

## EMDR solution focused

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### Abstract:

The aim of this article is to demonstrate a therapeutic approach integrating Solution focused therapy (SFT) and Eye movement desensitization and reprocessing (EMDR) in the treatment of complex traumatized people. EMDR is an effective treatment method for traumatic memories and its consequences. Originally, it seems to be rather problem-focused and its effectiveness is highest with simple trauma. In our work with severely traumatized people, we apply SF attitudes and ways of relationship building together with adjusted EMDR protocols to create a flexible, yet structured treatment plan. In this article, we go through all the eight phases of standard EMDR protocol highlighting our solution-focused modifications.

### Key words:

Solution focused therapy (SFT), Eye movement desensitization and reprocessing (EMDR), psychotraumatology, complex trauma, stabilization.

### Introduction

Eye movement desensitization and reprocessing (EMDR) is now a well recognized and one of the most effective methods in trauma therapy (Bisson & Andrew, 2007; van Etten & Taylor, 1998). Today, many adapted protocols make it possible to work on various problems (Luber, 2009) and with different populations (Luber, 2010). EMDR is based on the assumption, that every psychological or psychosomatic dysfunction, which stems from any kind of life experience, can be treated by reprocessing the original memory of that experience and the

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associated memory networks that might have emerged later (Shapiro, 2001). From immediate interventions for early acute reactions up to transgenerational trauma, emotional wounds can be healed and traumatic memories can be transformed into a learning experience, strongly connected to resources and competences.

It is no question that the solution focused (SFT) therapy (De Shazer, 1982, 1985, 1988) has also been recognized to be effective (Kim, 2008; Stams & al. 2006; Corcoran & Pillai, 2007; Gingerich & Eisengart, 2000). The SFT approaches emphasize the importance of the future perspective, hope and how much it is the professional's task to connect the people with their own expertise.

At first sight, the two approaches (EMDR and SFT) seem to be contradictory. The SF therapist's not knowing stance seems to be in conflict with the "all-knowing" stance of the EMDR therapist, who knows best when the person is ready for trauma work, who knows best which trauma has to be reprocessed first, and who, when it doesn't work, is more eager to look for the right protocol instead of asking the client. On the other hand, there are some commonalities. First of all, the discovery of EMDR was a result of what we would call a solution focused questioning (as we will show later). Secondly, its basic model is founded on the presumption that every living being has an intrinsic adaptive information processing system and the role of the therapist is only to kick start the system that was blocked as a consequence of adverse experiences (Shapiro, 2001). Thus, no EMDR therapist can do a good job without trusting the person and his/her self-healing capacities, as well as without the ability to "stay out of the way", when the client's process goes smoothly.

Since 2003 we try to combine what works best in those two apparently opposed disciplines. We would be eager to present research data in order to validate our clinical experience, but until today, we only can provide our observations. In our therapeutic practice with the most severely traumatized people, those who suffer from dissociative disorders, we learned, that the combination of SF attitude and tools and EMDR working mechanisms provides the best results. We would like to share our way of using EMDR in a SF frame in the treatment of traumatized people.

### **Solution focused metamodel**

At the very beginning, we would like to state that we use the SF model as a metamodel for our whole work. Our basic attitude is founded on the following principles:

- **The therapist's not knowing stance:** the therapist is an expert only of therapy in general; the person is expert of her/his life and what works in the context in which she/he lives. So the therapist doesn't know beforehand what will be relevant to the person, neither with solutions will fit the best.
- **Process orientation:** the therapist is responsible for the here and now process during the session: enabling good working conditions and a secure frame.
- **If it is not broken, don't fix it:** the person is responsible for the content brought into therapy and for the changes in her/his life. We have to keep this in mind especially with dissociative people, who often don't disclose important information in therapy in the time we might assess as appropriate. They may have various motives for that; they suffer from extended areas of amnesia, and even amnesia for amnesia sometimes, they have very strong urge to avoid some (often trauma-related) contents, which is a life-saving strategy for them, they need much more time to build trust in others, or they have any other good reason. Whatever the reason, we believe that as long as the person doesn't bring up a topic into therapy, she/he is not ready to process it. Accordingly, following the Bruges model, we always ask the person if she/he would like to address the topic which is brought up. And only when the answer is «yes», we go on to the next step and work on it.
- **If something doesn't work, leave it, and do something different:** e.g. during the stabilization phase, there is a wide variety of stabilization exercises, so if some don't work, there is no problem, a lot of other options are available. Sometimes people have their own very unusual self-soothing tools and techniques. Those are as valuable as any other tools.
- **If something does work, do more of it:** everything that works is encouraged, as long as it is felt as constructive by the person. When something works in therapy, people are generally eager to do more of it, no matter if it is EMDR, hypnosis, letter writing, or something else.

Here we would like to explicitly voice two more principles that stem out of the previous:

- **Begin with the easiest thing first:** this gives a good chance to be successful; the success experience releases dopamine in the reward center of the brain, which in turn builds up feelings of strength and motivation to go forward. Then it's easy to follow the person, as Steve De Shazer put it by saying: «lead from one step behind».
- **As fast as possible, as slow as necessary:** the Gear box (Dellucci, 2010), structured guidelines for using EMDR to approach gradually more and more difficult issues,

gives a good example of a hierarchy of targets as well as a degree of exposure. The main assumption is that if reprocessing goes at the right speed, the process is going smoothly. If there is something unforeseen happening, the possibility is given to gear back to a less faster way of reprocessing by focusing attention on the topic which is arising in terms of a specific emotion or fears, whether irrational or not. The most important is an ongoing adaptive process, regardless of the speed.

Additionally, we strongly rely on the Bruges model (Isebaert & Cabié, 1997; Isebaert, 2005), which helps the therapist to evaluate and respect the degree of person's engagement in therapy. The model encourages the therapist not to go faster than the person, while giving clear hints about what is possible and most useful at each stage.

In summary, as solution focused therapists in general and as psychotraumatologists in particular we work with resources, client's solutions and competences systematically and specifically, while we focus on problems unsystematically, i.e. only when they occur.

### **The SF birth of EMDR**

In 1987, Francine Shapiro was walking through the Golden Gate Park, troubled by lots of negative thoughts and feelings, and after a while she suddenly realized, that her distress disappeared (Shapiro 1997). She took up a very solution focused attitude asking herself: »What did I do, just now?« In her mind she went backwards in order to scan the behavioral sequence. She found that she had moved her eyes from left to right, back and forth, all the way. She went curious about the unintended action that relieved her from her suffering. Then she tried to ask her friends and co-students to move their eyes. As they didn't immediately understand this strange request, Francine started to move her fingers so that the other's eyes could follow. Step by step she explored, what was useful to maximize the effect she wanted to reach: desensitizing the no more useful emotions connected to past and present adverse experiences. She systematically studied the steps until she created a protocol that turned out to be one of the most effective tools in psychotraumatology, if it is carried out rigorously (Maxfield & Hyer, 2002).

### **Talking therapy does not suffice in the treatment of traumatized people**

The difference between any memory of a life event and a traumatic memory is in the way the experience is stored in the brain. While the "normal" memory is coded in the hippocampus

and frontal cortex, traumatic memory is fixated in the amygdala, the alarm center of the brain, which has been extremely activated during the traumatic event (Rauch et al., 2006). The inhibition of the higher function regions of the brain makes it impossible for the person to create a coherent narrative that is integrated into the whole of the individual's personality. Thus the traumatic memory, fragmented and dissociated, not accessible for new learning, can be kept in person's mind almost unchanged, unbearably emotional, for many years (Vojtová et al., in press). Acknowledging that it is stored more implicitly, we have to realize, that, at least partially, it is inaccessible to verbal (top-down) retrieval and communication. At the same time, when the traumatic memory is triggered and the traumatic memory network is activated, the emotions can be overwhelming, because trauma is experienced like it was happening just at this very moment. This extreme level of arousal is difficult to contain only by verbal means. The risk of retraumatization is high, especially for the people with complex trauma.

Furthermore, the more severe the dissociative disorder as a result of trauma is, the more the people disconnect their emotions and body sensations from their mental contents.

All in all, we need special tools for confronting trauma in an effective and safe way, tools that would address the emotional and somatic components of the memory as well as the cognitive ones and that would create a safe enough background for the traumatic experience to be recalled and then integrated.

Many complex traumatized people have been successful in going on with their everyday life and doing things according to their existential values. Nevertheless, often they are upset about their own reactions; their uncontrollable emotional and physiological responses make them doubt their mental condition to the degree that sometimes they think they are going crazy. Usually they don't realize, that an automatic survival reaction has been triggered, which was activated in the time of the trauma.

Research has shown (Le Doux, 1996) that when an emotionally loaded element, which in some way resembles the adverse experience, strikes the trauma network, then the emotional response is irrepressible. As long as trauma networks exist, they can be triggered by external or internal stimuli, which are often implicit. Not only an immediate physiological reaction arises, frequently followed by feelings of shame and panic, nightmares and intrusive thoughts, but also many people develop negative cognitions about themselves, which don't correspond with their existential choices. These cognitions, when reinforced further, can become core beliefs and influence basic orientation in terms of perceptions and relationships to others. This

can lead to depression from exhaustion; to addictions in order to suppress the painful emotions; to compulsive behavior, in a desperate trial to control and overcome those upsetting experiences.

### **Is it possible to use EMDR in a SF way?**

Since we consider ourselves solution focused in our basic therapeutic attitude, our goal was to use what is effective, especially in EMDR, to fill the gap left by talking therapy, especially for people suffering from trauma. The more or less problem-focused way of EMDR with its extensive problem diagnoses and orientation is not very helpful for people to regain hope, competences and solutions. According to Steve De Shazer and other solutionists, we closely stick to solution-focused principles: we do keep what is relevant in EMDR and change what is necessary in order to «make it solution focused».

The EMDR therapeutic approach has a thoroughly standardized protocol, which comprises eight phases: History taking (phase 1), preparation and stabilization (phase 2), assessment of the adverse experience (phase 3), desensitization and reprocessing until the emotional load of the experience has become neutral (phase 4), installation of a positive belief about oneself (phase 5), scanning the body in order to check if everything has been reprocessed (phase 6), closure of a session (phase 7) and re-evaluation of the worked out experience and changes in life during the next session (phase 8) (Shapiro, 2001).

Some of those steps are EMDR specific (phases 3 to 6), while others are common to most therapies. We will shortly highlight each of these phases and explain, how we work according to solution focused principles.

#### **Phase 1: History taking**

In phase 1 of EMDR, a trauma map is explored, in order to figure out the extent of trauma to be reprocessed and the targeting sequence plan (the order, in which traumatic experiences ought to be reprocessed). Client's functioning is assessed, but mainly in a problem oriented stance. Some EMDR therapists, especially working with complex traumatized clients, realized, that creating a kind of a resource map consisting of positive life experiences and relationships, as a counterbalance to the adverse events, is very useful.

In a SF way, we focus specifically on client's competences and resources, as well as those of people to whom she/he is related. When clients come to us to talk about trauma, our interest

goes to their survival reactions, and how he/she was able to go on with daily life: taking care of the kids, going to work, etc. We never ask for trauma details and we make sure the client can understand that it is not necessary for our work. From our perspective, while people are still alive, they have carried out at least as much surviving capacities that would counterweight the burden of their traumas. But they are seldom aware of it and they don't come to therapy with a curriculum vita of competences. It is the therapist's task to make them explicit.

In France, since the publication of mainstream books about EMDR (Servan-Schreiber, 2003, Roques, 2004), many people feel empowered to ask for EMDR, with the goal of getting rid of their emotional wounds. Seen according to the Bruges model (Isebaert & Cabié, 1997, Isebaert, 2005), many people ask for help and are ready to put themselves to work. We set goals, use scales, explore exceptions, and set a treatment plan together with the client. We extensively explore the clients «resistance history» to what she/he went through, as well as his/her desired future.

In general, the Bruges model gives us some useful benchmarks to follow:

As long as the person doesn't ask for any help and the therapeutic relationship is non-engaged, we do nothing more than getting acquainted with the client. Our main goal is to set a secure frame, in which the client can feel safe enough to ask for help. In trauma therapy, security, predictability and control in the hands of the client are especially crucial, as we need to create a setting, which is in complete contrast to the dangerous, uncontrollable and unpredictable traumatic situation. We ask the client to assess the subjective feeling of security on a scale from 1 (not safe at all) to 10 (completely safe). In a SF way, we explore first how the client makes it possible to be at the number he/she states, and then we ask what WE could do in order to make it possible for the client to climb on the scale. This safety scale is exceptional in the way that it is the therapist's role to implement a secure therapeutic frame, not the client's. They both have certain needs in order to feel safe in a setting that can be expressed. This topic is essential in the beginning of a therapeutic relationship and each time something unforeseen and upsetting has happened. Traumatized people have made the experience that their integrity was not safe, and each uncontrolled event may trigger this threat again. Particularly in cases of interpersonal trauma, the therapeutic process has to be in the strongest contrast to the past experience, otherwise it is a reasonable resource for the client not to engage in any relationship.

The next topic in the Bruges model is the client's willingness to put her/himself to work. From our point of view as psychotraumatologists, the issue of safety is strongly connected

with the attachment issue. Secure attachment is a necessary condition for sharing and metabolizing emotions that occur in the relationship and it is a prerequisite for exploration and learning. Michel Delage (2007) states that when emotions can be experienced among people without being overwhelming, this creates attachment. In trauma reprocessing we cannot avoid touching the hurtful aspects of the past experience at least a little bit. For traumatized people emotions and body sensations have been overwhelming. It is then very understandable, that they try to avoid re-experiencing this, which can be perceived as unwillingness to put themselves to work. Actually, it is more energy saving and reasonable for them, unless the therapist is trustworthy enough, meaning that she/he is able to offer efficient support in containing their intense emotions. Especially people with chronic traumatization, for whom the immobilization and passive waiting not to make things worse has become an overpowering habit, can need more time and more of shared good experiences, before they can overcome the fear of hope that things can get better. In these cases, the solution focused attitude and techniques are very useful.

To sum up, as long as attachment is an issue, it is difficult for the person to put her/himself to work, because for reprocessing trauma, the person needs to feel safe in the relationship, especially if the trauma included attachment issues.

After the client feels safely attached, it is of major importance to raise his/her awareness of his/her own resources. The goal to be reached is client's autonomy. As long as the client complies with the therapist and implements every assignment in therapy, but has no sense of his own resources, she/he may need never-ending therapy in order to maintain positive outcomes. Therefore, at each stage of therapy, the therapist is a close witness to everything the person was able to carry out; brings attention to how she/he managed not to make things worse, accomplish changes, even slight ones, and how he/she comes closer to his/her goals set at the beginning of the process. The more the clients are aware of their own strengths, the more we approach the last stage of the Brugge model, where we work together in a co-therapeutic relationship with a fairly competent person, who can direct the course of therapy according to their needs and well informed decisions.

When we work with complex traumatized people, we need to be patient and slow down, keeping in mind that their apparent incapacities are the other side of the coin of their trauma-induced survival strategies and they are not easy susceptible to change, even if they are motivated. While they may be perceived as "difficult clients", here we offer a collection of useful assumptions (Dellucci & Wolf, 2011), which we set down inspired by Insoo Kim Berg

and Therese Steiner (2003). They can help a clinician to stay focused on resources despite whatever may trigger a strong problem trance.

People in therapy maybe basically want to:

- Be acknowledged about their purpose for consultation.
- Be accepted as themselves, just as they are, even if they have difficulties to accept themselves as they are.
- Voice their opinions and choices, when asked for.
- Make choices, when given an opportunity.
- Be active and involved (whether resisting or going forward).
- Learn new things.
- Have a positive influence on themselves and their inner world.
- Hear good news about themselves and what they are good at (even if they have difficulties to acknowledge it officially).
- Be hopeful.
- Be accepted as a part of a whole (group, family, community, therapy setting).

## **Phase 2: Preparation**

In phase 2, preparation includes psychoeducation, stabilization, building a safe base for the trauma confrontation that comes with the next phases. We explore extensively everything the person was able to do when times were difficult, what is their particular style to self-soothe, what works when they help people around them. When we teach stabilization techniques, the people themselves are the only significant testers to evaluate, what is most useful in their daily life.

There are a huge variety of stabilization tools. We have classified them into six categories, from the most immediate to the most elaborate ones. The following sequence respects the hierarchy of the triune brain (MacLean, 1990), where we first need to take care of the oldest, most primitive reptilian brain by providing physiological comfort, then raise the affect tolerance of the limbic system and only after that, as the last stage comes the cortex with its most complex constructions, planning and easiest attainable volitional control.

1. Grounding exercises: “Bottom-up” techniques aiming to calm the body first, in order to be able to calm the mind. These exercises are the most instant ones and their purpose is to help the person to connect with her/his body in the safety of the here and now.

2. Containment tools (Kluft, 1998). All traumatized people, irrespective of the severity of their trauma, tend to avoid traumatic contents, sometimes up to complete amnesia. The avoidance can be a result of both automatic survival reaction and/or conscious volitional decision. Nevertheless, this avoidance is frequently punctuated by intrusive thoughts, flashbacks, sudden emotions or unexplained body sensations and substitute actions like addictions, acting out or unhealthy risk behaviors can be triggered (Van der Hart et al., 2006). All the unwelcome difficult material needs to be acknowledged, not forgotten, nor avoided, but contained, so that the person can prepare and consciously decide about the right time for confrontation. Avoidance represents a resource, as long as the client doesn't feel ready and willing to face what is painful. Containment exercises go into alliance with the client's need of avoidance and upholds the control in the hands of the person.
3. Self-soothing exercises: These "top-down" techniques help the client to calm down his/her mind, in order to control emotions, feelings and thoughts. The exercises include mindfulness elements, as well as relaxation and auto-hypnotic methods. The regular daily practice shows cumulative effect and decreases the level of overall emotional arousal. Full awareness of the here and now is the essence of these exercises.
4. Safe place exercises facilitate the establishment of an exclusively positive network and client's ability to linger with the positive body sensations and emotions is a good test indicating her/his stability. The aim is to set up a self-soothing method, which uses the client's capacity to project her/himself somewhere else, out of the here and now reality, using imagination and/or recollection of good memories or any other kinds of possible resources (Korn & Leeds, 2002).
5. Constructing more elaborate internal resource ego-states like inner helpers, inner advisor, a wiser version of the Self, e.g. when therapy is finished. When people need a more concrete support they can create collages, e.g. the collage of the symbolic family (Dellucci, in press) or about a three years plan in form of images, which can be seen as pictorial resources.
6. Crisis management tools can be useful when upsetting events occur, e.g. when life circumstances are not stable enough. The systemic goose play (Caillé, 1995) or the solution-focused debriefing might be useful.

The more severely the people are traumatized, the more it is necessary to install stabilization tools from more different categories. Only clients alone can evaluate their usefulness and pertinence for their life.

In solution focused practice, when the client cannot or doesn't want to implement something in therapy, instead of blaming the person for failure of compliance, we assume that there is important information we don't know yet. Thus we always reframe resistance as a substantial message, which for one reason or another cannot be expressed directly. Realizing this, we ask the client about his/her needs, about his/her choices. When a person shows a critic attitude or an unwillingness to carry out something specific, most often she/he has an alternative possibility to offer, whether conscious or not. It would be a pity not to ask for it.

To sum up, the aims of this phase of therapy are to develop feelings of safety in the here and now, providing the availability of a secure attachment and a stable and predictable therapist, and finally to open up the possibility for hope and future perspective.

Throughout the whole therapeutic process, we use psychoeducation as an effective stabilization tool. Coming out of the premise that we are the experts of psychotherapy and psychotraumatology in general and the client is the expert of his/her own life, we carefully choose ways and times to share our knowledge with the client and then let him/her to pick the relevant information. Traumatized clients have usually experienced profound feelings of not understanding, what is happening either inside of them or in the outside world, being left in chaos and fear of getting mad, losing control and rational perspective. The more they can understand, the more they can feel safe and in control and the more they can get in a position of cooperative and creative partner in a therapeutic dialogue.

### **Phase 3: Assessment**

After the first two phases have been successfully accomplished, the client asks for help and is willing to put her/himself at work, when he/she feels ready to begin with trauma confrontation, the specific EMDR phases 3 to 6 can start.

All these phases implement the general mechanism of trauma confronting therapy, the modification of the dysfunctionally stored memories. The therapeutic reconsolidation of memories is only possible, when they are activated in a context that enables their association with positive networks. Thus, the third phase is aimed at activating the memory network, and the following phases work to modify the memory in order to accomplish the previously

blocked learning experience, changing the traumatic dissociated memory into a “normal” memory associated with the whole of the personality.

We would like to emphasize that we do the treatment planning together with the client. This implies not only informed consent, but also the client making choices, deciding about the targeting sequence, according to his/her goals, whether they are explicit or not.

In phase 3, when we assess a memory of an adverse experience, we search for the worst image, the still active negative cognition and the positive cognition to focus, once the emotion has been released. The positive cognition is evaluated on a 7-point Lickert scale for the »validity of cognition« from 1 (completely false) to 7 (completely true). Then we ask the client to define the actual emotion connected with the image and negative cognition, and define the level of actual distress on a ten-point scale (derived from Wolpe’s SUD=Subjective Units of Disturbance) from 0 (neutral, not at all disturbed) to 10 (the highest imaginable disturbance). Finally the body sensations are also made explicit. This rigorous procedure is targeting the core of the trauma memory network, activating it as efficiently as possible. In classic EMDR, these 7 elements are asked thoroughly before the desensitization begins. Since the goal of this phase is to activate the memory network just enough to start reprocessing, in our approach, we only continue the questioning until the client shows signs that the memory is activated and emotions are emerging. If this happens just after having set an image, we start the next phase without finishing the whole sequence of the assessment.

#### **Phase 4: Desensitization/Re-Processing**

In phase 4, during the desensitization and processing, bilateral stimulation and regular pauses lead the client through the process until the activated memory network is associated with other, more resourceful memory networks and its emotional valence is neutral or even positive. Throughout the process, the client is encouraged to notice and “let whatever happens, happen”, meaning that setting out from the core of the trauma, free associations are allowed. The bilateral stimulation serves as a means to down-regulate physiological arousal, facilitate dual focus attention and stimulate information processing (Vojtová, Hašto, 2009). As a result, not only negative material is showing up. In classic EMDR, when two neutral or positive contents occur, we consider it the end of an associative channel; we stop the information chain and go back to the original incident. In SF EMDR we continue bilateral

stimulation as long as there are changes coming to client's mind. Doing this, we stay longer within the resource network, strengthening and developing the positive connections. Very often the client goes spontaneously back to the initial incident, when ready. Staying connected to resources enables the person to experience good moments too, even while confronting trauma, and respects each person's need for their own pace and rest. Especially when channels have been long and intense, we prefer spending some time in positive networks. At the end of the day, our goal here is to overcome the dissociated nature of traumatic memories and enable the person to install a reliable connection to their positive capacities.

Even the classic EMDR is rather non-directive here in instructing the therapist to "stay out of the way", if the process goes spontaneously in the direction of healing. However, the more severe and earlier the trauma, the more active interventions of the therapist are necessary. When needed in the process, we do body interweaves to help the client to stay connected to her/his body. These interventions can include grounding exercises that reinforce dual focus attention (be consciously present in the here and now while remembering the there and then), and support stability through the whole process.

### **Phases 5 and 6: Installation and Body Scan**

Once the memory has become neutral, the installation phase (5) aims to install a positive belief instead of the negative. Normally the negative belief is no more potent. The client is asked if the positive belief he/she has set as a goal in phase 3 is still accurate, or if there are other words, which go better with what has been learned. This part of EMDR is already resource oriented so we don't need to change it to become SF.

Even if we haven't set a positive cognition during the assessment phase (3) in order to protect the client from too much activation, we never finish the work on an incident without installing a positive belief about what the person would like to think about him/herself regarding this situation.

The rationale behind is that every traumatic experience, even the most adverse one, is nothing else than unfinished learning experiences. By installing the appropriate positive cognition after the memory has been reprocessed, we invite the client to express explicitly what has been learned through this experience. Sometimes even new elements emerge and the person feels grown up out of what he/she went through.

The last EMDR specific phase (6) is the bodyscan. Relying on Bessel Van der Kolk's (1994) statement that »the body keeps the score«, this phase aims to check with the body, if there are any remains left unprocessed. Even during this phase new associations may emerge. The body scan ensures that the complete process of memory-modification is finished while being fully connected to the body.

### **Phase 7: Closure**

Phase 7 implies the closure of the session. Like in other therapies, clients are appreciated by the therapist and asked to summarize what they have learned during the process. The therapist makes the aftermath of the session predictable by telling the client, that his/her brain can continue processing after the session and reminds him/her to use the safe place and the container when needed. We add that the client's job between the sessions would be enable his brain to rest, to use mindfulness opportunities, focus on daily life, and not go back to difficult memories. We make ourselves predictable that next time we will be interested what has changed, what is different, and how the client is making it possible. We don't give a straightforward task, but we inform the client what we will focus at the beginning of the next session.

### **Phase 8: Reevaluation**

The reevaluation phase (8) is also a non-specific part of the EMDR protocol. Changes are explored, and according to solution-focused approach, we put a magnifying glass on how the clients have implemented some changes, even slight ones, very concretely, or what did they do to support others, if they report that the change came from outside. We take time (a third of the session) to go into details, in order to highlight and sustain these networks. We also evaluate the degree of stability. As we don't know what the client has achieved in his/her life in-between, we ask the about his/her intentions for the next step in therapy.

Similarly to the phases 1 and 2, in the reevaluation phase client's resource and competence awareness is build, which aims to foster the person's autonomy.

During this phase the reactions of the near environment are explored, too. Sometimes the family members may find themselves confused by the changes happening to the client. It is not uncommon that we invite them to a therapy session at certain moments. On the one hand we listen to them, but we also accompany them towards changes, which, even if desired, can be felt as difficult because unfamiliar.

## Treatment Planning: the three pronged approach

The EMDR protocol, as it was developed by Francine Shapiro (Shapiro, 2001), plans to focus first on the past, starting with the touchstone memory, i.e. the memory identified as the earliest and thus original and then desensitize other memories of the past. After this, if necessary, EMDR focuses on present everyday triggers, and continues up to the installation of a positive future scenario, reflecting the client's desired goal regarding the specific problem. Thus, a problem is considered fully processed only after all the events identified in a targeting sequence plan have become neutral and an adaptive future scenario has been installed, allowing the person to say that this issue is resolved. This is in our opinion clearly a problem resolution approach, even if it goes towards a desired future scenario designed by the person.

The basic idea is that once the touchstone memory is desensitized and reprocessed, this will have a neutralizing effect on related memory networks. This approach works well for people with simple trauma or well functioning people with multiple trauma. However, such people don't represent the majority of our clients cohort.

For survivors of complex trauma and chronic traumatization this approach is mostly inefficient and leads to blockages, destabilization and therapy drop out. The EMDR world has invented a multitude of strategies in order to make EMDR effective and accessible for those people, who need it most: through oscillation techniques (Levine, 1997; Twombly, 2000; Fine & Berkowitz, 2001; Knipe, 2009), the inverted protocol (Hofmann, 2005), the resetting of emotions (O'Shea, 2009), working on early traumatic imprints (O'Shea 2009), and the letters protocol (Dellucci, 2009).

The letters protocol has been developed in a solution-focused way: Eliane (55 years), an insomniac client, despite a near toxic dose of sleeping medicine, sent by her psychiatrist, had come to therapy with the goal to work out a multitude of traumas, almost exclusively involving relationships. When Eliane returned from a hospitalization and a subsequent holiday, that followed a major destabilization due to an anniversary phenomenon, she said that she wanted to complete her therapy faster, without taking another twenty sessions. As she still presented her goal to get rid of all the trauma, the therapist, surprised and not knowing how to reach the goal, asked: "How do you think we can do that?" After a moment of reflection, Eliane evoked her inclination to write letters and the fact that she liked EMDR, "because it's effective". She asked whether the therapist could not help her to desensitize the letters she would write, by using EMDR. Having found Eliane's solution very ingenious, the therapist, although at first she did not know how to carry this out, didn't dare to say "no", and

decided to look for a way until next session. Throughout following sessions, the letters protocol was born, designed by Eliane and adjusted by H.Dellucci. In our opinion, the letters protocol is the best compromise between EMDR therapy and SFT, even if it is not appropriate for every trauma.

Continuing our efforts to adjust SF EMDR to each and every traumatized client, we have attempted a synthesis of different EMDR approaches. We intended to create an integrative structured protocol, which can be implemented in a solution focused way and which would allow the therapist to adjust to whatever emerges in the therapeutic process, following what is possible for the person, respecting his/her pace, ability and motivation, applying the two principles, i.e. "start with the easiest" and "as quickly as possible, as slowly as necessary".

The Gear box (Dellucci, 2010) is a result of this effort. In this approach, we use different “gears” to expose the client to the distress of his unprocessed material gradually and controllably. After stabilization, we usually start by asking for and desensitizing future or present fears, whether irrational or not, while taking care not to touch past traumatic memories. This significantly increases the comfort in everyday life, and produces a strong motivation in the person, who then engages in her/his role in the therapeutic team. We continue to address the problematic emotions to raise the affect tolerance, and then reprocess the early imprints, to build a more coherent sense of self. In classic EMDR, memories of the past are the first choice for the targets, however, in the Gear box, they belong to the latest, fastest gear, which requires the best conditions regarding stability and integrative capacity. The letters can be used anytime, when it comes to addressing unfinished business of relationships, whether traumatic or not. Thus for each person, the therapeutic path emerges in a special way, each tandem advancing rigorously and safely.

## **Conclusion**

In this brief journey through the standard EMDR protocol and the main solution focused principles, we walked the pathways that converge in what we noticed works the best with complex traumatized people. To conclude, we would like to draw the reader's attention to the fact that we just highlighted a brief excursion, when we considered various possibilities of adjustments available today in EMDR and trauma therapy. Nevertheless, whatever protocols we choose, we believe it is important to keep the solution focused attitude, agreeing with Snyder & Stukas (1999) that the way we look at the person changes the communication

sequence and thus the relationship. This research is consistent with what we know from traditional and body therapeutic approaches, like haptonomy, about the importance of intention to guide our practice. The solution focused approach, in its attitude and intention, also resembles the Buddhist teachings whose primary purpose is to reduce people's suffering, in order to be free to develop in accordance with their existential values and life choices.

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