EMDR and Trauma Processing: Getting Back to Basics.

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Adaptive Information Processing Model

- Past
- Present
- Future
Adaptive Information Processing continued:

- We have an information processing system which is geared for healing.
- Typically, if something is upsetting, we think about it, talk about it, dream about it, write about it and as time passes it is no longer upsetting.
- When a trauma occurs, the information gets encoded in the brain in a manner where there is a freeze frame.
- The traumatic material is stuck and does not process.
- With the AIP Model, we believe we are catalyzing the traumatic information and processing it to an adaptive resolution.
Adaptive Information Processing Continued:

- We think of memory networks as the basis of mental health and of pathology.
- Unprocessed large T or small t traumatic memories are considered to be the foundation of clinical symptoms (except for situations where there are organic deficits or there is a lack of information).
- The AIP model is the way that we understand and predict the clinical presentation and developmental deficits.
- The AIP model helps to understand case conceptualization and to help in treatment planning.
The body keeps the score (van der Kolk, 2014).

The past generates the dysfunction that we see in the present.

Dysfunctional beliefs, emotions, body sensation and images get stuck in the nervous system.

When they are triggered, the individual acts much as they did when the original trauma occurred.

The Flight, Fight or Freeze response occurs.
Physiological Impact of Trauma

- For Individuals with multiple, repeated, long-term trauma (complex) there is a level of chronic hyperarousal which impacts on the entire nervous system.

- With complex trauma there is a disruption of the HPA Axis in the brain, causing hypocortisolemic which can create long-term inflammation, resulting in chronic illnesses caused by inflammation, Bergman, (2012).
Physiological Impact of Trauma continued.

- These are illnesses such as Hashimoto’s, Fibromyalgia, Chronic Pain, Multiple Sclerosis, Crohn’s Disease, Depression, Migraine’s, Hypothyroidism...etc.

- We know from the ACE’s Study (Filetti et al 1998) that there is a graded relationship from Adverse Childhood Experiences to ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease.
Necessity of Treating Trauma

- Given the AIP Model and the emotional and physiological impact of trauma, we need to treat trauma completely.
- EMDR is one of the most effective tools we have to fully treat trauma.
- As clinicians, we need to explore our own blocks to treating trauma.
- Since avoidance is a hallmark of PTSD, we need to educate clients about the impact of untreated trauma.
- Many clients instinctively try to push traumatic memories away, down or to avoid stimuli. We need to educate them that this does not work in the long run.
Therapist Blocks to Treating Trauma

- Not sure of the protocol or what to do.
- Fear of the affect coming up.
- Worry about adverse events.
- Our own unconscious trauma gets triggered.
- Fear of making the client worse.
- Worry about the client being unable to tolerate processing.
Window of Tolerance, Siegel, Definition (2010)

“Our mental experiences and our neural firing patterns for particular emotions or situations appear to have a span of tolerance in which we can function optimally. Within the span, within the window, we do well; outside the window, we push beyond tolerable levels of arousal and move to either chaos or rigidity and lose our adaptive and harmonious functioning.”
“Sticking only within the center of the window, we do not enable the contained disorganization and reorganization necessary for the system of the person to change. Sensing these edges, moving with the client in and out of these precarious transition zones, but ending the session within the window are movements that make therapy tolerable and empowering.”
We often hear that this is interpreted as the notion that when working with trauma processing we must keep clients within a certain level of distress or something bad will happen (adverse event).

Stampfl and Levis et al 1967 used Implosion (or flooding) to have individuals process trauma. They would keep the client at a SUD level of 10 for 90 minutes and then send them home with a script to go over for one hour per day.
The treatment that we do in EMDR Therapy is much gentler.

Typically, the client will only have the strong emotional reaction briefly and then process the experience to an adaptive resolution.

We are doing a specific intervention in EMDR where at times we intentionally leave the window of tolerance in order to achieve lasting psychotherapeutic affects.
Window of Tolerance and Prolonged Exposure Habituation
Window of Tolerance, continued

- With EMDR therapy, the individual may get through the high level of distress much more quickly than in the graph if we just keep going.

- As clinicians, we need to determine if our concerns about the window of tolerance are due to real client limitations or our own concerns.
Think of the intense level of the affect as good news, because typically with EMDR therapy this will be the last time that the client has to experience affect about the target event at this high level.

Do we as clinicians have to improve our own ability to tolerate high levels of arousal and affect?
Window of Tolerance and EMDR Habitation

Current psychosis, personality disorder, substance dependence, and suicidal ideation were included in the treatment groups.

They found that both EMDR and PE were effective for treating trauma in patients with a primary psychotic disorder.
Research on EMDR, Psychosis and Adverse Events

- They also found that there was no difference in adverse effects among the three conditions.
- Ter Heide et al (2016), reported no increase in adverse events with EMDR treatment in refugees when comparing EMDR with stabilization.
Maxfield and Hyer (2002) EMDR Outcome and Fidelity to Treatment

- Maxfield and Hyer, (2002) found that the more rigorous the research study and the more closely researchers followed the EMDR Treatment model, the greater the effect size for EMDR Therapy.

- If we follow the protocol more closely we are more likely to have robust symptom decrease or resolution.
Review of Basic Protocol

- **Past** - what T or t trauma laid the groundwork for the current pathology?
- **Present** - What are the present situations that are causing distress, including current stimuli?
- **Future** - How would they like to be in the future without the current dysfunction?
Review of Basic Protocol

- History Taking
- Preparation
- Assessment
- Desensitization
- Installation
- Body Scan
- Closure
- Reevaluation
Remember that rapport is a key component in the preparation process.

If there is good quality rapport established, the clients are going to feel safer during processing.

One of the key components of EMDR processing is the dual awareness component where the client is maintaining awareness of the trauma and of the BLS and presence of the therapist.

Feeling the calm and connected presence of the EMDR therapist helps the client to maintain that dual awareness.
As part of the preparation phase, the Safe/Calm place allows the client to shift state.

We can use the Safe/Calm place as an assessment of the client’s ability to shift out of distress in the session or at home.

Typically, if a client can easily do the Safe/Calm place, they can begin EMDR trauma processing.

However, if they cannot do the Safe/Calm place, they may be able to shift state with breathing, imagery, progressive muscle relaxation or other self-control techniques.
The concept behind Resource Development and Installation in EMDR Therapy is to help access or develop resources to allow the individual to process the trauma. While helpful on its own, it is not sufficient treatment to just use RDI. If the individual can easily access positive resources and shift state, it is likely that RDI is not necessary. Trauma processing needs to be our main focus. We can use RDI to prepare for processing or to address developmental deficits.
Clustering of Traumatic Events for Generalization Effects

- Often, with multiply traumatized clients we use clusters to help organize and group trauma targets.
- With individuals who have multiple traumas, we are not going to process each one.
- In an exploration with the client, we select memories which represent an entire cluster.
- The selected memories can be organized according to types of trauma, body sensation, cognition, location of trauma or other clusters which make sense to the client.
- After reprocessing of the selected target, the client scans other memories in the group to see if they are still disturbing.
How to get through a client’s strong emotional reaction.

- If you feel that the client is having a strong emotional response and cannot proceed with normal processing you can try the following strategies:
  - Increase the length of the set of bilateral stimulation.
  - Change the direction or speed of the eye movements.
  - Change modality to tapping or to auditory tones.
  - You can use cadence sounds while they are following the eye movements (Here, Here... etc. in cadence with the bilateral stimulation).
Strategies to get through a strong emotional reaction, continued

- Remind the client of the metaphor that they have chosen: it is just scenery on a train or simply watching a video.
- Use the metaphor of a tunnel. If we are in the middle of a tunnel, as much as possible we want to keep going to get through as quickly as possible.
- A dental metaphor can be helpful: the trauma is like a cavity. We want to go in and clean it all out rather than leave it there to fester.
Therapist verbalizations to maintain dual awareness

- Use gentle words to nurture them through the strong emotional reaction.

- As EMDR therapists, our rapport and calm presence are important resources for the client. We can use gentle and calming words to help maintain dual awareness.

- You can say things such as, “It is old stuff. Just notice it. It is over and in the past. You’re doing fine. Hang in there: we’ll get through it... etc.

- The goal is to have them notice your calm presence and to continue to focus on the trauma.
Distancing Strategies

- Narrowing the Focus:
- Focus on one aspect of the experience at a time.
- Often, if we just concentrate on the body sensations the client is able to process through a strong emotional reaction.
- Alternately, The client can just focus on the thought associated with the target, or the emotion.
Distancing Strategies

- **TICES Strategies, Image:**
  - Change the image from color to black and white.
  - Change from a moving image to a still picture.
  - Have the client process, imagining they are behind a glass wall, a force field, an impenetrable bubble or other protective barrier.
Distancing Strategies

- Have the client visualize the event from a distance, and slowly move closer.

- Have the client experience the full affect but just briefly, for mere seconds. Then have them slowly build up to experiencing the full affect for longer and longer.

- Cognitions:

- Focus on one cognition (sound or thought) at a time.
Emotions:
- Have the client focus on one emotion at a time.
- Remember to always return to target after any modification of the protocol.
- This is to allow for full processing of the entire node.
Focus on the Resistance

- One technique is to focus on the client’s resistance to processing the trauma.
- Have the client notice where they are feeling it in their body.
- Add BLS.
- This can help decrease the resistance and to be ready to process the trauma.
Resistance, Continued

- For example, if the individual gets a headache or chest tightening when they think about processing the trauma, have them focus on the body sensations associated with the headache or chest tightening.

- Often, the client will process through the resistance quickly and be ready to process trauma.
At times, the client may have blocking beliefs that serve as resistance to trauma processing.

One way to elicit the blocking belief is to ask, “Are there any beliefs that something bad will happen if we process this trauma?”

Understanding the dynamics of the client can also be an important clue to finding blocking beliefs.

For example, if the client witnessed their parent raging, they may have the blocking belief, “It is not safe to feel.”
Examples of Blocking Beliefs

- It is not safe to feel.
- Once I start to feel it, the feeling will never stop.
- I am not worthy of getting better.
- I will be overwhelmed and go crazy if I face it.
- I will fall apart.
- I could die of fright.
- I am unlovable and the feelings that come up with that are intolerable.
- I will harm someone if I get in touch with my rage... etc.
Addressing Blocking Beliefs

- The clinician can engage in an exploration about where they learned the blocking belief.
- Often these blocking beliefs are trauma induced and if the trauma related to the blocking belief is reprocessed, the client is then able to face the trauma that was originally being blocked.
- You can target blocking beliefs directly.
- Sometimes, the client needs psychoeducation and support in order to address the blocking beliefs.
What are your worst case scenarios?

- Fear of decompensation
- Fear of dissociation
- Client can’t handle it
- Increased suicidal ideation
- Psychosis
- Self-harm
- Relapse on substance abuse
- Others?
Discussion of Worst Case Scenarios

- Fear of decompensation
- Fear of dissociation
- Client can’t handle it
- Increased suicidal ideation
- Psychosis
- Self-harm
- Relapse on substance abuse
Vignette Discussion

- Form a small group of 3-4 clinicians seated near you.
- Please discuss the following vignettes.
- Think in terms of the goal of processing the trauma while maintaining client stability.
- Use a brain storming approach to see how many different strategies and ideas you can generate.
Vignette 1

- Client has a single incident presentation where they had a life threatening car accident 2 years ago. They were severely injured in the accident and are quite avoidant of any reminder of the incident. They do not drive and do not like to be a passenger in a car. Their childhood history is benign and have no other trauma history. You start trauma processing and they immediately start crying and shaking. They use their stop signal. What do you as the clinician do?
The client has a complex PTSD history. They are the victim of child sexual abuse, emotional abuse and past domestic violence. They respond well to the safe/calm place exercise. They also respond well to several different self-control exercises and use them frequently in the first weeks of therapy. You develop a targeting sequence plan, including clustering the traumatic events.

The first desensitization session, they have a completed session with a SUD of 0 and a VOC of 7. During the second desensitization session, they are processing a memory of the sexual abuse. They begin to dissociate into the memory, having an acute flashback. What do you as the clinician do?
The client had a single incident trauma where they were choking. They had a loss of consciousness during the original incident. You begin the desensitization phase and the client starts gasping for air and saying that they can’t breathe.

What do you as the clinician do?
The client is diagnosed with Dissociative Disorder, unspecified. They have a history of complex PTSD. After working with the client during the preparation phase they have developed a number of resources and you have excellent rapport. You begin trauma processing and they report feeling floaty and numb.

What do you as the clinician do?
The client has multiple traumas including sexual abuse. You take a history. The traumas they have experienced are severe and complex. The first time you try the Safe/Calm place, the client tears up and says they can’t go on. They report sadness and feelings of overwhelm just to imagine that such a place exists. They say, “There is no safe place.”

What do you as the clinician do?
Eye Movement Desensitization: EMD

- Eye movement desensitization or EMD is a modified version of the full protocol.
- Used for complex trauma or for intervention with clients who do not have adequate stabilization.
- If your client is over-aroused or unable to tolerate full EMDR, you can start with EMD.
- The idea is to maintain processing within a smaller target, just related to the trauma itself and not allowing the channels of association to open up.
EMD Procedural Steps

- Identify the memory to target. You may choose to target only part of the memory.
- Use the standard Assessment Phase to identify and delineate the target.
- Start with short sets of BLS (12-15) and increase as tolerated by the client. If they are associating to other targets, you can shorten the sets further.
- Come back to target after each set of eye movements.
- Take a SUD level each time.
- If they are unable to process to 0 SUD, have them identify a new positive belief that expresses the shift from this session.
Examples might be “I am working to heal this.” or “I am learning to face my fears.” (Think of this as an intermediate positive cognition).

Install using the typical installation phase until VOC 7 or as close to 7 as possible.

Follow closure procedures for an incomplete session (e.g. SUD > 0) do not use the body scan after installation.

If they need to do a self-control technique or safe place, do so to aid in closing the session.

As the client progresses and stabilizes with EMD, then proceed to full EMDR processing.
If the information is processing, stay off the tracks

- The majority of what we do during EMDR processing is to say, “Just notice it.” (add BLS). “Take a breath and let it go.” (or “Blank it out.”). “What are you noticing now?” or “What do you get now?”

- In most of these situations we just continue until the SUD level comes down.

- Many times as EMDR Therapy clinicians we may not understand exactly how what the client is processing relates to the original target. However, the client is processing what needs to be processed (AIP Model).
How to know where to start?

- With individuals who have suffered from multiple trauma, we often feel helpless and don't know where to begin. We can be overwhelmed by the severity of the trauma and the sheer volume of traumatic events they have experienced.
- Typically, we start with Past, Present and Future.
- We can use clustering to help organize targets.
- Think of the pathology as a board pressing down on the client and we need to identify the screws.
- We may need to modify this approach depending on the client.
Modified Treatment Approach for Dissociation

- Sometimes it is hard to know where to start with individuals who have dissociation as part of the trauma or complex PTSD.
- If they have profound early trauma, starting with the early past memories may be too intense for the client.
- You can make a clinical decision as to where to start the processing, including more recent memories or present stimuli.
- With a comprehensive approach, we start with past, present and future.
- With DID we don’t typically start when they started dissociating but rather with more recent trauma.
When all else fails: Consultation

- If you are stuck, please reach out for consultation.
- It is not unusual to feel lost when knowing when to start or how to help more complex or fragile clients.
- EMDRIA.ORG has a list of certified EMDR Therapy Consultants.
- If you were trained by Trauma Recovery, EMDRHAP, they have a list of consultants who often will consult for a reduced rate.
Books and Websites

- Trauma Recovery EMDRHAP
- EMDR.COM
- EMDRIA.ORG
Thank you very much for attending our talk. If you have further questions, you can reach us at:

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References


References, Continued


