Two Method Approach: A Case Conceptualization Model in the Context of EMDR

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This article outlines a comprehensive model that helps to identify crucial target memories for EMDR treatment. The "Two Method Approach" can be used for conceptualization and treatment implementation for a broad spectrum of symptoms and problems, other than those related to PTSD *per se*. The model consists of two types of case conceptualizations. The First Method deals with symptoms whereby memories of the etiological and/or aggravating events can be meaningfully specified on a time line. It is primarily aimed at the conceptualization and treatment of *DSM-IV-TR* Axis I disorders. The Second Method is used to identify memories that underlie patients' so-called dysfunctional core beliefs. This method is primarily used to treat more severe forms of pathology, such as severe social phobia, complex PTSD, and/or personality disorders. The two methods of case conceptualization are explained step by step in detail and are illustrated by case examples.

Keywords: eye movement desensitization and reprocessing; EMDR; case conceptualization; model

With the help of EMDR, vividness and emotionality of unpleasant mental representations, which resulted from one or more traumatic events, can be reduced (Bisson et al., 2007; Günter & Bodner, 2008). This notion, that these observations are by-products of a comprehensive reprocessing, is the basis of Shapiro's Adaptive Information Processing (AIP) model (Shapiro, 1995, 2001, 2006), a framework that is considered to be helpful to therapists when developing a problem formulation in terms of a relationship between memories of significant events on one hand, clients' current symptoms on the other hand, and the use of EMDR to resolve these memories (Solomon & Shapiro, 2008). An underlying principle of this model is that negative events leave traces in the neural network of an individual in such a way that these cause a variety of symptoms, including dysfunctional beliefs about oneself (e.g., "I am a bad person") or the world ("I am in danger"). The unprocessed and dysfunctionally stored memory information is responsible for symptoms that may vary from the reliving of past experiences to fears, depressive states, sleep problems, or sexual dysfunction. The basic assumption of the AIP model is that by accessing the dysfunctionally stored memories and stimulating the innate processing system, symptoms diminish (Shapiro, 2001, 2002, 2006; Solomon & Shapiro, 2008).

Should a therapist, therefore, in the context of their treatment choose to use EMDR to reduce this disturbance, the therapy will focus on reshaping the significant memories that underpin the symptoms from which the client suffers. In practice, this means that before commencing treatment, the therapist will draw up a coherent theory or hypothesis regarding the relationship between complaints and a (series of) target memory/memories to be treated with EMDR. By formulating an explicit hypothesis regarding the relationship between memories and symptoms, the therapist gives direction to the treatment. This concerns the identification—and subsequent processing—of crucial memories, or memories of so-called *touchstone events*.

This article outlines a comprehensive approach aimed at identifying those memories that after having been reprocessed will result in a significant reduction of symptoms and, by extension, in an improvement of general functioning and the quality of life of the client. In other words, its purpose is to help therapists

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conceptualize a case in such a way as to "make it suitable" for treatment using EMDR's basic protocol. The "Two Method Approach" may be used for the conceptualization and implementation of treatment for a broad spectrum of symptoms and problems other than those related to posttraumatic stress disorder (PTSD) *per se*. In the Netherlands, over the past 5 years, a great deal of clinical experience with positive outcomes has been gathered using this model and its methods, and it has become the backbone and point of departure of most EMDR treatments (Ten Broeke, De Jongh, & Oppenheim, 2008).

Case Conceptualization in EMDR

As previously noted, EMDR treatment is based upon the AIP precepts that the cause of dysfunction (e.g., affect, sensations, behaviors, beliefs) are the unprocessed memories of etiological events. Therefore, after a careful delineation of current dysfunctional behaviors, emotions, negative cognitions, and other specific symptoms, the client is queried regarding each symptom: What was the original occurrence or most disturbing primary event, modeling, lesson, and so forth that represents the genesis of the dysfunction? What were the circumstances—including interactional, social, or family systems factors—at the time of the first event? A useful question is, "When was the first time you can remember feeling this way?" (Shapiro, 2001, p. 106).

In the literature on EMDR, an "affect scan" (Shapiro, 1995) or a variant procedure that is called the *float-back* technique (Browning, 1999) is also recommended to identify relevant targets for EMDR treatment. "This procedure may be used when the client is unable to identify easily an earlier target for processing" (Shapiro, 2001, p. 433). This technique is based on the principles of the *affect bridge* or the *somatic bridge*, which are also employed in hypnotherapy. It is a form of free association starting from the present emotional experiences of the client in which general instructions are given to the client. The basic assumption is that the client's neural network itself will indicate, based on affective affinities, what target memory or *touchstone event* is relevant. The client is requested to call to mind a situation during which the symptoms or problems frequently occur (e.g., a current situation that generated fear) and to identify a corresponding image, an negative cognition (NC), and an emotion. Then, the client is asked to go back to the time and place of a past, relevant event during which he or she felt or thought the same. This is formulated as follows:

> Now, please bring up that picture of _____and those negative words _____ (repeat client's disturbing image and negative cognition), notice what feelings are coming up for you, where you are feeling them in your body, and just let your mind float back to an earlier time in your life—don't search for anything—just let your mind float back and tell me the first scene that comes to mind where you had similar: Thoughts of _____ (repeat negative cognition), feelings of _____ (repeat negative emotion), in your _____ (repeat places in body where client reported feelings). (Shapiro, 2001, pp. 433–434)

The float-back technique utilizes the following step by step procedure:

1. "When was the last time you felt this way?"
2. "Hold the image that comes to mind in your thoughts and any thoughts which enter your mind in connection with this."
3. "Where do you feel this in your body?"
4. "Hold on to the image and the feelings and allow your thoughts to transport you back to the first time that you felt this way."

When the client encounters a disturbing memory, an image and NC/PC are subsequently identified. Next, a regular EMDR procedure (basic protocol) is performed.

Although clinical experience has demonstrated that the *float-back* technique is valuable, it is a relatively nonspecific method. Particularly because it is not clear to which extent the memories found using this method are actually important or meaningful enough to be reprocessed.

In our opinion, the Two Method Approach to be described hereafter is a valuable expansion of the direct questioning traditionally used in EMDR (Shapiro, 1995, 2001, 2006) and may be used in combination with other strategies including the float-back technique. It has the advantage that it is a structured procedure, which is more likely to generate easily testable hypotheses concerning the relationship between events and clients' symptoms, preventing the therapist from randomly reprocessing targets presented. To this end, the Two Method Approach provides the therapist insight into *what* needs to be done and *why*, and gives the therapist opportunities to re-evaluate and modify the treatment plan, should the treatment not deliver the desired results.

Basically, the two forms of questioning consist of two types of case conceptualizations. The First Method of the Two Method Approach deals with symptoms of which memories of the etiological (and aggravating) events can be meaningfully formulated *on a time line*. It is primarily aimed toward the

conceptualization and treatment of Axis I disorders, including simple PTSD. This method is in fact an elaboration of the standard EMDR protocol (Shapiro, 1995, 2001, 2006) and the phobia protocol (De Jongh & Ten Broeke, 2007; De Jongh, Ten Broeke, & Renssen, 1999; Shapiro, 1995, 2001).

The Second Method of the approach, in contrast, is used, among other things, to identify memories that in some way form the groundwork under the client's so-called dysfunctional (core) beliefs. It will primarily be used to treat complex forms of pathology such as complex PTSD and/or personality disorders in which core beliefs are believed to be central (Butler, Brown, Beck, & Grisham, 2002). However, in certain cases, this approach may also be preferable in the treatment of Axis I disorders, such as depression and generalized social anxiety disorders, especially when a disturbed self-image plays a significant role (Shapiro, 2006). These two methods of case conceptualization are outlined and explained step by step in detail below.

First Method: From Symptoms to Targets

The First Method begins with making an inventory of the existing symptoms and presenting problems (Shapiro, 1995, 2001, 2006). Examples include:

- "I can't sleep, because I'm having terrible nightmares about …."
- "These days I cry when I see a child on television."
- "I don't have any energy anymore, I'm always exhausted."
- "I don't dare fly in a plane."

A client may of course have more than one type of symptom (intrusive thoughts, sleep problems, anxiety, panic attacks, avoidance behavior, depressed moods, substance abuse, etc.), all of which may require treatment. The severity of the disorder experienced by the client will, however, strongly depend on the amount of—and relationships between—the various symptoms and symptom clusters. Therefore, the target memory, which is chosen to be treated prior to others, is determined by the severity of the symptoms or the disorder.

1. Make an inventory of the symptoms or complaints.

   Prior to commencing treatment, it is important to be aware that different symptoms may relate to different events and therefore to different targets. Of course, it is also possible that different symptoms belong to one single disorder, with a specific etiological history.
2. Decide which symptom (cluster) should be treated first.

   Once the various symptom clusters have been identified, treatment can focus on the symptom or cluster that is causing the most trouble. That is why the first step is making an inventory of the different symptom clusters. "Looking at this list, which of these complaints would have to disappear from your life first before you could be feeling good again?"
3. Identify the etiological and subsequent aggravating events.

   The next step is to establish a relationship between the symptoms and the so-called etiological experience responsible for the onset of the client's symptoms and which fuel the complaints. Some clients will indicate that they do not know exactly which event started their problems. This does not need to pose a problem since there are a variety of ways into the memory network. The goal of EMDR is to reprocess the stored memories of meaningful events in order to influence the client's complaints. Because these stored memories by no means have to correspond completely with what actually happened, the following question can be asked: "From your perspective, when do you feel that these symptoms started?" It is also possible to formulate the question in a broader fashion in order to identify various events that have contributed to the current problems (aggravating events). "From your point of view, which event or events is/are responsible for the current complaints or might have worsened them?" "Which events led to your symptoms?"

   In connection with this, it is important to emphasize that, in the context of a treatment with EMDR, we are not interested in the client describing the *events factually*, but rather narrating how the actual event is stored into memory. Therefore, the question should not be "What exactly happened?" but rather "I would like to hear from you how you remember this event/is stored in your mind."

   An important goal of the therapist is, therefore, to identify those events after which the complaints manifested themselves for the first time. It should be noted, however, that it is also important not to simply take the client's answer for granted, but to check whether or not he might have already had, for example, this anxiety before the first event. In doing so, the therapist should therefore try and find a memory that even better explains the complaints. To this end, the following question may be posed: "Are you sure that you did not already suffer from these symptoms before this event took place, even only a little bit?"

Treatment should be directed toward those memories identified as having a meaningful relationship with the existing complaints, and also being emotionally charged in the present; that is, not feeling "neutral." These events are subsequently arranged in a time sequence.

4. Outline *the course* of the complaints in time.

   Once an inventory of the meaningful memories has been developed, the course of the complaints should be outlined into a time sequence. This may be done by making a graph of the severity and the fluctuation of the complaints in time, in which "time" is represented on the *x*-axis and the "severity" of symptoms on the *y*-axis (see Figure 1). In order to select a meaningful and important target memory, one must basically look for the "bend" or "elbow" in the curve representing a particular symptom in time.

5. In case of anxiety disorders and phobias, check for other potentially relevant memories of events.

   In all cases it is important to check for potential of other memories that are crucial, but may not become readily accessible when asking the questions described above (Shapiro, 1995, 2001, 2006). However, in regard to the anxiety disorders, the current authors have found it useful if the therapist starts with conceptualizing clients' anxiety-related problems in terms of an "if–then" relationship (see De Jongh & Ten Broeke, 2007). Here the "if" refers to the stimulus that evokes emotional disturbance (the conditioned stimulus or CS), while "then" refers to the predicted outcome, the catastrophe the client expects to happen (the unconditioned stimulus or UCS). Using the conceptualization of an if–then relationship, there are two additional search strategies that can be used to identify the memories of events that may have laid the foundations for the presenting problems. In the first step the stimulus is identified, for instance by asking: "Which (aspect of this) object or situation is most directly responsible for your fear? (or: "What would make you instantly scared?"). The next step should focus on identifying core memories pertaining to the stimulus component (e.g., injection needle, dog). A typical question referring to such memories is: "Which incident causes you to become afraid of …?" This question may give access to additional memories.

   Another series of questions pertains to the feared consequence. Typical catastrophe memories can be found by identifying the client's catastrophic ideation: "What do you think will happen if you are confronted with … [stimulus]?" The next step is the identification of the memory: "When did your fear of … [catastrophe; e.g., fainting, extreme pain] begin (and when did it worsen?)." If other memories appear, these may need to be added to the time line or graph, but only if there is a "bend" in the graph.

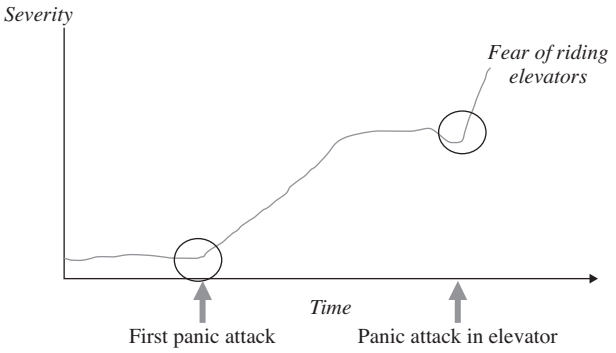

FIGURE 1. Outline of course and severity of the complaints in time as displayed by a graph representation.

6. Determine which memories should be reprocessed and in which order.

   There are various arguments to take into account in considering which memories to reprocess first. It should be emphasized that in almost every case the memories that will be chosen first are the ones that caused the onset of the symptoms ("etiological experience"), and subsequently, the events that worsened the symptoms.

7. Identify the target and apply the basic protocol.

   It is now time to select the correct target image—and NC from the most relevant memory (in terms of its fueling effect on the existing symptoms): "How do you remember that traumatic experience, beginning from the point when you feel it started to where it feels like it really ends; that is, give an outline of the whole event." "What's important is how you remember the event, not what actually happened." Or simply: "What image represents the event for you?"

   Together with the client, the therapist selects the target image that is to be reprocessed.

8. Together with the client, re-evaluate the current symptoms and make an inventory of the remaining targets (back to step 1).

   In order to continue the treatment, in a subsequent session, the therapist will need to determine to what extent the treatment has been successful so far. Following this, the targets which will need

to be completed are those that have not yet been completely desensitized (Subjective Units of Distress [SUD] > 0) and those for which no PC has yet been fully installed (Validity of Cognition [VoC] < 7).

Once all targets of the identified symptom clusters have been adequately reprocessed, a new hierarchy of these clusters will need to be made in consultation with the client, including current situations that continue to be disturbing. Processing these triggers is the second part of the three-pronged protocol (Shapiro, 1995, 2001, 2006). On the basis of this, and that founded on clear arguments, the symptom cluster with the strongest (causal) relation to the client's quality of life will need to be chosen for treatment. In effect, we are again returning to step 1. After this, a time line or graph is made after which the most meaningful events/memories are categorized. These can be treated in future sessions.

9. Preparing the client for the future.

   Once the treatment reaches closure, it is often recommended to install one or more *future templates*. This applies to all problems. By installing the *future templates*, a blueprint of functional reactions to future objects or situations is installed and can be activated or become accessible when the client is confronted with concrete stimuli of such a situation. This may include incorporating new skills, information, and knowledge to deal with new situations, as well as those that were previously disturbing. In treating anxiety disorders, it is recommended to make a list of situations that are avoided or confronted with severe anxiety. The avoidance of such situations is, after all, most often the reason for commencing treatment.

   In addition to the installation of a *future template*, a *video check* is usually carried out with regard to the future situation (Shapiro, 2001, 2006). The purpose of this is to ascertain whether there are still elements or aspects present within these types of situations that might be able to prevent the client from seeking out such situations and that therefore still require directed reprocessing. In a *video check*, the client is asked to close his eyes and imagine a future experience from start to finish, in addition to introducing some difficult elements into the situation.

An Example

When Joan sees her therapist for the first time, she presents herself as someone with many emotional difficulties. But after history taking and further assessment, Joan and her therapist decide that Joan's phobia of elevators needs attention first. This condition most significantly influences her present life and work because Joan refuses to ride the elevator up to her 12th floor office. In response to the question: "In your experience, when do you feel that these complaints started?" she answers that these problems started 2 years ago. Joan experienced a panic attack inside an elevator and from that moment she has been avoiding elevator rides. The first 2 weeks after this incident, she stayed at home sick as she did not feel able to go to work.

The therapist asks: "Did you suffer from any of these symptoms before this happened?" Joan indicates that prior to the incident she had found it difficult to make use of elevators as she was afraid of being trapped, although she still managed to do so. The therapist also asks her a question pertaining to this elevator-related fear: "When did this fear of being trapped begin?" Joan realizes that this fear started after she had had a panic attack 6 months earlier. She was home preparing for an important work presentation when, suddenly, she felt an intense wave of fear. The room started spinning, and she felt like she was going to throw up and that she could not get away. Her whole body was shaking, she could not catch her breath, and her heart seemed to be pounding out of her chest. After that she had visited a general practitioner, but he could not find any somatic problem. When her fear of having a panic attack increased, her doctor prescribed her benzodiazepines. Yet, Joan had experienced several of these attacks since then. The therapist asked Joan to draw a graph in order to outline the course of the complaints over time (see Figure 1).

He also checked for other potential targets, but could not find any additional ones. For example, he inquired about what Joan would fear most when trapped inside the elevator. She responded that she would fear a panic attack so severe that she would die. However, since the question "When did your fear of dying start?" did not evoke any new memories the graph did not need modification. The therapist selected the memory of Joan's first panic attack as the one that needed to be reprocessed first because he postulated that this event had laid the groundwork of her fear. Next, a standard EMDR basic protocol procedure was carried out.

Second Method: From Core Beliefs to Targets

Thus far, we have described how to understand the clients' symptoms by drawing a time line that

contains the relevant experiences that contribute to these symptoms. However, in certain cases, the First Method may appear to be too cumbersome or even impracticable. Too many events might end up on the time line, and it is not always clear how or which to choose. This may be the case when the wealth of events has led to the development of a dominant or abstract meaning that increasingly became part of the so-called "dysfunctional" or "core beliefs" of the person (Beck, 1976). In this case, the client's symptom pattern is driven by a range of memories that in turn contribute to a particular (negative) belief about how the world works and who he or she is (i.e., his or her self-image). This configuration generates affective and behavioral responses, which in turn contribute to new interactional experiences that appear to confirm the cognitive bias and increase the burden of the memory network as they are themselves stored in memory. In these cases, core beliefs are viewed as a primary symptom that can act as a means to organize the secondary complaints (e.g., problems at work and personal relationships) and can be directly used to access the etiological and exacerbating memories that need to be processed (Shapiro, 2001, 2006).

Particularly, when we are trying to change a person's core beliefs it is reasonable to assume that these came into being under the influence of etiological and subsequent learning experiences. Because many different kinds of events have contributed to the core belief and generate behavioral and affective responses that are consistent with the dominant belief, rather than asking about relevant memories, it is more efficient to use the belief to identify the memories to be processed. In other words, if the therapist's hypothesis is that the problems are largely consistent with certain predominant dysfunctional beliefs that help define the psychopathology, the therapist may be better off choosing the so-called Second Method.

The Second Method involves the following:

1. Choosing the dysfunctional belief that is consistent with the client's problems
2. Identifying experiences that have led to the formation of and perpetuation of this belief and (therefore)—so to speak "prove" that the belief is true
3. "Discredit" this "evidence" with EMDR.

Similar to when one "Googles" something, when applying the Second Method, the therapist is not ordering relevant events chronologically, but is instead selecting memories on the basis of relevance in terms of the credibility of the respective belief. Following the analogy with Google, the relevant dysfunctional belief is the keyword used to find the relevant experiences and the client's learning history is the World Wide Web. Next, the most important pieces of "evidence" in support of the beliefs are dismantled, one by one.

So-Called Evidence in the Second Method

In the terminology of the Second Method of EMDR, reference is made to "evidence." We are obviously not talking about actual evidence, but rather, evidence which the client *perceives* as valid. Precisely because we are dealing with past experiences, from which the client falsely derives the conclusion that these still prove today that he is, for example, worthless, EMDR makes it possible to re-evaluate the present meaning of those experiences. It should be noted that, conceptually, what we are talking about are experiences which are *current* evidence for the "truth" of the relevant belief. The therapist therefore does not ask: "When did you have the feeling that you were worthless?" But rather: "Which experiences from the past do you feel prove to you even now that you are worthless?" or: "What have you experienced in your life that still proves to you that you are worthless?"

Rigid dysfunctional beliefs usually indicate that there are more than a few relevant events or experiences. In fact, there will usually be an extensive range of experiences and events, in general beginning in the client's childhood and running through their entire life. If the damaging experiences were of an extreme nature—and took place in the client's childhood—one may often assume that there will be more than "only" one dysfunctional core belief. This is especially the case in complex PTSD or personality disorders.

In any event, the therapist must help the client to make a useful selection from all of the memories that contribute to the credibility of the dysfunctional, problematic beliefs. Experience shows that an initial choice of five of the most relevant experiences is usually enough material to start off with. The criterion with regard to selection is the (strength of the) evidence for the relevant belief: "From all of the experiences you feel prove to you that you are worthless, select five that provide the strongest evidence at this moment."

This question can be posed directly to the client during a therapy session, but one must keep in mind that carrying out such a "Google search" on the spot will be quite a task, both emotionally and cognitively, for the client. If the client is unable to do this,

or becomes too overwhelmed, then more work needs to be done in the preparatory phase, for example, stabilization. If the client is deemed to be extremely stable and able to access disturbing memories with no problems, then it may be permissible to have them do this for homework. More concretely, the client can be asked to select five experiences, write a short essay about them, and email it to the therapist prior to the next session.

The above mentioned Second Method strategy was developed in order to expand the traditional types of questions used to arrive at relevant memories that may then be treated using EMDR. Nevertheless, this method is not exclusively limited to (working with) EMDR and can be used for interventions of different types as well. For obvious reasons, we shall not go into these interventions further here. We will, however, describe below, step by step, how the Second Method works for EMDR.

1. Identify the most relevant belief.

   Identify and formulate the most relevant dysfunctional belief. On the basis of the case conceptualization, decide to treat a particular belief. Pay close attention to the relationship between the actual problems and the way the relevant beliefs reflect them.
2. Identify the "evidence."

   Identify a number (3–5) of memories of actual situations (events) from the person's life in various contexts that for the client currently still "proves" that the dysfunctional belief is "true." If it is a core belief, preferably begin with a situation as early as possible in their youth. For example, by asking:

   > "What caused you to (start) believing/believe that you were (a) ... [core belief]?"
   > "What 'taught' you that you were (a) ... [core belief]?"
   >
   > "Which early situation currently 'proves' so to speak, that you are (a) ... [core belief]?"
   >
   > "Think of a more recent situation that makes it clear to you that you are (a) ... [core belief]?"
3. Homework (essays).

   If appropriate, ask the client to do the selection of experiences as homework and write a short essay about each specific experience.
4. Identify the strongest "evidence."

   Together with the client, first select (the memory of) the situation (event) that for the client is the strongest "proof" that he/she ... is (a) … (core belief).
5. Identify the "target image" (that proves strongest that …)

   "Which image currently proves (the strongest) that ... (fill in: core belief) … is correct?"
6. Start basic protocol with the strongest "piece of evidence."

   The selection of the NC takes place in accordance with the rules of the basic protocol. If one is working on a core belief ("I am ..."), then it is important to remember that the NC may not necessarily have the same formulation. After all, the *negative cognition* within EMDR is connected to the target image and is credible as soon as the image is brought up. The *core belief* is a general statement about oneself as a person, and may not be directly connected with a specific target image. For instance, it is possible that in a case that client's dysfunctional core belief is "I am a loser," the NC of one of the target memories providing crucial evidence for this belief is "I am powerless." Hence, although the NC will often be found to be in the same domain as the core belief (in most cases pertaining to any form of negative self-esteem), this should never simply be taken for granted.

An Example

The Second Method is illustrated by the case of a person with a negative self-image who is suffering from a depression.

Frank seeks treatment for recurrent depressive episodes. In the past, he received cognitive-behavioral therapy (CBT) and medication, combined or not. Although Frank did recover from his depressions each time, "in the back of his mind" remained a feeling of darkness, and—in his own words—an inferiority complex. Frank feels that this inferiority complex is the cause of his recurrent depressions, not in the least because his depressions always seem to be triggered by experiencing failures. Both at work and at home, Frank proves to be very sensitive to criticism and he himself is his biggest and most devastating critic. At the time of seeking treatment, things are actually going rather well for him, that is why following the advice of his former therapist, he is requesting (additional) treatment with EMDR. During the first meeting, it becomes clear that Frank has believed for quite a long time now that he is a failure, this in spite of many objective successes, particularly in his work. The people around him are frequently telling him "you have everything a man could wish for" that invariably results in Frank thinking "if only they knew." As Frank presently does not fulfill criteria of

a depression, the therapist confers with on Frank the possibility of using EMDR to work on his chronically negative self-image in general and his fixed belief that he is a failure in particular. It is decided to use the Second Method to search for relevant experiences in his past.

The therapist identified Frank's core belief ("I am a failure"). After asking "Which past situation 'proves' so to speak, still now, that you are a failure?" the therapist assessed the following memories that made it clear for Frank, on an emotional level, that he is a failure:

1. Humiliated frequently by his father in his youth
2. Bullied extensively at school
3. Missing a penalty shot in the finals of a very important soccer game
4. Fired at work
5. Severe family fights in which he was heavily criticized

The therapist began to arrange the different pieces of "evidence" in terms of their order of importance. This appeared to be premature, however. The humiliations by his father and being teased at school would seem to, at least quantitatively, belong to another order than the penalty shot, the family fight, and being fired. Consistent with the AIP model regarding etiological childhood events, Frank indicates that his father's behavior is what most likely had the strongest impact on his self-image. His father never once complimented him and on various occasions publicly humiliated Frank after he had failed to carry out a task to his father's satisfaction. Frank was asked to write a short essay about the three most humiliating experiences with his father. This supplied enough material to make a start with EMDR treatment. In the course of the planned EMDR sessions, Frank was also asked to write essays about the bullying and the other "pieces of evidence." Frank wrote the following essay:

> I am 11 years old—during a weekend with my family; I am given the task of collecting wood for a big campfire. The entire afternoon, I am doing my best to find sufficient wood, a good place for the campfire, and to stack the wood in such a way that the fire will burn well. When it is finally time to light the fire, my father roughly shoves me aside and tries to light it himself. This doesn't work, and, in front of the whole family, he begins shouting how I didn't stack the wood right, after which he tears the

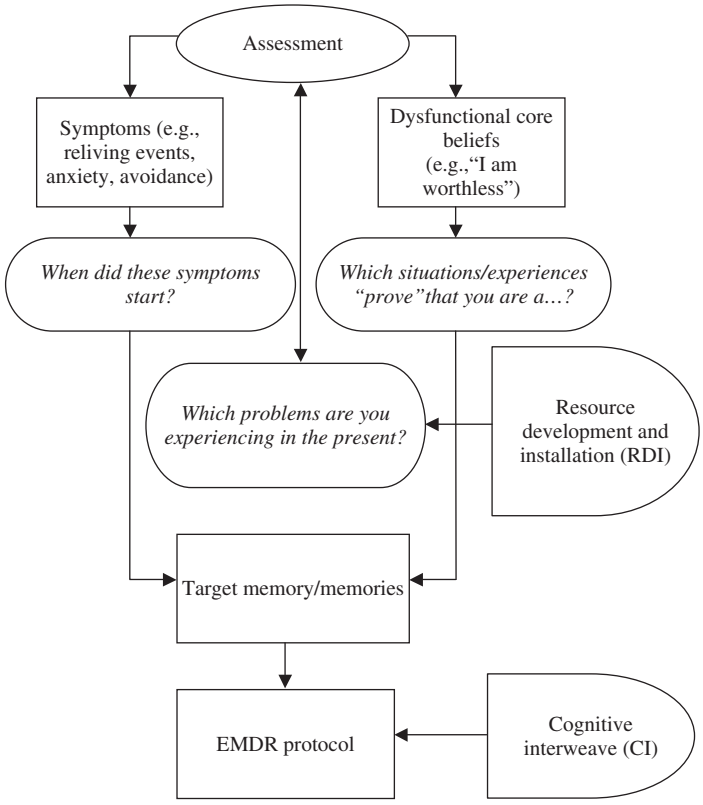

FIGURE 2. Integration of the Two Method Model within the EMDR procedure and its various components.

TABLE 1. First Method Versus Second Method

To Consider	First Method	Second Method
Type of problems and pathology	Simple trauma and other Axis I disorders in which stored memories directly influence the discrete symptoms (anxiety and avoidance reactions, stress disorders, intrusive thoughts, mourning, sleep problems)	Complex PTSD, personality disorders, and Axis I disorders characterized by self-image problems (e.g., a depression or seriously debilitating generalized social anxiety or phobia)
Origin	Primarily problems that started in adulthood	Primarily, but not exclusively, problems that started in (early) youth
Posited number of memories that require reprocessing	Relatively few	Many
Method of target selection	Targets can be selected using the *time line method*	Targets can almost not be put on a time line due to unclear origin, fragmentation of memories, or, rather, a profusion of traumatic events and bad memories. A *Google-like approach* using the negative cognitions to target selection is better suited
Cognitive domains (NCs)	Especially control, danger, guilt, and vulnerability	Particularly personal responsibility manifesting as self-esteem issues
Key question	"When did the complaints begin or worsen?"	"Which experiences 'prove' so to speak, still now, that you are a ...?"

whole thing down and makes a new pile and—with some difficulty—finally manages to light it after all. The rest of the evening, he makes belittling remarks about me as his "failure of a son," which repeatedly makes the other children laugh. No one dares to correct my father, not even when he wonders out loud if I'm even his real son, because he can't imagine having such a fool for a son.

Starting from here, the EMDR basic protocol was carried out.

Conclusion

The purpose of the current questioning suggestions is to provide a tool (or "model") that can be used to help with case conceptualizations that are aimed at treating clients with EMDR. The EMDR trainings in the United States emphasize a broad range of case conceptualizations, particularly the use of negative beliefs as the search engine. The Two Method Approach may be a useful addition, making it possible to formulate hypotheses regarding which targets are essential; that is, those which, when reprocessed, will lead to an alleviation of complaints. It also can easily be used in combination with techniques such as the affect scan and the float-back technique as integral parts of the EMDR approach (see Figure 2).

When should one choose to use the First Method, and when should one opt for the Second Method? The two methods are both specific protocols for EMDR treatment. In fact, these are just two ways of arriving at (often the same) targets, albeit coming from a different approach. Yet, one method may be more suitable for some clients than for others. For people who have experienced a single traumatic experience and for many people with Axis I disorders of the DSM, the First Method will allow the relevant target memories to be found more quickly. On the other hand, for those who have experienced multiple traumatic events in their youth and who as a result of this suffer from low self-esteem, the Second Method can better enable the therapist to find the crucial target memories. In such cases, it would not be possible to get all of the events to fit into a time line. For example, on the one hand, there will simply be too many of them, and on the other, it will prove difficult, or even impossible, for the client to (chronologically) organize the memories. For these clients, it is often an impossible task to determine the causes and events that have led to the worsening of the complaints. As can be seen in Table 1, there are also other differences that might determine which method to choose.

It seems obvious that the First Method has the most empirical support of the two methods. The dozens of randomized effect studies in the area of PTSD support the proposition that EMDR based on the First Method results in a swift reduction of complaints. Although there is as yet no empirical support that shows that the Second Method leads to a reduction of the influence of dysfunctional beliefs on the symptoms of the client, clinical practice seems promising. The search strategies and the application of EMDR to the identified experiences can, in many cases, be utilized without problems in a more general treatment regime. However, it is not to be expected that the use of EMDR for reprocessing will in all cases be sufficient to reach a satisfactory result. There should always be an overall treatment plan containing the eight phases, comprehensive goals, and the addition of other types of interventions, if needed, to supply the education and experiences needed for adequate preparation and templates.

Experience gained from the application of EMDR over the past years has shown that it is possible to extend treatment possibilities to a broad variety of psychological symptoms. Unfortunately, in many countries, EMDR is still mainly advertised as a treatment method for trauma only. Yet, if it could be shown that EMDR is not exclusively a trauma therapy, but that it must be seen as an alternative treatment for many more conditions, then EMDR would be more readily accepted in mainstream psychotherapy approach on par with CBT. To do so however, it is necessary to expand the understanding of therapists during (and/or modify the content of) the EMDR trainings and support extensive research on the wide range of pathologies other than PTSD.

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