Chapter 11
Doing a Sensible Phase One

Shapiro (2018) describes several approaches to Phase One of EMDR therapy. They are all appropriate and reasonable for people who have had generally good lives but have experienced some trauma. Quickly identifying those experiences and developing a plan to resolve them (probably starting with the worst first) is the most efficient way to work with generally healthy people.

These Shapiro approaches to Phase One are not ideal for many people whose whole life has been awful. With clients with severe and complex trauma, I am not focused on the most efficient way possible to resolve a limited number of memories. I anticipate that these clients will need to be on my caseload for a few years and we may need to resolve 80 memories or more. Complex trauma is that complex. In fact, a few years of weekly therapy may not be enough for some. My focus and urgency are adequately preparing the client to start somewhere. The risk is that we never start at all.

Multiple things that appear to conflict can be true at the same time. How we approach clients who are healthy is different from how we approach clients who have pervasively traumatized nervous systems. This is true of every approach to psychotherapy. EMDR therapy is no exception. On second thought, because EMDR therapy has a way of quickly and directly floating back issues to the experiences that are central and potentially volatile, we should perhaps be more careful about what we activate in the sessions before the client has the capacity to manage any of that activation.

I invite you to go on a mental journey with me. For a moment, please rewind to the day before you started the first day of your Part One EMDR training. Subtract everything from your awareness that you now know about EMDR therapy. Many of you had been working with complex trauma for months, years, or decades prior to taking your EMDR training. Think about everything you know about complex trauma from sitting with many clients across hundreds, thousands, or tens of thousands of sessions. Would it make sense to ask them to touch three, nine, or 27 of the worst and most unspeakable experiences that could possibly happen to a single

person on this planet? Is getting a detailed and comprehensive trauma history the first time you meet a person with extreme trauma a trauma-informed intervention based on what we know about how trauma is stored and how it might be activated even from gentle inquiry? Is asking a client who has been complexly wounded to tell you ten of the worst things that have happened to her the moment you first meet her something that a decent person does to another person? Before you participated in an EMDR training, would exploring trauma in this way have been a reasonable, appropriate, and trauma-informed approach with a client who is probably coming to this first therapy session as an act of survival? If it isn't, what is it about EMDR therapy that makes this seem like a good idea? Why do you need to know these details on first contact? Is it because you think EMDR is a magic wand? Is it because you think EMDR therapists somehow have ways of exploring trauma histories that don't risk over-activation? Or are you trying to do a detailed Phase One with clients with extreme trauma because that's how we trained you to do it (even though parts of you already know that's probably a really bad idea)? Please, don't do things with clients with complex trauma in EMDR therapy that your years of clinical expertise suggest is a horrible idea. Everything you know about complex trauma should heavily inform how you do EMDR therapy. It should make you a better EMDR therapist. You shouldn't have to forget anything you know about complex trauma in order to do EMDR therapy well or "correctly."

To be fair, Shapiro repeatedly reassures us that we can do a comprehensive Phase Two before we do a comprehensive Phase One, if that is appropriate. However, that does not match the agency and billing mandates that shape how many of us are forced to practice. We typically need to develop a treatment plan within the first session or two, and that treatment plan has to capture the presenting issues, symptoms, history, severity, diagnosis, approach, and concrete goals and objectives for therapy. In short, we do not have the time, resources, or stability needed to do Phase One in many of the ways that Shapiro envisions immediately, yet we still need to get information that will allow us to conceptualize the client's case and develop an initial approach to treatment.

If we can agree that we should have additional options for working with severely traumatized clients on our first few contacts, perhaps we should explore what those options might look like.

Some Options for Phase One for Agency Contexts

If you work at a community mental health agency, you will probably need to do an intake and symptom-based treatment plan in the way the agency requires. You will usually need to get metrics to support the diagnosis and you can use many of these metrics (anxiety, depression, or trauma assessments) to build a trauma-focused treatment plan. If you intend to do EMDR therapy with your clients who do not currently meet the criteria for PTSD, it is important to make sure that your initial treatment plan conceptualizes the current symptoms as trauma symptoms through the AIP model lens, meaning that these symptoms are the result of difficult past experiences or learning. A symptom-based treatment plan that anticipates the need for a comprehensive Phase Two; anticipates further exploration of specific target memories related to the presenting issues; includes a plan to target (currently unnamed) central memories implicated in the development and maintenance of the current issue; and the plan to do future templates to leverage work conducted with past memories is a workable way to get started. The treatment plan should also include many of the other non-EMDR interventions that you may anticipate utilizing. Again, clients with complex trauma often have complex needs and you will wear the most hats with these clients. The treatment plan can always be revised as additional information becomes available.

The "Buckets" of Wounding often Emerge Organically

When conducting a treatment plan in this way, it is highly likely that you will start to get a sense of the broad categories or "buckets" of wounding that the client has encountered at different developmental eras organically. For instance, you may become aware of the presence of developmental trauma, difficulty in early dating relationships, or an abusive first marriage. From there you can start to get a glimpse of other ways that the past may be affecting the present quality of life. Clients can often connect current symptoms to past developmental eras in ways that are helpful but do not necessarily include specific and potentially activating memory content.

Phase One Should Also Assess for Adaptive Information

It is important to remember that we need to assess for the presence of adaptive information, since adaptive information is the "boat" that the difficult memories will need to be landed into. A simple way to think about

adaptive information is: What has the client learned about himself and the world outside of the lessons of the trauma? Sometimes having our own children can teach us about the things that humans are born needing, when our own childhoods did not provide that information. On occasion, clients with complex trauma may find fortune in love and have a long-term relationship with someone who is kind, patient, and loving. We can explore ways that these experiences have provided corrective information for trauma learning. The most usable adaptive information is best learned experientially. From what you have learned about this client's life, when would they have had the opportunity to develop the needed adaptive information? Also, adaptive information isn't one thing. Some clients may have large amounts of adaptive information for one category of belief about the self, but severely lack it for others.

Using Resources to Assess for Potential Somatic Deficits

It is possible to use some initial resourcing exercises as a way to get important information about the state of the client's nervous system, and this information can be incorporated into the treatment plan. In addition to assessing existing resources that the client may have, it can be helpful to assess for embodiment as soon as possible. I typically do a quick body scan (see Chapter 21: Dip Your Toe In Body Scan) to assess for somatic dissociation. If the client appears to have poor awareness of how stressors are embodied, body awareness exercises may be incorporated as interventions in the treatment plan in preparation for the EMDR processing phases.

Helpful Assessment Instruments

It can be helpful to obtain metrics of trauma symptoms and do so in ways that are not overly triggering. The PCL-5 is a helpful public-domain instrument. While not a diagnostic instrument, the Dissociative Experiences Scale (DES-II) can be a helpful survey of dissociation symptoms. Trauma approached from an AIP model lens conceptualizes most depression and nearly all anxiety as symptoms of past wounding. Thus, standard anxiety and depression inventories can be helpful trauma metrics to include in treatment planning.

Helpful Intake and Treatment Planning Questions

One of the most important questions in my intake sessions is to assesses for attachment wounding. Attachment wounds are often the whales of memory. Some of the most difficult sessions I have witnessed in EMDR therapy involve attachment wound targets. Events have a beginning, middle, and end. Attachment wounds are about everything. They are about belonging, connection, family, safety, identity, importance, and value. Attachment wounds have compounding costs developmentally because: not getting our needs met was wounding, we were often blamed for having those needs (which is also wounding), we had to develop coping strategies to cope with those unmet needs (which typically have long-term costs), and we may be missing a lot of the implicit learning (adaptive information) that getting our needs met would have provided. Not having the experience of this adaptive learning tends to be both informationally and developmentally stunting.

The question I ask is simply, *"When you were young, who was really and consistently there for you?"* The consistency part is important. The client may have had a fantastic grandmother, but she may have lived hundreds of miles away. Consistency is also important for people who were physically present. Inconsistent attachment is the foundation of some of the most difficult and deeply complex presentations that we encounter clinically.

When a client answers the above question with "no one," they will do so in less than a second. This math was conducted by the client's nervous system a long time ago. It's one of the truest things that they know. I know then that we will attempt to develop an attachment figure resource or do other forms of targeted parts work to create and model the possibility of self-nurture and more effective self-communication. When clients grow up in a context of insecure attachment, assume that significant developmental deficits exist that will likely impact the client's current fund of adaptive information.

It can be helpful to do a general survey of childhood for the client's gut-level impression of difficulty without asking about individual experiences or memories. I will do this by asking the following questions:

Without thinking about any specific memories, but just checking your gut-level impression, how difficult was life for you before five years old on a ten-point scale?

Between five and ten years old?
Between ten and 15 years old?
Between 15 and 20?
Between 20 and 30? Etc.

It is possible to get a very general overview of the extent of wounding in the lifespan from this simple, and generally non-triggering, way of inquiring. When I ask these questions, it is easy for me to form a mental line chart in my mind (similar to the figures below) of the client's impression of life difficulty by age range. Severe stressors in very early to middle childhood generally result in significant dysfunction in later life. I anticipate a much longer and more complicated course of treatment for the client on the left than the right. I anticipate that the client on the left may have substantial deficits in adaptive information because of the ways that the difficulty of early experiences may have been developmentally disrupting.