■ CLINICAL Q&A ■

Editorial Note: The Clinical Q&A is a regular journal feature in which master clinicians answer questions posed by readers who are requesting assistance with clinical challenges. In this issue's column, responses are written by two psychologists who are EMDRIA Approved Consultants, Dr. Denise Gelinas and Dr. Howard Lipke. Readers can send questions to journal@emdria.org

Question: I recently took the EMDR training, but I'm having trouble getting started with EMDR. What do you suggest?

ANSWER FROM DENISE GELINAS:

It seems to me that your experience is not unusual—most of us have paused for that deep breath as we moved from practicing EMDR in a training setting to doing it on our own for a client. For most clinicians, EMDR is a new way to work. There are a number of strategies to manage this. I'll mention the ones I know about to add to the ones you may have already come up with for yourself.

My first suggestion is for the clinician new to this way of working to review why and how EMDR works, and what elements of EMDR it would be helpful for his or her clients to know, and to actually write down the major points for themselves. [Shapiro's *Eye Movement Desensitization and Reprocessing* (2001) and the EMDR training manuals are excellent resources for this, as they are both accurate and well organized.] Depending upon the clinician and the client, these elements might include the following: the adaptive informative processing (AIP) model; why we use eye movements or some other form of alternating bilateral stimulation; the dual focus of awareness; information about how EMDR is supported by numerous "gold standard" outcome studies; and that EMDR is the recommended treatment or treatment of choice for posttraumatic stress disorder in the national health care systems of many countries, the U.S. Departments of Defense and of Veterans Affairs (2004) as well as the International Society for Traumatic Stress Studies (2000) *Practice Guidelines*. This conversation could end with the procedural aspects of how EMDR is actually done.

Since each clinician has his or her own style, a second suggestion might be to practice reviewing those elements out loud, so that when the time comes to provide this information to the client, it is all fairly organized and coherent.

Third, it might be useful at this point to work with the safe place exercise. As well as being a necessary preparatory element of EMDR treatment with every client, safe place provides the client with a gentle introduction to some of the procedural and experiential aspects of EMDR, and, just as important in this present context, it does the same thing for the clinician!

Fourth, I am an advocate of using so-called cheat sheets while learning to do EMDR (i.e., copies of any lists or protocols that might be useful). It can be useful for clinicians to print out copies of the actual steps for doing safe place or for the assessment and desensitization of a memory or for the closure for both a complete and an incomplete session. Many clinicians find it helpful to have lists ready on hand of negative and positive cognitions, and also of cognitive interweaves. Obviously, the idea here is simply to provide yourself with the procedural protocols for whatever helps you to feel more comfortable in providing EMDR. (For the artistically inclined or the merely marginally obsessive, you can use different colored paper for each type of cheat sheet to be able to find it rapidly when you need it!)

When the time comes to choose the first target memory to desensitize, my suggestion for the clinician new to EMDR is to keep target selection basic. It is usually best to begin doing EMDR with clients who have old traumatic memories in the context of a personal history with relatively few traumas. (Clinicians who tend to work with extensively traumatized individuals may have to look rather carefully to see if they have one or two such individuals in their caseloads and begin moving into EMDR work with these clients, rather than their more extensively and repetitively traumatized clients.)

This "start basic" target selection approach allows a clinician to more easily identify a relevant target memory and thus concentrate his or her attention on the procedural aspects of the Assessment, Desensitization, and Reevaluation phases. As these procedural aspects become well learned, the clinician's confidence in both his or her own abilities and in EMDR are reinforced. At that point, he or she might feel ready to address clinical situations that require more complicated EMDR case conceptualization and target choices. These might include using EMDR for current anxieties, phobias, trauma-based

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depressions, complex PTSD, or recent traumas. (EMDR treatment of each of these is clearly described in either the training manuals or in Shapiro's texts.)

This implies *not* embarking on one's EMDR learning trajectory by beginning with clients who have extensive childhood trauma (which usually requires more extensive case conceptualization and/or strategies for target choice), nor with clients with a very recent trauma (which requires the recent trauma protocol). Recent trauma is usually regarded as a traumatic experience that occurred only 2 or 3 months previously. Since recent traumas require a protocol different than almost all other traumas, why start with this? It's more useful to learn the basic approach, and when the clinician is comfortable with this to begin to address cases calling for more complicated EMDR case conceptualization and target choices.

Finally, most clinicians find that making the transition to actually using EMDR with their clients is inestimably aided by meeting regularly with an EMDR consultation group (either of peers or with a consultant) or by working regularly with an EMDRIA Approved Consultant. It seems that some clinicians have come to feel that they should be able to do EMDR immediately upon their first exposures to it, but this seems to me unrealistic and perhaps even unduly harsh in terms of their expectations of themselves. Perhaps this expectation contributes to some clinicians' hesitancy in making that transition from training to actually using EMDR. It is probably helpful to remember that just because EMDR works rapidly for the client does not necessarily mean that it can be learned just as rapidly by the clinician. Realistically, it cannot. EMDR does work rapidly and thoroughly, but it is in fact a rich and widely applicable approach, and it can take time and practice to learn a variety of applications.

So, for all those clinicians inhaling that deep breath before taking the plunge into actually using EMDR, I would encourage you not to feel that you absolutely need to know everything overnight and to instead just take it one step at a time, getting consultation along the way and enjoying this way of working, which, I would guess, will surprise and delight you and will be a gift to many of your clients. Best wishes.

Denise Gelinas
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ANSWER FROM HOWARD LIPKE:

In my experience, there are a number of reasons clinicians have trouble beginning to use EMDR. Not all of them could be addressed in the amount of space available; they probably all couldn't even be listed. I think the most common of the issues is related to clinician, rather than client hesitancy. Even when therapists have seen the method be startlingly effective during the training practica, they still sometimes feel uncomfortable explaining the method to clients. They become nervous about waving their arms in front of clients' faces or taking out a contraption like the light bar.

Understanding the Underlying Theory

I think the core of getting over this barrier is for the therapist to have satisfactory understanding of how EMDR, and the eye movement in particular, fit into a scientific understanding of the therapeutic change process. One of the basic principles of EMDR practice is that we work in the specifics of experience. I think it is reasonable for new EMDR therapists to imagine the specific scenario in which they are asked by their client to explain this "crazy" idea. If they cannot imagine themselves responding expertly, many therapists are going to hesitate to go ahead.

It is a reasonable hesitation.

While several hypotheses are offered for the mechanism of effect in EMDR training, there is little time to practice explaining the theoretical and research justifications to the client. Therefore, this first step of integration in practice is given little time. So, my first recommendation is for the therapist to be very clear about the justification for using eye movement. Bob Stickgold's 2002 paper is strongly recommended for the therapist to not only read, but study.

There are two main parts to Stickgold's sophisticated analysis. The first involves memory. Based on my interpretation of the psychophysiological and memory research he addresses, I explain to my clients that we can consider two types of memory: (1) reliving and (2) historical. Traumatic events may become stuck in reliving memory because of the emotion attached. The memory is prevented from moving and becoming historical memory.

For example, if one has a reliving memory of an event in which one felt terror, then the terror is felt again. If one has an historical memory of the event, then one does not relive the fear; instead, one remembers that fear was felt, and in fact, the emotion experienced with the now historical memory could be relief. Therapy then could be considered the promotion of moving memory from the reliving system to the historical system. The above is a brief version of what I explain to clients.

The second part of the analysis concerns the role of the eye movement. This is shorter and less fully understood. What I usually explain to clients is that the understanding is still theoretical, but that it is reasonable to believe that the eye movement or other activity creates a so-called orienting response in the brain, which is associated with the brain being less stuck in its patterns of remembering.

Consequently, I suggest that when new EMDR therapists are familiar with the information that Stickgold describes, they will likely be more comfortable getting started. The next step, after becoming familiar with the material, is to practice explaining the ideas to a colleague or friend. Do as we suggest to our clients, role-play the explanation. The ability to discuss the theoretical underpinnings of EMDR should lead to an increased level of confidence, born of expertise. I think the therapist can approach the beginning of using eye movements (or other sensory/motor stimulation) with justified confidence.

While the theoretical understanding will help the therapist, and may interest the client, acceptance of the

plausibility of eye movement may sometimes be more effectively explained by putting the activity in a context outside EMDR. The therapist might consider and ask the client if he or she has found music to be calming when try to relax or, alternatively, invigorating when trying to exercise. The exact mechanism by which music has these effects may not be known, but we accept, and even seek out, its effects regardless.

Borrow Assessment Phase Questions Into the History Phase

Another issue that might keep beginning EMDR therapists from applying the method is the number of new specific steps added to the therapeutic interaction. New therapists may be so concerned about getting so many new things right that they may just give up. Practice in actual therapeutic situations can be obtained by borrowing the questions from the Assessment Phase and putting them into the History-Taking Phase. If during our initial history taking we ask clients about beliefs, emotions, and sensations connected to a traumatic event, and have practice rating these in the history section, we gain several benefits besides the therapist just getting more comfortable with the questions. In getting the cognitions and VoC and SUDs, the therapist has an opportunity to incorporate some of the valuable lessons of cognitive and behavior therapy early in treatment. For some clients, attention to emotion and body sensation allows them to be aware of the importance of these dimensions. For other clients who are all too aware of these dimensions, they get to see how emotion and feeling can be considered systematically, that the therapist is aware of their importance, and that therapy is not just about so-called thought games. The above does not even include the value in the assessment of early knowledge about the client's way of experiencing the world and himself or herself.

Borrowing the Assessment Phase questions into an earlier phase of treatment also results in the client having familiarity with this way of understanding experience, so that when it comes time to use assessment questions in the Assessment Phase, to produce the target for desensitization, the work proceeds more efficiently.

Beginning therapists should be aware, however, that using the assessment questions can lead to insight and therapeutic change even before the Desensitization Phase. The other side of this is that a very few clients are too fragile for the therapist to ask such specific questions about their trauma during the History-Taking Phase, so the above suggestion should be used with some caution.

The above is recognized to be a very brief response to only some aspects of the general question raised. Nonetheless, I hope this discussion has been helpful.

Howard Lipke
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