Rupture and Repair in the EMDR Client/Clinician Relationship: Now Moments and Moments of Meeting

Mark Dworkin
East Meadow, New York

Nancy Errebo
Department of Veterans Affairs, Missoula, Montana

This article proposes that eye movement desensitization and reprocessing (EMDR) would be strengthened by being conceptualized as a two-person therapy; that is, a therapy that employs dialogue between clinician and client about the resonance, attunement, and intention of their relationship. Current research on the mirror neuron system provides a hypothetical neurological underpinning to this proposal. Detailed clinical examples illustrate rupture (Now Moments) and subsequent repair (Moments of Meeting) of the therapeutic relationship in the Eight Phases of EMDR. The high potential for relationship rupture during EMDR therapy is discussed. Suggestions are made for improving EMDR practice, training, and consultation by attending to the intersubjective experience between client and clinician, especially when working with clients who have experienced repeated and pervasive disappointments in love and work.

Keywords: EMDR; therapeutic relationship; integrative therapy; now moments; moments of meeting

Relational theory, a synthesis of diverse areas of psychotherapy traditions, has sprung from studies showing that the quality of the therapeutic relationship is a robust predictor of success in psychotherapy (Norcross, 2002). Relational Theory holds that client and clinician are constantly interacting in an unseen relational matrix, and that the process of explicating, understanding, and strengthening that matrix is a major source of psychotherapeutic change (Safran & Muran, 2002). No matter what the client and clinician happen to be talking about, their respective brains are understood to be simultaneously, wordlessly resonating and attuning to one another, constantly engaging in unspoken, implicit interaction, each always assessing the intention of the other (Siegel, 2007; Stern, 2004). Much of this process is nonconscious, meaning that it occurs outside of conscious awareness but, unlike unconscious material, can be brought readily to awareness where it can be reflected upon in the present moment of the therapy session. In this way, minor ruptures in the fabric of the relationship can be detected and repaired, and the tapestry can be strengthened in the process (Stern, 2004).

The discovery of mirror neurons has provided a possible understanding of the formation of bonds between two people. The mirroring properties of one person's brain perceive the intentions of another person's brain and then create an identical action by linking with motor neurons. The other person's mirroring properties respond in like fashion. Gallese (2005, 2008, 2009) calls this embodied simulation. These links can create resonance, attunement, emotional safety, and empathy when intentions are positive (Siegel, 2007). However, when intentions are hostile or rejecting, these links can create disharmony, misattunement, and rupture to the relationship. Fortunately, relationship ruptures can be repaired by the explication of implicit communication (Stern, 2004). Patients should be encouraged by their therapists to express a different perspective from the therapist and to assert negative feelings about the therapy. The therapist must take a nondefensive stance while exploring these ruptures (Safran, Muran, Samstag, & Stevens, 2002). Therapists benefit from training that teaches the skills to recognize and resolve relationship ruptures (Norcross, 2002).

 DOI: 10.1891/1933-3196.4.3.113

Therapies that employ dialogue between clinician and client about the resonance, attunement, and intention of their relationship are called two-person therapies. Two-person therapies are co-created by clinician and client. In contrast, in one-person therapies, a clinician creates rapport and trust with a client and applies a treatment; in one-person therapies the interaction between the brains of the clinician and client remains implicit. Wachtel (2002) noted that eye movement desensitization and reprocessing (EMDR) is taught and practiced as a one-person therapy and suggested that EMDR would be improved by being taught and practiced as a two-person therapy. This article proposes that EMDR can become an explicitly two-person therapy, so that ruptures to the therapeutic relationship may be repaired within the intersubjective matrix of the present moment of the therapy session. The shift of EMDR from a one-person therapy to a two-person therapy may be particularly important in expanding the scope of EMDR from a treatment for posttraumatic stress disorder (PTSD) to a therapy that relieves the suffering of those who have developed pervasive negative patterns in career and personal relationships subsequent to disturbing earlier life experiences.

Clinical vignettes illustrate the rupture and repair process in all eight phases of EMDR. Suggestions are made for adding the intersubjective dimension of repairing ruptures of attunement that will benefit EMDR practitioners, consultants, and trainers.

Eye Movement Desensitization and Reprocessing

EMDR is an integrative approach to psychotherapy guided by Shapiro's (2001) Adaptive Information Processing (AIP) model, which states that within each person is an inherent information processing system whose purpose is to transform, integrate, and transmute disturbing life experiences to a healthy, adaptive resolution. This system normally operates automatically and outside of conscious awareness. However, a disturbing event may unbalance, block, or overwhelm the system, with the result that the memory of the event is stored in the nervous system in state-dependent form. Maladaptively-stored memories are considered to be the basis of psychopathology. Present stimuli that resemble the traumatic event trigger the identical emotions, physical sensations, and behaviors that were present at the time of the original event. EMDR is believed to activate this inherent information processing system and keep it active long enough to do its healing work.

EMDR is an Eight-Phase Model (Shapiro, 1995, 2001). In Phase 1, History-Taking, a treatment plan, based on the client's symptoms, present problems, disturbing past events, and desired future outcomes, is developed. The past, present, and future constitute the Three-pronged EMDR Protocol. Disturbing memories are designated as targets for EMDR reprocessing. The client's internal and external resources are assessed, for they determine the pace of Phase 2, Preparation. Phase 2 consists of creating a therapeutic alliance, teaching the client about EMDR, and developing relaxation and safety procedures necessary for managing intense emotional states that may occur during the reprocessing of the traumatic memory. Phases 1 and 2 are conducted over several, or even many, therapy sessions.

Phases 3 through 7 take place in one therapy session. In Phase 3, Assessment, the components of the target memory are identified and the intensity of the disturbance is measured on two subjective scales. The components of the memory include a representative image, a negative cognition (NC) about the self that goes with the image, a positive cognition (PC) that will replace the NC during reprocessing, emotions, and physical sensations. The strength of the PC is measured on the Validity of Cognition Scale (VoC) where 1 is completely false and 7 is completely true. The intensity of the disturbing affect is measured on the Subjective Units of Disturbance (SUD) scale where 0 is neutral and 10 is the worst disturbance imaginable.

In Phase 4, Desensitization, the client focuses on the target memory while attending simultaneously to Bilateral Stimulation (BLS)—most often eye movements, but sometimes alternating taps or tones—for about 25 s. After each "set" of dual attention to the memory and the BLS, the therapist asks the client, "What are you getting (or noticing) now?" This deliberately ambiguous question is designed to elicit a report of the client's visual, sensory, and cognitive shifts during the set of BLS. After the client reports his or her current experience, the clinician says, "Go with that," a deliberately ambiguous statement designed to encourage the client to continue to observe his or her internal experiences during the next set of BLS. This process is repeated numerous times during the therapy session. As long as the client reports spontaneous shifts—that is, differences in images, thoughts, and physical sensations—whether the shifts be negative or positive, the clinician refrains from intervening in the process except for offering supportive statements and guidance. If, however, the client reports no change after two sets of BLS, the clinician

may need to offer a brief statement, called a Cognitive Interweave, to restart the reprocessing. Phase 4 is complete when the SUD reaches zero—emotionally neutral—as the client accesses the formerly disturbing target memory. Shapiro (2001) stated that the irrational NC is the verbalization of the negative affect around the traumatic memory. So, according to AIP, when the client feels neutral rather than emotionally upset when thinking of the traumatic event, the NC should no longer feel emotionally valid. Rather, the client should fully believe, at a gut level, on the VoC scale of 1 to 7, with 1 being completely false and 7 being completely true, that the PC identified in Phase 3 feels completely true at a level 7 on the VoC scale.

Therefore, Phase 5, Installation, focuses on strengthening the PC that was identified during Phase 3. Phase 5 is complete when the strength of the belief in the PC reaches 7 on the VoC. In Phase 6, Body Scan, the client scans his or her body from head to toe and reports any sensation. If there is any sensation, BLS are applied until the disturbance clears. In Phase 7, Closure, the client returns to equilibrium in order to make the transition to the activities of daily life and is asked to keep a log of events related to the therapeutic work. Phase 8, Reevaluation, occurs at the beginning of the next session when the clinician asks the client to reaccess the target memory in order to determine if treatment effects have been maintained. The clinician and client together decide the future direction of the treatment plan.

Review of the EMDR Literature on the Therapeutic Relationship

Shapiro (2001, 2009a), the developer of EMDR, has stated that clinician/client rapport and a therapeutic alliance are prerequisites to beginning the Desensitization and Installation Phases of EMDR, and has described ways for the clinician to be "optimally interactive" (2007a, p. 76) during EMDR reprocessing. Several authors have addressed the issue of needing additional time to build trust and rapport for more complex cases and for clients with insecure attachment status (Dworkin, 2005; Gelinas, 2003; Korn & Leeds, 2002; Leeds, 2009). van der Kolk (2002) speculated that positive results are possible with EMDR even in the absence of a trusting therapeutic relationship, though in a personal communication to M. Dworkin (2008, July), he agreed that attunement and resonance were crucial factors in the healing of trauma. Edmond, Sloan, and McCarty (2004) suggested that transference and countertransference might be less of a factor with EMDR than with eclectic therapy. Marich (2009) found that the patient's relationship with her EMDR therapist was "concomitant with Dworkin's (2005) work on the relational imperative." Silver and Rogers (2002) highlighted therapist self-awareness as an integral part of treating war veterans with EMDR. While most clinical case descriptions have emphasized the EMDR method with little description of the clinician/client relationship (Shapiro & Silk-Forrest, 1997), several lengthy descriptions by clients of their EMDR therapy have included much detail about their relationships with their clinicians (Houston, 2000; Parnell, 1997, 2007; Scarf, 2004). The EMDR literature on how therapeutic relationships are ruptured or repaired is sparse, though Leeds (1996) has written about resource installation to resolve therapeutic impasse, and several authors have discussed resistance and countertransference in EMDR (Dworkin, 2005; Kaslow, 2007; Knipe, 1996; Leeds, 1996, 2009; Moore, 2007; Parnell, 2007; Snyker, 1996; Wachtel 2002).

Now Moments and Moments of Meeting

EMDR literature and training provide little detail about the formation of safe, trusting therapeutic relationships and little description of the look and feel of such relationships. In contrast, the relational theory literature abounds with descriptions of the nature and nurturance of the therapeutic relationship. For example, Stern (2004) posited that psychotherapy is largely composed of clinician and client seeing the same mental landscape for a moment. These present moments when clinician and client are almost reading each other's minds become new memories that change the client's perspective and create healing and new ways of relating to the world. In part, trust in therapy is built by testing the relationship. In the testing, relationship ruptures, in the form of moments of misattunement, will almost certainly occur. Stern called these ruptures Now Moments. These ruptures may be subtle but should not go unrecognized.

Recognition of a rupture begins with the clinician's mindfulness of his or her own affective and somatic states, which reflect the never-ending dance of continual implicit relatedness in which the client's memory networks affect the clinician's memory networks, which in turn affect the client's memory networks and on and on. On becoming aware of his or her own inner signals that something is subtly amiss in the relationship, the clinician shares this information with the client in an authentic way that alters the intersubjective field between them. The sharing may be nonverbal, such as a look or a gesture, or it may be

an invitation to engage in an explicit dialogue about what happened in the Now Moment. In these interactions, which Stern (2004) called Moments of Meeting, the relationship is repaired and the intersubjective field is expanded, creating a wider and deeper space for therapeutic change.

A Now Moment: A Rupture of Attunement in Developing an Appropriate Negative Belief During History-Taking

Gary, a 28-year-old single teacher of special needs children, sought psychotherapy after receiving a poor evaluation by a supervisor. He felt anxious, believed he was inadequate and stupid, and worried that he would lose his job. From their very first meeting, Gary's EMDR clinician conceptualized the case from an AIP point of view. That is, he assumed that Gary's problems were rooted in past experiences, probably in childhood, and that he had formed a negative belief about himself related to a network of negative memories. During Phase 1, History-Taking, the clinician asked Gary a series of questions scripted in the EMDR Institute Training manual (Shapiro, 2009a) in order to help Gary verbalize the NC associated with the memory of his supervisor giving him a poor job evaluation. Later in Phase 1, the NC would help Gary and the clinician identify earlier experiences associated with the same NC and organize a series of target memories for EMDR reprocessing. The following vignette shows how, during this interaction, the negative memory networks of the clinician become activated, and, in response, Gary's dysfunctional memory networks of inadequacy were activated. The result is a misattunement; a now moment, that becomes a therapeutic rupture.

> **Clinician:** What image represents the worst part of that incident?
> **Gary:** I see my supervisor frowning.
> **Clinician:** When you think of your supervisor frowning, what negative belief do you have about yourself?
> **Gary:** I feel ashamed of myself.
> **Clinician:** What does that say about you as a person?
> **Gary:** I hate myself.

The clinician's intention is that the client will state a self-referencing, irrational negative belief associated with the memory of the supervisor frowning. Thus, the clinician feels mild frustration with Gary's simple statements of feelings. Outside the clinician's conscious awareness, his own memory networks of failure and inadequacy have been activated and are producing tension in his eyes, lips, and hands. The clinician brushes his negative feelings aside and continues to follow the script in the EMDR training manual.

> **Clinician:** What negative belief about you goes with that emotion of hating yourself?
> **Gary:** Well, I have hated myself since I was a child.
> **Clinician *(irritably)*:** Not what you believed about yourself then, what do you believe about yourself now?
> **Gary *(anxiously)*:** I don't know what I am supposed to say. *[Gary's mirror neurons respond to the clinician's irritation; Gary embodies anxiety.]*
> **Clinician *(more irritably)*:** Gary, in your worst moment, when you see your supervisor's frown, what negative belief do you have about yourself when you think of that event?
> **Gary:** I'm doing this all wrong now, aren't I? *[The clinician's increasing irritation activates Gary's network consisting of memories of subservience to authority figures.]*

A Moment of Meeting: Repairing the Rupture

The clinician's mirror neuron system notices Gary's fear, and in response becomes conscious that his irritation is the result of the activation of his own failure networks. In turn, the clinician's adaptive memory networks containing compassion are activated. The following vignette is a deviation from the manualized script, and is provided to illustrate rupture repair.

> **Clinician:** I know that this question is difficult for you to answer the way I want you to; is it possible that my responses to you made you feel like you were failing again?
> **Gary:** *(shrugs his shoulders and nods.)*
> **Clinician:** So maybe the questions, or the way I was asking them, made you experience your negative beliefs now. Let's see if we could try this again a little differently. Would that be okay?

Both client and clinician experience relief in this Moment of Meeting, and they repair the rupture. Implicitly, the clinician is letting the client (and himself) know that misattunements can be resolved creatively, hence, misattunements do not equal failure. The Moment of Meeting becomes a positive memory that is a resource for both client and clinician. In fact,

client and clinician have co-created what Siegel (1999) terms mental state resonance.

Now Moments and Moments of Meeting During the Preparation Phase

The Preparation Phase is replete with opportunities for rupture and repair of the therapeutic relationship because it makes specific demands of the clinician and client that may activate the negative memory networks of both. The tasks of the Preparation Phase include explaining the AIP model, demonstrating the eye movements, creating a Safe Place in the client's imagination, setting expectations for the treatment, and addressing the client's fears, questions, and doubts about EMDR (Shapiro, 2001). The major requirement for the client is to demonstrate the ability to shift emotional states. The ability to shift from a high level of emotional distress to a state of grounded awareness is vital to treatment success. Without this ability, the client is at risk of hyperarousal and retraumatization. The Calm/Safe Place exercise is one way of helping the client develop the skill of shifting emotional states. Activations of dysfunctional memory networks can occur when attempting to develop a Calm/Safe Place, especially for clients with limited experience of safety. These activations can be frustrating for both client and clinician.

Such was the case with Gary, the client in the first vignette with the history of subservience to authority figures.

> **Clinician:** I'd like you to think about some place you have been or imagine being that feels calm or safe. As you think of that place, notice what you see, hear, and feel right now. What do you notice?
> **Gary:** I'm on the beach. It's a sunny day, the sand is warm, and the ocean is calm.
> **Clinician:** Bring up the image of that calm place, concentrate on the pleasant sensations in your body, and follow my fingers. *[Clinician leads Gary in four sets of slow BLS].*
> How do you feel now?
> **Gary:** I'm not a good swimmer. I feel anxious.
> **Clinician *(feeling compassionate as he remembers Gary's difficulties in developing a negative cognition)*:** Let's think of another place. Is there another place where you feel safe and calm?
> **Gary:** The woods are calm and peaceful.
> **Clinician *(still feeling compassionate but hoping this one will work)*:** Okay, notice the image, sounds, smells, and the sensation in your body and follow my fingers. [*Four sets of slow BLS]*
> **Gary:** I'm thinking of Boy Scout Camp. I could never get a fire started, and the other guys made fun of me. I don't really feel safe in the woods either.
> **Clinician:** Do you ever feel safe when practicing yoga or in any physical activity?
> **Gary:** Not really. No.

The two are at a therapeutic impasse—a Now Moment. The clinician, at a loss for what to do and say next, feels frustrated. Gary's mirror neuron system accurately reads the clinician's distress, and, in response, his memory networks of failure are activated. They sit in silence for a moment. Gary, feeling woefully incompetent, contemplates making up a Safe Place and pretending to feel safe in it. The clinician notices a feeling of numbness in his body and realizes that a memory network of his own, which consists of experiences in which he felt helpless, has been activated. The clinician uses a brief compartmentalization technique (Dworkin, 2005) to ground himself. He takes a cleansing breath, thinks of his own Safe Place, alternately taps his big toes inside his shoes, and makes a mental note to reflect on the memory networks of helplessness after the session. Thus grounded, he is ready to transform this Now Moment into a Moment of Meeting.

> **Clinician:** I notice that I just went numb all over my body. I am wondering if you are feeling anything similar right now.
> **Gary:** Yes, as a matter of fact, I am. I am glad you asked. Finding a Safe Place is such a simple thing. Why can't I do it?
> **Clinician:** It seems like the memory feels safe at first, then an unpleasant memory intrudes and destroys the safety.
> **Gary:** I am beginning to realize that I don't know what safety feels like. I don't think I have ever felt safe anywhere with anybody. Does this mean I am never going to feel safe? Does this mean I can't do EMDR?
> **Clinician:** We are doing EMDR right now. But before we can proceed to the trauma-reprocessing phase of EMDR, we need to help you develop the inner resource of being able to shift from a distressed emotional state to a calmer, more relaxed emotional state. The memory of a Safe Place is a simple way to do that. But for people who don't have a memory of a Safe Place, we can work to develop that inner resource of safety. This work can be quite interesting.
> **Gary:** I would really like to do it.

Using Resource Development and Installation (RDI) procedures (Leeds, 1997; Shapiro, 2001) Gary

and his clinician develop an inner resource of sitting in his apartment listening to Mozart. Using this resource, he is able to shift emotional states and proceed to Phases 3 through 8 of EMDR. The memory of working together with his clinician to achieve this skill is also an inner resource for Gary and for the clinician as well.

Now Moments and Moments of Meeting During the Desensitization Phase

In the following case example of blocked processing, a Now Moment occurs when the strategies taught in EMDR training failed to get reprocessing back on track. The clinician and client attain a Moment of Meeting by tuning into their somatic reactions. They are then able to resume EMDR reprocessing.

Robert, a 36-year-old social worker, was devastated when his girlfriend broke up with him. He sought EMDR treatment because, after a year of talking to his previous therapist, he was still tormented by his girlfriend's parting words and by the belief that he was hopelessly defective. Robert engaged easily, saying he felt comfortable because the clinician was a "kind, compassionate older man." Robert had many resources—a successful career, strong coping skills, loyal friends, and a good relationship with his parents, especially his father. Of his mother, he said, "I love her, but she is a bit too emotional for my taste, just like most women." He reported a happy childhood and normal development. The clinician asked him to search his memory for early traumatic memories, large and small, that involved rejection. Robert identified a cluster of memories about rejection in athletic competition that were suitable targets for EMDR reprocessing.

The Preparation Phase went smoothly. Attunement and mental state resonance were strong. Robert's Dissociative Experiences Scale (DES-T) score was unremarkable. He was able to shift emotional states by thinking of his Safe Place of hiking in the mountains. Though the clinician experienced a somatic flutter when he thought of initiating the Desensitization Phase of EMDR, he could not think of any reason why reprocessing of traumatic memories should not go forward given that all checklists had been completed.

The first target memory was his Little League teammates refusing to speak to him after a championship game in which he flubbed two ground balls, resulting in the other team scoring the winning runs.

Image = My teammates turning their backs on me.
NC = I am a failure.
PC = I did the best I could.
VoC = 3.
SUD = 8. *(Sadness and guilt felt in heart and stomach.)*

Robert *(after the third set of BLS)*: I see the ground ball. As I go to scoop it up, I see my teammate, Lisa, at third base with her glove up ready to make the catch. And I flub the ball.
Clinician: Go with that. *[BLS]* What are you getting now?
Robert: At practice two days before that game I saw Lisa crying, and I asked her what was wrong. She told me that her dad and my mom were having an affair. I remember just staring at her. I didn't know what to say to her, but I felt scared.
Clinician: Go with that. *[BLS]* What are you getting now?
Robert: Oh my gosh, I see what happened. Seeing Lisa on third base broke my concentration, and that's why I flubbed the grounder. That's amazing. I never put that together.
Clinician: Go with that. *[BLS]* What are you getting now?
Robert: I see my father. He's crying and I go over to comfort him.

Here, reprocessing, which had been flowing beautifully, becomes blocked.

A Now Moment

Clinician: Go with that. *[BLS]* What are you getting now?
Robert: Nothing.
Clinician: Go with that. *[BLS]* What are you getting now?
Robert: Nothing.
Clinician: I am going to change the direction of the eye movements to the diagonal we practiced. *[BLS—a longer set this time]* What are you getting now?
Robert: Not much. Really nothing.
Clinician: Go back to the target. What do you get when you go back there?
Robert: I can't picture the Little League Game. I see my father crying, and I feel myself wanting to comfort him.
Clinician: Notice what you feel in your body and the image of your father crying and go with that. *[BLS]* What are you getting now?
Robert: Nothing really. Not much.

Clinician: Go with that. [BLS] What are you getting now?
Robert: Nothing. I just don't get anything.
Clinician *(thinking it is time for a Cognitive Interweave)*: Robert, I wonder what might have happened if your best friend, as a 9-year-old boy, tried to comfort his father and couldn't. What would you feel toward your best friend?
Robert: I'd feel compassion.
Clinician: Go with that *(BLS)*. What are you getting now?
Robert: I'm sorry, but I can't picture it. I am not seeing or feeling anything.

Taking a mental step back, the clinician wonders if his mirror neuron system might be sensing Robert's nonconscious, nonverbal memories of helplessness, and if he, the clinician, was embodying this helpless feeling.

A Moment of Meeting

Clinician: Robert, just this minute, my thoughts are clouded, and I really can't figure out what to do. I had the idea that you might be having that same experience right now and that you also might have had that experience when you saw your father crying so long ago. Can you relate to that at all? [*This intervention by the clinician in which he disclosed his internal experience of confusion, is an example of an Intersubjective Interweave (Dworkin, 2009b).]*
Robert: That's it! That's what I experienced. I had forgotten all about it. I couldn't think clearly and I blanked out.
Clinician: Go with that. *[BLS]* What are you getting now?
Robert: This is weird. I remember being in the first grade in my first school play. I forget my lines. I look out into the audience, and I see my mother burst into tears.
Clinician: Go with that. *[BLS]* What are you getting now?
Robert: I wet my pants.
Clinician: Go with that. *[BLS]* What are you getting now?

Several sets of BLS followed with intense emotional release—sobbing, nausea, heavy breathing—during which the clinician provided supportive, nurturing, encouraging statements.

Clinician: Go with that. *[BLS]* What are you getting now?
Robert: All the women I have dated are critical. Why am I choosing these critical women?
Clinician: Go with that. *[BLS]* What are you getting now?
Robert: I see my father—his pain. I wanted to help him, and I didn't know how. I guess I have been repeating the same pattern of choosing rejecting women in my own life.

Once this block is detected and reprocessed, Robert is able to adaptively reprocess his dysfunctional memory networks, which related to a merged sense of himself with his father.

The Three-Pronged Protocol

Three more 90-min sessions were needed to reprocess the memories of his past problems with women, the romantic breakup that had sent Robert into therapy, his present-day referents (dating women with similar characteristics to his mother), and his future template of finding a more appropriate partner. Robert did meet and marry the woman he visualized in this future template. Every year, the couple sends the clinician holiday cards with pictures of their two children.

Now Moments and Moments of Meeting During Closure and Reevaluation

The following vignettes and case description illustrate a rupture that occurred in a long-term therapeutic relationship.

Alexis, a 35-year-old single woman working as a computer programmer, entered therapy after discovering that Justin, her boyfriend of one year, had been e-mailing other women requesting romantic and sexual relations. Justin had led her to believe that he loved her and that they would marry someday, but now she knew that he was just like her father and every other man who had let her down. Devastated, Alexis poured out her feelings about her father's extramarital affairs and betrayals by boyfriends. The clinician's mirror neuron system resonated empathically with Alexis' distress, and he expressed his desire to help her find love. Alexis was overjoyed to have found an understanding male therapist. Thus, they bonded and began their work together with high hopes.

The tasks of the Preparation Phase were achieved rapidly. However, as sometimes happens when the client has experienced repeated rejections and humiliations, the Desensitization Phase was long and laborious. The first EMDR target memory was seeing her father kissing a woman who was not her mother. The target memory was linked to other childhood memories and also memories of disappointment and

betrayal by a series of men she dated before Justin. In 6 months of EMDR reprocessing, she stopped hating her father, let go of the pain around her other former boyfriends' behavior, and stated that she was learning to trust. She realized that she had made progress, but she was not over Justin, and she was still too vulnerable to connect with another man.

Consciously, the clinician tried to be understanding when she complained that her "biological clock was ticking" as the therapy dragged on and on. Suspecting that Alexis could not yet bear to face blocked beliefs that she was defective and unlovable, he silently compartmentalized his pain every time she said, "All men are pigs." Outside of his awareness, his own dysfunctional memory networks of rejection and defectiveness had been activated by her complaints and criticism. Though neither of them said so, both client and clinician were disappointed in the way therapy was going.

Seven months into the therapeutic work, they targeted the memory of the incident that brought her into therapy.

Image = The emails on Justin's computer screen.
NC = I cannot trust.
PC = I am learning to trust.
VoC = 3.
Emotion = Anger.
SUD = 7.
Body: Chest.

Desensitization proceeds with rage, torrents of tears, and insights about the negative relationship patterns. Toward the end of the session, to her surprise, positive memories and feelings about Justin surface.

Alexis: You know, it's funny, but I can see Justin looking at me. He is smiling, and I feel like smiling back at him.
Clinician: Go with that. *[BLS]* What are you getting now?
Alexis: I don't know why, but I remember telling Justin about a book I read. He said my ideas were original. No other guy had ever been interested in my ideas.

The clinician, thrilled to hear a sign of positive affect tolerance, decides to encourage this direction in closing the session.

Clinician: Go with that. *[BLS]* What are you getting now?
Alexis: Now I am seeing the e-mails on his computer screen again.
Clinician: We are running out of time. Would you be OK starting to debrief from this session?
Alexis: Sure, I think I made some real progress this time.

A Now Moment

Clinician: I noticed that you were experiencing some positive feelings about Justin. That's new for you.
Alexis: Yes, there were some good times with Justin, but looking at those emails to other women, I don't believe a word he said to me. It was all a line.
Clinician: Alexis, I see progress here in your ability to feel those good feelings, and I want to encourage you to continue in that direction. During the week, I'd like you to make a list of Justin's good qualities and the good things about your relationship.
Alexis *(tearing up as she detects a subtle tone of criticism and hostility)*: How can you say that to me? Justin used me. He made me trust him and then he threw me away. You don't want to hear how I feel. You just want me to get over it, so you order me to think positive thoughts.

A Moment of Meeting

Clinician *(chagrined)*: Alexis, I hear you. I can see that I have made a mistake. I am sorry this is happening at the end of the session when there is no more time to talk about it. I am going to think about this, and we will talk about it next time. Please call me during the week if you want or need to. We can also schedule an extra session if that would help. What do you think?
Alexis *(impressed by the clinician's acknowledgement of his mistake, and moved by his compassion)*: I'll be all right. I know you were trying to help me. I'll see you next week. I will call if I need to.

As she leaves the clinician's office, Alexis turns to smile at him. He returns her smile, and in that Moment of Meeting, the intersubjective field between them expands.

Clinician's Introspection in Preparation for the Repairing of the Relationship

Based on his knowledge of the mirror neural system, the clinician accepted as accurate Alexis's perception of nonconscious negative intent on his part. Thus, he took responsibility for the misattunement even though his only conscious motivation was a desire to support her capacity to tolerate positive affect

toward someone who had hurt her. As he reflected on her criticism of men and her complaints about the length of therapy, memories of his mother's criticism and impatience cascaded into his consciousness. He knew then that he had reenacted his mother's impatience with him in his relationship with Alexis. He started looking forward to repairing the therapeutic relationship in the next session by acknowledging his misattunement and without disclosing the content of his dysfunctional memory networks. The following vignette illustrates Dworkin's (2005) Relational Interweave.

Relationship Repair in the Reevaluation Phase

Clinician: I have been thinking a lot about our last session. I felt happy when you experienced positive emotions for the first time, but you know and I know that I was wrong to ask you to make a list of Justin's positive qualities. How are you feeling about the whole thing?

Alexis: Well, it felt good that you recognized that you had hurt me. I do know you want the best for me.

Clinician: We have been working hard for a long time, and I think in trying to move the process along, I ended up pushing you, and telling you what to do. Instead, we should have been walking side by side.

Alexis: You know, my parents were always bossing me around. I had to do what they said when I was a kid, but I always told myself that when I grew up I would never submit to authority again. You and I haven't really talked about that—I guess, because up until now, you haven't told me what to do. But I really hate being told what to do.

Clinician: That makes perfect sense. Where do we go from here?

Alexis: I have been thinking about that. Right this minute, I still feel that anger in my chest and throat and body that I felt last week and that also I felt as a child. Could we do EMDR with that?

Clinician: Absolutely. Go with that. *[BLS]* What are you getting now?

Alexis: Oh my gosh. You are not going to believe this. I haven't told you, but I have kind of started seeing this guy named Chad. He is more into me than I am into him. You know, he is controlling, and it makes me mad. Oh my gosh. I didn't see it until just this minute.

Clinician: Go with that.

The next week, Alexis announced that she had told Chad about the EMDR session and about how she felt about him telling her what to do. To her amazement, Chad said he wanted to understand why he was so controlling, and he made an appointment for himself with an EMDR therapist. Alexis and the clinician went on to reprocess the memory of Justin's emails within the expanded intersubjective field they had created together.

Discussion

EMDR has been an integrative therapy from the beginning (Shapiro, 2001). In their discussion of incorporating other theories and methods into EMDR, Norcross and Shapiro (2002) asked, "How can EMDR be strengthened?" (p. 342). One answer to their question is that EMDR could be strengthened by harnessing the power of EMDR to alleviate the suffering of all people, not just people who meet DSM criteria for PTSD. Shapiro (1989), in her controlled study of sexual trauma survivors and war veterans whose flashbacks and nightmares remitted in one to three EMDR sessions, introduced EMDR to the mental health community. Since that initial study, more than 20 controlled studies, corroborated by thousands of clinical reports, have established EMDR as an evidence-based treatment for PTSD. EMDR practitioners, impressed by powerful treatment results with PTSD, adopted the AIP assumption that present dysfunction is rooted in past experience, and utilized the eight-phase EMDR protocol to relieve the pain of clients with various diagnoses from phobias to depression to generalized anxiety disorder to personality disorders to dissociative disorders.

Ironically, EMDR treatment of traumatic memories of catastrophic events that have resulted in PTSD often proceeds more rapidly and produces more relief than the reprocessing of memories of commonplace rejection, disappointment, invalidation, failure, and humiliation that have produced negative life patterns that have resulted in lives lived in quiet desperation, to use Thoreau's immortal term. The pain of the latter clients is subtle, but horrible in its relentlessness. In contrast, the pain of the PTSD client is acute. Accordingly, with EMDR treatment, the PTSD patient may experience dramatic relief from acute emotional pain compared to barely perceptible positive shifts in the emotional pain of clients who have experienced ordinary, albeit emotionally devastating, experiences. The clinician's own memory networks of rejection and failure may be activated in resonance with the client's memories of pain and longing. Herein, the

possibility of ruptures of attunement heightens as the work becomes tedious and client and clinician each bear their solitary pain, never mentioning to one another their suffering and their longing for relief.

The potential for relationship rupture in EMDR treatment is very high. First, EMDR, as a structured therapy, entails specific tasks during the Preparation and Assessment Phases, which may tax the skills of both client and clinician, thus triggering in one or both of them a negative memory package of images, emotions, body sensations, and negative beliefs about the self. Second, decades of clinical evidence have revealed that it is impossible to predict where the trail of associations will lead in the EMDR reprocessing of a negative memory. Therefore, the Desensitization Phase of EMDR requires facing the unknown, an inherently fearful position. Client's and clinician's fears of facing the unknown increase the possibility of relationship rupture, especially if the fears remain nonconscious. Third, during the Desensitization Phase, rapid shifting of emotional states and sudden, unexpected opening of channels increase the probability of an abrupt exit from the therapeutic window, Briere and Scott's (2006) term for the optimal state of arousal for the reprocessing of a traumatic memory. The therapeutic window lies between inadequate access to the memory networks, where little if any reprocessing occurs, and excessive access to the memory networks, where the client employs avoidance responses, such as dissociation, to shut down overwhelming emotions. Twombly's (2000) Window of Tolerance describes a similar process. Briere and Scott (2006) point out that, though the avoidance of distressing memories wastes the time, money, and energy of a client who has the capacity to tolerate greater exposure and processing, there is a certain safety and comfort in undershooting the therapeutic window by focusing forever on support and validation. That kind of comfort and safety, however, are not afforded the EMDR clinician, because EMDR is, by definition, a therapy of desensitization and reprocessing.

In EMDR training, participants are taught to help the client stay within the therapeutic window. When reprocessing slows or stops, the clinician uses techniques designed to increase access to the memory networks. When affective arousal threatens to become intolerable, the clinician uses techniques designed to bring the arousal back to an acceptable level so reprocessing can continue. An EMDR clinician's mindfulness of his or her own emotional state is crucial to the therapeutic relationship. A clinician whose own negative memory networks have been activated by the client's emotional shifts and sudden emergence of a disturbing channel may be more likely either to back off of moving through an emotional storm by continuing BLS or to push a client past his or her emotional tolerance, thus precipitating a rupture of the therapeutic relationship.

Consequently, the authors recommend that this shared experience of rupture and relational repair—now moments and moments of meeting—should be taught in EMDR trainings and consultations. Case examples, such as the ones in this article, could be provided to illustrate how the therapeutic relationship may falter and be righted.

Many participants in EMDR training who are knowledgeable in relational theory have shared the fear that they must relinquish attunement with clients in focusing on EMDR procedures and protocols. This is not what EMDR trainings intend, but it is what many participants struggle with in learning EMDR. This article proposes that EMDR training and practice could be strengthened by including instruction in recognizing and repairing relationship ruptures like those illustrated by the clinical examples in this article. This may give clinicians and clients the encouragement, hope, support, connectedness, and shared vision to stick with EMDR reprocessing and not give up in their quest to heal.

References

Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. Los Angeles: SAGE.

Dworkin, M. (2005). *EMDR and the relational imperative: The therapeutic relationship in EMDR treatment*. New York: Routledge.

Dworkin, M. (2009a). The clinician awareness questionnaire. In M. Luber (Ed.), *EMDR scripted protocols: Basic and special situations* (pp. 401–408). New York: Springer Publishing.

Dworkin, M. (2009b, September). *Solving transference and countertransference with dissociative disorders (slides 54-55): Steps for the intersubjective interweave*. Paper presented at the EMDRIA Conference 2009, Atlanta, GA.

Edmond, T., Sloan, L., & McCarty, D. (2004). Sexual abuse survivors perceptions of the effectiveness of EMDR and eclectic therapy. *Research on Social Work Practice, 14*, 259–272.

Gallese, V. (2005). Intentional attunement: mirror neurons and the neural underpinnings of interpersonal relations. *JAPA, 55*, 131–176.

Gallese V. (2008). Empathy, embodied simulation and the brain. *JAPA, 56*, 769–781.

Gallese, V. (2009). Mirror neurons, embodied simulation, and the neural basis for social identification. *Psychoanalytic Dialogues, 19*, 519–536.

Gelinas, G. (2003). Integrating EMDR into phase oriented treatment of trauma. *Journal of Trauma and Dissociation, 4*, 91–135.

Houston, P. (2000). Seeing is believing. *Elle, 16*, 236–240.

Knipe, J. (1996). It was a golden time…treating narcissitic vulnerability. In P. Manfield (Ed.), *Extending EMDR* (pp. 232–255). New York: Norton.

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*, 1465–1487.

Leeds, A. (1996). Lifting the burden of shame: Using EMDR resource installation to resolve a therapeutic impasse. In P. Manfield (Ed.), *Extending EMDR* (pp. 256–282). New York: Norton.

Leeds, A. (2009). *A guide to the standard EMDR protocols for clinicians, supervisors, and consultants*. New York: Springer.

Marich, J. (2009). EMDR in the addiction continuing care process. *Journal of EMDR Practice and Research, 3*(2), 98–108.

Moore, P. (2007). Medical family therapy. In F. Shapiro, F. Kaslow, & L. Maxfield (Eds.), *EMDR and family therapy processes* (pp. 365–384). New York: Wiley.

Norcross, J. (Ed.). (2002). *Psychotherapy relationships that work*. New York: Oxford.

Norcross, J. C., & Shapiro, F. (2002). EMDR and integration. In F. Shapiro (Ed.), *EMDR as an intetgrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism* (pp. 341–356). Washington, DC: American Psychological Association.

Parnell, L. (1997). *Transforming trauma: EMDR*. New York: Norton.

Parnell, L. (2007). *A therapist's guide to EMDR: Tools and techniques for successful treatment*. New York: Norton.

Safran, J. D., & Muran, J. C. (2002). *Negotiating the therapeutic alliance*. New York: Guilford.

Safran, J. D., Muran, J. C., Samstag, L. W., & Stevens, C., (2002). Repairing alliance ruptures. In J. Norcross (Ed.), *Psychotherapy relationships that work*. New York: Oxford.

Scarf, M. (2004). *Secrets, lies, betrayals: The body/mind connection: How the body holds the secrets of a life, and how to unlock them*. New York: Random House.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing: Basic principles, protocols and procedures* (1st ed.). New York: Guilford.

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

Shapiro, F. (2007). EMDR adaptive information processing, and case conceptualization. *Journal of EMDR Practice and Research, 1*(2), 68–87.

Shapiro, F. (2009a). *The EMDR approach to psychotherapy: Part 1 of the two part basic training*. Watsonville, CA: EMDR Institute.

Shapiro, F. (2009b). *The EMDR approach to psychotherapy: Part 2 of the two part basic training*. Watsonville, CA: EMDR Institute.

Shapiro, F., & Silk-Forrest, M. (1997). *EMDR: The breakthrough therapy for overcoming anxiety, stress, and trauma*. New York: Basic Books.

Siegel, D. J. (1999). *The developing mind*. New York: Guilford.

Siegel, D. J. (2007). *The mindful brain*. New York: Norton.

Silver, S. M., & Rogers, S. (2002). *Light in the heart of darkness: EMDR and the treatment of war and terrorism survivors*. New York: Norton.

Snyker, E. (1996). Into the volcano. In P. Manfield (Ed.), *Extending EMDR* (pp. 91–112). New York: Norton.

Stern, D. N. (2004). *The present moment in psychotherapy and everyday life*. New York: Norton.

Twombly, J. H. (2000). Incorporating EMDR and EMDR adaptations into the treatment of clients with DID. *Journal of Trauma and Dissociation, 1*(2), 61–81.

van der Kolk, B. (2002). Beyond the talking cure: Somatic experience and subcortical imprints in the treatment of trauma. In F. Shapiro (Ed.), *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism* (pp. 57–83). Washington, DC: American Psychological Association.

Wachtel, P. L. (2002). EMDR and psychoanalysis. In F. Shapiro (Ed.), *EMDR as an integrative psychotherapy approach: Experts of diverse orientations explore the paradigm prism* (pp. 123–150). Washington, DC: American Psychological Association.

Correspondence regarding this article should be directed to Mark Dworkin, EMDR Instructor in Basic Training and Private Practice, 251 Mercury Street, East Meadow, NY 11554. E-mail: mdworkin@optonline.net