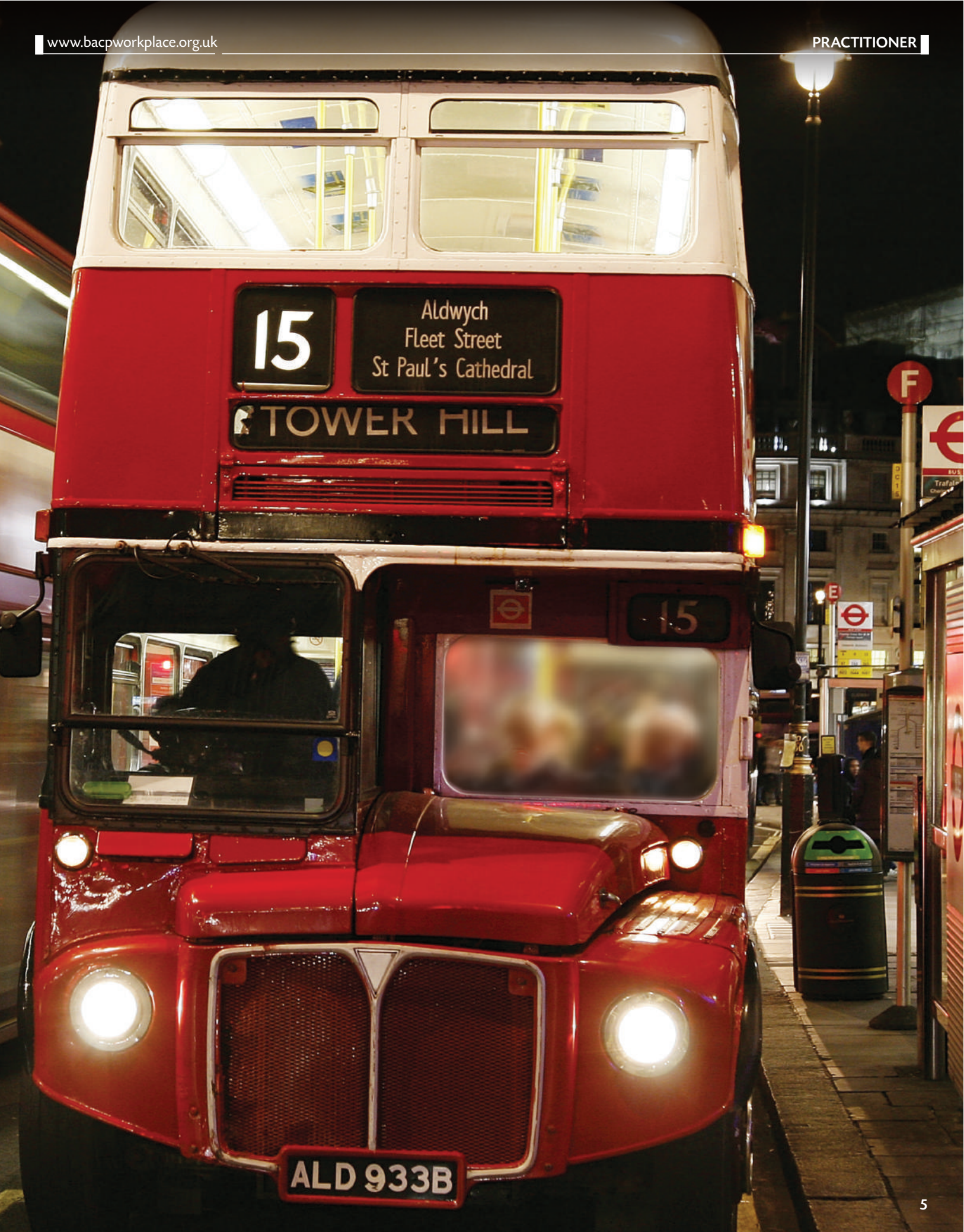
Eye movement desensitisation and reprocessing (EMDR) in practice at Transport for London

Fiona Dunkley and **Melvin Claridge**
explain how the trauma intervention model works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The Counselling and Trauma Service (CTS) at Transport for London (TfL)

The CTS is based within Transport for London's Occupational Health Department. Our aim is to help employees stay in work or return to work quickly and safely after illness or injury. Over the last few decades the CTS has developed from a welfare service to a specialised trauma department. On a day-to-day basis, the counsellors are responsible for supporting employees who are off sick or assessed as 'at risk', working on restricted duties or carrying out safety-critical work. Assistance is offered to employees who are experiencing work-related issues, work-related traumatic experiences, or personal issues that are impacting on their performance at work.

Being a trauma specialist department, practitioners are trained to use various trauma modalities. For this article we are focusing on our work using EMDR. Over the last six months we have practised EMDR with 33 per cent of our total client cases. Ninety-three per cent of our clients have returned to work having received help from CTS.

Introduction to EMDR

EMDR is the acronym for a type of psychotherapy called eye movement desensitisation and reprocessing. Research and practice since the development have shown that the benefits are due to alternating stimulation of the right and left hemispheres of the brain, which leads to a lessening in reported feelings of disturbance.

- Eye movement – bilateral stimulation of both hemispheres of a client's brain, as a result of visually following the therapist's fingers or a bar of light. The same can also be achieved through alternating bilateral tones in the ears, buzzes in the hands, or taps on the body;
- Desensitisation – reducing the emotional disturbance felt when recalling distressing memories;
- Reprocessing – the adaptive reformulation of dysfunctional information held about oneself in relation to traumatic experiences, which is replaced with positive self-reflecting beliefs.

Simply put, EMDR helps to take the sting out of a person's felt response to trauma.

Francine Shapiro, PhD, Senior Research Fellow at the Mental Research Institute, Palo Alto, California and Executive Director of the EMDR Institute, California, is the 'originator and developer' of EMDR. She made a chance discovery in 1987, when she realised that the intensity of her disturbing thoughts decreased as she moved her eyes from side to side while looking at the trees on both sides of a path along which she was walking. She researched this phenomenon for her psychology doctoral thesis, which was published in 1989 and released in 1995 as her book *Eye Movement Desensitization and Reprocessing (EMDR): Basic Principles, Protocols, and Procedures*[1]. Since then, EMDR has been adapted and reworked, to some extent, based on the research and contributions of therapists and researchers the world over, from a variety of therapeutic approaches, including CBT, client-centred therapy, psychodynamic therapy and body-work.

The National Institute for Health and Clinical Excellence (NICE) recommends EMDR for the treatment of post traumatic stress disorder[2]. The guidelines are based on a number of high quality randomised control trails (RCTs) that have provided an evidence base for the effectiveness of EMDR in the treatment of traumatic memories. EMDR is also now recommended as a frontline treatment for trauma in the Practice Guidelines of the American Psychiatric Association, and those of the US Departments of Defence and Veterans' Affairs.

EMDR has been successfully used to treat:

- PTSD
- Anxiety
- Panic attacks
- Depression
- Phobias
- Complicated grief
- Addictions
- Abuse (physical, sexual and emotional)
- Performance anxiety
- Dissociative disorder

EMDR use at TfL

As part of a treatment plan, EMDR is used to treat the trauma which has led to a client's presenting problem. At CTS, we use EMDR to treat both major traumatic events, which are generally single incident (sometimes called Big T Traumas) or smaller events which occur regularly and lead to a reinforcement of negative automatic thoughts (sometimes called little t traumas).

We provide therapeutic treatment for employees of TfL who have been involved in or witnessed trauma incidents (train suicide, near misses, assaults, critical incidents), major incidents (bomb, fire, explosion resulting in flooding, exposure to noxious chemicals, major train crashes) and less major but still critical incidents (derailments, minor collisions, violent incidents resulting in injury or death of another). We also work with developmental complex trauma, if this is feeding into the current presenting problem. In addition, we provide treatment for stress, bullying and distressing workplace issues.

The first stage of any trauma treatment we undertake involves normalisation, psycho-education and resourcing. When assessing whether to use EMDR with a client, it is important for us to know that the client is able to self regulate and have good resources. If a therapist is concerned about a client's risk of dissociation, we use the Dissociative Experiences Scale (DES)[3] form as an indicator of whether it would be appropriate to offer EMDR or not, depending on the therapist's experience and ability to work with dissociation.

EMDR protocol (EMDR Europe Association and EMDR International Association)

The EMDR protocol sets out an eight-phase treatment plan, which we follow in all EMDR treatment:

1 Client history and treatment planning – Information gathering, relationship building, formulation, assessment

of risk, affect tolerance and capacity for self-regulation. At this phase, we would also explain what EMDR is, how it will be used and get client consent.
2 Preparation – Evaluation of the client's expectations and understanding, work on confidence building, self-regulation and exploration of coping strategies. The therapist would also consider contraindications and any medical considerations, explaining fully how this may affect the processing, ie if indicated, explaining that EMDR will not cure personality disorders, OCD or addictions, but it is effective in reducing disturbances.
3 Assessment – Following the seven steps outlined below.
4 Desensitisation – Bilateral stimulation.
5 Installation – Slow bilateral stimulation to install confidence in validity of the newly acquired positive cognition.
6 Body scan – The client undertakes a mental scan of his or her body to check physical sensations.
7 Closure – End of session. If there is still some disturbance, the therapist would guide the client through containerisation and soothing place exercises.
8 Re-evaluation – This is done in the following session to check the level of the subjective unit of disturbance. If there is still disturbance, we would return to the desensitisation phase to continue processing.

The general protocol for setting up the assessment phase of EMDR involves seven steps. It is possible to work on an incident even if the client struggles to identify a specific memory, as the EMDR process can focus on an identified feeling or body sensation.

1. Identifying the target image or feeling – It's important to note that EMDR incorporates a three pronged approach, looking at the past (core memories and events which provide a root for the present problems), present (continuing issues which feed the problem) and future (visualising and processing appropriate feared scenarios).
2. Negative cognition – Negative 'I am' statement which the client connects to the incident.
3. Positive cognition – Positive 'I am' statement which the client would ideally like to believe.
4. Validity of Cognition (VoC) – Rating of how true the positive cognition feels from 1-7.
5. Emotions – Identifying feelings associated with the trigger.
6. Subjective Units of Distress (SUDs) – Rating the level of disturbance from 1-10.
7. Physicality – Identifying where the feelings are loacted in the body.

The therapist would then start the desensitisation, installation and body scan phases until all triggers are cleared and the client reports feeling calm. In our experience, clients then feel ready to take on challenges and feel confident at work or ready to return to work.

Case study 1: George – one under

George was referred to the CTS by his manager. He had been with the company for over 20 years and loved his job as a train operator. He had experienced a suicide on the line and was suffering from flashbacks, hypervigilance, difficulty sleeping and concentrating. He arrived for the assessment session in an anxious state and my immediate focus was to help him calm down his nervous system using grounding and relaxation exercises. Rothschild describes this as the client, 'learning to put the brakes on'[4]. This enables hippocampus functioning, allowing the client to integrate the therapeutic work and confront emotionally disturbing events. After completing the assessment it was apparent George had no previous traumas, he had good resources, including support from family and friends, and hobbies he enjoyed. We installed a 'safe place'[5] successfully and he began practising this exercise between sessions.

During the first counselling session we set up the EMDR protocol and George's preference was to use eye movements for the bilateral stimulation, rather than tapping or sounds. George's worst memory of the incident was, 'when the person dived onto the track'. He felt 'powerless', and I asked him where he felt that in his body. He said he felt it in his chest, 'like a weight bearing down on me'. His SUDs rated '9' (1 [low disturbance] – 10 [high disturbance]). His negative cognition was, 'I am responsible for his death'. This is a common irrational belief that many train operators hold after experiencing this type of trauma. Statements I often hear from clients are, 'if only I wasn't working that day, I could have prevented this from happening', or 'maybe there was something I could have done differently'. George's ideal positive cognition was, 'I did all I could and I am not responsible for his death'. He rated the VoCs as '3' (1[completely false] – 7 [completely true]).

During session two we started the EMDR processing. I said to George, *'Try and stay with the discomfort, it is like going through a tunnel and you want to come out the other side.'* I also said that if he felt he wanted to stop, he was in control of the process and could put the pause button on at any time. As we started the process, he described a strange sensation in his stomach.

George: 'It's in the pit of my stomach, it feels really uncomfortable'.

He spoke about a tingling sensation; he kept saying 'this is weird; like electricity moving around my body'. He asked me if this was normal, to which I responded, 'I often hear clients describing a tingling sensation; this is usually a good sign; it means something is shifting and processing.' The tingling sensation started in his feet and as the session progressed it moved up his legs towards his torso. The neuropsychologist R Hanson states that the direct flow of energy and information through our neural circuits can directly alter the brain's activity and its structure[6]. Communication between neurons often involves an electrochemical process.

George: 'I am not happy with what he has done to me; it has messed me up. He has messed up my life'.

Therapist: 'Go with that; you are just noticing/just observing'.

George: 'Such a violent passing, seeing death right in front of you.'

The tingling George was experiencing eventually reached his head. I noticed his face turn red; as the tension grew, he started to cry. He said this was the first time he had been able to cry since the incident; in fact he couldn't remember the last time he cried.

The next time we met he had practised his safe place during the week and felt much more able to self-regulate his nervous system. We carried out a second session of EMDR processing. During this session he again spoke of a strange sensation, but this time it started in his face, moved to his ears and then out through the top of his head.

George: 'I seem to be coming back; I feel like I've been somewhere; I'm becoming more like me'.

'I've been stuck in a dark place: bottomless, in fact. Maybe everyone should visit this place with a guide'.

During our fourth session George's SUD had reduced to 'zero' (low intensity of emotional disturbance) and he now believed that 'I did all I can and I am not responsible for his death'. We continued the therapy for a total of six sessions. During the last couple of sessions we focused on George's return-to-work plan in correspondence with his manager. I carried out visualisation with him, focusing on his first day back in the workplace (a type of exposure work without physically being at the triggering site). By the sixth session, George was back at work and, once again, enjoying his job as a train operator.

Case study 2: Sam – developmental trauma

Sam works at an underground station as a Customer Support Assistant (CSA). He referred himself to the service for counselling after he was verbally threatened with violence by a passenger at the station. He was assisted at the scene by his manager and one of our Trauma Support Group volunteers, who had recommend the CTS service to him.

In the taking of his history, I found out that he and his siblings had been put in an orphanage for two years when he was three years old; that his father had left when he was nine years old and he has not seen him since; and that he was repeatedly beaten by his mother. In exploring our treatment plan, it became evident that the threats during the incident at work had reminded him of the constant threats and abuse he suffered as a child.

He was shaking constantly, not sleeping well, and had trouble concentrating. He was signed off sick and felt incapable of returning to the station. He was having flashbacks of the incident at work, along with images of his mother beating him. He had also started having nightmares about both.

In preparation, EMDR was explained to him and I taught him a light-stream visualisation exercise for him to calm himself down. He had not realised that this was possible. He felt anxious constantly, with a heavy feeling like a steel ball in his stomach. Through the exercise, the ball changed colour from red to blue, then silver and became lighter in weight, melting away. He practised the exercise between sessions and reported feeling a lot calmer and more relaxed. We also worked on establishing a safe place visualisation, which was a beach scene from a holiday he had enjoyed.

In working with someone with a history like Sam's, it is important to target the early trauma memories initially. These memories feed into the most recent trauma and if we start with the most recent and presenting issue, channels to previous trauma may still be accessed, which could lead to longer processing times. In his distress, Sam was having a hard time differentiating between the recent and the past traumas. Mindful of the three-pronged approach, we decided to target the past, present and future, using the first/worst/last model to target the past, including the work incident. We agreed to then look at whatever was present after we had reduced his disturbance levels, and then to do a future template of him visualising himself back at work, in a confrontational situation with a passenger.

His first traumatic memory was walking into an orphanage with his younger brother. The negative cognition he held was, 'I deserve only bad things' and the positive cognition we agreed to work toward was, 'I deserve good things'. At the time of our preparation, he rated his belief in this statement (VoC) as 2 on a scale of 1-7, with 1 being completely false and 7 completely true. He felt anxious and afraid, rating his level of disturbance (SUD) as 8 out of 10. He felt this all over his body.

During the desensitisation phase in most EMDR sessions, the therapist generally stays out of the way. We used eye movements, with Sam following my hands with his eyes. After about 24 repetitions of eye movements (called a set), I stopped, asking him to take a deep breath and tell me what was happening. He started with the image of him entering the orphanage. Each semicolon represents the end of a set in the excerpt below:

Tension throughout my body; clutching my brother's hand; feeling lost; looking around; scared; calmer; seeing light coming in through a window in the orphanage; looking up at the light; (he started to cry) I cried so much in there; I tried to find my father once and got his address; he never wrote back; hearing stories about my mother chasing him away; not sure what to do; dad was probably too afraid of her to come back; heard he had come back once, but mum chased him away again; I feel compassion for dad and angry with mum; feeling hot; ball of fire in my stomach; a bit cooler; calmer; (looked up at the window) light's coming in through that window; calm; light from the window is calming; I feel OK; (laughs) this is weird; I'm fine; (I then asked him to go back to the image we started with) It feels far away, like that was a little boy who experienced that, not disturbing at all now (I asked how disturbing it felt from 0-10) Zero...this is really weird; I'm thinking, 'I'm a grown man and I've survived.'

The positive cognition 'I deserve good things' now seemed completely true to him and we installed this with slow eye movements. We completed the session with a body scan and he reported a wonderful feeling of peace and calmness.

In the subsequent session, he reported feeling elation for about three days after the session and after that, he felt really relaxed and was able to get to sleep and stayed asleep for five to six hours per night. His SUD rating for that incident remained at 0 on this incident. We then targeted what he had rated as the worst incident, which was his mother beating him almost to death on one occasion. Prior to the EMDR session, he had rated the SUD for this incident as 10 out of 10. In this session, he rated it at 7. His negative cognition was 'I am to blame'. At the end of the EMDR session the SUD rating was 0 and he came to the realisation that he was not to blame for his mother's or anyone else's

actions. In the week after this, he agreed to return to work on alternative duties, working in the administrative office, helping out with paperwork.

In the following session, we targeted the latest traumatic incident, which was the assault at work. In our preparation session, his SUD rating for this incident was 9 out of 10. After having desensitised and reprocessed the developmental trauma, he rated the SUD for the incident at work as 5 out of 10. His negative cognition was, 'I am not safe'. We went through the desensitisation phase and the disturbance level quickly came down to zero. The memories and images he processed were related only to this incident and he quickly came to see that he had been able to take care of himself during the incident and realised that he could now feel safe. He was able to return to his station and work confidently on full duties the following week. His shaking and nervousness had completely stopped, he was sleeping all night and his concentration was now good. He also reported feeling more confident than he had ever remembered feeling.

Summary

EMDR works effectively, particularly with 'one-off' trauma events, and helps the client return to work quickly and safely after a traumatic event. At CTS we have found that EMDR often gets relatively quick results. When discussing the EMDR treatment, Professor Gordon Turnbull states, 'Therapists and patients were reporting that problems that had been resistant to years of psychotherapy were being resolved in a very short amount of time – sometimes within a few sessions'[7].

When I was carrying out a presentation on EMDR recently, someone asked me, what if the client is resistant to using EMDR'? I answered, 'don't use it'. It is important that the therapist has knowledge of various techniques when working with trauma and can therefore be adaptable and flexible to the client's needs. It is necessary to carry out a thorough assessment to consider which trauma technique is most appropriate for each client.

As George and Sam returned to the jobs they love, we also feel passionate about the work we carry out at the Counselling and Trauma Service within Transport for London. For the clients, recovery can be a rewarding, transformative journey back to health. For the practitioners it can be a real privilege to share in that journey, including the satisfaction of seeing employees back to full duties.

To protect privacy and confidentiality, all identifying client information has been altered throughout this article or client consent has been obtained in line with BACP's Ethical Framework for Good Practice in Counselling and Psychotherapy.

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