” in naming Phase 2 instead of “stabilization,” the word used in the consensus model of trauma treatment referenced by the ISTSS task force tracing to the early work of Pierre Janet. Stabilization is a big word that sets a high standard. Preparation, deriving from the Latin praeparare, meaning “to make ready beforehand,” truly focuses on the aspect of readiness. Consider how the questions that opened this chapter might look if clinicians embraced the challenge to engender readiness in their clients:

- What activities do I have to engage in with my clients to get them ready for trauma reprocessing?
- What kind of tone needs to be established in our therapeutic relationship?
- What other factors of living must be at least addressed (e.g., living situation, nature of support, secondary gains) to help the client and therapist feel more secure about taking a journey into the later phases?

As a foundation, Phase 2, Preparation, must include introducing clients to mindfulness practice—this core assumption informs the chapter. Such training can allow clients to enhance their coping skill repertoire, build internal resources, and widen their affective window of tolerance. Special attention is paid to the role that cultivating mindfulness practices can play in heightening distress tolerance. Allowing for this practice in the Preparation phase will allow for successful trauma reprocessing in the later phases of the protocol. The information offered in this chapter guides both seasoned EMDR therapists and those who are newly learning EMDR in how they can
deliver EMDR Phase 2, Preparation, in a more trauma-focused manner by attending to it mindfully.

A TRAUMA-FOCUSED APPROACH TO PREPARATION

The Broader Context for Healing Trauma

In his landmark work *The Body Keeps the Score*, Dr. Bessel van der Kolk (2014) asserts, “For real change to take place, the body needs to learn that the danger has passed and to live in the reality of the present” (p. 21). Van der Kolk expounds three key pathways to intervention that can help survivors of trauma feel alive in the present and live a more adaptive, transformed life:

- **Top-down methods**: talking, connecting with others, self-knowledge,
- **Technology**: medications to shut down inappropriate alarm reactions; other therapies/technologies that change the way the brain organizes information, and
- **Bottom-up methods**: allowing the body to have experiences that deeply and viscerally contradict the helplessness, rage, and collapse that result from the trauma

Many clinicians operate from only one of the pathways to intervention, all of which correspond with MacLean’s (1990) triune model of the brain. For instance, clinicians whose main skill set involves helping clients to talk out their problems, develop a support network, and acquire a mountain of psychoeducational knowledge about what ails them are primarily working with the neocortex (i.e., the more rational brain unique to primates). In the field of addiction recovery, many programs believe that this “top down” style of intervention is enough. However, much of the damage caused by unprocessed trauma affects the lower brain (i.e., the limbic/mammalian brain and the brain stem). Thus, the styles of intervention Van der Kolk describes as technology and bottom-up methods are also required for total healing to take place. He emphasizes that a combination of all three styles of intervention is needed for optimal healing to occur.

EMDR therapy encompasses all three pathways to intervention. This chapter addresses how the trauma-processing phases of the EMDR standard protocol bring about deep visceral experiences that can contradict and transform trauma’s legacy in the body (Phases 3–6). Some of the preparation skills described in this chapter can initiate the process of healing at this bottom-up level. At the very least, engagement in these exercises can help to strengthen or frontload more adaptive material. In EMDR therapy, maladaptive material links with adaptive material for successful processing to occur.
Some clients arrive at EMDR therapy with more adaptive material than do others. The absence or dearth of adaptive material and experiences does not rule out further phases of the EMDR journey; it does mean that more time will need to be spent in Phase 2, Preparation, engaging in what Shapiro calls “frontloading.” Quite literally, frontloading is the practice of helping clients acquire healthy, adaptive, or transformative experiences, even something as simple as finally connecting with a deep cleansing breath, in the Preparation phase. Teaching mindfulness skills as part of Phase 2 enhances the process of frontloading, which, according to Shapiro, allows for greater generalization effects in the latter phases of EMDR therapy. The specific skills of mindfulness, whether or not bilateral stimulation is used in Phase 2, can be an active ingredient in both bottom-up healing and top-down healing. A commitment to being mindful in your personal practice can help you more strongly attend to the therapeutic relationship you establish with your clients, a vital aspect of both bottom up and top down healing.

**Filling Out the Missing Pieces**

**RESOURCE DEVELOPMENT AND INSTALLATION**

In 2012, Stephen Dansiger conducted a series of short video interviews with Dr. Andrew Leeds regarding EMDR therapy. In one of these videos, Dr. Leeds described the genesis and the history of the Resource Development and Installation (RDI) protocol, which has often been called the “missing piece” of Shapiro’s original standard protocol (Dworkin, 2005; Korn & Leeds, 2002; Sonoma Psychotherapy Training Institute, 2012). Leeds described how this protocol developed out of a series of treatment failures, particularly with one client. This complex client would go into what Leeds called a “shame meltdown” every time they went into the standard reprocessing.

The client came into session one day and described a positive image she had in a dream, the type of positive image the client had previously been unable to identify, let alone hold onto. Leeds asked her if she wanted to try and “install” that image using slow passes of eye movements. The client agreed and the results were very positive. Over the course of about 45 minutes, they installed other positive images and beliefs. In a sense, they were frontloading the experience of the Installation phase of the standard protocol, since the client could not get there through standard reprocessing. When the client returned the next week, Leeds found her “almost unrecognizable.” The gains included improved sleep, abatement of physical symptoms, and greatly reduced anxiety. Perhaps most importantly, after this successful foray into installing the positive, they returned to the work of trying to reprocess the client’s trauma. As a result of their resourcing, the standard protocol went smoothly, bolstered by this new foundation of positive neural networks.
Leeds (2016) insists that the protocol itself has its roots in the work of others, but that he did in fact take it out of its fragmented state and its focus on specific populations (such as Ron Martinez helping children to visualize themselves as superheroes) and solidified it into the form of a now widely used protocol. Leeds contacted Shapiro and suggested he would like to teach this method in advanced EMDR trainings. Shapiro suggested that its success may have been unique to Leeds’s skill set, so they agreed to have other EMDR institute trainers try it out. Those other trainers reported the same positive results. It was formalized into a protocol, and the case that began it all was documented in Philip Manfield’s *EMDR Casebook* (2003).

Like the Preparation and Closure work suggested by Shapiro with Calm Safe Place, Light Stream, and Container, the RDI protocol (Leeds, 2016) uses visualization as its driving force. Internal resources are identified, and then four types of manifestations of these resources are visualized: mastery resources, role models, coaches, and symbolic/metaphorical resources. Mastery resources are those events or phases of life where the client was able to access and act upon those resources. Role models are those people who represent the successful manifestation of those resources. They do not have to know the person; it could even be a fictional character or a public figure. Coaches are those people who also display those resources and would be helpful if they were right there in the moment, encouraging and coaching the client. Finally, symbolic or metaphorical manifestations are identified, for instance, a tree, which represents strength and flexibility in the way it moves with the wind but has strong roots. All of these are visualized and strengthened using slow, short sets of bilateral stimulation. Two versions of the RDI protocol can be found in Leeds’s 2016 *A Guide to the Standard EMDR Therapy Protocols for Clinicians, Supervisors, and Consultants*, Second Edition (pp. 371–375). While Parnell (2007, 2013) and others have adjusted some of the language around what may be visualized, for the most part the flow of the protocol has remained the same: discover new resources and identify already existing ones; visualize one identified resource; strengthen with slow, short sets of bilateral stimulation; and be open to more adaptive responses in the visualization and continue to strengthen those as needed.

The discovery of the wisdom of frontloading resources, and the development of the RDI protocol to allow for clients to titrate their way into reprocessing through building the positive, opens the door to an almost endless variety of resources. Much like we have suggested that Calm Safe Place, Light Stream, and Container are not necessarily enough, RDI and its visualization emphasis contain only part of the story. Mindfulness skills can be fundamental elements of the resourcing picture that allow clinicians to work with more than just the visual domain.

Using the Four Foundations of Mindfulness, a primary teaching of the Buddha, clinicians can witness how this might be implemented. Mindfulness
of the body allows clients to become more aware and more connected with
their present time experience. Mindfulness of feeling tone, where all expe-
rience is seen as pleasant, unpleasant, or neutral, can simplify and balance
out the extreme edges of the client’s experience. Mindfulness of mind and
mindfulness of dharmas (conceptual thought) can be utilized to resource a
client when applied from a positive direction. For instance, a client can be
guided through the Heart Practices, which allow the client to access and
install the resources of Loving Kindness, Compassion (for self and others),
Appreciative Joy, and Equanimity. Clinicians can use their own mindfulness
practice and clinical judgment to assess which of these mindfulness skills
would most resonate with and be successfully installed with each client.

One of the keys to helping our clients to identify and develop their in-
ternal resources is our own commitment as clinicians to our own practice of
mindfulness. Our own practice serves as a resource through our modeling
its practice and benefits, as well as through whatever psychoeducation we
need to provide in order for the client to understand and pursue mindful-
ness skills. Another reason for developing further mindfulness for ourselves
is that we can maintain a deeper sense of presence in the therapy room.
Mindful attunement to the client’s experience will result in more skilled
judgment as to what type and degree of resourcing our clients will need in
order to prepare for reprocessing. That mindful presence brings us to the
next missing link: the relational elements of EMDR therapy.

**THE RELATIONAL IMPERATIVE IN EMDR THERAPY**

Shapiro (2001) teaches that EMDR therapy is an interaction between client,
clinician, and method. In his landmark work, Mark Dworkin (2005) went
a step further by proposing that relational issues between client and clini-
cian often impact whether EMDR therapy results are positive or negative.
The vital role of the therapeutic relationship as a mechanism of change
within larger psychotherapy has been long established (Duncan, Miller,
Wampold, & Hubble, 2009). Dworkin’s work continued with a paper (along
with Nancy Errebo) offering EMDR clinicians direct suggestions for how
to repair breaches in the therapeutic relationship; in other words, how to
attend to the relationship when the client senses something has gone wrong
(Dworkin & Errebo, 2010). EMDR is now regarded as a distinct approach
to psychotherapy, rather than a simple technique. Thus, it is important that
we EMDR therapists regard this larger truth of the field—the transforma-
tive power of the relationship as an element in the change process—and
integrate it into our work with EMDR clients.

Attending to relational matters is an important component of laying the
groundwork in Phases 1 and 2. Having this strong foundation will serve
your client throughout the remaining phases of EMDR therapy, particularly
when it comes to navigating difficult clinical decisions around case conceptualization. In Marich’s qualitative phenomenological study investigating how EMDR therapy was implemented as part of addiction continuing care with women (2010, 2012), the participants contributed a wealth of thematic insight into the role of the relationship with their EMDR therapy. The women who described initially negative experiences with their EMDR therapist used words/phrases like rigid, scripted, unclear, and not comfortable with trauma work to describe the therapists. The two women who had these unfortunate experiences found their opinions about EMDR and how it worked for them transformed as soon as they switched to a new therapist. They described the new therapist using words like natural, wonderful, intuitive, smart, and having good common sense. Consider how embracing a commitment to mindfulness and a mindful approach to EMDR therapy can assist you, as a clinician, in cultivating these qualities.

NECESSARY SKILLS FOR PREPARATION AND THE ART OF MODIFYING THEM

NO SUCH THING AS “ONE SIZE FITS ALL”

There is no such thing as a simple set of steps you need to follow to perfectly complete EMDR therapy Phase 2. The EMDRIA (2012) definition of EMDR therapy is open to a great deal of clinical finesse, depending on the needs of the client. According to the definition, the key aspects to cover in Phase 2 are:

- Orienting the client to EMDR therapy sufficiently so client can give informed consent.
- Establishing a therapeutic relationship to give the client a sense of safety and foster the client’s ability to tell the therapist what they’re experiencing throughout the reprocessing.
- Developing mastery of skills in self-soothing and in affect regulation as appropriate to facilitate dual awareness during the reprocessing sessions and to maintain stability between sessions.
- Promoting the development and expansion of positive and adaptive memory networks, thus expanding the window of affect tolerance, and stimulating the development of the capacity for relationship (especially critical for complex trauma).

The definition also cautions that some clients may need lengthier preparation than others, especially if more frontloading of adaptive material is needed.
To achieve these key aspects of Phase 2 in our delivery of EMDR therapy, clients ought to learn skills for affect regulation and expanding distress tolerance that can be grouped into these major categories:

- Mindfulness and grounding strategies
- Breathing strategies
- Visualization and multisensory soothing
- Movement, expressive arts, and identification of other recovery capital

In the pages that follow each category is covered, with attention to issues of implementation. A major part of implementation is knowing how to modify the exercises when clients tell you, “I can’t meditate; I can’t sit still,” or “Breathing makes me more anxious.” In covering each category, skills covered in previous chapters are referenced, and some new material is shared in this chapter.

The depth and breadth of preparation material can include skills that do or do not directly work with slow bilateral stimulation/dual attention stimulus. For guidelines on applying bilateral stimulation to the various skills as a resource, which will be important for at least some of these skills before moving into the later phases of EMDR therapy, refer to the earlier section in this chapter on RDI (Leeds, 2016). Once you and your client come to understand the value of slow bilateral stimulation as a mechanism for strengthening adaptive connections to resources, you discover that literally anything adaptive can be strengthened, tapped in, toned in, or locked in using eye movements. For some clients, the bilateral stimulation can overwhelm at first. You may be better served to first teach the skills as they are written, without any stimulation. If the client shows a good response, you can integrate slow bilateral movements or another dual attention stimulus for strengthening. Other clients may require the bilateral components to engage with the exercise. Get accustomed to gathering feedback from the clients about which style or combination of skill styles is working for them and be prepared to adapt your preparation plan accordingly.

**Mindfulness and Grounding Strategies**

Van der Kolk (2014) makes a powerful case for how mindfulness practice can benefit survivors of trauma. He notes that traumatized people are often afraid of feeling, and that mindfulness practices can help orient them to and ease them into this process by widening the sensory experience. Practicing mindfulness can be calming to the sympathetic nervous system, lessening the destruction of fight/flight responses. Mindfulness practices also help
to promote distress tolerance as awareness develops that emotional states constantly shift. Hopefully, if you are already an EMDR therapist, you are connecting some dots about how teaching these skills in advance of trauma reprocessing may allow for these phases to progress more smoothly (Phases 3–6).

A significant skill cultivated through mindfulness practice is that of grounding, which literally and figuratively challenges us to find a foundation and be able to remain there. If individuals are unable to remain there, through practice, they can learn to return there. Having a workable set of grounding skills is particularly important when treating dissociative clients or those with complex trauma. If a client can continue to stay grounded in the trauma reprocessing phases of EMDR, they will be much more likely to stay within their affective window of tolerance and not push themselves too far with their reprocessing. In the event abreactions or other elements of reprocessing take an unexpected turn, being able to return to a grounding element at any time throughout the session is crucial. Remember the age-old axiom that an ounce of prevention is worth a pound of cure? Frontloading clients with as many skills as possible defines proactive prevention in EMDR therapy.

For orientation to many of the classic skills within the tradition of mindfulness, please refer to Chapter 3. Clients may balk at learning some of these skills. Many clinicians are tempted at this juncture to abandon the interventions as not working. Please do not give up so easily. Recall, if you can, the frustrations you’ve personally experienced when learning something new. From this place of lived experience, you can genuinely share on how you’ve dealt with working through frustrations in your own practice. People can set themselves up to fail with meditating because they are transfixed with some perfect picture, fresh off the cover of *Time* magazine, about what meditation “should” look like. As people, we think that if we can’t get to that perfect stillness, we’re not really meditating. If you’ve explored the book to this point and have explored some of the practices, you know that nothing can be further from the truth. The practice of mindfulness is not about clearing your mind or staying perfectly still; the practice is about returning to the moment or to the object of your focus when the attention wanders. Something as simple as clarifying client expectation about what meditation even means can inspire the client to give the practices another attempt.

In trauma-focused care, modifications can always be made. If the time parameter that you, as the clinician, suggest for a practice seems too long, shorten the length of the practice. Some tips on how to do this are offered in Chapters 3 and 4. Also remember that developing consistent practice is more important than developing a lengthy one. If a certain practice doesn’t particularly resonate with a client or they are struggling in despair, consider sharing a mindfulness practice in another style.
Breathing Strategies

Several specific breath practices from the yogic traditions are covered in Chapter 4. They can be integrated throughout the phases of EMDR therapy as a resource for clients. So often in EMDR therapy clinicians say things like, “Take a deep breath,” especially when checking in for content during the later phases of EMDR therapy. Even this task can be tricky for clients if they’ve not yet moved passed holding their breath as a protective response. Steady breathing can assist in expanding a client’s affective window of tolerance. However, there is an art to teaching clients how to become more comfortable with their breath and to use it in the service of their recovery. Recognize that connecting with the breath in such a way can be much easier said than done for our clients who have been living in a state of hyperarousal.

Demonstrating Hyperarousal and Release

- Try something—if it’s physically available to you, go ahead and squeeze your shoulders up toward your ears. See how long you can hold them there.

- Notice what is happening to your breath as you tense your shoulders in this manner. It’s very likely that the breath is shallow or short.

- Now go ahead and release the clench in your shoulders and notice immediately what happens to the breath.

This simple exercise demonstrates how much the breath can be affected by living in hyperarousal. It’s often useful to take clients through this exercise if they ask you why doing breath work is so important to the healing process. Do not push, and remember that critical modifications for working with people too overwhelmed with breath are noted in Chapters 3 and 4. Clinicians must be mindful of teaching the practices in a way that pays special attention to how the practices themselves may be vulnerable or triggering. The notion that breath can be both a trigger and a resource is a central teaching in trauma-informed yoga. Many of the practices that we suggest throughout this book can be both a trigger and a resource, especially if modifications are not offered and if you do not work with client feedback.

Allowing for variability in time spent in practices is crucial. Also consider how being in silence for too long may be more distressing for certain clients. In our experience, people have different preferences on how much verbal instruction they may require during a meditation or a guided visualization. Sometimes clients will beg clinicians—in a very polite way, of course—to shut up if we are getting too wordy with leading one of our favorite exercises. It’s a good practice to get feedback from a client about
whether or not they want more or less of your verbal instruction during an exercise. For many clients, the sound of your voice can be anchoring and assuring whereas being in silence for too long can trigger distress. Another safety tip is that if you are leaving clients in silence for any length of time, let them know how long they are going to be in silence (e.g., “For the next minute verbal instruction will stop”) or in an exercise (e.g., “Let’s try six full inhales and exhales on this breath”). Finally, always assure your clients that closing their eyes is optional. Many clients get overly distressed when they are in the literal dark for too long, even if closing the eyes may have some benefits for promoting relaxation. In some meditation traditions, it’s advised to keep the eyes open, and following this lead is a solid best practice for introducing mindfulness skills and breath work to clients.

Multisensory Soothing

Shapiro and other writers on EMDR therapy have long favored guided visualization techniques for preparation, particularly the Calm Safe Place. Having one Calm Safe Place for a client to retreat is rarely adequate preparation, especially in cases of complex trauma. More importantly, EMDR clinicians must also consider that the Calm Safe Place exercise has a potential to be triggering for clients. In many EMDR trainings, clinicians are advised to help their clients choose a place that does not have people involved to minimize some of this triggering, although this can be difficult to avoid. For some clients, the disruptive or distressing elements just appear, even if clients start with every intention of using the exercise for soothing. Also consider that the Calm Safe Place exercise is a form of intentional dissociation. The exercise advises people to go to a place outside of themselves and the present moment. Clearly, it is not the most mindful skill to use. The Calm Safe Place skill can be useful with certain clients in certain contexts. However, if you are going to implement it with regularity, have other grounding exercises at your disposal for bringing people back into the present if the distress is heightened by the Calm Safe Place. While all preparation exercises run the risk of going awry and potentially serving as experiences for practicing distress tolerance, having the grounding anchor as a safeguard is advised.

In brainstorming potential anchors for grounding or other ways to promote adaptive self-soothing, think outside of the guided visualization box. Although many guided visualizations incorporate other sensory elements, why not actually bring in other sensory elements if they are available? Consider the use of textural elements like rocks, stones, and marbles. In the Preparation phase you can guide a client through a meditation, paying attention to the texture as the primary anchor of focus. Many clients have reported benefit from holding on to their rock, stone, or marble in the later phases of EMDR therapy as they are reprocessing trauma. The very object
is a reminder of holding your ground. Using essential oils, scented candles, or other smell elements can serve a similar purpose. You can also use spray bottles holding a mixture of water and several essential oil blends. Keep several of them around your office. Clients, after doing a gentle spray away from their body to test the scent, will have them available in your office to access both the textural element of feeling the water and the olfactory element of noticing the scent. In the Preparation phase, use of these multisensory elements can all be strengthened with slow bilateral stimulation/dual attention stimulus and then accessed when needed throughout the EMDR therapy.

Another skill for sensory grounding is walking meditation, with a focus on the sensation of the feet hitting the floor. Even in a small office, all that is needed is a four- to eight-foot walking path. Depending on the level of grounding needed, one can slow the walking to the level of super slow motion (like Jim Carrey in one of his films), and add verbal cues, either guided or self-guided. These might include “lifting,” “stepping,” “forward,” “placing,” and “grounding,” or verbiage that further deepens the client’s experience. For clients who are anchored and inspired by more poetic imagery, Thich Nhat Hahn’s guided cue, “as I walk, my feet are kissing the earth,” is lovely. The bilateral stimulation inherent in the act of walking also may help the client achieve a grounded state.

Listening to sound, whether nature sounds or music of the client’s choosing, is another option. Consider having your client make a personal playlist of particularly healing music in a genre or combination of genres. During Preparation you can experiment with strengthening these with bilateral stimulation; after the session, the client will have the music to access. Taste might be used in a similar way: Something as simple as strengthening the sensation and taste of one’s favorite tea as it moves through the body could be a valuable resource, as could the sensation of hot or cool water. In several of his autobiographical writings, the Dalai Lama (1990) shares that when he was a young man he drank large amounts of a Tibetan classic called butter tea. He eventually realized that his body was craving the warmth rather than the taste of the tea, so he switched to primarily consuming hot water as a stress reducer. In many of his works, he recommends drinking hot water and really connecting to the warming sensation.

Guided Visualizations

As you examine the following scripts for three visualization skills, consider where there may be room for improvisation and creativity in working with clients who may struggle with traditional visualization. This collection is by no means exhaustive. You can always encourage your EMDR clients or consultees to bring forward ideas for visualizations that they read in other
resources, EMDR-specific or not. These exercises can be used as general visualizations. You can use the bullet points as guideposts for where you can apply the slow, bilateral stimulation/dual attention stimulus if the responses you are getting are adaptive.

**Light Stream Multisensory Visualization Exercise**

- Imagine that a bright and healing light has begun to form overhead. This light can be whatever color you want it to be, whatever you associate with healing, happiness, goodness, or any other positive quality. If you don’t like the idea of a light, you can think of it simply as a color or an essence. What are you noticing?

- Now, think about this light beginning to move through your body or over your body like a shield or force field (your choice), from the top of your head, moving inch by inch, slowly, until it reaches the bottom of your feet. What are you noticing now?

- Spend a few moments just hanging out with the presence of this light or essence in your body. Notice if it has any other qualities besides color, like a texture or a sound or a smell. What are you noticing now?

- Draw your attention back to where you first may have cued your body stress. What’s happened to it? If the distress is still there on some level in your body, think about deepening your belly breathing so it makes the light or essence more brilliant and intense, so brilliant and intense that the distress can’t even dream of existing within it.

- Keep practicing the exercise, in the attitude of patience, if you don’t notice much of a shift the first time. If you have a spiritual practice and feel comfortable bringing in one of your spiritual or religious principles into the exercise, you are welcome to do that.

**Tree Grounding Visualization Exercise**

- Whether you are sitting or standing, notice the connection of your feet to the ground below you. Take a few moments here. Maybe pump your feet back and forth a few times and then let them come to stillness. Really be mindful of the connection.

- If this works for you, imagine that roots are coming out of your feet and shooting into the earth below you, like the roots of a tree.

- Notice the roots moving deep, deep, deep into the earth, through all of the different layers. Take a moment to just be with this experience. Think of yourself being firmly rooted in the earth, in the here and now.
MODIFICATIONS FOR CREATIVITY

- For children or willing adults, have them name what kind of tree they are (e.g., an oak, a banyan, an elm, a pine, etc.).
- If you have earth elements around your office, such as essential oils like cedar wood or pine, or even a Mason jar full of dirt (try it, it smells like the “good earth”), consider bringing those in—it can add to the grounding experience.

SIMPLE CONTAINER VISUALIZATION EXERCISE

- In this exercise, we will help you choose a visual that you can use to “pack away” memories, emotions, body sensations, or anything else that you are not quite ready to deal with, or that we may not have time to address in a specific session.
- Containers come in various shapes, and they can hold things for us that we are not quite ready to digest and address. What are some examples of containers that you can think of? A Mason jar? A shelf with a drawer? A piece of Tupperware? A tin? A backpack? Pick a visual representation of a container that works for you. Although many containers may work for this purpose, try to pick something that has great meaning or significance to you. What are you coming up with?
- Picture yourself opening the container. Send in or picture yourself placing whatever you may need to place in the container. Consider that this exercise is not about stuffing it away. It’s simply helping you to manage the negativity until you are ready to deal with it. What are you noticing now?
- Close the container. Notice the experience and any sensations that come up with closing the container. Remember to breathe evenly. What are you noticing now?
- If you wish, you can give your container a name or a phrase. You can use this to remind you of the container if you are feeling distressed.

Movement, Expressive Arts, and Identification of Other Recovery Capital

For clients who thrive on creativity, you can bolster the possibilities in Phase 2. The container exercise, a classic used by many EMDR trainers, offers numerous possibilities. Many clients prefer to make a container or bring in a vessel of some type to optimally resonate with the exercise. Clients have brought in backpacks that they’ve chosen to decorate and have with them as a physical symbol. Using a container like a shoebox or a plain jewelry box
(available at many craft stores) allows for decorating with markers, paint, and other collage elements that can be affixed with glue. Richard, a former EMDR client, decorated a coffee tin for use as a container. He brought it to sessions as a visual symbol. Between sessions, he would write what was bothering him on slips of paper and put it in the coffee can. Many clients in addiction recovery are accustomed to using a similar technique called a “God box,” with the box or the vessel being symbolic of a spiritual figure receiving what you are turning over.

Challenge your clients to explore outside of your office as part of their healing journey. Reconnecting or delving deeper into their hobbies and interests, or enrolling beloved pets as allies in the healing process are all viable methods for bottom up healing to take place. Many clients choose to receive bodywork or energy modalities like reiki as an adjunct to their psychotherapy. Great success can ensure when clients have connected with competent and trauma-sensitive providers. For many clients, seeking out or deepening connection with a faith community or church can also be helpful, although as clinicians take care to assess whether or not engagement with certain groups could potentially be replicating prior trauma dynamics. As clinicians we generally encourage exploration with resources and recovery capital, yet it is important to help clients evaluate whether these resources have more adaptive or maladaptive qualities.

Work with your client to develop a plan for how these resources can best be accessed. Addiction counselors have done this for years, recommending 12-step meetings in the community to clients. In this day and age, those recommendations are still relevant, and newer styles of fellowships such as Buddhist-based Refuge Recovery meetings are continuing to grow. Related to mindfulness and the holistic arts, perhaps you do some online searching with your clients, or suggest that they do some of their own research about meditation groups and classes now offered in many communities. Blue Star Family Counseling, a trauma-focused practice in Cortland, Ohio (where all clinicians are EMDR trained), offers a regular 8-week meditation class at a low cost. The same practice makes drop-in meditation groups and various styles of yoga available to their clients and to the larger community as well. Many in the Buddhist mindfulness and secular mindfulness community are finding their initial and ongoing teachings on podcasts, many, if not most, of which are free. For example, Against the Stream Buddhist Meditation Society posts many of the talks given at their Los Angeles and San Francisco centers, allowing students worldwide to take in talks and guided meditations for their use. Also, in addition to Buddhist centers, secular mindfulness centers set up in the tradition of yoga studios with drop-in classes are starting to pop up in many areas. Talks and guided meditations from a variety of teachers including Tara Brach, Jack Kornfield, Jon Kabat-Zinn, and others are freely available on YouTube and other distribution points.
Classes in yoga, tai chi, qigong, and other conscious dance or movement may also be viable options for your clients. Some basic movement practices appear in Chapter 4. If types of exercise resonate with clients, or if they struggle with them and you believe a well-guided class may help them to see the value of movement, consider making a suggestion. Not all classes are necessarily good fits for clients, so it may be advisable to get a sense of what classes and teachers are available in a community before recommending one to your client. Many teachers of these practices can have more of a fitness mindset and may not be well attuned to issues of trauma sensitivity. On the other side of this coin, more classes and workshops specifically geared for trauma-informed or recovery yoga are becoming available. If you are not sure of what’s available in your community, consider asking around for referrals from colleagues or contacts who may engage in these types of classes. Encourage clients to check out at least three types of classes at three different places before they make a definitive judgment about whether movement classes are for them. If cost is an issue, many yoga studios in cities throughout the United States and Canada are known to offer periodic donation-based classes and workshops. A growing number of programs are seeking to make yoga and movement practices available to those who traditionally have not been able to access them. Please visit the resources list at the end of this chapter on some ideas for where you can start to search for these community resources in movement, wellness, meditation, and recovery.

**TYING IT ALL TOGETHER**

In some quarters, particularly during the early years of its genesis, EMDR therapy gained a reputation as a cold, clinical exercise. Many came to see it as a magic pill to bring out for quick resolution to what were unfortunately complex problems. Nothing could be further from the truth when EMDR therapy is presented as a complete approach and practiced as such. A mindful approach and mindful energy allows you to work on possibly the most important collaborative resourcing effort of all, the decision-making process as to whether the client is ready to move on to Phases 3 through 6, the dedicated reprocessing of traumatic memories. Having collaborated for a time in the realm of history, preparation, mindfulness training, and resourcing, clinicians can confidently move clients into the next phases of work. We may come back here again even in moving forward. The process is a dance to navigate: building resources, reprocessing, reassessing readiness. Clinicians can do what we need to do in the first two phases as thoroughly as possible. The fruits of Phase 2, Preparation do not disappear as we move forward. They remain as a strong foundation for the work ahead and a safe haven to return to whenever necessary.
QUESTIONS FOR REFLECTION AND PERSONAL PRACTICE

● How can the mindfulness practices I’ve learned thus far help me widen the possibilities of preparation in EMDR therapy?

● What factors, if any, keep me from thinking outside of the box with EMDR Phase 2, Preparation?

● What are my own fears and trepidations about moving clients from Phase 2 into Phase 3?

● How can developing a mindfulness practice (or strengthening an existing practice) help me to address these fears and trepidations?

RESOURCES FOR FURTHER EXPLORATION

Information on community-based classes and other resources that can be used to expand your practice can be found at:

● Against the Stream Buddhist Meditation Society: An international Buddhist meditation group founded by Noah Levine, with centers in Los Angeles and San Francisco and satellite groups around the country and internationally. Group meetings and other mindfulness resources including podcasts can be found on the website.
  www.againstthestream.org

● The Breathe Network: A national listing of providers in several modalities (e.g., bodywork, yoga, meditation, psychotherapy, intuitive healing, energy work) who identify as trauma-informed.
  www.thebreathenetwork.org

● Conscious Dancer Magazine: The official publication of the Dance-First Association, it provides links to events, classes, and communities within conscious and ecstatic dance.
  www.consciousdancer.com

● Dancing Mindfulness: The movement and expressive arts community founded by Dr. Jamie Marich provides links to dancing mindfulness communities, classes, and resources in the United States, Canada, and emerging areas globally.
  www.dancingmindfulness.com

● Exhale to Inhale: A nonprofit organization dedicated to promoting trauma-informed yoga training and advocacy; a listing of some free and low-cost classes and trainings are available on the website.
  www.exhaletoinhale.org
• InTheRooms.com: An inclusive directory of 12-step-based and alternative recovery programs includes a platform hosting several hundred web-based weekly meetings using video technology.  
www.intherooms.com

• Refuge Recovery and Refuge Recovery Centers: A peer-led addiction recovery program based on the Four Noble Truths and the Eightfold Path of the Buddha. A list of meetings nationally and internationally, along with literature on how to start and conduct meetings, is available on the website.  
www.refugerecovery.org

• Street Yoga: A nonprofit organization founded by Mark Lilly that aims to train facilitators to carry yoga into underprivileged communities. Select classes specific to Street Yoga are available in the Pacific Northwest; trainings are offered nationally.  
www.streetyoga.com

• Yoga of 12-Step Recovery: A modality founded by Nikki Myers that combines a general 12-step meeting format and a yoga class for working with somatic elements of recovery. Meeting communities are available globally.  
www.y12sr.com

• Yoga Unchained: The trauma-informed yoga training program cofounded by Dr. Jamie Marich and Jessica Sowers is offered as a component of a larger expressive arts therapy training program.  
www.yogaunchained.com

• Yoganonymous: It provides a comprehensive list of yoga classes and studios across the United States and Canada.  
www.yoganonymous.com

REFERENCES


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