The Blind to Therapist (B2T) EMDR Protocol: Two case examples

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ABSTRACT

From time to clients attending for EMDR are reluctant for one reason or another to disclose the details of target imagery (Brile 2005, Brile & Holshaw 2006), something that would normally result in difficulties conducting EMDR with the standard protocol. The reason for non-disclosure may be because clients are not confident in their ability to manage their control in therapy and the event being treated represents a significant loss of control in a situation in which they were trained to always be in control (as in Case 1 below). It was this type of clinical situation that prompted the first author to devise a protocol so as to administer EMDR without the need for disclosure until such times as the client felt comfortable enough to disclose the targeted imagery. However, it wasn’t long before a second use for the new ‘Blind to Therapist’ (B2T) protocol was found and it is possible that this newer use may prove to be the most common use of the new protocol (Case 2 below). This poster presentation details the treatment of two clients with EMDR using the B2T protocol—one of each of the two types of presentations listed above.

CASE 1: Train Driver

Client and circumstances of referral:
Train Driver, aged 36, The Train Driver was involved in a fatal incident in which a 60 year old man committed suicide by jumping in front of the train travelling at almost 125 mph. Subsequent internal and external enquiries exonerated the train driver from any blame. A subsequent private medical opinion noted that he had been depressed for over a year and, at the time of the suicide, was attending a psychiatric outpatients clinic.

Assessment:
The Train Driver was referred for EMDR under the existing service-agreement between the rail franchise holder and the private company providing EMDR for the after-effects of major trauma. Following routine assessment it was discovered that the Train Driver, who, by then, was suffering from Post Traumatic Stress Disorder (PTSD) was extremely reluctant to disclose the proximal-impact memories of the incident. The Train Driver explained that despite every assurance from his employer, British Transport Police and the Coroner—he still felt entirely responsible for the fatalities. The level of perceived responsibility was clearly assessed with being trained to always be in control of the train being driven. The auditor ‘proved’ he had ‘failed’.

Treatment:
EMDR was conducted using the B2T protocol (see synopsis below). The undisclosed image was originally given the cue word ‘27’ by the Train Driver. As per the B2T protocol no negative or positive cognitions were sought, The Train Driver was carefully coached in relation to the experiences of change often noticed during EMDR Phase 4 processing.

- When Phase 4 commenced, the Train Driver was asked to:
  - Notice ‘27’
  - And the emotion (horror)
  - And where the emotion was experienced in the body (hands and chest)
  - And bilateral stimulation then commenced.

The first few sets were characterised by obsessions, but the Train Driver did not use the safe place previously instigated and was able to keep going with EMDR. Eventually the Train Driver announced that in the split second available he had applied the emergency brakes. The train came to a halt on the emergency brakes almost half a mile down the track. He then described all the various safety of the line procedures that he had done announcing that there was nothing else he could have done.

On returning to ‘27’ he then described the vivid image of blood diagonally across the windscreen and completely the left windscreen. A little later he described that he had been in control throughout despite what he had toed. He finally revealed the full nature of the original target and even that ‘27’ was the figure on a trackside signal immediately prior to the impact. EMDR then proceeded as per normal from that point.

Outcome:
The Train Driver successfully completed EMDR in 5 sessions and was asymptomatic on discharge. He was subsequently assessed independently for safety critical work, and returned to Train Driving. That was in 2004, He is still driving trains in 2009.

Discussion:
The two cases are very different, but clearly illustrate that the effect of treatment is not dependent upon disclosure. Aversive situations such as recalling extreme, claustrophobic memories prove attempts to reassert control (Thompson 1981), especially in those people with a strong internal locus of control – including, it would seem, where the person involved (Case 1) has been trained, and learnt, to always be in control. Clearly there is a problem in this circumstance.

It is impossible to teach Train Drivers to always be in control, whilst at the same time it is also impossible to be totally in control when someone jumps in front of a train. The laws of physics will not yield no matter how much the individual wishes to be in control.

In Case 2, Ruth retained control over disclosure throughout. This point highlighted here is that her reasoning did not change despite the obvious removal of the traumatic nature of the event herself. One interpretation is that she must be still affected at some level because she did not disclose, yet another explanation is that her thoroughness for others was more powerful than the effect of the trauma on herself.

Perhaps aside from all other ways, these two cases illustrate the potential in changing treatment to accommodate the client rather than insisting the client conforms to traditional expectations to disclose traumatic material at all costs.

CASE 2: Childhood Sexual Abuse

Client and circumstances of referral:
A 54 year old woman, Ruth, who suffered childhood sexual abuse between the ages of 7 and 11. She had sought help for complex PTSD problems in the past with little success although she had never had a course of EMDR previously. Ruth was referred for EMDR having had some of the intrusive memories emigrated by an event in which she had become aware of the sexual abuse of one of her rescuers.

Assessment:
At assessment, Ruth had been troubled by one specific image of her own abuse. The perpetrator, now deceased for several years had never been confronted concerning the abuse. She reported having never told anyone about the details of the memory below. At assessment, Ruth said that the diagnostic criteria for chronic PTSD and suffered additionally with bouts of moderate to severe depression. Ruth explained that she could not discuss the memory because “it was too disgusting for anyone to hear”. Therefore not only could she not discuss the memories, but she did not wish to treat them anyone else other than the therapist.

Treatment:
EMDR was conducted using the B2T protocol (see synopsis below). The undisclosed image was originally given the cue word ‘lamp-post’ by Ruth. Again, as per the B2T protocol no negative or positive cognitions were sought, Ruth was carefully coached in relation to the experiences of change often noticed during EMDR Phase 4 processing.

Then, when Phase 4 commenced, Ruth was asked to:
- Notice ‘lamp-post’
- And the emotion (terror and ‘terrible disgust’)
- And where the emotion was experienced in the body (genitalia area and legs)

And bilateral stimulation then commenced.

The first few sets were characterised by slight or no change followed by rapid change and abstractions. Ruth’s post-set feedback was provided in a vague way, but mostly accepted by the therapist. A second cue word ‘nearby’ relating to a different event was used during the first channel of association and subsequently more definite change was reported. ‘Lamp-post’ was reported as less threatening and further sets yielded the more definite feedback “it was left”. Eventually, Ruth rated the ‘lamp-post’ SDS as zero yet she still did not wish to detail the content of the memory itself which explained that although she was never passed up by the memory she was ashamed she would not ‘think the picture on anyone else’s mind’. Ruth was content to continue the treatment without having had a NIC “it’s my fault”, however, as in the Train Driver example, the disclosure of the NIC had been preceded with a PC. In Ruth’s case this was: “Oh I don’t know if I’m not my fault, [sic]. Note the negatively worded PC.

Outcome:
Ruth went on complete treatment and disclosed herself much improved which was supported by psychometric measurement. The original details of the memories whose cue words were ‘lamp-post’ and ‘nearby’ were never disclosed.

This type of treatment outcome would traditionally be seen as further indication however, Ruth had experienced throughout treatment and believed that her efforts (if non-disclosure) had saved hurting others.

BLIND TO THERAPIST PROTOCOL (Brile, D.C., & Holshaw, E.M., 2005a)

BRIEF SYNOPSIS
- Identify non-disclosures during safety assessment/history-taking.
- Description: treatment of ‘not better if material cannot be disclosed’
- Client drawn change, the change of therapist unlikely to have sufficient information to judge if change is happening
- Cue word: non-disclosure
- NIC: Non-identifiable cue
- ‘Nearby’
- Commercially not yet being said: Notice (cue word) (emotion) (location)
- Propose as normal
- Disclosures may never occur, but PC may do so later
- Even if PC does not predict disclosure
- NIC for PC in normal manner

REFERENCES

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