E.M.D.R. treatment for complex P.T.S.D. in military and civilian clients

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Internet Resources: [www.EMDRIA.org](http://www.EMDRIA.org) and [www.EMDR.com](http://www.EMDR.com).

**Please do not consider this workshop training in E.M.D.R. This workshop is intended only as an overview. Dr. Murrell takes no responsibility for any participant who attempts to do the treatments outlined here without obtaining the Level 1 training from one of the workshops presented by trainers via E.M.D.R.I.A. org.**

1. **What is E.M.D.R. and what is its historical development?**

This technique was developed by Francine Shapiro, Ph.D. quite by accident when, as a graduate student, she was working with Vietnam era combatant diagnosed with P.T.S.D. in a California V.A. treatment center. In May 1987, Dr. Shapiro discovered, while on a walk, that her eye movement from side to side could actually evoke a deep sense of relaxation and calm. Through trial and error over the next several months she developed a treatment protocol that has developed into what has become the core of the techniques that is used today in a variety of settings.

What was originally a means of quieting the mind has become a revolutionary (and weird) treatment that has been endorsed by the Department of Defense, the American Psychological Association, and a number of professional societies outside the United States. As you professionals know P.T.S.D. is a diagnosis given to anyone who has witnessed another person’s death (or near death) or have themselves been severely injured by another person or an event that was outside the normal range of human experiences. These traumatic events might include battlefield injuries or the witnessing of another’s injuries. Or perhaps it may be a more mundane event such as a motor vehicle accident, physical abuse, or even a repressed childhood memory of severe abuse.

The personal impact of such events varies widely from person to person. It has been noted that only about seven percent of all workplace trauma (ie. deaths of a coworker) result in the development of symptoms that are diagnosable as P.T.S.D. However, for those individuals who do develop symptoms the results can be devastating. These may be in the form of panic attacks, hypervigilance, nightmares, flashbacks, or any of the myriad other symptoms of P.T.S.D.

There are certain cautions that must be considered before employing E.M.D.R. and proper screening the client is the first step in determining whether or not this technique will be appropriate for use with the client. More will be said about client screening later in the presentation.

1. **The details of the E.M.D.R. technique:**

As such the E.M.D.R. therapist will first of all take a complete biopsychosocial history of the client to get as complete an understanding as is possible of the traumatic events that may have affected the client from childhood to their present age. The movement of stimuli, originally using the therapists fingers moving before the client’s eyes, as also evolved into a variety of techniques that stimulate alternate sides of the brain. The rapid metabolizing and processing of the negative effects of trauma is facilitated by what has come to be called B.L.S. (bilateral stimulation of the brain). This pattern of stimulation initiates an unusual response of what Shapiro called A.I.T. (advanced information processing) of the various aspects of the traumatic experience.

The memories of the traumatic event are viewed, in this model, as being stores as four separate, but interrelated, experiences that often interfere with the client’s ability to optimally function in their everyday activities. Those clients diagnosed with P.T.S.D. are frequently troubled by disturbing thoughts, emotions, bodily sensation, and images that may intrude on their experience at any given moment either during the day or at night.

The basic components of the E.M.D.R. procedure include understanding these four elements: the internal image of the trauma, the negative cognition involving the often pessimistic view of themselves and the nature of life, associated bodily sensations with the traumatic memory, and the various negative emotions triggered by the traumatic memory. These four elements are closely examined by the therapist so that each one is clearly delineated and then monitored as to the changes that occur in each element during the process of treatment.

**Internal Image:** This is the image that has been recorded by the client as being the sensual record of the traumatic event. It may consist of visual, auditory, kinesthetic, olfactory, or gustatory cues. The image may be entirely recorded as being only one of the five senses or some combination of them. Often time the nature of this recording determines the type of trigger that sets of the P.T.S.D. symptomology. For example, a woman may first recall a childhood sexual abuse incident by the triggering of a certain type of touch or smell with her lover that may resurrect a memory that has remained forgotten for decades. Or perhaps a combatant may be watching a movie or reading a novel about war that may trigger a forgotten incident of seeing a battle buddy die that had been repressed for many years. It may be something as simple as the look on someone’s face or the sound of a belt buckle being undone that provokes a huge reaction in the client because it is part of their internal imagery associated with their personal trauma.

**Cognition associated with the trauma:** The client is also asked to describe in detail what their perception of themselves was at the moment of the trauma and this is then recorded as their *N.C. (negative cognition).* This thought is often a distorted perception of the traumatic event as it was interpreted at the time (ie. “I am a bad person”, “I am not good enough”, “It was all my fault”, “I don’t deserve to be happy”). Often this N.C. leads the client to have a chronic level of anxiety, depression, or neurotic guilt for reasons that are not always apparent to themselves or even their therapist. The deep seated nature of trauma related beliefs about themselves or the nature of life (ie. “Something bad is always going to happen to me”, “I will never get a break in life”) may manifest itself in persistent self-defeating behavior in addition to the normal symptoms of P.T.S.D.

The client is also invited to create a statement that describes a perception that they would like to have of the traumatic event that is less threatening and much more egosyntonic. In other words, the client is encouraged to develop a statement that they would choose to think if and when the traumatic memory is reactivated. For example, the client might choose to develop the thought or *P.C. (positive cognition)* that the situation is from the distant past and the danger is gone (ie. “It is over and I am safe now”). This P.C. is assessed periodically during the treatment by asking the client, “On a scale of 0-7 how true is your positive cognition?”

In other words, once the client has the new more rational and positive thought to reframe their trauma how much do they actually believe on an emotional level? Often during the course of the treatment a P.C. will start as a 0/7 and end the session as 7/7; the meaning being of course that the P.C. has become completely true on an emotional level. The change in the N.C. is usually much more rapid and is the focus of the treatment until the S.U.D.S. is down to a 1or 0/10. Then the focus changes to moving the P.C. upward until it reaches a 7/7.

**Emotional discomfort scale:** The scale used to describe the intensity of the emotional discomfort associated with the trauma is known as the S.U.D.S. (selective units of discomfort scale). The client is asked, “When you think about the trauma today what emotion do you feel? If you were to rate the intensity of discomfort from 0-10 how high would that number be?”

**Physical discomfort scale:** The client is then asked similar questions regarding their level of physiological discomfort that they experience when the trauma is recalled during the session. The areas of the body that become tense or painful are then noted and will be monitored during the course of the session.

**Activating the Advanced Information Processing System:** Once the therapist has established with the client what the nature of each of the above elements of the traumatic memory consists of, the B.L.S. will begin. Assuming that the therapist has determined that the client has been extensively educated as to the nature of E.M.D.R. and is appropriate, then they are ready for E.M.D.R. The therapist will careful to have trained the client, by this time, in deep relaxation and “safe place” imagery so that the client will have the capacity for bringing themselves into a relaxed state both before and after the E.M.D.R. treatment during the session. The therapist will also have taught the client to change the memory of the trauma so that it can be viewed via guided imagery from the third person.

In other words, the client may now remember the trauma as if it were a video or a movie that could be seen from the point of view of a more distant observer and not from their former perspective in the first person. The therapist will also have done some training, using the “safe place exercise” in training the client in developing the skill of “dual attention”. This simply means that the client has the capacity to be aware that they are in the session with their therapist (and not dissociated) yet they are also paying very close attention to their internal imagery and the four elements of the trauma.

The traditional means of doing E.M.D.R. meant that the client would side opposite of the therapist and the latter would position their first two fingers of their dominant hand approximately 12-18 inches from the client’s face. The therapist would then quickly move their entire hands back and forth horizontally. One bidirectional movement would be from extreme right-to-left-to right from one side of the client’s vision to the other. This would occur silently and quickly with the therapist making 24 bidirectional movements in a brief period of time.

After this first set of movements, the therapist would stop and ask the client, “What do you notice now?” In other words the therapist is asking, “Are their changes in any of the four elements of the NC, SUDS, body sensation, or image?” Normally what happens is the client will report a high level of discomfort (ie. SUDS = 9/10) at the remembering of the image. However, after the first set the client will often report an increase in discomfort as the full impact of the trauma is felt once again. In effect E.M.D.R. is an “exposure therapy” because the client is allowing him/herself to be re-exposed to the memory of the trauma without the usual ego defenses of denial or repression. By not avoiding the imagery and associated emotions the client finds that by the second or third set that the remembering experience has begun to change.

Typically the client will report a change in either the image or the S.U.D.S. That is to say, that the emotional intensity often begins to drop dramatically (ie. from a 9/10 to perhaps a 7/10 or even less by the fourth set). Coincidently the image often begins to morph into something less threatening. For example the perpetrator may seem to shrink in size to a less intimidating form and the client may simultaneously gain in stature. Depending on the nature of the trauma, the client may also find that in the middle of a set that their perception of themselves, the NC., begins to change so that they no longer view themselves as a victim but rather as simply the observer of an unfortunate event.

1. **How does E.M.D.R. differ from other treatment modalities?**

Actually E.M.D.R. incorporates elements of a number of other modalities into a comprehensive treatment protocol. The basic assumption of cognitive behavioral therapy, C.B.T., is that thought is the prime trigger for emotional responses. That is to say that C.B.T. therapists seek to build an awareness in their clients of their own “thoughtlife” and with that awareness begin to notice the impact of their thoughts on their emotions, behavior, and even their physiological responses. The same awareness is cultivated in E.M.D.R. clients as part of the preparation for their B.L.S. treatment. It is an assumption of both modalities that once awareness is developed in clients they can begin to exercise choice in what they think about and in doing so change their emotional reaction to previously stressful events in their present and past environments.

In addition, E.M.D.R. therapists teach relaxation training (in my practice I teach my clients biofeedback and guided imagery work) again as preparation for the B.L.S. sessions that will follow when the client is ready. Additional preparation for the client would include whatever is necessary to empower them to a stable condition so that they will have the necessary ego strength to endure remembering, and to a certain extent reliving, the traumatic memories of their past. This might include stress management, family therapy, group therapy, psychoactive medication, meditation training, or treatment for addictions.

The client must be in a stable life situation and have good rapport with their therapist. Rogerian therapy is always useful in the beginning stages of E.M.D.R. treatment to establish a solid therapeutic alliance. Developing a P.C. for the trauma allows the client to develop a cognitive reframe of the experience which is similar to the basis of Neuro-linguistic Programming (N.L.P.) as well as hypnotic suggestion therapies. Encouraging the client to state what they want instead of what they don’t want is empowering and affirming that the client does have a choice in how they wish to perceive the world and themselves.

1. **How does E.M.D.R. compare to other therapies in terms of symptom reduction?**

You may choose to review the huge number of studies that are enumerated on the E.M.D.R. com website. One study that I am familiar with that was most impressive to me was completed in 2007 by Bessel Van der Kolk with several colleagues in Boston. It was published in the Journal of Clinical Psychiatry, 68, pp.37-46. They compared the effects of E.M.D.R. treatment (eight sessions) with daily dosages of Prozac (fluoxetine) and a placebo. What they discovered was that Prozac and E.M.D.R. both reduced the symptoms of depression associated with P.T.S.D. However, in a six month follow-up to the study it was found that the Prozac treated clients had most of their symptoms return while the E.M.D.R. treated clients not only did not have their symptoms return but actually had fewer symptoms of P.T.S.D. than when the study ended six months previously. I have experienced many clients reporting that their symptoms have been resolved after four or five session of E.M.D.R. This is not uncommon with type 1 P.T.S.D. but less common among complex P.T.S.D. cases.

1. **What other diagnoses has E.M.D.R. been successful in treating besides P.T.S.D.?**

The studies done as of this date do not confirm that E.M.D.R. is any more effective than C.B.T. in treatment of panic disorder with or without agoraphobia. However, my own experience is that E.M.D.R. can be an effective treatment if the client is given extensive preparation and it is used on an every other session or every third session basis. Interestingly E.M.D.R. has been shown to be somewhat effective in increasing empathy between intimate partners. The technique is modified so that one of the partners is an observer to the other partner’s work on their own traumatic issues. This technique often provides both parties with insight as to the nature of their respective triggering situations.

1. **Civilian Case History:**

As an example, I once had a client, we’ll call her Mary, who was referred to me because they had been in a very serious car wreck. They had been driving on a four lane highway when a car passing them side swiped them and they bounced off them into a telephone pole. The car my client was driving was traveling at highway speeds so it hit the pole sideways sheering it off at about two feet above the ground. The car my client was driving hit the pole on the passenger side and the vehicle was cut into two pieces just behind the front seat. The crash was of course accompanied by loud noises as the car hit the pole and both were ripped apart. Fortunately my client was not seriously injured because she was wearing her seat belt. She was briefly hospitalized for bruising caused by her air bag and seatbelt. She was released after several days and began a law suit against the driver who ran her off the road and into the telephone pole. The client was in exceptionally good health prior to the accident and recovered quickly from her injuries. Unfortunately Mary suffered P.T.S.D. as a result of the wreck.

Among her many symptoms she was scared to death of getting in a car and driving even around the block. If she ever saw a car that approximated her car brand, model, or color she would immediately experience a very high level of anxiety and feel her heart race so fast she initially thought that she had heart disease. She also had anxiety attacks whenever she was in a car that drove near the scene of her accident. She suffered insomnia and when she was able to go to sleep she often found herself dreaming of the accident and awakening abruptly from a nightmare to stare into the darkness until morning arrived.

The client also found that watching car chases or car wrecks in a movie was equally terrifying for her. Despite her best efforts she found that she was not able to make herself get into a car and drive to work. The woman was a highly paid professional and it was extremely inconvenient for her to not be able to drive an automobile. Mary found that taking a taxi was expensive and time consuming not to mention embarrassing to explain to her peers. Her attorney, who was a friend of mine, suggested that she might need to see a psychologist to help her deal with the non-medical aspects of recovering from her wreck.

The client was reluctant to see a psychologist about her problem; in her first meeting she told me, “I am not a crazy person. Why do I have to see a shrink just because I am afraid to drive?” She was angry when she was seated across from me in my office. However, she was also confused as to why she kept having these moments of extreme panic for no reason, at least that she could see, at all. I explained, to my somewhat reluctant client, that she was having difficulty with panicking because she was feeling threatened, at least on an unconscious level, by the possibility that she might be involved in another car wreck.

I further explained that her limbic system in the brain was exercising extreme caution by ramping up all of her autonomic nervous system to prepare for another car wreck. In a sense her limbic system was like an “overprotective mother” who would not let her get near another care for fear that she might get hurt. The client went over her personal history noting her best and worst moments over her life. We discussed that events in her life in which she was most proud of her efforts and also those moments in which she felt most “safe and accepted”.

These positive memories were expanded upon so that she could begin to feel some of her personal power that she seemed to have forgotten during her recent bouts of panics. We also went over those worst moments, including the car wreck, during which time she felt most helpless and vulnerable. These moments would be used later to better understand her unconscious belief system about her own ability to protect and manage her environment.

The first goal for her treatment was doing some psychoeducation on the nature of the stress response. That is to say that the client needed to have an initial understanding that her uncomfortable symptoms were her limbic system’s way of keeping her far from harm’s way. However, the problem was that this “overprotective mother” was ruining her conscious mind’s ability to drive by flooding her body with adrenalin and raising her heart rate to the point that my client could not function well at all.

Whenever she approached a car all she could feel was her body racing with adrenaline and a mind filled with racing thoughts about how much danger she felt that she was in. She was so preoccupied by the thoughts and feelings of being in danger that she could not possibly focus on anything else. She began to understand that the limbic system evolved to be sensitive to any sight, sound, touch, smell or taste that reminded us of any past danger.

It was this deep unconscious library of past experience that the limbic system maintained that kept us as a species from putting ourselves in the same dangerous situation more than once. We then began on work on developing her ability to relax herself without the direct dependence on medication. She developed a routine in which she would spend a few minutes each day breathing deeply and remembering her “best moments” from her past.

The effect was to give her a new ability to calm herself in a matter of a few minutes. She found that certain music helped her accomplish deep relaxation, along with stretching, hot bathes, reading inspirational literature, keeping a journal, and spending time talking with friends. In a matter of four weekly sessions, she was able to relax herself fairly deeply with fewer moments of high anxiety and lessened bouts of “thought racing”.

She was still unable to force herself into driving a car, but she did establish some new abilities to calm herself down. We used various methods of helping her to learn to calm herself. These included prayer (she was a religious person who really benefitted from prayer and meditation), regular physical exercise, listening to her favorite music, long hot baths, talking with friends, as well as relaxation training. In addition, she began to keep a journal of her thoughts and feelings. What I asked her to notice was the content of her thoughts and the emotions that were connected to her thoughts.

What she became aware of was that she had certain thoughts that had very strong emotions associated with them. These included thoughts about her car wreck which elicited very strong negative emotions as well as thought about her successes that elicited very strong positive emotions. She had noticed that since the wreck most of her thinking was about how awful the wreck was and how she could successfully avoid being exposed to any future car accidents.

We then set up the protocol for E. M.D.R. The 11 step protocol for standard E.M.D.R. treatment. This included the extensive biopsychosocial **client history**, screening for any type of seizure disorder or medical problems that might be exacerbated by the treatment, and making sure that she was emotionally in a stable place in her life. Then we entered the **preparation phase** by providing her with psychoeducational information about E.M.D.R. and continued to work on her ability to maintain “dual attention” focusing on guided imagery. We then started the **assessment phase** as we worked on selecting her N.C. and P.C. as well as began developing a means of experiencing her trauma from a distant third person perspective.

We assessed her S.U.D.S. level and began the **desensitizing phase** of actually doing the B.L.S. During this phase we did a set, which took perhaps 30-45 seconds, and then paused to process whatever imagery and/or emotions emerged during that time. When the S.U.D.S. finally went to 0 then we switched to the **installation phase** during which time we essentially ran the same visual field again but this time with a different perspective (the P.C.). As the client processed each set again we would periodically assess the V.O.C. (veracity of the positive cognition) and when it went to 7/7 we would stop. At that point we would switch the focus of the processing to the physiological sensation and do the **body scan phase** of the protocol. If the client had a 0 on the S.U.D.S. and a 7 on the V.O.C. we still had to keep processing until they had no more unusual tension in their body. As their body was cleared of tension we would then go into the future template phase of treatment during which such time we would project into the client’s future a situation in which they might encounter a trigger of their old trauma and we would rehearse how they would react to it using their P.C. as a guide.

When this was accomplished they would be done with that session and we would enter the **closure phase** of the treatment in which they would use their relaxation training to calm themselves and prepare for re-entering the outside world. In Mary’s case she had simple P.T.S.D. so she did not require extensive pursuit of previous traumatic events.

1. **Case History: Military**

This individual I will call Marvin. His was most difficult because his trauma was very severe and he had multiple traumas both before and after the presenting trauma from Vietnam. Marvin was on patrol in 1968 in a rice paddy in Vietnam. He was a foot soldier who was a veteran of many firefights involving small bands of Viet Cong who attacked his Army unit, primarily at night, with rockets and mortars. On this particular mission Marvin was on a reconnaissance patrol with six other men and they had all stopped for lunch. It was an uneventful mission and it was very hot. They were sitting under a tree at the edge of a clearing. Marvin had been talking with a “battle buddy” when his friend was shot by an unseen sniper in mid-sentence and his head literally exploded all over Marvin without any warning.

The trauma was severe because the man who was shot was Marvin’s best friend and particularly painful because they had no warning that anyone in their squad was in danger. Marvin took cover, called for reinforcements, and then when they arrived carried his friends body more than eight miles to an aid station. He quit the Army as soon as his tour of duty was up and returned to the states expecting a hero’s welcome for his honorable service of three years. Instead what he found when he landed in LAX was mobs of angry civilians who spit on him and called him a “baby killer”. Marvin was married at the time and had a two year old son. Unfortunately he suffered from flashbacks almost every night and attempted to use alcohol to overcome insomnia.

He was afraid to sleep because of the nightmares and yet exhausted by the flashbacks. After he became violent at home his wife divorced him and he became a very angry drunk who re-enlisted after the war and served as a career Army man until his twenty year retirement. It was only after he attempted suicide that he was referred for E.M.D.R. treatment. His treatment targeted the death of this battle buddy and it was resolved in three sessions. However, during the third session as he was winding down the S.U.D.S. of his Vietnam experience he then tapped into an earlier trauma that occurred in childhood when he found his mother being unfaithful to her husband when Marvin was only nine years old.

This trauma was triggered by a similar feeling that Marvin had when his battle buddy was lost in Vietnam. The common denominator was that a loved one, someone that he trusted, was suddenly and abruptly abandoning him.

1. **How does a therapist integrate E.M.D.R. into a treatment plan?**

The answer is “very carefully”. I have never found a technique that was as powerful or intense as E.M.D.R. For that reason it is always advisable to make absolutely certain that the client is in every way ready for treatment and as stable as possible in their work, support system, and medication if necessary. There are a number of ways to do B.L.S. now that offer conveniences rather than doing strict eye movement. Many clients prefer the use of “tapping” on their hands or knees. A number of E.M.D.R. therapists use “light bars” instead of their arms to provide the client with a target to follow with their eyes.

I prefer the “Neurotech” approach that allows the client to modify the sound and kinesthetic stimuli that allows them to close their eyes and use their imagery without being disturbed by having to follow an outside stimulus.

1. **What are the training requirement to be properly trained in E.M.D.R.?**

You may wish to consult the websites noted at the top of this outline. Training is available to those who have a Masters Degree in a mental health field, to graduate students who are enrolled in their internship portion of their program, and to R.N.s who have a Masters Degree. To be certified as a Level 1 practitioner requires two weekend workshops with a practicum and supervision in between them. The supervision needs to be for a minimum of three hours before the second weekend is undertaken. Each weekend workshop costs approximately $750 plus traveling expenses. It is expensive training; however, the training is excellent and the results are quite impressive. There is a great deal more to be said about E.M.D.R. and a full day would not be enough to cover all the nuances of practicing this technique. Unfortunately this is all the time we have for today.

I would recommend any of the books written by Francine Shapiro, Ph.D. She has written extensively on this treatment and has built a very impressive international organization that has trained more than 40,000 therapists all over the world in this technique. They have volunteered to go to the scenes of natural disasters and war torn countries all over the world.

If you have questions you may reach me at my offices at 417-881-1580 or check out [www.murrellpsychologicalservice.com](http://www.murrellpsychologicalservice.com).

Thank you