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Utilizing EMDR Consultation in a Concurrent Treatment Model

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Concurrent psychotherapy is valuable for providing timely interventions to patients with specialized needs. Clinicians refer patients for psychiatric consultations, group work and to therapists who specialize in problem areas such as panic disorder, trauma, child abuse issues and substance abuse. Such traumas as child sexual abuse, family violence and disasters result in a large population suffering from Post Traumatic Stress Disorder and other Dissociative Disorders. Other patients have long-standing depressions, panic and psychosomatic disorders, performance anxiety and phobias stemming from traumas which do not resolve in traditional psychotherapy.

Given such high rates of patients suffering from trauma and relatively low numbers of clinicians trained in trauma work, EMDR-trained therapists with experience in these specific areas are uniquely positioned to provide adjunctive treatment.

Treatment with sexual abuse survivors, for example, is often complex. Intrusive and dissociative aspects of Post Traumatic Stress symptoms produce treatment difficulties, which range from destabilization and dissociative episodes to more typical treatment impasses.

Resistance may involve fear of exposure or of violating taboos against "telling". Sequelae to revelations, overwhelming shame, and concern about rejection by the therapist are other issues. Patients fear being flooded by feelings and memories.

Immobilized and frozen, the patient may have a sense of "pseudo-safety" in the familiarity of these feelings. As the symptoms persist with small or no reduction in distress, patients experience high levels of frustration, feelings of defeat, depression and anxiety. Loss of belief in the efficacy of therapy often follows. This is often an appropriate time for the therapist to consider EMDR as an adjunctive course of treatment.

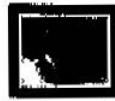
The primary therapist refers the patient to an EMDR-trained clinician who is experienced in trauma work. They develop a collaborative relationship, analyze risks and benefits of EMDR treatment for the patient relative to the stage of trauma work and the patient's present functioning (for example, if the EMDR work is for restabilization or for uncovering). During the course of EMDR treatment, goals are established, safety is maintained, and risk analysis continues. The patient signs appropriate releases and provides feedback to both clinicians.

Patient Responses

Patients report that this approach has contributed to the following perceptions:

- The primary therapist is not "giving up."
- The therapist recognizes the need for additional intervention.
- Abandonment issues are minimized as the relationship with the primary therapist is maintained.
- Two therapists can be models for collaborative teamwork that benefits the patient; providing open communication without secrets and a joint concern for the patient.

The patient has the opportunity to focus on specific problems in the EMDR treatment while continuing to explore feelings, dreams, reactions, etc. with their therapist. This provides additional targets for EMDR work. The patient with safety issues stays in the "known" with their primary therapist.



Since the EMDR protocol posits a patient-centered approach, the patient has significant control and choices regarding length of "sets" (eye movements) and choice of targets. This approach can shorten total treatment time. As targeted issues resolve, skill development and future planning can occur in the primary treatment.

In the author's experience, the following classification of sexual abuse survivors would be appropriate for EMDR referral:

A) Patients presenting with adult onset Post Traumatic Stress Disorder following a sexual assault. They were not sexually abused in childhood, but lived in families with conditions of chronic instability and violence. Such patients actually have chronic PTSD. The developmental deficits which ensued compromised their ability to resolve current trauma.

B) Certain trauma patients manifest somatic problems that are psychogenic. These symptoms represent symbolic body memories or are the results of injuries. Many trauma patients have been misdiagnosed or told to "live with the problem". Problems, such as muscle spasms, chronic pain and sleep disorder have not responded to either medical treatment or standard stress reduction/pain management treatment. These conditions are distressing and interfere with functioning.

C) Patients who have experienced childhood sexual abuse are especially vulnerable to assaults and may not restabilize in conventional treatment.

Case Examples

Prior to entering treatment, Ms. P., a woman in her late forties, was raped in her bedroom at four in the morning. "All of a sudden the impossible happened," she said. "The door knob turned and a hand holding a knife came through the doorway."

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She had intrusive symptoms of PTSD, and was extremely hypervigilant. She had repetitive nightmares, flashbacks and insomnia.

Her mother (who had bipolar disorder) was often unstable during Ms. P's childhood. She never knew "which mother would be home," the normal mother or the mother who could burst from the doorway and attack her with her "claws."

After 18 months in treatment, the patient had progressed. She had more insight into her reactions and their link with childhood terror. She was able to drive in the dark (with discomfort) and she could stay alone in the house for a couple of hours. But she began to worry about ever completely resolving the trauma. She had expanded "her cage," but had not left it.

At this point, the patient was beginning to feel hopeless and frustrated. I proposed EMDR treatment to her. I discussed her problems with the EMDR consultant and she began weekly treatment. For several sessions the image of the hand coming through the doorway remained the same and then the doorway "became empty."

In sessions with the author while she also worked with EMDR, Ms. P. shared anything significant that had occurred. She became more optimistic after two sessions. After 10 sessions she happily reported that, while alone in the house, she could take a shower and wash her hair. After the EMDR work concluded, she continued to make gains in resolving trauma. She soon felt free of residues from the rape and terminated therapy.

A second patient, Ms. B, was referred to the author by a therapist who had worked with her for two years. She was a child sexual abuse survivor with a 10-year history of panic anxiety and sleep disorder. The symptoms included difficulty falling asleep and frequent waking (every 1-2 hours). Her most overwhelming problem was the compulsive need to stretch her legs and arms throughout the night. Both psychiatric and medical intervention had not been helpful; several trials of medication were unsuccessful. Ms. B. believed that she was powerless and inadequate to solve her problem, crazy and undeserving of help.

She was eager to try "anything". In the first session, the patient almost immediately remembered that she had been bound, hand and foot for several hours after being sexually abused. The EMDR work explored her need to/and fear of expressing the anger she felt toward the perpetrator. In primary therapy, she dealt with the need to feel stronger before she could express anger. When she decided to register for a Tai Chi course, she experienced heightened anxiety. This was processed in an EMDR session and the patient visualized herself kicking out at her father and kicking the ropes off. The need to stretch ceased and she began to sleep normally. She enrolled in the course and enjoyed the work. The panic symptoms disappeared. Ms. B. ended EMDR work after eight double sessions and continued with her primary therapist. During the course of treatment the therapists had several telephone conferences. It was noted that the patient adapted well to the dual therapy, experienced no complications and felt the EMDR work was extremely helpful.

The author's experience with patients referred for concurrent EMDR work has been very positive. Patients have reported successful experiences working with EMDR while they continue with their primary therapist.■