Using EMDR Therapy to Treat Clients Remotely

Naomi Fisher

Hove, United Kingdom

During the COVID-19 pandemic, eye movement desensitization and reprocessing (EMDR) therapists have been faced with the choice of either abruptly terminating therapy with their clients or moving to working remotely, usually by videoconferencing. This poses particular challenges to therapists who may have never worked online. The standard EMDR protocol can be effectively delivered remotely when therapists are aware of how to make necessary adaptations. Based on clinical and supervision practice, this article describes ways in which EMDR therapists can adapt their ways of working in order to work effectively with clients remotely. This ensures that clients can still benefit from this effective and evidence-based treatment during a global health crisis. It suggests a number of ways in which bilateral stimulation can be achieved remotely, as well as discussing special considerations which arise with online therapeutic work. It considers adaptations which need to be made at each stage of EMDR therapy. It uses case examples from children and adults to illustrate how these adaptations work in real life. The case examples discussed in this article are illustrative of the techniques and adaptations necessary for remote EMDR and therefore reflect composites rather than individuals.

Keywords: COVID-19; remote therapy; eye movement desensitization and reprocessing (EMDR) therapy; trauma-focused; online therapy

Eye movement desensitization and reprocessing (EMDR) therapy is a highly effective, evidence-based form of psychotherapy which is recognized by the National Institute for Health and Clinical Excellence (NICE) and the World Health Organization (WHO) as an effective treatment for posttraumatic stress disorder (PTSD). It was developed by the American clinical psychologist Francine Shapiro in the 1980s (Shapiro, 1989).

EMDR therapy is used widely across the world, both in public health services and by therapists in private practice. Until recently it was assumed that EMDR could not be used remotely. However, the COVID-19 pandemic meant that many therapists were no longer able to see clients in person. At the time, guidelines for the use of EMDR online were only just being developed by EMDR International Association (EMDRIA; Rollins et al., 2020) and were nonexistent in many other areas of the world. Guidelines often focused largely on concerns about security online and the legal and risk aspects of working remotely. While these are important, this is not the focus of this article, which is about the practicalities of delivering EMDR therapy remotely.

Some clinicians, including myself, were already using all the stages of the EMDR protocol remotely before 2020. Due to personal circumstances, I had been using EMDR remotely for 2 years before the COVID-19 pandemic. This article describes how EMDR can be successfully adapted for use remotely, thereby allowing clients to continue to benefit from trauma-focused therapy during the pandemic. The EMDRIA guidelines identified that particular concerns for clinicians were safety, establishing a therapeutic relationship, how to do bilateral stimulation (BLS) remotely, and abreactions, and this article will aim to address these.

EMDR therapy is underpinned by the adaptive information processing (AIP) model (Shapiro, 2001). This states that when someone experiences a traumatic event, this memory is stored in a different way to other memories and is not integrated into existing memory networks. These “unprocessed” memories then cause problems such as flashbacks and

© 2021 EMDR International Association

http://dx.doi.org/10.1891/EMDR-D-20-00041

intrusive thoughts. The unprocessed memories can remain distressing for years after the events have ended. EMDR therapy works by processing those memories, enabling them to be encoded in the same way as any other memory and allowing more adaptive memory networks to link to the trauma memories.

This processing is achieved through pairing emotional activation of the distressing memory with BLS. This BLS can be, but is not exclusively, eye movements. The client focuses on the distressing memory while also either moving their eyes, tapping their hands alternately, or listening to alternate clicking sounds through headphones. The therapist follows a standard protocol which asks the client to focus on the worst part of the memory and to identify what it means about them, and then to engage in BLS, led by the therapist. Dual attention is therefore a key feature of EMDR therapy.

EMDR goes beyond desensitization into a reconsolidation of the memory—the "reprocessing" of the name. During EMDR, clients typically experience a change in their relationship with the memory, with new, more adaptive material emerging as well as the traumatic memory itself becoming less distressing. In this way the traumatic memory becomes integrated into their adaptive memory networks and becomes more like other autobiographical memories.

EMDR therapy follows an eight-phase protocol and focuses on the past, present, and future (Shapiro, 2018). It starts with history taking, a preparation phase, and then moves onto trauma processing. This phase involves the client identifying specific target memories, what it means about them, and the emotions and body sensations associated with that. While EMDR is a structured, protocol-based therapy, it is highly responsive to the client's individual experience and is different for each client. Its flexibility makes it highly effective for a wide range of clients, and also means that adjustments can be made to develop remote practice without compromising the core elements of EMDR therapy.

To date the strongest evidence for the efficacy of EMDR is with PTSD. EMDR is, however, a transdiagnostic approach. Given recent concerns about the lack of reliability of diagnostic categories and the findings of shared genetic risk factors (Caspi et al., 2014; Hengartner & Lehmann, 2017; Insel et al., 2010), it would appear somewhat arbitrary to restrict a therapeutic technique by diagnosis. EMDR is used successfully with people who have had a range of adverse experiences, including neglect, abuse, domestic violence, and traumatic bereavement.

Literature Review

Several meta-analyses and reviews have shown that EMDR is an effective treatment for PTSD in adults (Bisson et al., 2013; Bradley et al., 2005; Chen et al., 2015; Chen et al., 2014; Khan et al., 2018; Novo Navarro et al., 2018; Seidler & Wagner, 2006) and children (Barron et al., 2019; Rodenburg et al., 2009). A systematic review of randomized controlled trials (RCTs) of EMDR found that it is useful for a range of other mental health problems (Valiente-Gomez et al., 2017). EMDR has been shown to work successfully in RCTs with depression (Malandrone et al., 2019), anxiety and panic disorder (Faretta & Dal Farra, 2019), and chronic pain (Tesarz et al., 2019). Studies with people with a diagnosis of a psychotic disorder and comorbid PTSD showed that EMDR was as safe as other therapies and reduced PTSD symptoms (Van den Berg et al., 2015). Larger scale RCTs of EMDR with people with psychosis are currently underway and this is an emerging area (de Bont et al., 2019).

A recent comparison study of cost-effectiveness of 10 different interventions and no treatment for adults with PTSD found that EMDR was the most cost-effective intervention for adults with PTSD (Mavranezouli et al., 2020). The other interventions included trauma-focused cognitive behavior therapy (CBT), medication, and combined medication and trauma-focused CBT.

EMDR therapy is therefore an effective and cost-effective treatment. It is imperative that methods are developed to enable clients to continue to safely receive this therapy during the COVID-19 pandemic. This means working remotely in most cases.

Remote Trauma-Focused Therapy

Discussion of online therapy sometimes confuses computerized treatment (which is delivered without a therapist) and online therapy. Remote therapy of the type we are describing here aims to deliver the same evidence-based therapy as a client would receive in person, but delivered remotely. Some studies which are cited as being supportive of the use of particular therapies remotely are actually evaluating an app or computer program (e.g. Sander et al., 2020). Remote individualized trauma-focused therapy is very different to treatment delivered via an app, which is more akin to a self-help program.

There are a few studies which look directly at trauma-focused therapy delivered remotely, as opposed to computerized treatment programs. A study of trauma-focused CBT found that treatment

over the telephone can achieve significant reductions in PTSD symptoms (DuHamel et al., 2010) and cognitive processing therapy over videoconferencing has been found to be acceptable to clients (Ashwick et al., 2019). Randomized trials have shown that prolonged exposure therapy is as effective when delivered remotely as it is in person (Acierno et al., 2017), and the same applies for cognitive processing therapy (Morland et al., 2015).

There is therefore evidence that trauma-focused therapy can be effectively delivered remotely. Activating a trauma memory is usually the part of EMDR which therapists feel least confident about attempting remotely, and so it is important to know that therapies which include the activation of trauma memories can be successfully carried out remotely.

We start with considering some of the challenges of working remotely and suggestions of how to address them. We will use case examples throughout to illustrate how therapists can make the adaptations necessary to deliver successful EMDR therapy online.

Using EMDR Remotely

Establishing Safety and the Therapeutic Relationship

As with all therapies, a good therapeutic relationship is important in order for clients to be able to participate in EMDR therapy. There is evidence that a strong alliance can be formed online (Knaevelsrud & Maercker, 2007) but therapists and clients are sometimes nervous and unfamiliar with how this can be done.

Therapists can use the first session to set out the "virtual clinic room," establishing how it will work and what they will do if something goes wrong. This could include problem solving with the client as to how they might find a quiet and uninterrupted space. Therapists have reported working successfully with clients who are in their bathrooms or sitting outside in their cars.

It is important that clients feel able to be truthful about their living situations, and one way to do this is to keep the first session quite open, rather than sending out a list of requirements in advance. Not all clients will be able to do EMDR therapy online. Some will not be able to find a confidential space and some will not feel safe in their homes. The therapist will need to remain open minded in that first session, and should see it as an assessment of the environment surrounding the client as well as the client themselves.

Safety. Not all clients can talk safely at home. It is important to check with clients who can hear them and whether they are concerned about being overheard. If a therapist is concerned about whether a client can speak freely, it may be useful to arrange a brief telephone session when the client is outside the house. Communicating by e-mail or text message may not be safe for someone who is in an abusive relationship, and the therapist should err on the side of caution when sending confidential information to a client electronically.

Asking clients who else is in the room can be surprising, as it is possible for others to be hidden on the other side of a device. It is useful to ask clients routinely if there is anyone else in the room with them, even after the initial sessions.

If a client is not safe, then establishing safety should be the priority before starting therapy. If they cannot make a space which is separate from their family, then it may be that therapy needs to wait until it is possible to meet in person.

Risk. Therapists need to follow appropriate safeguarding procedures whether working remotely or in person. Clinical assessment of risk to self and others is important in order to decide whether someone can be suitable for remote EMDR therapy. If a client reports suicidal ideation, then the therapist needs to explore this and may develop a plan of how the client stays safe in a crisis, as well as what the therapist will do if they are concerned for the client's safety.

In cases where the therapist is concerned about risk, it is important to have a person to contact if the session is ended abruptly or if a client cannot be contacted for their session. This could be a person who they live with, a neighbor, or, if there are no other options, the general practitioner (GP).

Technology. Not everyone has access to a computer with Internet access. Remote EMDR therapy can be conducted on computers, tablets, and mobile phones, although some adaptations will be necessary if therapy is to take place over a mobile phone. Therapists report using a range of platforms successfully, including some which are specific to phones, such as WhatsApp. Reliability is essential, as it does not matter how sophisticated a platform is if you regularly cannot hear your client speak. Where computer-based platforms are used, talking through their installation on the phone with clients may help to overcome accessibility issues. It is important to have a backup method of communication, usually a telephone. All this should be planned in the first session, and therapists should be ready to quickly ring their client if there are difficulties with technology.

Many clients are wary of remote therapy, and offering to talk this through with them on the phone can help their willingness to "give it a try."

EMDR therapy requires the therapist to help the client to engage with trauma memories. When working remotely over video conferencing, the proximity to the client's face can actually facilitate the therapist's understanding of their emotional state. This is harder to achieve over the telephone when the client and therapist cannot see each other, and therefore we would recommend that for the memory processing sessions it is preferable to use a video link. Therapists have successfully done history taking and assessment over the telephone, but trauma processing requires a sensitivity to nonverbal signals which is impossible to achieve over the phone.

Engaging Clients. Feeling safe in the relationship and environment is a necessary prerequisite for EMDR. EMDR therapy has a collaborative style, helping clients to maintain control and to establish trust. Being in their own home can help clients to feel more in control, as rather than coming into the therapist's environment the therapist is effectively coming into theirs.

This can be particularly useful for young people and children, who can gradually approach the therapist from the comfort of their bedroom or front room. Remote therapy can enable therapists to be more flexible about length of sessions than they would otherwise be, since there is no problem with travel time or room bookings.

Jack was 7, and was not keen to see a therapist. He had been involved in a car accident 2 years previously and since then had sleep problems and separation anxiety. He did not want to talk about the accident. For the first two remote sessions, he was present under a duvet while his parents talked to the therapist in their front room. The therapist discovered that Jack was interested in Pokemon, and found a virtual Pokemon background which she used behind her video image. She also sent Jack some pictures of Pokemon by e-mail and asked him to draw some and send them back. By the third session Jack poked his head out from under the duvet and he and the therapist started to talk about Pokemon. From early on it was clear that Jack lost focus after about half an hour, and so the sessions were conducted twice a week for 30 minutes, rather than once a week for an hour. Jack went on to engage successfully in EMDR therapy, his sleep improved and his separation anxiety reduced.

Therapeutic Considerations. Remote therapy is sometimes contrasted to "face to face" therapy, terminology which we find inaccurate and unhelpful. Remote therapy (apart from telephone) is very much "face to face," in contrast to in-person therapy where faces may be looking elsewhere for some or much of the time. There is an extra intensity about video-based remote therapy which both clients and therapists report. Microexpressions of both client and therapist can be more obvious, and therefore the reactions of both client and therapist are harder to hide.

This helps emotional attunement, but can also mean that sessions are more tiring than those conducted in person. Therapists may need to account for this in the number of sessions they complete each day. Clients may need to factor this into their plans for what they will do after the session.

When clients come to the therapist's office, they typically have to travel to get there. They may also wait in a waiting room or outside. This creates a "liminal space"—a time of transition—between their everyday life and the therapy. For young people, this may be an important time when they can talk to their parent or carer alone. In remote therapy, this time is lost as clients go directly into another room to start their session. It is useful for therapists to recommend creating a space which we call a "buffer zone" between the therapy session and a return to everyday life. This could be a time of reflection, a relaxation exercise, or 10 minutes to sit quietly or chat with a parent.

Therapists also lose this liminal space, and even the loss of the small time it takes to walk down to the waiting room can take a toll if therapy sessions are scheduled back to back throughout the day. It can therefore also be useful for therapists to build in a small gap between sessions, as well as a break between the end of their working day and the start of their evening. It may help to change clothes or to move the layout of the room about if the therapist is working and living in the same space.

Assessment and Case Formulation

When EMDR therapy is delivered either remotely or in person, the therapist will start with a detailed history taking before moving to an assessment of the current problems and collaboratively setting goals for therapy. They will then develop a case formulation which guides the intervention. The structure through which therapy is developed is an eight-phase protocol, and all of these phases can be delivered successfully remotely. While EMDR is a protocol-based therapy, it is highly responsive to individual needs and goals and the structure enables a flexible approach to trauma processing.

The framework used in EMDR is the AIP model (Shapiro, 2001). This model suggests that trauma causes a disruption of normal, adaptive information processing, which results in the memory of the event being held in an "unprocessed" form. These memories do not connect with more adaptive information networks. These unprocessed memories can cause problems in the present day. These include flashbacks and intrusive thoughts, but also a wide range of other symptoms. The therapist will help the client identify memories which are still causing them problems in the present day, and together they will identify negative cognitions, emotions, and body sensations associated with that memory.

Several different approaches are used in this assessment, all of which can easily be used remotely. These include creating a timeline of traumatic events, using present-day triggers to map back to earlier memories, listing 10 worst memories, or starting with present-day fears. The therapist may help the client to "cluster" traumatic memories or to identify particularly important early memories. The therapist can share their screen and use a virtual white board (which is an integrated part of many video communication platforms) in order to draw timelines or map things out together with the client. Therapists can also draw or write, take a photo of the image and then send it to the client via the Chat function of the videoconferencing platform or another platform, such as WhatsApp.

Assessment of Symptoms. Outcome measures can be used effectively online. Symptom measures such as the PTSD Checklist for *Diagnostic and Statistical Manual of Mental Disorders* (*PCL-5*) (Weathers et al., 2013) or the revised Impact of Events Scale (Weiss, 2007) enable the therapist and client to track progress. The Dissociative Experiences Scale (DES-II) (Carlson & Putnam, 1993) should be used to assess for dissociation, and other measures can be used to assess specific symptoms of depression and anxiety. Measures used remotely include the Patient Health Questionnaire (PHQ-9) (Kroenke et al., 2001) and the Generalised Anxiety Disorder Questionnaire (GAD-7) (Spitzer et al., 2006), but could include any outcome measures. Questionnaires can either be sent to clients to complete over e-mail or read out in the session by the therapist. It is possible on many platforms to share screens with the client as the therapist reads them out. Remote completion of questionnaires has been shown to be acceptable to clients (Price et al., 2018).

Preparation and Stabilization

Once the client and therapist have a good shared understanding of the problem and goals have been identified, the first part of EMDR therapy involves learning techniques for self-soothing and emotional regulation.

This stage is even more important when working remotely than when working in person, as the therapist cannot use their physical presence in the room to help the client self-soothe during or after sessions. It is therefore important that both client and therapist are confident that the client will be able to manage the emotional reactions which will be triggered during the sessions.

During EMDR, various techniques are used to help clients practice self-soothing. These include the "calm/safe place" exercise (Shapiro, 2001) and Resource Development and Installation (Korn & Leeds, 2002). These exercises can be effectively carried out remotely. In fact, working remotely in a client's home can make these exercises easier, as the client may choose to have objects around them which help them to feel safe or may use pictures they have at home.

Kasia had experienced childhood abuse. She now lived with a supportive partner and their three dogs. She would sit in her bedroom to do EMDR therapy. Kasia struggled to think of a place where she felt safe or calm until one of her dogs came into the room and sat on her lap. Kasia stroked the dog, and described a sense of calm spreading through her body. The therapist used this experience as Kasia's "safe place" and, later, when her other dogs also came into the room, they added these dogs to the imagery.

Young people may choose toys to represent safety which they can also have with them during the remote therapy session. They can also make collages or drawings to represent their resource figures and this can be shared through photographs sent online. This is easy to do in real time over messaging apps or the chat function of a videoconferencing platform.

We suggest that therapists ask clients to find some paper and pens, and also have their own set so that they can draw with the client. Pictures can be sent by photograph, scanned in, or just be held up to the camera.

Dissociation. If clients are likely to dissociate during sessions, then this needs to be anticipated. In person, a therapist will have items they use for grounding in their office. Remotely, the client needs to have

these for themselves. Clients can be asked to prepare a box or basket of resources which will help them to stay grounded. These will engage the client's different senses. These can include a stress ball, squishy, plasticine, essential oils or strong-smelling soap or lip balm, and other objects which are specific to the client. Some find it helpful to write down phrases on index cards, while others might choose photos of their family or of important places. It can also help for a client to get up and move around the room, or to stretch their body.

If a client is particularly vulnerable, it may be helpful for the therapist to ask for the phone number of a trusted person who will also be in the house and who could be called to come in if the client dissociates and the therapist is concerned about them.

Preparation Techniques. Several techniques have been developed to help prepare clients for trauma processing which do not require full activation of the distressing memory. These are particularly useful when working remotely, as they give the therapist an opportunity to see how the client responds to BLS, and they also may help desensitize traumatic memories prior to processing.

The Flash technique (an early version of which is described in Manfield et al., 2017) desensitizes highly distressing memories and has been widely used remotely. It can be used very safely as the client is not asked to engage with their distressing memories. It may be used as a stand-alone technique but also can be used to prepare highly distressed clients for EMDR processing.

Constant Installation of Present Orientation and Safety (CIPOS) is a titration technique (Knipe, 2014). This develops the client's ability to stay present in the room while practicing confronting the disturbing memory. These skills are particularly important in remote therapy, where the therapist cannot use physical grounding technique and so the client's own skills are more important.

Laurel Parnell suggests installing a supportive team of protective, wise, and nurturing figures which can then be used in the EMDR processing (Parnell, 2013). EMDR therapists can use imagery techniques to develop resources, for example, developing a compassionate nurturer (Lee, 2012). These images will then be installed with slow BLS, as with other resources. This can be done remotely using the "butterfly hug" or slow tapping.

Sam had been assaulted just before lockdown was imposed, and had developed a fear of leaving the house which had then been exacerbated by lockdown. He had a sense that he was unsafe, and this was dominating every area of his life. He woke up sweating at night and was constantly checking doors and window locks. Sam had panic attacks whenever he thought about his assault, and this made EMDR processing impracticable as Sam could not stay within his window of tolerance. The therapist therefore decided to start with the Flash technique. This was effective as it did not trigger Sam's panic. He became able to talk about the assault, and was then able to progress to standard EMDR processing.

Trauma Processing

EMDR therapy involves the activation of an emotional memory which is then paired with BLS. When conducted in person, the BLS is usually either eye movements, tapping by the therapist on the client's hands, or alternate buzzing delivered by an electronic device such as Theratappers.

Activation of the emotional memory can be achieved remotely without need for adaptation.

The therapist needs to adapt the type of BLS they use when working remotely. Fingers moved horizontally tends to blur on the screen, which is hard to follow and often irritating for clients. Therapists cannot touch their clients to tap, and they cannot hand buzzers or headphones to clients. There are, however, a range of alternatives.

The most straightforward of these is to use the "butterfly hug" (Artigas & Jarero, 2013), or else to ask the client to tap their hands alternately while the therapist does the same. In both cases, in our experience it is important for the therapist to tap along with the client to enhance therapeutic attunement and to avoid any sense that the therapist is watching the client rather than joining them. The advantage of this approach is that it does not make any further technological demands on either the client or the therapist. If the screen freezes, the client can be asked to simply continue tapping until it unfreezes. It does not matter if the client and therapist keep time when tapping. It is recommended that both clients and therapists find a pillow or cushion to tap on if they choose to tap on the table, as otherwise it will become noisy.

During in-person EMDR therapy the therapist is advised to keep out the way, and chairs are often placed in a "ships passing by night" position so that the therapist is not directly in the client's line of vision. This is not practical remotely, since if the therapist moves to the side they will be entirely invisible to the client. Instead, it is important for the therapist to be present as a containing and nonintrusive figure.

Therapists may therefore need to speak more than they would do in person, using reassuring phrases such as "let it go," "just observe" or "it's old stuff." These should be said gently with a warm, empathic tone. Some clients may prefer to look slightly away from the screen while processing. Therapists may want to explicitly give them "permission" to do so.

It is possible to use eye movements if the client attaches post-it notes or similar to both sides of their screen and then moves their eyes from one post-it to the other.

There are several EMDR apps for smartphones which clients can download and which will provide alternate clicks to each ear. These can be used by the client, who will have control of stopping and starting. The disadvantage of this is that the therapist cannot control the speed and may find it hard to signal to the client when to stop. Again, asking the client to keep their eyes open can facilitate this.

There are a range of EMDR platforms which are available to use on a computer. Popular options include EMDR Cloud, RemotEMDR, and Bilateral Base, but there are others. These mostly involve a ball bouncing from side to side within the screen or alternate clicks being delivered to the client's headphones. These can be highly successful and the therapist can set it up so they can see the client at the same time as the client sees the screen.

It is important for the therapist to have a number of different techniques ready for the BLS, because the individual circumstances of the client will make some approaches impractical. If a client is using their mobile phone, the small size of the screen means that observing a ball bouncing across the screen will not provide a wide enough range of movement. If the client is using a handheld device, then some method of propping it up will need to be used in order to allow them to tap and also to see the therapist.

Ella had been involved in a traffic accident. Ella was skeptical about remote EMDR but had agreed to give it a go despite not having a computer. She and her therapist communicated over Whatsapp on her mobile. The therapist had initially wanted to use an EMDR audio app, but Ella kept losing the connection with the therapist while she tried to get the app working. Then they tried tapping, but Ella couldn't get the phone to stay in one position while she was tapping and it kept falling on the floor. Lastly, the therapist introduced butterfly tapping, which Ella found painful due to an old arm injury. During Ella's accident her legs had been trapped and she had been unable to move them. The therapist suggested that she stand up and tap with her feet instead of her hands. Tapping with her feet was very powerful for Ella as it provided an immediate update that she was no longer trapped and could now move her legs.

Ending Sets. We have found that online it can be necessary to give a more explicit signal at the end of a set, as clients may not notice the therapist stopping tapping. Therapists have added phrases such as "And pause" or "And stop," or a visual cue such as moving hands downwards in an arc.

Abreactions. When a client becomes very distressed during processing, the EMDR therapist will encourage them to keep going while also being gently reassuring, often using the metaphor of a train in a tunnel. This is even more important when working remotely. Clients needs to be encouraged to keep processing but also to keep the dual focus.

It can be helpful for the EMDR therapist to talk more than they usually would to remind the client of their presence. Phrases like "Just watch," "Just observe," "It's in the past," or "I'm here with you" can be repeated softly to keep the connection with a very distressed client. It is important to ask the client to keep their eyes open so as not to shut off another method of communication. If the client starts to dissociate, they can be asked to toss a ball or cushion from hand to hand, or they can be asked to stand up and move around. It can be useful to have the number of someone close by to call if the therapist is concerned that the client may not be able to self-soothe.

Unblocking Processing. When processing is not progressing as expected, the EMDR therapist may intervene using a range of techniques. In person, these can include switching modality (e.g., from eye movements to tapping). Remotely, the therapist might move from using butterfly hug to tapping, or to using eye movements with sticky notes. The therapist may go faster if the client can keep up, or may add in an extra mode of BLS (e.g., adding tapping as well as eye movements, or adding clicks as well as taps). Flexibility is key.

EMDR therapists use cognitive interweaves to help clients whose processing is blocked. These are very brief interventions designed to introduce adaptive information which was not available to the client at the time of the trauma. They may ask questions to introduce a different perspective, bring in new information, or ask the client to bring in a resource figure. These can be used in the same way as they are in person. Sometimes the presence of a person in their own home can be used as an interweave, with questions such as "Where are you now?" or "Are you safe now?" reminding them of their surroundings.

Taking SUDS Ratings. An important part of the EMDR protocol is asking the client to rate how disturbing a memory is by use of a Subjective Units of Disturbance Scale (SUDS). This can be done verbally, but if clients find this difficult a visual scale can be shared with them through screen sharing. It is also possible to create a visual scale together with both the therapist and client drawing faces to represent different scores on the scale. Pictures can then be shared remotely or simply held up to the camera.

Dual Focus. An important part of EMDR therapy is the focus on both the memory and the present-day reality. This is sometimes characterized as "one foot in the present, one foot in the past." When in person, the therapist uses their own presence and the environment of their office as a way to keep the client present. They can use smell, touch, sound, and vision. Remotely the therapist can only use vision and hearing to keep contact with the client.

For this reason, the therapist may tell the client not to close their eyes during remote EMDR therapy. Clients frequently want to close their eyes as they say this helps them get into the memory better. Since dual focus is an aim of EMDR, it may not be desirable for them to get too deeply into the memory as this can lead to dissociation.

When a client closes their eyes during processing, the therapist has only sound as a way of communication. If headphones stop working, then they have no communication at all. Therefore for safety many therapists ask clients to keep their eyes open, particularly if the client is likely to dissociate.

Dual focus can be enhanced through remote working, because the client is actually surrounded by reminders of their present-day life.

Hetty was having EMDR therapy following the traumatic birth of her daughter last year. During the birth she had thought that her baby had died and had also broken her pelvis and had lost her ability to walk for several weeks afterwards. When processing, Hetty kept remembering the moment of silence after her daughter was born, when she had been convinced that she was dead. At that moment, her daughter broke into babbles from the room downstairs. Hetty's attention was caught by the babbles. The silent newborn was now a noisy and lively 10-month-old. Her disturbance reduced significantly, and she was able to integrate her present-day knowledge with the distressing memory.

Timing of Processing. It is important for there to be sufficient time after remote trauma memory processing for a client to self-soothe with the help of the therapist. Clients may be going straight back into caring responsibilities or work, with no gap at all, or they may be totally alone and unable to visit others. Therapists therefore may want to consider doing trauma memory processing as early on in the session as possible. This can sometimes be done by doing the assessment phase in the session before so that the targets are already identified. Then the therapist can do a quick check-in with the client and start processing early on in the session, thus "front loading" the processing. Therapists can arrange with clients to start with processing and to make time to discuss their week afterward. In this way, the session is flipped and more time is left for the client to stabilize after processing.

Complications and Unpredictability

When seeing a client in person, the EMDR therapist holds much of the control over the environment. They set the rules for how the space is set up, and it is their preferences which dictate how the room is arranged or decorated.

When seeing a client remotely, the EMDR therapist loses some of the control. They may also have lost some control over their own environment, since many therapists are working from home and may have children or animals whom they cannot always prevent from entering. This can mean that the reality of remote working is far removed from the ideal of an enclosed virtual clinic room.

This can be a problem for therapists who would like to reproduce the privacy of the clinic room virtually. Accepting that this isn't always possible makes it easier to deal with the inevitable disturbances when working at home.

Interruptions during remote sessions can include phone calls, doorbells, deliveries arriving, children or pets bursting in, or other people walking past. The more complicated the circumstances of a person's life, the more likely there are to be interruptions. Insisting on an interruption-free session may exclude those who have most trouble in accessing services.

Responding flexibly to these situations is important to maintain the therapeutic alliance and to maximize the chances of effective therapy. If the client feels unable to respond appropriately to their children or to their doorbell, they may apparently be continuing with the session but actually have lost their focus. It's important for therapists to "give permission" for the client to respond to emergencies, while also aiming to create an effective therapeutic space. The space needs to be good enough, and for many people aiming for no interruptions is unrealistic.

Paul was in the middle of processing when the doorbell rang. He tried to continue but then ruefully stopped. "Do you mind?" he said. "We've been trying for weeks to get this delivery and there's no one else here." The therapist nodded and Paul went to answer the door. A few minutes later he returned, the therapist tuned him back into the target and they continued processing. The delivery was not an issue, and processing was effectively resumed.

Past, Present, and Future

EMDR therapists take a "three-pronged" approach, focusing on past memories, present-day triggers, and future fears. During the COVID-19 pandemic, present-day triggers and future fears are particularly salient. Many clients describe intense fears about their health and the health of their families. Remote therapy may itself be a trigger as it is a reminder that life is not as normal.

It's important to make space for clients to express their feelings about remote therapy, and to talk about their experience of the pandemic. These may not need to be processed as sometimes the client will just need to talk, but for some clients using EMDR processing can be a useful part of their coming to terms with the current situation.

Present-day triggers can be used as a target for EMDR processing, either directly or through use of a floatback, where clients are asked to float back to an earlier time in their life that they felt like this. It is likely that processing of present-day triggers may need to be paired with behavioral interventions if a client has developed particular safety-seeking rituals.

These can be done remotely, with record sheets being emailed to clients if necessary.

Future fears can be addressed using the FlashForward technique (Logie & de Jongh, 2014). Future templates can also be used to help clients imagine what it might be like leaving the house for the first time, or meeting up with friends after months of isolation.

Callum's life was dominated by fears about COVID-19. He treated everyone else as if they had the virus, every object which came into the house was quarantined for 3 days, and he disinfected the entire house twice every day. He wore a mask for most of the day, even if he saw no one. He had seen no one for 4 months as he deemed it too high-risk, and he only received food by no-contact online delivery. He had lost his job due to the amount of time it was taking him to disinfect his house and because his employer wanted him to plan to return to work in person. He was depressed and anxious, particularly because no one else seemed to take it as seriously as he did.

The therapist asked Callum to focus on his worst fears and to float back to an earlier time he had felt like that. He retrieved a memory of his mother developing pneumonia when he was 6. He had thought that she would die and had felt completely helpless. She had in fact survived but Callum was left with ongoing health anxiety which had been become overwhelming during the pandemic. The therapist used remote EMDR processing (using the butterfly hug) to address this early memory, and Callum's distress reduced. He was still anxious about COVID-19, but they were then able to do a balanced risk assessment and to make some plans as to what Callum could do safely.

Callum then expressed how afraid he was of dying alone and lying dead in his house for weeks before anyone found him. He connected this with contracting COVID-19 but it had long been a fear of his. The therapist first checked whether this was in fact possible due to Callum's level of isolation, or whether it was an irrational fear. Callum said that before lockdown he had seen family members regularly and during lockdown they checked in on him remotely on a daily basis. The therapist used FlashForward to process this fear. When Callum's intense fear of the future was processed, he was able to take a more balanced perspective on the risk of contracting the virus and how he wanted to handle this. After this Callum was able to think about how he wanted to live his life, taking sensible precautions against the virus but not allowing it to dominate every aspect of his daily routine.

Discussion

EMDR therapy is a highly effective and evidence-based therapy which provides important treatment for distressed people. It is cost-effective when compared to other trauma therapies. The typical structure of EMDR therapy can be used remotely with some adjustments.

In this article, I have described how to adapt the core features of EMDR therapy in order to deliver them over videoconferencing. The adaptations I suggest here are recommended on the basis of my own experience in treating clients remotely since 2018, my conversations with other "early adopters," and also my experience of supervising many EMDR therapists as they made the transition to working remotely.

We do not yet have the data to show whether remote EMDR is as effective as in-person EMDR. There are clinical trials which indicate that other trauma-focused PTSD treatments, such as prolonged exposure therapy and cognitive processing therapy, are as effective as in-person versions of these interventions (Acierno et al., 2017; Morland et al., 2015). It is important that studies are set up to compare

the effectiveness of remote EMDR therapy with in-person EMDR therapy. The unique situation of the COVID-19 pandemic has precipitated a major change in approach, and the research must follow.

Remote therapy is acceptable to many clients but it is not always appropriate. It is imperative that the client is safe in order to do trauma-focused therapy, and therefore the therapist needs to be alert to signs that they are not safe in their home and cannot speak freely about their experiences.

There may be a tendency to focus on the perceived deficits of remote EMDR therapy as compared to in-person therapy, but for some clients, remote therapy may actually be superior. For those who are too anxious to leave the house or who find the environment of the therapist's office triggering, being able to see the therapist remotely in their own home makes therapy possible. It also may make therapy more accessible for parents of young children and those with chronic health problems or caring responsibilities. It makes it easier for people to fit therapy into their working day if they cannot get time off.

What is clear is that during the COVID-19 pandemic, in-person EMDR therapy is not an option for many clients and therapists. The choice is therefore between no EMDR therapy or remote EMDR therapy. It is therefore crucial to develop ways of working which enable clients in need of EMDR therapy to access it, even if they are not able to see their therapist in person.

References

Acierno, R., Knapp, R., Tuerk, P., Gilmore, A. K., Lejuez, C., Ruggiero, K., . . . Foa, E. B. (2017). A non-inferiority trial of prolonged exposure for posttraumatic stress disorder: In person versus home-based telehealth. *Behaviour Research and Therapy*, *89*, 57–65. https://doi.org/10.1016/j.brat.2016.11.009

Artigas, L., & Jarero, I. (2013). The butterfly hug. In M. Luber (Ed.), *Implementing EMDR early mental health interventions for man-made and natural catastrophes: Models, scripted protocols and summary sheet*. Springer Publishing Company.

Ashwick, R., Turgoose, D., & Murphy, D. (2019). Exploring the acceptability of delivering cognitive processing therapy (CPT) to UK veterans with PTSD over Skype: A qualitative study. *European Journal of Psychotraumatology*, *10*, 1.

Barron, I., Bourgaize, C., Lempertz, D., Swinden, C., & Darker-Smith, S. (2019). Eye movement desensitization reprocessing for children and adolescents with posttraumatic stress disorder: A systematic narrative review. *Journal of EMDR Practice and Research*, *13*(4), 270–283. https://doi.org/10.1891/1933–3196.13.4.270

Bisson, J., Roberts, N., Andrew, M., Cooper, R., & Lewis, C. (2013). Psychological therapies for chronic post-traumatic stress disorder (PTSD) in adults. *Cochrane Systematic Review*, *2013*(12), CD003388. https://doi.org/10.1002/14651858.CD003388.pub4

Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry*, *162*(2), 214–227. https://doi.org/10.1176/appi.ajp.162.2.214

Carlson, E. B., & Putnam, F. W. (1993). An update on the dissociative experience scale. *Dissociation*, *6*(1), 16–27.

Caspi, A., Houts, R. M., Belsky, D. W., Goldman-Mellor, S. J., Harrington, H., Israel, S., . . . Meier, M. H. (2014). The p factor: One general psychopathology factor in the structure of psychiatric disorders? *Clinical Psychological Science*, *2*(2), 119–137. https://doi.org/10.1177/2167702613497473

Chen, Y-R., Hung, K-W., Tsai, J-C., Chu, H., Chung, M-H., Chen, S-R., . . . Liao, Y-M. (2014). Efficacy of eye-movement desensitization and reprocessing for patients with posttraumatic-stress disorder: A meta-analysis of randomized controlled trials. *PLoS One*, *9*(8), e103676. https://doi.org/10.1371/journal.pone.0103676

Chen, L., Zhang, G., Hu, M., & Liang, X. (2015). Eye movement desensitization and reprocessing versus cognitive-behavioral therapy for adult posttraumatic stress disorder: Systematic review and meta-analysis. *The Journal of Nervous and Mental Disease*, *203*(6), 443–451. https://doi.org/10.1097/nmd.0000000000000306

De Bont, P., De Jongh, A. & Van den Berg, D. (2019). Psychosis: An emerging field for EMDR research and therapy. *Journal of EMDR Practice and Research*, *13*, 4. https://doi.org/10.1891/1933-3196.13.4.313

DuHamel, K. N., Mosher, C. E., Winkel, G., Labay, L. E., Rini, C., Meschian, Y. M., . . . Redd, W. H. (2010). Randomized clinical trial of telephone-administered cognitive-behavioral therapy to reduce post-traumatic stress disorder and distress symptoms after hematopoietic stem-cell transplantation. *Journal of Clinical Oncology: Official Journal of the American Society of Clinical Oncology*, *28*(23), 3754–3761. https://doi.org/10.1200/JCO.2009.26.8722

Faretta, E., & Dal Farra, M. (2019). Efficacy of EMDR therapy for anxiety disorders. *Journal of EMDR Practice and Research*, *13*(4), 325–332. https://doi.org/10.1016/j.beth.2013.07.002

Hengartner, M. P., & Lehmann, S. N. (2017, June). Why psychiatric research must abandon traditional diagnostic classification and adopt a fully dimensional scope: Two solutions to a persistent problem. *Front Psychiatry*, *8*, 101. https://doi.org/10.3389/fpsyt.2017.00101

Insel, T., Cuthbert, B., Garvey, M., Heinssen, R., Pine, D. S., Quinn, K., . . . Wang, P. (2010). Research domain

criteria (RDoC): Toward a new classification framework for research on mental disorders. *American Journal of Psychiatry*, *167*(7), 748–751. https://doi.org/10.1176/appi.ajp.2010.09091379

Khan, A. M., Dar, S., Ahmed, R., Bachu, R., Adnan, M., & Kotapati, V. P. (2018). Cognitive behavioral therapy versus eye movement desensitization and reprocessing in patients with post-traumatic stress disorder: Systematic review and meta-analysis of randomized clinical trials. *Cureus*, *10*(9), e3250. https://doi.org/10.7759/cureus.3250

Knaevelsrud, C., & Maercker, A. (2007). Internet-based treatment for PTSD reduces distress and facilitates the development of a strong therapeutic alliance: A randomized controlled clinical trial. *BMC Psychiatry*, *7*(1), 13.

Knipe, J. (2014). *The EMDR toolbox*. Springer Publishing Company.

Korn, D. L., & Leeds, A. M. (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *Journal of Clinical Psychology*, *58*(12), 1465–1487. https://doi.org/10.1002/jclp.10099

Kroenke, K., Spitzer, R., & Williams, J. B. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, *16*, 603–613.

Lee, D. (2012). *The compassionate mind approach to recovering from trauma: Using compassion focused therapy*. Robinson.

Logie, R., & de Jongh, A. (2014). The flashforward procedure: Confronting the catastrophe. *Journal of EMDR Practice and Research*, *8*, 25–32.

Malandrone, F., Carletto, S., Hase, M., Hofmann, A., & Ostacoli, L. (2019). A brief narrative summary of randomized controlled trials investigating EMDR treatment of patients with depression. *Journal of EMDR Practice and Research*, *13*(4), 302–306.

Manfield, P., Lovett, J., Engel, L., & Manfield, D. (2017). Use of the flash technique in EMDR therapy: Four case examples. *Journal of EMDR Practice and Research*, *11*, 195–205.

Mavranezouli, I., Megnin-Viggars, O., Grey, N., Bhutani, G., Leach, J., Daly, C., . . . Dias, S. (2020). Cost-effectiveness of psychological treatments for post-traumatic stress disorder in adults. *PLoS One*, *15*(4), e0232245. https://doi.org/10.1371/journal.pone.0232245

Morland, L. A., Mackintosh, M. A., Rosen, C. S., Willis, E., Resick, P., Chard, K., . . . Frueh, B. C. (2015). Telemedicine versus in-person delivery of cognitive processing therapy for women with posttraumatic stress disorder: A randomized non-inferiority trial. *Depression and Anxiety*, *32*, 811–820. https://doi.org/10.1002/da.22397

Novo Navarro, P., Landin-Romero, R., Guardiola-Wanden-Berghe, R., Moreno-Alcázar, A., Valiente-Gómez, A., Lupo, W., . . . García, F. (2018). 25 years of eye movement desensitization and reprocessing (EMDR): The EMDR therapy protocol, hypotheses of its mechanism of action and a systematic review of its efficacy in the treatment of post-traumatic stress disorder. *Revista de Psiquiatria y Salud Mental*, *11*, 101–114. https://doi.org/10.1016/j.rpsm.2015.12.002

Parnell, L. (2013). *Attachment-focused EMDR: Healing relational trauma*. W.W. Norton & Company.

Price, M., Van Stolk-Cooke, k., Legrand, A. C., Brier, Z. M. F., Ward, H. L., Connor, J. P., . . . Skalka, C. (2018). Implementing assessments via mobile during the acute posttrauma period: Feasibility, acceptability and strategies to improve response rates. *European Journal of Psychotraumatology*, *9*(suppl. 1), 1500822. https://doi.org/10.1080/20008198.2018.1500822

Rodenburg, R., Benjamin, A., de Roos, C., Meijer, A. M., & Stams, G. J. (2009). Efficacy of EMDR in children: A meta-analysis. *Clinical Psychology Review*, *29*(7), 599–606. https://doi.org/10.1016/j.cpr.2009.06.008

Rollins, S., Hughes, T., Cordes, G., Cohen-Peck, M., & Watson-Wong, J. (2020, January). *Guidelines for virtual EMDR therapy. A report of the virtual training and therapy task group*. Presented to the EMDRIA Board of Directors.

Sander, L. B., Schorndanner, J., Terhorst, Y., Spanhel, K., Pryss, R., Baumeister, H., . . . Messner, E. M. (2020). 'Help for trauma from the app stores?' A systematic review and standardised rating of apps for post-traumatic stress disorder (PTSD). *European Journal of Psychotraumatology*, *11*(1), 1701788. https://doi.org/10.1080/20008198.2019.1701788

Seidler, G., & Wagner, F. (2006). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: A meta-analytic study. *Psychological Medicine*, *36*, 1515–1522.

Shapiro, F. (1989). Efficacy of the eye movement desensitization procedure in the treatment of traumatic memories. *Journal of Traumatic Stress*, *2*(2), 199–223.

Shapiro, F. (2001). *Eye movement desensitization and reprocessing: Basic principles, protocols, and procedures* (2nd ed.). Guilford Press.

Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures* (3rd ed.). Guilford Press.

Spitzer, R. L., Kroenke, K., Williams, J. B. W., & Löwe, B. (2006). A brief measure for assessing generalized anxiety disorder: The GAD-7. *Archives of Internal Medicine*, *166*(10), 1092–1097. https://doi.org/10.1001/archinte.166.10.1092

Tesarz, J., Wicking, M., Bernardy, K., & Seidler, G. H. (2019). EMDR therapy's efficacy in the treatment of pain. *Journal of EMDR Practice and Research*, *13*(4), 337–344.

Valiente-Gomes, A., Moreno-Alcazar, A., Treen, D., Cedron, C., Colom, F., Perez, V., . . . Amann,

B. L. (2017). EMDR beyond PTSD: A systematic literature review. *Frontiers in Psychology*, *8*, 1668. https://doi.org/10.3389/fpsyg.2017.01668

Van Den Berg, D. P., De Bont, P. A., Van Der Vleugel, B. M., De Roos, C., De Jongh, A., Van D'er Gaag, M., . . . Van Minnen, A. (2015). Prolonged exposure vs eye movement desensitization and reprocessing vs waiting list for posttraumatic stress disorder in patients with a psychotic disorder a randomized clinical trial. *JAMA Psychiatry*, *2*, 259–267. https://doi.org/10.1001/jamapsychiatry.2014.2637

Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD checklist for DSM-5 (PCL-5)*. https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp

Weiss, D. S. (2007). The impact of event scale-revised. In J. P. Wilson & T. M. Keane (Eds.), *Assessing psychological trauma and PTSD: A practitioner's handbook*. Guilford Press.

Disclosure. The author has no relevant financial interest or affiliations with any commercial interests related to the subjects discussed within this article.

Funding. The author received no specific grant or financial support for the research, authorship, and/or publication of this article.

Correspondence regarding this article should be directed to Naomi Fisher, 18 St Keyna Ave., Hove, BN3 4PP, United Kingdom. E-mail: naomicfisher@gmail.com