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Integrating EMDR into Clinical Work: When Getting Started is a Problem for Client and/or Therapist

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As EMDR is traditionally taught the components are each described and then combined for the practice sessions. When EMDR is then used with clients it is natural for therapists to expect themselves to apply it as a whole, with the exception of perhaps pairing eye movement with a "safe place" or "resource installation" exercise instead of a trauma processing protocal. For many new EMDR practitioners this is an effective and satisfactory way of introducing EMDR. For many others it does not work as well, for reasons such as differential comfort thresholds in trying a new method with a client, or having no clients who appear to meet the criteria for beginning EMDR. Because, in these, and other situations, it is difficult to bring the whole package to clients at once, the method doesn't get used, even when the practitioner has had positive experiences in the training sessions.

In 1997 Hyer and Brandsma wrote a paper for the *Journal of Traumatic Stress* titled "EMDR Minus Eye Movements Equals Pretty Good Therapy". As has Shapiro, they point out ways in which EMDR has integrated traditional methods of treatment. They also point out that the EMDR formula adapts these methods to make them particularly efficient. Taking off from Hyer and Brandsma, it may be that the best way for many therapists to begin to integrate EMDR into practice is to pull some of the EMDR reworking of traditional methods out of the overall package, and then practice them in the context of the therapist's usual approach. As these components are gradually integrated the therapist may find that the benefits of the overall method may be easier to incorporate.

Because they are probably most easily incorporated we will start with EMDR activity from the assessment phase, and then go back to the client preparation phase.

Assessment

One to the most important principles of EMDR is that therapy is done in the specific- for example we don't work on "self-esteem" we work with specific incidents with images, emotions, feelings, thoughts etc. Self-esteem follows from work with specific experiences and self

judgments. For a few clients prompting back to specific images may not be advisable as the alliance is just being formed, however for most clients the full basic assessment formula is appropriate. This basic formula can be an part of history taking that has the therapeutic value of helping the client learn, or be reminded, of basic principles of understanding human experience and working toward change.

In the EMDR trainings the assessment phase immediately precedes the desensitization (eye movement) phase. As I practice EMDR the assessment phase is first incorporated into the history taking. For at least one of the notable events the client reveals I ask if there is an associated visual image, and then ask about a negative cognition etc., following the EMDR formula. When it comes time for the desensitization phase we start anew with the assessment phase, and it goes much faster.

The Negative Cognition

Very often clients do not initially offer a present tense, irrational, generalizable self beliefs that constitute the ideal type of negative cognition. When this work is done in this history taking context clients have the opportunity to learn the basics of cognitive restructuring that will be useful to them beyond the therapeutic sessions. I have found the language of the EMDR assessment, asking about the self beliefs in this way, in this context, has made this kind of instruction highly efficient.

When clients have difficulty establishing negative cognitions that are broad schema central to the target associative network, several approaches can be helpful. Two examples are described below, many others can be derived from the therapists past training and experience.

Example A : When there is some difficulty obtaining a negative cognition I sometimes ask "When you think about this event what names do you call yourself?" This often elicits a valuable cognition, and it affords the chance to gain further understanding if I ask " Where did you first learn to call yourself this name?"

Example B: Some clients, especially therapists when they are clients, have difficulty developing negative cognitions. They have learned to apply the lessons they have taught their clients and generally avoid general negative self beliefs. However, we all probably have some vestiges of these schema that accompany past events that still give unnecessary pain. One helpful question in this situation is " Though it is not a general self belief, at your worst moment when you think of this event what is the worst you say about yourself?". Even though the statement is not in the

present tense, and violates the hoped for emphasis on the "right now", this is a worthwhile tradeoff when necessary. Another way to approach is to ask: "Now you are strong enough to not have negative self beliefs in the context of this event, however if you somehow lost your strength what negative self belief might you fall into." I sometimes also use this opportunity to discuss the idea that we all have many parts, and one aspect of ourselves may have one kind of judgment while other aspects have other judgments.

If these or other approaches are not successful, or you think pushing for a negative cognition may endanger the rapport, certainly continue in the history taking session without one. Even if you are in the assessment phase you can, with client agreement, move on, but be aware that if processing gets blocked it may be around the issue of a negative cognition the client is unwilling to entertain.

The Positive Cognition

Much of psychotherapy is geared toward elimination of the negative, without a clear notion of the positive. One of the most interesting aspects of EMDR is the consideration of the path to positive resolution, and the specifics of the positive aspect of experience. Just as the identification of negative cognitions can take place during history taking, so can positive cognitions.

Obtaining the positive cognition affords and excellent opportunity to quickly and concretely teach about perfectionism. If a client gives the positive cognition "I am a good person" I take this opportunity to ask, if by this she or he means perfectly good, or just generally good. Clients often quickly indicate they get the point. This issue can also be addressed in obtaining the VoC, where one can explain how a 7 means complete belief in general goodness, not completely good.

While it is usually better for clients to have positive rather than negative self beliefs, I find that sometimes clients are either ready, or find it necessary, to be nonjudgmental rather than positive about themselves. This means that sometimes a neutral cognition is preferred. (In Shapiro's earliest work, in 1989, what in generally now called "positive" was called "preferred"). In my work with combat veterans, with guilt in particular, this concept has been very helpful. It should also be mentioned that my personal bias is to for nonjudgmental positive cognitions such as "I can learn from this" or " I can maximize my safety" to more self judgmental cognitions such as "I'm a good (competent/lovable/etc.) person". But, again, the

client must be given the choice, we shouldn't offer alternatives unless there is good clinical reason.

Other Aspects of the Assessment Phase

Just as the cognition part of the assessment phase can be practiced in the history taking so may the other aspects of this phase. Asking clients to name their "emotions" instead asking "How do you feel about it?" gives clients a chance to learn to accurately use emotions words. Too often when clients are asked how they "feel" about something, they respond with a judgment e.g. "I felt it was wrong". When they are stated as "feelings", judgments are difficult to examine for potentially useful reconsideration. Also, describing thoughts as emotions helps cover up emotions that may need to be aired. Just as asking for emotion words help clients learn about emotion, asking about body sensation helps clients learn to focus on the body, and getting VoC and SUD ratings help teach about the behavioral principles of thinking in measurable units, which some may say helps develop a sense of mastery, whatever that is.

Most therapists have effective ways of doing therapeutic work around identified emotions. Some ways in which I have used the distinctions between emotions and thoughts are available in an paper describing an emotion assertiveness group called Feelings Identification and Behavioral Rehearsal (FIBRe). The paper is written for use with combat veterans in the context of a PTSD program, but may be adapted more widely.

When the assessment stage features are initiated in the history phase, much information can be obtained quickly, and Sullivan's (1954, p54) advice "It is not enough that the interviewer should find out something and give a really convincing demonstration of it. The interviewee must also get something out of it.", is easily followed.

The above comments are specifically related to using assessment phase material in history taking. However, as has been pointed out by my colleague William Zangwill, the EMDR assessment formula can be well applied when necessary without eye movement in ongoing therapy. For example, if a client comes in and talks of a recent troubling incident you may simply ask "Can we try exploring that incident in a different way than usual?"

Preparation

Now, a step back in the sequence of eight phases. A part of client preparation that is delineated in EMDR, but often neglected in general practice is the information that the

therapeutic work may entail some unpleasant aspects. (e.g. "...unpleasant pictures, sensations or emotions may come up as we do the eye movements..." Shapiro, 1995, p.126) If a therapist is avoiding offering EMDR to avoid the necessity of raising the possibility that distressing emotion may occur during the course of therapy, then the following two sets of research findings be considered:

1. In reviewing the psychotherapy literature Mohr (1995) found negative effects to be pervasive. Such effects were described even in relaxation training studies supervised by prominent researchers, not to mention exposure treatment of anxiety disorders.

2. A survey (Lipke, 1995) of the first 1100 EMDR trainees, to which there were over 350 responses, found EMDR led to less suicidal ideation and/or activity, violence and post-session dissociation than did other methods. About the same number of therapists thought EMDR led to decreased agitation or panic as thought it led to increase in these negative effects. The survey finding that EMDR led to more in session "emergence of repressed material" was the only finding that suggested greater concern for EMDR that other methods, which in the context of the comparative overall positive rating of EMDR may be taken as positive finding.

In deciding whether or not to offer EMDR I think there are two relevant messages from the above cited studies, first that all methods of treatment, especially when trauma material is dealt with, may lead to at least temporarily increased distress. Second, that EMDR is generally no more likely to do so than other methods. Therefore, preparation that includes at least informal informed consent about the possibility of unpleasant effects may be a good idea for clients beginning any type of psychotherapy; EMDR should not be singled out in this regard.

The point might be raised that mentioning possible negative consequences may heighten the possibility of these, and thereby be detrimental to clients. My understanding of the informed consent ethics of our profession is that there is no justification for not addressing the question of possible negative effects of treatment.

So the main points here are, in regard to psychotherapy, in general, is that there is little reason to consider competently practiced EMDR more dangerous than other methods, especially if severe trauma will be directly addressed, and that excluding EMDR from practice does not end the possible obligation to inform the client of possible negative effects. The specific advice being offered is that if you are not already doing it, consider making your clients aware of possible

negative effects for any treatment you do. Following is a section the new client information paper I to give to my new clients:

> It should be mentioned before we go much further that the therapy process can also increase discomfort, especially if the experiences being considered are very painful. Being asked to reconsider experiences in depth, or even being asked to try something new, as part of the psychological healing or growth process can lead to increased discomfort no matter what method is used. This is true in psychotherapy just as it is in medicine, and for that matter any creative effort. And, you should know this before proceeding with any therapist.

The client warning included above does not take the place of the EMDR protocol specific statement,"...unpleasant pictures, sensations or emotions may come up as we do the eye movements..." , but it does help put it in context. An earlier version of this client information paper mentioned EMDR by name, in the current version I don't mention EMDR. I have decided to follow this course because I think singling EMDR from the other therapeutic activities we engage in leads to more potential for disruption than benefit. Consider this possible interaction:

> Client: It was a horrible thing for her to comment on something so trivial after I lost my job.
>
> Therapist: Let's try a little Client Centered Therapy. OK?
>
> Client: (nods)
>
> Therapist: I hear you saying you were really hurt.

When I inform clients about psychotherapy, and about what science has learned about human nature, I try to be clear and complete, I try to avoid the jargon of our profession. (Why expose clients, who have already suffered and are seeking help, to that increasingly meaningless language?) I don't think we should withhold the name of any method we employ, or almost any other information when it is helpful to mention it, or if the client expresses curiosity. However, to hold the name up like a banner may distract both the client and the therapist from the work itself.

Desensitization

The desensitization phase is the one in which eye movement, or some other sensory or sensory/motor activity, is paired with the therapeutic target. The inclusion in psychotherapy of eye movement, or any unusual activity for that matter, may be what blocks application of EMDR

by some practitioners. This point was made especially clear to me when a public critic of EMDR, a therapist who attended an EMDR training, privately told me that he could not try EMDR, even if he thought it might work, because he would feel embarrassed moving his arm back and forth in front of the client. For others there may be not be an issue of embarrassment, but rather a concern about practicing any new activity, and not feeling comfortable with the skill, at the time the client is beginning the potentially most difficult and unpredictable part of treatment.

The concern about discomfort with a new activity is partially addressed by the use of eye movement in the safe place exercise or during "resource installation" activities or other pairings of eye movement with positive material. The more practiced the therapist is with incorporating eye movement into less intensive activities, the more comfortable the therapist will be with more difficult activities.

It may also be helpful for the therapist to "normalize" the use of sensory/motor activities in therapy by looking at them outside the context of EMDR. If a client has concern you may want to explain that sensory or sensory/motor activities can aid in various psychological activities. Ask if clients have found music to be relaxing or, when exercising, invigorating. Or, ask if any other activity, like walking, or breathing exercises, helps them think. In this context you may give clients the opportunity to try eye movement or tapping with comforting activities such as in safe place exercises. Later, as the situation indicates, you may find it easier to apply eye movement back into the overall EMDR protocol as a method for therapeutically enhancing information processing.

Relationship and Expertise

The nature of the client/therapist relationship may be the most important consideration in beginning EMDR, or any new approach. A relationship in which the sense of partnership and experimental attitude are strong promotes the therapist offering something new to her or him. A relationship in which the therapist must see her- or himself, and be seen by the client, as in complete control makes it less likely something new for the therapist can be tried.

Other aspects of the relationship, such as perceived caring, respect, and or durability, can be considered as factors helping clients access strengths that allow them to take the chance of beginning trauma work, and persevering with painful material until it is processed. The more the

therapist sees that these are mutually recognized characteristics of the relationship, the more likely the therapist will be to offer intensive trauma work.

Also to be considered, is that if full expertise is expected before any therapist initiates any innovation, a "postdoc" or equivalent training, would be required for any therapist to try anything leaned after initial graduate training. While this may be appropriate in some fields, psychotherapy has not evolved to where technique, rather than relationship, accounts for enough of the outcome, in most situations, to make such a requirement good for clients or therapists.

Finally, A General Framework to Consider EMDR and Psychotherapy Integration.

All of the above suggestions can be considered in an overall framework, which has been developed out of Shapiro's work, called the Four Activity Model. This model was developed to understand EMDR in the context of psychotherapy in general. (Lipke, 1996, 2000) In this model all psychotherapeutic activity can be seen as involving four broad categories of activity that the therapist encourages to a greater or lesser extent. These categories are: accessing of information, introduction of new information, abstract facilitation of information processing (e.g. eye movement) and inhibition of accessing (e.g. relaxation exercises. It is introduced here because the relationship between EMDR and the methods already in use may become more evident thus it will be easier to incorporate EMDR into practice.

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