



Dutch research gives birth to EMDR 2.0

In their keynote presentation and subsequent workshop, Ad de Jongh and Suzy Matthijssen provided compelling evidence for an intensive trauma therapy approach that goes to the heart of treatment-resistant PTSD and complex trauma. Omar Sattaur reports

Anyone keeping half an eye on research developments in EMDR will know the name of Ad de Jongh, the Research Director of an intensive EMDR trauma treatment facility called PSYTREC, in the Netherlands. In a keynote presentation to the first online EMDR UK national conference in early June, De Jongh and his research associate, Suzy Matthijssen, who heads an intensive outpatient trauma treatment programme at Altrecht GGZ, reinforced the message he gave two years ago at the EMDR Europe conference in Strasbourg – namely that EMDR is highly effective in the treatment of complex PTSD and that there is no evidence for the need for prior stabilisation in these patients.

In talking over a draft write-up of his presentation in Strasbourg, I happened to have alluded to his position on stabilisation as controversial. De Jongh immediately pulled me up: “Why do you say it is controversial?”, he wanted to know, “What is controversial about it?”. I countered that many therapists hold that stabilisation, particularly of people with complex PTSD, is an essential safety precau-

tion. De Jongh immediately asked me where he might find the research evidence for that position. This time round, apropos the same point on stabilisation, I mentioned the Mekong 2 study which showed that stabilisation alone can be an effective treatment for trauma but, of

are unacceptable risks to adult patients with CPTSD if they skip stabilisation prior to trauma-focused treatment. De Jongh and his colleagues repeatedly point to the fact that though the received wisdom is that stabilisation is an essential prerequisite for therapy in this client group there is no research to back up this claim. In contrast, his team is garnering a growing body of evidence for the efficacy of its treatment regime, sans stabilisation.

The keynote presentation set the scene for the workshop that followed in which De Jongh and Matthijssen describe what they have packaged as EMDR 2.0, a result of their work with treatment-resistant complex PTSD cases. The approach comes out of the research and practice at PSYTREC (Psychotrauma Expertise Centre) and from



Ad de Jongh and Suzy Matthijssen: EMDR should be as effective and as fast as possible for every client

laboratory studies performed by Matthijssen and other colleagues from Utrecht University. At PSYTREC, clients diagnosed with PTSD sign up for an intensive 8-day course of therapy. The course is residential and split into two four-day treatment periods separated by a three-day rest period. Each day,

course, De Jongh is not disputing this. He readily accepts that stabilisation alone can be effective, albeit more time consuming and with an average drop-out rate of around 30 per cent. The main questions are whether there is a need to stabilise prior to trauma-focused therapy, and whether there

▶ videos in which the client enters *e.g.* a bar and a stranger approaches them. Or it could involve smelling alcohol if this is a potential olfactory trigger that will get the client in touch with the traumatic memory. The principle here is to encourage the client to bring the triggering objects or experiences more fully into consciousness and to encourage their participation.

Once the memory is activated in this way, the therapist will use as many strategies as necessary to tax the working memory and De Jongh and Matthijssen go to great lengths with their clients to achieve this. For example, clients may be encouraged to make rapid eye movements while counting backwards, tapping out a complex rhythm with their hands and stamping their feet, if necessary, all at the same time as trying as hard as they can to hold onto the disturbing memory.

If the client is motivated, the traumatic material is fully in the working memory and the client is trying to keep it there, and if the therapist taxes the client's working memory sufficiently, the SUDs should fall rapidly. If they do not, the presenters say, then either the memory is not activated or the client's working memory is insufficiently taxed.

In some cases, after an initial reduction of SUDs, it plateaus without dropping to zero. Here it may be necessary to go 'deeper' into the

disturbing material. De Jongh and Matthijssen draw attention to how we make mental images of our experience. A person who has been raped, they say, may not have 'seen' the act of penetration – it may have been hidden from view – but this does not mean that the client who was raped has not made such an image of penetration which their minds then repeatedly replay.

Bringing the client back to target, they may be asked to focus in on the most distressing portion of the image they have made to symbolise the trauma event. Clients may remember a rape, but when asked to bring the memory to mind they may choose to focus on the how the ceiling looked during the experience rather than on the most distressing aspect of the experience which, for example, might have been the sensations they felt on the thighs or face whilst in contact with the perpetrator.

Memories are not like the flat images of two-dimensional postcards; the therapist might invite the client to imagine they are in control of a drone with an infra-red camera that can see through clothes, blankets and so on, and 'fly around the picture'. Keeping the hotspot of the memory as activated as possible is crucial, the presenters say, and the emotional charge must be as high as it can get. Clients are therefore encouraged, on returning to target, to 'zoom in' on the 'hotspot'.

De Jongh's and Matthijssen's aim is to make EMDR as effective and fast as possible for every client but particularly for those with complex PTSD or PTSD deemed resistant or unresponsive to treatment. They are already speculating on EMDR 3.0 and what that might entail. To illustrate the vision De Jongh recalls a client he treated who, during treatment, was wearing shorts. The impact of her hands on the skin of her thighs during the desensitisation phase brought to her mind the sound and feel of being raped from behind. This increased the emotional charge of the memory she was working on, and therefore raised her SUDs. But it was happening *at the same time as the desensitisation* because she was in an EMDR session, tapping her thighs. The result for this particular client was to enhance the effectiveness and speed of the desensitisation; her SUDs fell even quicker than expected. EMDR 3.0 then, is maximising activation at the same time as the desensitisation is taking place.

De Jongh said that when EMDR first came on the scene the number of sessions required to treat memories was vastly greater than today. "Now at PSYTREC we sometimes treat 3-5 memories in an hour. I think we can even further improve on this. And then the next step would be to have RCTs to investigate the efficacy of our practice."