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

Howard Lipke, PhD Wheeling, IL

I have been involved in providing EMDR training since 1992. Over that time I have noticed that 1) many participants have a positive personal experience when they are in the client role in the practicum and 2) that despite personally experiencing rapid positive effects many of these participants do not go on to use EMDR with their clients in their practice. I am hoping that the following helps overcome the reluctance of clinicians who have had a good experience in the training to use EMDR with clients.

When therapists use EMDR in the small group practice all aspects of EMDR, explaining it, getting a "safe place", identifying cognitions etc. are made to fit into the hour or less available for each "therapist/client" turn. As the clinicians then go on to apply EMDR in their clinical work they may have the mind set that all of the stepst must fit into the first session in which they use it with their clients. I don't think it is often emphasized in the training then much more time can be taken with those steps before the first set of eye movements (or alternatives). In fact, when therapists take the time to develop the answers in the Assessment phase EMDR becomes at least the "pretty good therapy" Hyer and Brandsma described (1997), even before eye movement[[1]](#footnote-1) is added. 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, well before intensive processing. As these components are gradually integrated the therapist may find that the benefits of the overall method may be easier to incorporate.

Because it is probably most easily incorporated and can be useful completely outside an EMDR context, we will start with EMDR activity from the Assessment phase, and then go back to the client Preparation phase.

**The Assessment Phase**

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 be too evocative as the alliance is just being formed, however for most clients the full basic assessment formula is appropriate. This basic formula can be part of history taking[[2]](#footnote-2) which 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[[3]](#footnote-3) 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 or have the client to consider the event as a whole, 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 questions and it goes much faster.

*The Negative Cognition* Very often clients do not initially offer a present tense, irrational, generalizable self- belief that constitutes the ideal type of negative cognition. When this work is done in history taking context clients have the opportunity to start to learn the basics of cognitive restructuring that will be useful to them in and 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 very efficient and effective.

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 do you call yourself names?” 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 tend to avoid general negative self -beliefs. However, even the most enlightened of us probably have some vestiges of 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 swhen 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 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*

Often psychotherapy is geared toward elimination of the negative, without a clear notion of a potential adaptive resolution. 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 an 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 they mean perfectly good, or just generally good. Clients often quickly indicate they get the point. This issue can also be addressed in obtaining the VoC rating, where one can explain how the top rating means complete belief in general goodness, not perfect goodness.

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 is generally now called “positive” was called “preferred”). In my work with combat veterans, with dysfunctional guilt in particular, this concept has been very helpful. It should also be mentioned that I believe nonjudgmental positive cognitions such as “I can learn from this” or “I can maximize my safety” are better than 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. I also cannot recommend against showing the client list of possible cognitions when a cognition cannot be obtained.

*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, as is often done, “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 attend to the body, and getting VoC and SUD ratings help teach about the behavioral principles of thinking in measurable units, which helps teach about gradation of experience.

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 a program designed to help prevent destructive anger called HEArt (Hidden Emotion Articulation)[[4]](#footnote-4). The program was initially developed for use with combat veterans in the context of a VA medical center PTSD treatment program, but may be adapted more widely. It is described in the book *Don't I Have the Right to Be Angry*.

When the assessment stage features are initiated in the history phase, clients can gain some insight quickly, and Harry Stack 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?“ and then proceed with the questions.

**The Preparation Phase**

Now, to take 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 not offering EMDR so as to prevent distressing emotion from occurring during the course of therapy, then the following two sets of research findings might 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 1,100 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. Of the 91 therapist who had used both EMDR and exposure methods, eleven thought EMDR to be more stressful for clients and 59 thought it to be less stressful.

In deciding whether or not to offer the reprocessing part of EMDR I think there are two relevant messages from the above cited studies, first that any method 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; there is no support for singling out EMDR in this regard.

The concern 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. Also to be considered is that any potential increase in discomfort distress from psychotherapy is consistent with any activity that calls for people to try something new to change their and improve their lives. It is true for such things as varied as medical treatment and learning new skills. I think it is worthwhile to put psychotherapy in this context.[[5]](#footnote-5)

In my clinical practice I do not make it a point to talk about the name of the methods of psychotherapy I am offering. But, I do carefully describe the activity. Consider this possible interaction:

Client: I was bothered that my friend talked about something so trivial as not being able to go to the movies that night after I just said I had 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 start work with clients who have had traumatic experiences that they want to have less of an impact on them I explain how events are differentially held in memory, with memories stuck in "reliving" form producing more disruptive effects than those held in "intellectual/historical" form. I explain the various ways to decrease the effects of the memory and describe the basics of EMDR as what I think is the most effective way to do this when we are ready. The fact that it is called EMDR is incidental, not the centerpiece of the interaction.

**The Desensitization Phase**

This phase, which would more accurately be called the reprocessing phase[[6]](#footnote-6) is the one in which eye movement, or some other sensory or sensory/motor activity, is paired with accessing 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. ( It is a good thing surgeons are able to overcome aversion to what they have to do to people to help them.) For others there may 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.

It may 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. You might cite scientific articles such as by Webb (et al. 2017) about the effects of walking on problem solving, or the fact that REM sleep, associated with back and forth eye movement is connected to problem solving (Zarda & Stickgold, 2022).

**Relationship and Expertise**

The nature of the client/therapist relationship may be the most important consideration in beginning EMDR, or for any therapeutic effect in general. A relationship in which the sense of partnership and experimental attitude are strong promotes the therapist offering something new. A relationship in which the therapist must see themselves, 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 the kind of expertise that comes from many years of experience after training for general competence was required to practice, then no one would ever be able to get that experience. While training for many more years than is required in the practice of psychotherapy may 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**.

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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1. I am going to refer to activity (tapping etc.)often called bi-lateral stimulation or dual attention as eye movement because I am not completely satisfied that either of those general descriptions accurately describes the mechanism they are meant to. [↑](#footnote-ref-1)
2. Specific suggestions in that regard are available in papers about a history questionnaire, the GLEQ, at the website HowardLipke.com [↑](#footnote-ref-2)
3. The current paper follows the traditional use of Shapiro's eight phases of EMDR and the still standard view of these. For a recent attempt to update understanding of eight phases see the paper, *A Reconsideration of the 8 Phases of EMDR* at HowardLipke.com. [↑](#footnote-ref-3)
4. The initial version of this program, under another name was describe, in my book EMDR and Psychotherapy Integration. The name was changed to prevent the misleading idea that there was quest for feelings not hidden emotions. [↑](#footnote-ref-4)
5. Boisvert. (2010) offers an interesting discussion of warning about negative effects of psychotherapy. [↑](#footnote-ref-5)
6. see the paper the 8 Phases of EMDR Reconsidered at HowardLipke.com [↑](#footnote-ref-6)