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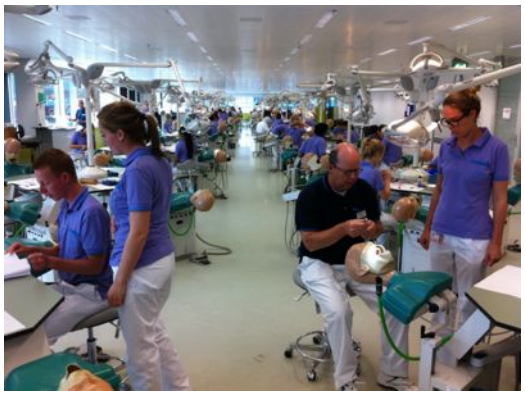
Looking to the future: Flashforwards

Robin Logie explores and explains the difference between the future template and flashforwards

'What's the worst thing that could happen to you?'
'I might fall again and break my arms.'
'What does that make you believe about yourself now?'
'I'm not in control.'



Ad is based at the University of Amsterdam Dental School

After obtaining a Positive Cognition (PC), VOC, SUD, emotion and bodily location, this target was processed in the usual way. Only one EMDR processing session was required for this client who suffered from agoraphobia following a tripping accident. The original accident was never processed as she maintained that it was not distressing her at the start of therapy. This is an unusual case but it illustrates the powerful use of the Flashforwards procedure in EMDR.

'Flashforwards' I hear you say? 'I thought that was called the Future Template'?

Use of the term 'Future Template' is rather confused but generally refers to 'running a movie' of some future event that the client predicts will occur and which they might have difficulties with because it relates to the trauma that they have resolved through EMDR. There are two main aspects of the Future Template. The first of these involves the processing (using the standard EMDR protocol) of the anticipated distress related to the future event. The second is the use of resources to deal with the anticipated event.

Flashforwards is distinct from both of these. Rather than being about some future event that is predictable, it is about a future event which is unlikely to occur although the client fears and is preoccupied by it; in other words, a future 'catastrophe' or 'the worst thing that could happen.'

For those of you who can still remember learning about Pavlovian Classical Conditioning as an undergraduate:

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What actually happens during BLS?

A research group based in Rome has published the first evidence for EMDR's strong neurobiological basis (Pagani,M. et al., September 2012, *PLOS ONE*, Vol. 7, No. 9). Marco Pagani of the Institute of Cognitive Sciences and Technologies and colleagues had two main objectives; they wished to discover whether EEG could provide real-time monitoring of neural activity during EMDR therapy and, secondly, whether it could monitor a relevant shift in brain activity, correlating with EMDR theory, as a direct result of bilateral stimulation.

Despite the small size of the study – there were only five male and five female subjects with

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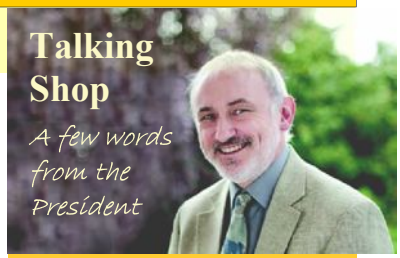

En route to meeting Ad de Jongh in Amsterdam (see Flashforwards article, left) I was wandering round looking for inspiration for my next column when, in the famous Oude Kirk (old church), I found a carving in the choir stall which illustrates an old Dutch saying: 'Sail when the wind allows'. Through my EMDR-tinted spectacles I immediately thought about how important it is to work with our clients rather than against them. This may sound obvious, but how often do we forget it!

I should confess that I know next to nothing about sailing and I'm not even very confident on the water; I blame the Oude Kirk for my maritime musings but ask you to bear with me. Firstly, we should not even attempt to set sail if there is no wind at all. Our client may not be ready to make the journey and may have come to our consulting room, for example, because someone else wants them to be there. Secondly we should always be aware of where our client wishes to sail to. It might not be the destination that we assume or think is 'best for them'.

• the mental representation of the anticipated catastrophe is an Unconditioned Stimulus (UCS). This would be the target in Flashforwards.

• the predicable event which would normally be targeted in the Future Template Protocol is a Conditioned Stimulus (CS) which has been learned as a result of the trauma

In the example above, my client was fearful of going out and we could have used the Future Template to help her cope with a normal trip to the shops. However any fear of such a trip was still being fuelled by the fantasy of the worst scenario ie, falling and breaking both her arms and being dependent on her family as a result. By targeting the fundamental dread that was feeding her everyday anxiety we were able to produce swift and lasting change.

The term 'Flashforwards' was coined by Iris Engelhard in the Netherlands and she has published several papers demonstrating how it works in an experimental situation. Her colleague, Ad de Jongh, has also been using this term for some time now and did a brief presentation on Flashforwards at the EMDR Europe conference in Madrid this summer. My interest in finding more about it led me to travel to Amsterdam to meet Ad in September this year.

Before becoming a psychologist, EMDR trainer and leading researcher in EMDR, Ad started his professional life as a dentist and developed a special interest in dental phobia in which fear of future catastrophe is endemic. He is still based in the university dental department in Amsterdam and showed me round their high tech facilities. If you have a dental phobia in Amsterdam you don't get put under a general anaesthetic as you would here. Instead you attend the special dental phobia clinic at the university where you stay conscious and receive EMDR, often using the Flashforwards protocol. Ad and I have agreed to write a paper on Flashforwards for the Journal of EMDR Practice and Research.

The Flashforwards protocol is identical to the standard EMDR protocol except that it relates to a feared future catastrophe rather than to a past trauma. The client is asked to form an image which represents that catastrophe and this image is used as a target. The negative and positive cognitions (NC and PC), VOC, emotions, SUD, and bodily location are all elicited in the usual way and the target is then then processed.

Ad believes that an NC of 'I am powerless' and a PC of 'I can deal with it' will, in fact, be appropriate in most cases. All the remaining phases of the eight stage protocol are utilised in the normal way.

major psychological trauma – the researcher's results show conclusively that EEG is indeed an effective methodology but, more importantly, that neural activity during therapy shifts from the limbic regions (associated with traumatic memory) to cortical regions of the brain, which are associated with higher cognitive functions. The researchers say their study supports the evidence for "distinct neurobiological patterns of brain activations during BS associated with a significant relief from negative emotional experiences". This, they write, "suggests a strong neurobiological rationale of EMDR, thus supporting its efficacy as an evidence-based treatment for trauma".

The researchers also believe that their study is the first in which psychotherapy has been "monitored and dynamically represented by functional imaging throughout its entire duration." It paves the way for larger studies using EEG methodology.

Read the full paper at: http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0045753

Once we have set sail we should be sensitive to any resistance the client may have to processing their material (cross winds?). In fact, conceptualising this problem as 'resistance' may be a problem in itself. It's perhaps worth remembering that our client will have developed an attachment style that best fitted the environment in which they found themselves and this is what we need to work with. Joanie Spearings says to her clients 'you must have a very good and important reason for …' Jim Knipe might say to his, 'you believe it's important for you to be strong at all times. How important is that for you on a scale on 1 to 10?...go with that.'

We should always be prepared to take a step back, re-assess and be humble enough to admit our mistakes and set off in a different direction. We should accept that processing doesn't have to occur in every session once it has started. We might have to re-evaluate whether we have selected the right target or we might have to target a blocking belief.

And are we aware of the client's own resources, so we may use them to our best advantage? I can hear you groaning 'Oh god, please leave the sailing metaphor alone now' but this is the final reference, I promise. One thing I do know about sailing is that the process of 'tacking' means sailing against the wind. You have to set the sails in a particular way which results in the boat zig-zagging into the wind. This reminds me of the many clients I have worked with who are resistant to showing any emotions in my office because they believe this is a sign of weakness. There is no quick answer to this one but to tack gradually against the prevailing wind with interweaves such as, 'do you believe your children should share it with you when they are upset? Go with that.'

To conclude and summarize I'd like to adapt an old joke: How many EMDR therapists does it take to change a light bulb? Only one, but the light bulb must want to change and the therapist needs to turn it in the right direction.

With best wishes,
Dr Robin Logie,
President

How EMDR 'miracles' won me over

Dr Syed Ali Naqvi says he was critical and sceptical about EMDR. He talked to Omar Sattaur about how his employers ended up including EMDR therapy in its care plans.

Syed Naqvi is a Clinical Psychologist who is also trained in CBT, REBT and behaviouristic approaches. He first came across EMDR when employed by the Pakistan Army and Ministry of Defence. Like many other clinicians, he answered the call for help following the devastating earthquake in Kashmir (Pakistan) in October 2005 which claimed at least 79,000 lives. That was when he came across the impressive work of the Humanitarian Assistance Programme (HAP) which was already on the scene treating earthquake survivors using EMDR and training Pakistani professionals in the therapy. He had just completed a research study into domestic violence and PTSD and this, naturally, was his main interest. But after the earthquake, he said, "my interest shifted completely to PTSD and EMDR". When I asked him why, he replied vehemently, "quite honestly, Omar, miracles seemed to be happening".

His story echoes that of many other practitioners who have been taken aback at the rapidity with which EMDR can produce lasting clinical improvement. But Naqvi confesses it was difficult for him to accept. "I was critical and sceptical for a long time", he told me. "What was this mishmash of hypnosis, psychoanalysis..... it seemed to have no scientific or empirical base". The case that changed it all – and there's probably at least one case for almost every EMDR practitioner – was when he was assigned an ex-soldier who during service had witnessed his colleagues being killed when the truck they were sit-

Normally one should only use Flashforwards once all past traumatic events have been fully processed or it appears that a preoccupation about a future catastrophe seems to be the only remaining block to further processing of the past event.

The Flashforwards procedure can be particularly useful when working with clients, such as those with PTSD or phobias, who are avoiding some situation as a result of a specific trauma. Once the trauma has been fully resolved, they are still often left with the avoidance behaviour which has become a self-maintaining habit. My experience of working with individuals who have been involved in recent single event traumas, such as a road traffic accident, shows that the first processing session often resolves the trauma whilst the second session, using EMDR applied to the client's Flashforwards, can, literally, get them "back on the road".

There are also circumstances in which Flashforwards might be utilised even when a past event has not been processed:

Firstly it may be the case that no identifiable past event appears to exist that seems to relate to the current psychological problems. For example, I have used it with considerable success with OCD which is all about dread of some future catastrophe and making strenuous efforts to avoid it. It should be accepted however, that during the Flashforwards processing, the client may spontaneously bring up a past event that neither the client nor therapist had previously been aware of. Or this may occur whilst doing a floatback or affect-bridge on the cognitions or emotions relating to the future catastrophe. If any old material arises (either a previously processed trauma or some other memory that has not already been processed) the therapist should simply continue processing in the usual way and say "go with that". The Flashforwards procedure may therefore involve spontaneously flipping between past events and feared future scenarios and connecting the two in the process.

Secondly, it may also be necessary to first target future events before looking at past ones because the current symptoms are so debilitating that the client is not ready to look at past ones.

Flashforwards can assist the progress of EMDR in situations where the processing of past events is not sufficient. Whilst it should never be regarded as a 'stand-alone' therapy, it should exist as another valuable tool in the therapist's toolkit.

ting behind overturned. Naqvi's client had been struck on the head by a huge crane hook; the ex-soldier's scans showed evidence of brain damage and he suffered amnesia. He could not remember anything following the accident and lost even the ability to recognise family members.

Naqvi's patient was stricken by survivor guilt and as far as Naqvi and his medical colleagues were concerned, the prognosis for this man was extremely poor. There was something about him, however, that made Naqvi doubt the diagnosis of physical damage to the brain. Despite his scepticism he began treatment with EMDR and, to his amazement, the client retrieved all his memories after just three sessions. "I thought he was pretending", Naqvi said, "but I could see his emotional level changing during the processing. It was a total paradigm shift for me".

Naqvi went on to use EMDR to treat victims of torture, former captives of the Taliban with equally good results. He has since moved to the UK and has persuaded the East London NHS trust, where he works, to allow him to use EMDR. "My dream is to be fully on board with HAP",

Dr Syed Naqvi was a reluctant practitioner

he said. But realising that dream is still some way off. Find out more about the inspiring work of HAP at: **https://www.emdrhap.org/home/index.php** and the HAP UK & Ireland website: **http://www.hapuk.org/**

Regional News

The NW Region is holding its inaugural meeting on Saturday, 19 January 2013 in the Friends' Meeting House, central Manchester, from 1.30 – 5pm.

Dr David Blore will present his doctoral research on post-traumatic growth and Lt Matt Wesson will speak about intensive EMDR work with military personnel.

There will also be an "Ask the Panel" session. Early Bird fee for members is £30 and members from other regions are most welcome.

For further information contact Fokkina McDonnell on info@fokkina.co.uk.

Your shout!

When hospitalisation proves a double setback

Dear EMDR Now,

This is a request for information regarding the impact of abuse being re-ignited following hospitalisation. I worked with a client who had been frequently abused as a child and as a teen by a family member and was later violently raped. She struggled with suicidal thoughts for the first 18 months as we uncovered the depth of the trauma and her aloneness in it. For the next 18 months suicidal thoughts ceased and her relationships with others began to deepen and strengthen. She experienced reciprocated relationships for the first time in her life.

Meanwhile she had her first experience of a medical problem which worsened over this period to the point of warranting surgery. We and others helped prepare her for the operation, understand how hospitals work and what she might expect. However, the operation, which was scheduled to be completed as a day case, lasted longer than expected. She became unwell and had to stay overnight. She was well enough the following day to be discharged.

Therapy restarted after her recovery from the operation whereupon she became depressed and suicidal again. We couldn't move forward and she was too unwell to work. None of this seemed to make sense given that the 18 months prior to her hospitalisation had gone so well. After a few weeks of being stuck, I suggested we target the recent hospital experience. This began to free her and within six weeks she stopped feeling suicidal and was contemplating going back to work (at home, but working nonetheless). I am told that there might be some literature on this phenomenon of the traumatic impact of abuse being rekindled following hospitalisation and I would be grateful if anyone knowing of this literature could send me references. Many thanks.

Maryann Richard

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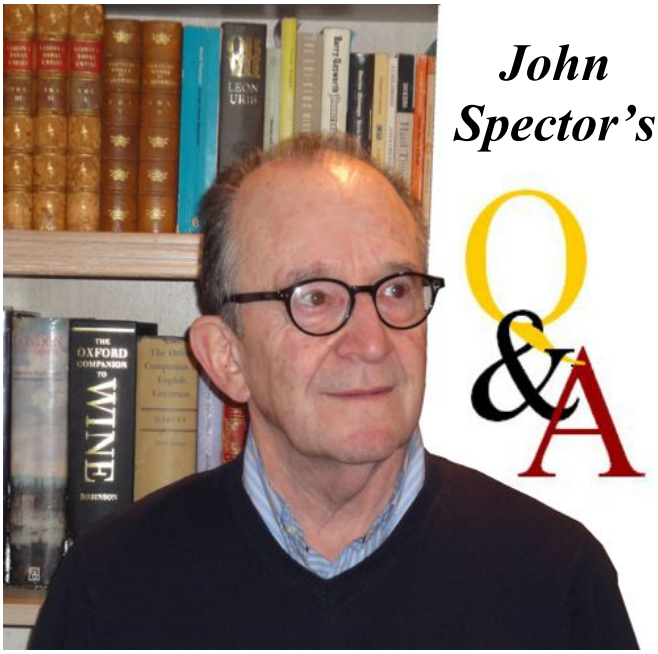

John Spector's Q&A

In the interests of confidentiality, names and addresses have been withheld. Please send your EMDR questions to the editor: o.sattaur@gmail.com

Q *What are the reasons clinicians trained in EMDR report in Supervision that they 'cannot find anyone suitable for EMDR'?*

A Sometimes the reasons are to do with the clinicians' client group and sometimes to do with the clinicians' anxieties. As for the former, clinicians and especially NHS clinicians often work with seriously mentally ill clients with highly complex problems, which may not obviously lend themselves to EMDR, especially to newly trained clinicians encouraged to find "simple" trauma cases to begin with. Additionally, sometimes professional colleagues don't see EMDR as appropriate outside of PTSD and of course there are still a few work environments with antipathy towards EMDR. Conversely in the private sector many clinicians see clients primarily presenting with relationship problems and existential crises, which again sometimes do not obviously lend themselves to EMDR.

Having said that, anxieties or "resistance" in the new EMDR therapist can also play a part. Post-Basic Training clinicians are encouraged to be creative in finding clients – perhaps working with more complex but very familiar clients with whom safety and rapport has been established using very discreet events or blocks to target. Or practising on friends or colleagues. But reluctance may spring from a sense of clumsiness in application, proximity to the client, the intensity of EMDR, and the fear of "getting it wrong". We have all been there!

Q *In view of the growing evidence that EMDR can be used for a much wider range of problems than solely trauma related conditions, are there any types of difficulties or client factors that would definitely be contra-indicated e.g., epilepsy, pregnancy, addictions?*

A Neither epilepsy, pregnancy, or addictions are definite 'noes' for EMDR but all require cautions. Clients with controlled epilepsy can use EMDR but therapists should liase with medical supervisors and not use eye movements. EMDR may be used with pregnancy, again in liaison with medical supervisors, but generally not in the first trimester. EMDR may also be used with addicts in remission or controlled environments in liaison with carers using some of the new addiction procedures and protocols eg, Miller R 2010, Marich J 2010, Popky-De Tur urge protocol.

Definite contra-indications apply not so much to the type of problem but 1) the severity of the problem and 2) whether information and emotional processing is impaired and 3) whether risk factors are too great.

1. Clients with severe, enduring, and endogenous depression are unlikely to respond to EMDR and clients with active and florid psychosis are inappropriate. Severely dissociated clients will need much preparation and stabilisation.
2. Processing problems will rule out clients with some kinds or traumatic brain injury, severe obessionality, poor motivation or secondary gains for dysfunction (including sometimes compensation factors).
3. Risk factors will rule out some clients with high suicidality or active self mutilation, clients incapable of emotional regulation, or clients too fragile or lacking in resources.

Whilst EMDR is not contra-indicated for most disorders it is not necessarily always indicated as first choice treatment outside of PTSD. Where problems are not acquired through trauma or critical incident but say through learning or modelling, CBT or other approaches may be more effective.

Q *I have a 38 year old adult male client who has no memory of being sexually abused by his father. However, his brother told him when he was 19 years old, after his father's death, that the father seriously sexually abused them both regularly between the ages of 2 and 6. This man is now very lost and confused over the relationship he thought he had with his father and the rest of his family. He is often depressed and angry but is not sure where to channel his feelings. My question is, with NO memories of abuse, what would we be looking to target in EMDR?*

A There is quite a lot of information missing that would help in answering this question e.g., did his problems begin when his brother told him about the alleged abuse when he was 19 or did his problems develop more recently at the age of 38 perhaps in response to other life events? And how reliable are his brother's allegations?

So I will answer your question in the generality. Whilst it is helpful to know the details to an old trauma, it is not vital. And it is not so unusual for a client to <u>believe</u> they were abused as a child without having clear memories of that abuse. Possible targets are: The experience of being given the information about abuse by the father (from the brother) at age 19; The belief he has about himself assuming he <u>was</u> abused by the father, and/or what he believes now about his relationship with his father; Any corroborative evidence of the abuse; Any sensations or dysfunction he associates with possible abuse.