Using Eye Movement Desensitization and Reprocessing to Address

Spiritual Concerns in Psychotherapy

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Abstract

The difficulty therapists often have when incorporating spirituality into psychotherapy is generally recognized and attributed to 1) the frequency of mismatches between therapist and client spiritual beliefs, and 2) therapist beliefs that science based psychotherapy should avoid the spiritual realm. This paper primarily addresses the first of these. EMDR, a method of psychotherapy widely acknowledged to be evidence based, has a client centered structure that allows client spiritual beliefs to be incorporated into psychotherapy with minimal or no need for the therapist to have their own personal beliefs intrude. EMDR may be of particular value in helping clients when spiritual issues overlap with “moral injury”. Case examples are provided

Key words: EMDR, Spirituality, Religion, Psychotherapy, Trauma, Moral Injury

Introduction

 Some aspects of client qualities and concerns have led to the development of whole specialty fields of psychotherapy practice, such as pastoral counseling and feminist psychotherapy. Despite the existence of these specialty fields, the concerns they primarily address are often an inextricable part of general psychotherapeutic practice. Thus, consideration of spiritual concerns is warranted and sometimes essential in psychotherapy in general. For those clients who look to psychotherapy to do more than solve narrow problems, such as phobias, addressing meaning of life questions related to spiritual beliefs can be of utmost importance. This is especially true in therapy for the effects of traumatic experience, which as Janoff-Bulman (1992) describes, can be integrally related to abiding assumptions of world benevolence, the meaningfulness of life, and self-worth.

 However, as Walker, Courtois, and Aten (2015) note, when therapist and client spiritual belief systems do not significantly overlap, or the therapist is concerned that the practice be fully science based, there can be difficulty working with these spiritually based concerns. For example, when a client who has suffered a traumatic experience is profoundly troubled by not being able to reconcile her beliefs in a benevolent God with the occurrence of tragic events, the therapist may find it difficult to help the client using methods of conversational psychotherapy (e.g., cognitive, existential, psychodynamic). One cause would be that since the therapist does not share the beliefs, they may not be able to comfortably consider ways of reconciling the ideas. In addition, consideration of the client’s spirituality may be antithetical to the therapist’s understanding of what it means to provide science based treatment. Because of the way in which EMDR is structured differently than other therapies, it more easily allows for the possibility of the client working through spiritual questions and dilemmas without the therapist’s beliefs intruding on the process.

 To address the other impediments to therapist in addressing spirituality, i.e. the need to have practice based in science, we assert that science in psychotherapy refers not to the truth of the client’s or therapist’s belief about life, but rather to the objective understanding of the methods employed and their effects. This paper will not further address how including spirituality in psychotherapy can be considered compatible with scientific practice, but rather focus on the possible problems of an inconsistency between therapist and client spiritual/philosophical beliefs. The basic principles and procedures of EMDR will be introduced and examples will be offered from clinical cases in which the EMDR therapeutic stance can optimize the spiritual resources of the client.

 Integrating EMDR and Spirituality

 EMDR (Shapiro, 1989,1995, 2018) is a method of psychotherapy that is widely acknowledged (e.g. Foa, Keane, Friedan and Cohen, 2009, WHO, 2013) to be effective in helping clients overcome the harmful effects of psychological trauma, which may include among other problems, maladaptive emotions, cognitions, and somatic reactions. Shapiro posits that the detrimental psychological effects of trauma are best understood in terms of how the traumatic event is held in memory. For example, a client who experiences threats to life and/or identity may be haunted by intrusive memories of the trauma, variously feeling guilty, frightened, ashamed, enraged, and emotionally numb, with thoughts of worthlessness and loss of hope. These responses can be triggered by stimuli related to the traumatic event. Shapiro’s understanding is consistent with Horowitz’s (1976) seminal position that (what we now call) PTSD is based in events being stored in short term memory instead of long term memory where they belong. This understanding corresponds to more recent formulations of these memory systems offered by psycho-physiologists. (e.g. Squires, 1987).

 When EMDR is successful, the trauma memory is reprocessed so that former symptom triggering stimuli no longer produce a pathological reaction. This adaptive processing includes not only the fuller understanding that the trauma is in the past but also that the memories no longer have the sensory reliving components. EMDR also helps the client bring to bear current helpful ways of understanding the events and adaptive self-beliefs that allow for effective responses to current situations, which reflects it positive psychotherapy focus. For example, when aspects of a traumatic event are accessed by current events, instead of the client thinking that they are weak and helpless, she may realize that she has many strengths. Or she may realize that there is no need to judge herself at all and instead focus on how to achieve her goals.

 EMDR shares many aspects of conventional psychotherapeutic approaches such as establishing goals, understanding client history, developing a therapeutic alliance, and teaching stress management skills (internal resources). These are conceptualized by Shapiro (1995, 2018) as consisting of eight phases of treatment. The particularly unique features of EMDR are 1) the efficiency with which maladaptive self-beliefs and alternative adaptive beliefs are identified in what is called the assessment phase. And 2) the use of guided repetitive eye-movements (or other forms of usually bilateral stimulation, i.e. auditory, tactile) which often lead to reprocessing target memories and desensitization in what is called the desensitization phase. 1Along with the distinct way in which trauma associative networks are accessed, alternative adaptive cognitions are invoked and desensitization/reprocessing is fostered through the signature guided eye movements.

 For the purpose of this paper, we will focus on the assessment and desensitization phases in the EMDR protocol. It is in those two phases the EMDR has the greatest potential to overcome any therapist/client mismatch in spiritual beliefs and to help the client employ spiritual resources.

 After history taking and helping the client develop stabilizing internal resources (e.g. stress management skills) the therapist and client collaborate on choosing a trauma target to reprocess. The client is asked to bring to awareness a disturbing image related to the event, usually the most troubling moment. The client is asked to report the self-referential maladaptive negative thought that is currently connected to the image (e.g. “I am a weak person.”) Following identification of the negative cognition, the client is asked to state a substitute preferred adaptive self thought (e.g. “I have many strengths.”) The client is also asked to identify the emotion and body sensations felt as the trauma experience is accessed.

 Asking for the current experience of the details of the event serves to access the associative network, which has the client at least partially “stuck” in time, that is, when remembered it feels like it is happening again. The desensitization phase begins with the client bringing to mind the negative material identified in the assessment phase and then immediately being led to the repetitive sensory/motor activity. When that activity is stopped, usually after 20 - 30 seconds, the client is asked to briefly report the content of consciousness present at the end of each set of eye movements.

 The therapist generally avoids commenting on or interpreting the new material unless processing is “stuck”. (This is difficult for therapists and is one of the reasons training is important.) This staying out of the way allow the client to more fully consider the traumatic event in a more adaptive way using a depth of personal knowledge the therapist cannot possibly be expected to have. In the best case this repetition of sets of eye movements leads to complete reprocessing of the memory (which is more than desensitization in that valuable insights are added) and the positive therapeutic results outlined above.

 For many people, part of this reprocessing can involve spiritual/religious thoughts and/or imagery that arises spontaneously during the bi-lateral stimulation. Frequently in this context, the spiritual/religious imagery serves to comfort the client by reducing inappropriate guilt or feelings of helplessness, or overwhelming vulnerability. Interestingly, the accessing of the client spiritual beliefs very rarely leads the client to find the beliefs disconfirmed. Once during an EMDR presentation on a related subject one of the authors (L) asked the other audience members whether or not they had ever invoked client religious beliefs and had the beliefs disconfirmed. Of at least twenty respondents only one indicated that they had. Ironically this client was a minister.

 Clinical Examples

 The fictional example offered below is of extreme loss, and it may be disturbing to contemplate. However, it does represent the magnitude of loss often confronted when offering psychotherapy.

 In this example a template is provided to show how spiritual/religious elements might occur at the beginning of an EMDR reprocessing session. In this imagined case six months prior to therapy the client was walking across a street with her child when a car ran a red light and hit and killed the child. Of the many devastating aspects of such an event she is most distressed by the thought that she could have prevented the event. During the EMDR assessment phase, the clinician asks what negative thoughts she has about herself now. The client might respond, “It was my fault. I should have saved her. I am pathetic.” And when asked for a possible preferred thought she would have about herself when she remembers the event, she might respond “I was doing the best I could and it was God’s will.” Though the therapist might not believe such accidents are part of God’s will, disputing the client belief would clearly render the therapist unable to help the client. In EMDR the belief would just be acknowledged and subject to the client’s reconsideration during the eye movement part of the process. The client would not be asked to consider more secularly based attributions of responsibility. During EMDR reprocessing, the belief might shift to “ I was a good parent; She is with God now.” Moving away from a focus on blame can allow the grieving process to focus more on the loss itself. In subsequent EMDR sessions, the client, as shown in subsequent actual clinical examples, might spontaneously see her child in heaven or have some other comforting images.

 The following examples taken from actual therapy sessions highlight the ability of EMDR to incorporate spirituality. These shifts in beliefs occurred not as a result of the therapist asking the client to consider specific ideas before the eye movements were implemented, but rather more spontaneously in the midst of reprocessing after the therapist asked a question that might provoke a spiritual response if that was part of the client’s belief system. The first example of trauma reprocessing involving spiritual beliefs is of a combat veteran who saw a friend die near him in battle. (L, 2000) Intellectually he knew that he could not have saved his friend and that even trying to do so would have been suicidal. Nonetheless, as often occurs in such situations, he was overwhelmed by guilt. During the eye movement phase, the client was experientially stuck in memory. Thoughts, images, and feelings were not changing. Consistent with standard EMDR practice an intervention was offered based on knowledge of the client. He was asked, “Where is your friend now?” he replied “In heaven.” After more bi-lateral stimulation, he became calm and smiled. He reported that he saw an image of his friend in heaven smiling at him. In this clinical case, the therapist asked a leading question which resulted in evoking the client’s comforting spiritual beliefs.

 It should be noted that both the fictional example and that of the combat veteran would now be considered in the domain of “moral injury” (MI) which can have considerable overlap with spiritual concerns in psychotherapy ( Currier, Foster and Isaak, 2019).

 A second actual psychotherapy example involving spiritual/religious beliefs is that of a woman dying of cancer. (H) The client originally came to therapy to deal with some significant life stressors related to her family of origin and her present work situation. During the course of treatment, she was diagnosed with a late stage virulent cancer. Consequently, the focus of therapy shifted to coping with and optimizing the efficacy of her cancer treatment. Over the course of three years, she received aggressive cancer treatment including a course of experimental chemotherapy. Initially her response was positive with the tumor shrinking and much hope for a remission. During that period of time EMDR treatment focused on maintaining reasonably positive attitude about her health prospects and reprocessing traumatic experiences from her childhood. However, the cancer returned and the focus of therapy shifted to acceptance of the prospect of a shortened life. Toward the end of her life, she began to focus more on her husband who she loved very much. Part of her grieving was for him and what he had to cope with during her years of fighting cancer. The client frequently had spontaneous religious images during EMDR reprocessing that calmed and reassured her. One particular image showed her how to think about her impending death and her husband’s survival.

 In the imagery that arose after a set of eye movements, she saw herself walking down the aisle of a church in a wedding gown, accompanied by her husband. In the sanctuary stood Jesus waiting for them with a smiling visage. Her husband took her hand and placed it in Jesus’ and then stepped back. Jesus and my client turned and walked toward the altar. The scene stopped there. The therapist’s response was to simply have the client continue with eye movements, rather than commenting on the client report. The client expressed a profound sense of peace and happiness about her life and her love for her husband. She passed away with her husband by her side a few weeks later.

 In none of the cases described, fictional or actual, did the therapist actively suggest specific religious based solutions to the client, though the therapist could have asked a client whose processing was not progressing: “Consider what your spiritual beliefs offer as you contemplate this situation.” and then lead a set of eye movements. The therapist can thus help the client employ faith based beliefs that are adaptive ways to manage the painful and sometimes debilitating emotions that go with both the unfortunate and the inevitable challenges and loss in life without specifically endorsing them. This is not unlike the way military chaplains minister to soldiers whose faith they do not share. To not employ what we know of the science of psychotherapy (in this case the procedures of EMDR to allow clients who have such beliefs) be comforted by those beliefs would seem to be a violation of principle for therapist who try to practice client-centered psychotherapies

 Conclusion

 EMDR can mobilize a client’s ability to reprocess disturbing memories by tapping into adaptive beliefs, including spiritual/religious resources. Because EMDR at its core is a client-centered methodology, the therapist can facilitate the adaptive processing without needing to share the religious/spiritual beliefs of the client. Rather than spirituality being evaded or presenting a problem to psychotherapy, the client can benefit from incorporating spiritual beliefs in the healing process. This can make it particularly helpful for clients have suffered what is now called “moral injury”.

 Footnotes

1 There is considerable discussion about the nature of the sensory/sensory-motor activity in EMDR. Early in her work Shapiro would describe this as bilateral stimulation and/or dual attention. The underlying mechanism that leads such activity to facilitate information processing is subject to much discussion and research, which is beyond the scope of this paper. HL, in the context of his model of psychotherapeutic integration chose to refer to this as Category 3 activity – abstract activity that facilitates the processing of information- in an effort to avoid prematurely attributing this facilitation to a particular mechanism. This is consistent with Shapiro’s acknowledgement of the limitations of understanding.

The names of the phases of EMDR come from Shapiro’s early conceptualization of her method which was in a desensitization rather than information processing model. She changed the name from EMD to EMDR as a corrective. She did not make other name changes which might seem to follow as she chose to maintain continuity.

2 None of the cases described contain information that would allow for identification of the client.

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