Using EMDR With Survivors of Sexual Abuse Perpetrated by Roman Catholic Priests

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This article reviews research that investigated the idiosyncratic effects of sexual abuse perpetrated by Roman Catholic priests and makes related treatment recommendations. The research determined that this distinct form of sexual trauma generated unique posttraumatic symptoms not accounted for within the existing Posttraumatic Stress Disorder conceptual frameworks. These included significant anxiety and distress in areas such as theological belief, crisis of faith, and fears surrounding the participant's own mortality. This article makes recommendations about EMDR treatment with clergy abuse survivors, based on these research findings utilizing a survivor's story to illustrate case formulation and the utilization of process and content cognitive interweaves in addressing episodes of blocked processing.

Keywords: EMDR; clergy sexual abuse; idiosyncratic trauma; cognitive interweaves; treatment

The sexual abuse of children by priests and members of the clergy has been a problem for centuries. In 1389 Chaucer wrote the following in his *Canterbury Tales:*

> For if the Priest be foul, in whom we trust. What wonder if a laymen yield to lust? And shame it is, if priest take thought for keep, a shitty shepherd, shepherding clean sheep. Well ought a priest example good to give, by his own cleanness, how his flock should live. (Jokinen, 2003)

Clergy Sexual Abuse in the Roman Catholic Church

Within the United States compensation claims relating to sexual abuse perpetrated by priests and religious leaders within the Roman Catholic Church have now exceeded US$1 billion (Farrell, 2009). Ever since the infamous case of Father Rudolph Kos who was convicted in 1998 of sexually abusing 11 altar boys while he was serving as parish priest in Dallas Texas, there has been an explosion of international media attention focused upon this form of sexual trauma. Yet sexual abuse perpetrated by clergy and religious is certainly not just a 20th or 21st century phenomenon. Richard Sipe (1995), an excommunicated priest who spoke vociferously about sexual abuse perpetrated by clergy, stated that in spite of all the good done by clergy for both children and adults, there is an ancient awareness of the danger of and potential for their corruption. The "Didache of the Twelve Apostles," the oldest extant commentary of the gospels, specifically relates to the issue of the sexual abuse of children by clearly commanding, "Thou shall not seduce young boys." At the start of the 4th century the "Council of Elvira" stipulated in Canon XVIII that "clerics committing sexual sins" and "those who sexually abuse boys … are threatened with irrevocable exclusion." The punishment for doing so was Excommunication, the act of officially excluding a baptized member of the Christian

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faith from taking part in the Eucharist, and also "Nec in Finem" where a person is not permitted to receive communion even at the time of their death.

Burket and Bruni (1993), Sipe (1995), Jenkins (1996), and Kennedy (2000, 2009) argue that sexual abuse by clergy or religious leaders is more significant in the Roman Catholic faith because of the vow of celibacy taken by priests, monks, and nuns. Sipe (1995) cites Cantor and argues that this law has never been well observed and deem that <50% of priests actively practice celibacy. Nonetheless celibacy has been an essential part of the functioning of the clerical system for the last thousand years.

So what are the ways in which sexual abuse perpetrated by Roman Catholic priests is potentially different from that of other types of perpetrated sexual violations? Furthermore, if there is a difference, what are the subsequent implications for psychological treatment in particular to that of eye movement desensitization and reprocessing (EMDR)? In many ways the characteristics of priests who violate sexual boundaries are as diverse as those who sexually abuse and harass and who are employed in a variety of other occupations that involve privileged positions of trust. Nonetheless there are a number of distinct characteristics that are closely associated to the priestly role that have significance to survivor's traumatic experience including that of community trust, charisma, patriarchal privilege, and power. Furthermore, there is one distinct attribute that is unique to the Roman Catholic priest over that of other religious denominations and that is that a priest is ostensibly designated "God's representative on earth." Consequently their role within a community is by its very nature considered to be profoundly different from that of any other role or position.

One of the reasons why the issue of sexual abuse by priests has been so problematic for the Roman Catholic Church is that in 2,000 years no Christian Church has developed an adequate theology of sexuality, or developed an overarching, comprehensive, and integrative understanding of the nature and place of sexuality within the scheme of salvation and theological systems. Religious pronouncements on sex are ordinarily moralistic and marked by rhetorical, polemical, and highly charged emotional overtones designed to compensate for the essential lack of substantive foundation (Sipe, 1995).

Effects of Clergy Abuse on Survivors

The long-term consequences of sexual trauma have been well documented in the literature (Ainscough & Toon, 2000; Bass & Davis, 2008; Kennerley, 2000; Resick, 2000; Willows, 2008). In relation to some of the effects of clergy abuse on survivors, many describe symptoms consistent with other sexual trauma including fear, horror, re-experiencing phenomena, avoidant behavior, and increased hyperarousal to a degree that impacts upon a person's social and occupational levels of functioning. These are seen as core to the diagnosis of posttraumatic stress disorder (PTSD) in the *Diagnostic and Statistics Manual of Mental Disorders* (*DSM-IV-TR*; American Psychiatric Association [APA], 2000). Survivors also frequently report difficulties with issues such as trust, responsibility, altered sense of self, and potential for re-victimization (Ainscough & Toon, 2000; Willows, 2008).

Sipe (1995), Fortune (1999), and Kennedy (2008) consider that the pathological impact of sexual abuse perpetrated by clergy is consistent with other types of perpetrated sexual abuse in that it tends to be enduring and invariably characterized as being both repeated and prolonged. Sexual abuse thrives by perpetrators frequently using methods of deception, secrecy, and collusion, and in these the perpetrating priest is no different from any other sexual predator However, nuanced and unique differences exist in levels of deception, secrecy, and collusion, when the perpetrator is a religious leader who on one hand acts as a spiritual leader for a congregation and on the other commits a sexual crime.

The Farrell Study

Research conducted by the first author investigated the phenomena of sexual abuse perpetrated by clergy or religious (Farrell & Taylor, 1999a, 1999b; Farrell, 2003, 2004, 2009). This was a phenomenological study in two parts. The first involved in-depth qualitative interviews of 12 clergy abuse survivors throughout the United Kingdom. The second is ongoing and involves the utilization of EMDR with a small cohort sample ($N = 5$) of clergy abuse survivors.

Unique Symptoms Related to Clergy Abuse

A significant finding in the Farrell study was that many of the 12 participants believed that "God" played a fundamental part within the abuse either through the explicit or implicit silencing strategies utilized by perpetrating priests or by God's "non-intervention" in preventing the abuse from happening in the first place. Although the omnipotence of God is not unique to Roman Catholicism nonetheless research participants considered God's omnipotence

as fearful, untrustworthy, perpetrating, collusive, and co-conspiratorial (Farrell, 2009). As will be demonstrated later, when issues such as these emerged during the EMDR desensitization phase, processing often became blocked and therefore required intervention.

Inadequacy of Diagnostic Criteria

The findings in the Farrell study (2009) demonstrated the limitations of the PTSD diagnostic criteria (*DSM-IV-TR*; APA, 2004) in accounting for the myriad of long-term sequelae this client group experiences. The study explored alternative diagnostic frameworks including Complex PTSD (Herman, 1992), Disorders of Extreme Stress (DESNOS) (van der Kolk, 1994, 1996), and Enduring Personality Change after a catastrophic experience (F62.0 – International Statistical Classification of Diseases and Related Health Problems ICD10; 2007).

Many survivors of sexual trauma experience psychological fragmentation around multiple losses relating to a sense of safety, trust, self-worth, and coherent sense of self, and have a tendency for further re-victimization (Sanderson, 2006). Of the myriad of psychological symptoms encountered by survivors of sexual abuse, some of these have been identified in the diagnosis of PTSD. However, Farrell (2009) argued that the diagnosis is fundamentally flawed for sexual trauma clients because it misses other posttraumatic symptoms, including depression, self-blame, guilt, shame, psychosexual difficulties, self-destructiveness, re-victimization, re-traumatization, betrayal, abandonment, distorted sense of over-responsibility, stigmatization, and pervasive schematic beliefs (Bass & Davis, 2008; Farrell & Taylor, 1999a, 1999b; Farrell, 2003, 2004, 2009; Fortune, 1999; Herman, 1992, 2001; Janoff-Bulman, 1992; Ormerod, 1995; Parkinson, 1997; Sanderson, 2006; Scot, Garver, Richards, & Hathaway, 2003). Although many of these aspects are covered to some degree in other various diagnostic and conceptual frameworks, namely Traumagenic Dynamics Model of Child Sexual Abuse (Finkelhor & Browne, 1986); Complex PTSD (Herman, 1992); Disorders of Extreme Stress (DESNOS) (van der Kolk, 1994, 1996); and Enduring Personality Change after a catastrophic experience (F62.0 – ICD10; 2007), even these do not account for some of the experiences of clergy abuse survivors as demonstrated in Table 1.

Farrell (2003) noted that because the diagnosis of PTSD is secular and atheoretical, it does not account for symptoms experienced by survivors whose trauma experiences contained political and/or religious attributions. He argued that this inadequate identification of symptoms produces a misdiagnosis, which could mean that survivors might then subsequently receive inadequate treatment. The outcome of his research was to propose a new diagnostic, conceptual framework; Post-Enduring Traumatic Stress Disorder (PETSD) and included the following:

- Pervasive feelings of guilt, shame, and over-responsibility.
- Alterations in systems of meaning, characterized by loss of sustaining faith or beliefs, or assumptive world, including loss of religious faith, religious identity, shattering of theological beliefs, and existential related phenomena.

Currently, the ongoing development of both *DSM-V* and ICD 11 appear to acknowledge that new diagnostic frameworks are required in order to better account for survivors' experiences of more complex trauma.

Treatment of Clergy Abuse Survivors

A significant finding from the Farrell study (2003) indicated that 10 of the 12 research participants had engaged in some form of psychological treatment prior to the research interviews, with some having received many years of psychotherapy. This therapy was either psychodynamic or client-centered. During assessment all 12 research participants met the requirements to merit a current diagnosis of *DSM-IV-TR* PTSD. One of the participants was sexually abused some 50 years previously and still presented as having significant, currently held psychological trauma difficulties (Farrell, 2009). Despite many years of psychological treatment the core trauma symptoms had not been effectively alleviated. This then raised the question of what would be a more appropriate psychological treatment intervention.

Treatment of sexual abuse survivors is often a complex, and at times quite protracted process, often incorporating integrative approaches (Ainscough & Toon, 2000; Bass & Davis, 2008; Lew, 2004). Therapy tends to be trauma focused, with the utilization of cognitive behavioral strategies (CBT) and EMDR (Hetzel-Riggin, Brausch, & Montgomery, 2007; Briere, 2002; Cohen, Mannarino, Zhitova, & Capone, 2003; Courtois, 2004; Edmund, Rubin, & Wambach, 1999; Foa & Rothbaum, 1998; Kennerley, 2000; Korn & Leeds, 2002; Shapiro, 1995, 2001; Smucker, 2004; Smucker & Dancu, 1999; van der Kolk, 2002). In 1997 and 1998, Farrell and Taylor presented research regarding the specific utilization of EMDR with survivors of clergy sexual abuse.

TABLE 1. Trauma Themes Specific to Survivors of Sexual Abuse by Clergy or Religious Leaders

Theological conflict
Idiosyncratic silencing strategies
Spiritual identity
Existentialism
Political anger
Re-traumatization by the Church

Treatment of Clergy Abuse Survivors With EMDR

It is the opinion of the authors that clergy abuse survivors have very specific issues that need to be addressed in treatment. In the following section we make recommendations about the application of EMDR with these clients. Although the EMDR Protocol has eight phases (Shapiro, 1995, 2001, 2007), this article specifically examines Treatment Conceptualization during Phase 1, History Taking, and blocked processing and cognitive interweaves during Phase 4, Desensitization.

EMDR

It is 20 years since Francine Shapiro formulated and introduced EMDR to the international mental health community. Shapiro (2007) describes EMDR as an integrative, client-centered psychotherapy that emphasizes the brain's information processing system and memories of disturbing experiences as the bases of those pathologies not caused by organic deficit or insult. She goes on to state that EMDR addresses the experiences that contribute to clinical conditions and those needed to bring the client to a robust state of psychological health.

EMDR assumes that a trauma memory is information about the event that has become locked in the nervous system almost in its original form (van der Kolk, 2002). These are manifested in terms of images, thoughts, sounds, smells, emotions, physical sensations, and beliefs (Servan-Schreiber, 2004). A central hypothesis within EMDR, purported by Shapiro (1995, 2001, 2007), is the proposed model of Adaptive Information Processing (AIP) and learning. It acknowledges that as human beings we possess a physiologically based information processing system that is responsible for digesting or metabolizing information so that it can be used in a healthy life-enhancing manner. Part of our hard wiring is an innate natural tendency toward mental health where psychological self-healing is just as purposeful as other physiological processes (Farrell, Keenan, Tareen, & Rana, 2010).

EMDR, over these last 20 years, has moved from that of a simple technique and method to a distinctive psychotherapeutic approach that guides case conceptualization and a protocol treatment intervention (Shapiro, 2007). The ever-increasing evidence based practice (EPB) and practice based evidence (PBE) of EMDR suggests its potential effectiveness with other mental health conditions. Maxfield (2009) points out that in the 20 years since its inception, the only disorder for which EMDR has established efficacy is PTSD. While the vast majority of EMDR clinicians routinely report success with a myriad of other mental health conditions, including anxiety and affective disorders, the provision of EMDR for non-PTSD disorders can only still be considered experimental and untested.

EMDR (Shapiro, 2001) contains eight treatment phases and addresses past, present, and future aspects of disturbing memories. In the first phase (history taking), the therapist identifies memories of traumatic events that have been inadequately processed. The second phase (preparation) is focused on building a therapeutic alliance and ensuring the client's readiness for treatment. Processing of unresolved memories is conducted during the next four phases (assessment, desensitization, installation, body scan). Phase 7 outlines steps for closure of the session, and Phase 8 (re-evaluation) is conducted at the beginning of each subsequent session.

During the processing phases, the client first identifies the perceptual, cognitive, somatic, and affective components of the target memory, and rates the level of emotional disturbance, using the Subject Units of Disturbance scale (SUD; 0 = no disturbance; 10 = worst possible). Then the client focuses on the memory while simultaneously attending to an external dual attention stimulus (DAS) for about 25 s. DAS can be horizontal eye movements, or alternating bilateral tactile or auditory stimulation. After each set of dual attention the client is asked what new material was elicited; this new material generally becomes the focus of the next set of DAS. This procedure continues throughout the session, with alternating elicitation of new material, and subsequent focus on that material with DAS. Sometimes, the client's processing may stall, with no new material reported. When this happens, the therapist can suggest a new topic for attention during the next set of DAS. This intervention is called a "cognitive interweave," and its purpose is to facilitate processing. As the session continues, the client typically describes the elicitation of

more adaptive information and reports a decrease in distress. When the SUD rating becomes 0, a new positive belief about self is paired with the memory of the targeted incident, using DAS. The memory is considered to be fully processed when the client reports no distress, and endorses a new adaptive and positive perspective. Processing is expected to result in an alleviation of related symptoms and reduction of problematic behaviors.

Treatment Conceptualization

When telling their individual stories, many survivors of sexual trauma recount extremely harrowing material. During the History Taking Phase of treatment, the clinician seeks to understand the uniqueness of each client's narrative. It is recommended that the therapist listen for specific themes related to clergy abuse (see Table 1). Careful questioning and supportive responses will help in eliciting painful features related to clergy abuse.

When Erin was 16 years of age she was repeatedly raped, over a period of several months, by a Roman Catholic priest, while she was a novitiate in waiting to take her vows to become a nun. Erin was born to a devout Roman Catholic family where priests were revered and respected, and the entering of a life of vocation and dedication to God was a cause of great celebration, being cherished by the family with great pride and admiration. Now as an adult in her early 40s Erin continues to be significantly traumatized by her abuse. She has lost her faith in the Church, Roman Catholicism, and God.

The following are three examples of narratives of Erin's trauma experiences that expressed significant presently held disturbance.

> **Erin:** I think the reason I don't go to church anymore is because I can't engage in any of the sacraments. I am not sure of the spiritual significance of them. All I can think about was taking communion from a priest who had raped me the night before, yet as a young novitiate I couldn't not go to Holy Communion as difficult questions would have been asked.

This excerpt illustrates the themes of theological and spiritual trauma in that for Erin the meaning and significance of the sacraments within her Roman Catholic faith had been fundamentally distorted as a consequence of her abuse. Her sense of faith, her Roman Catholic beliefs, her view of the Roman Catholic Church as an institution, her relationship with God, and the safety and sanctity of heaven had all fundamentally altered. It provides a clear example of the importance, during Phase 1 History Taking, of considering aspects that are much broader than those within the diagnostic constructs of PTSD and the conceptual constructs of Complex PTSD.

A further dimension to this argument relates to the importance of forgiveness. Forgiveness is a concept with deeply religious roots that is transcendental in nature and is central to the theology and piety of the great western monotheistic traditions (Exline, Yali, & Lobel, 1999; McCullough & Worthington, 1999). A question arises as to what may be the consequences of forgiveness for a clergy abuse survivor? As Erin recounted:

> **Erin:** We are told that God is a forgiving God, so what if my abuser repents? God will forgive him and allow him into Heaven. So this will make Heaven unsafe. Death frightens me as I don't want to go to a place where my abuser will be.

This excerpt also illustrates the theme of existentialism and highlights how Erin fears for her own death to such a degree that it presented as a currently held level of disturbance. When asked to score her distress using the Subjective Units of Disturbance (SUD) scale (0 = *none*, 10 = *worst possible*), she rated this at 10. What was so significant about her distress is that her level of disturbance is not just past, present, and future, as her future distress is not just of this world but fundamentally centered upon her beliefs about the afterlife. As Erin stated:

> **Erin:** I couldn't believe that somebody can be so evil at night, to then celebrate the Eucharist the very next morning. Consequently I didn't want to go to church, and this just made it worse. How could I not go to church? I even told him my concerns during confession. What I think is really significant about what happened, is what he used to say when he was abusing me. He would take some of the things that I mentioned during confession, and then use them against me while he was abusing me. He said things like "God will punish me if I don't go to church," "God will punish me if I don't do as I am told," and "God will punish me if I ever tell anybody." All my life I wanted to serve God and become a nun. God let me down. God let me down badly.

This excerpt illustrates the themes of theological conflict, idiosyncratic silencing strategies, concerns around her spiritual identity, fears of death and dying,

and of being betrayed and let down not just by an individual, but also by her faith, her priest, and her God. All of these factors have to be considered and explored in more detail during History Taking and then in guiding case conceptualization. In evaluating diagnostic and treatment conceptualization, it is apparent that although Erin's presentation fulfilled the diagnostic requirements for PTSD (309.81 *DSM-TR IV*) this did not take fully into account the myriad of symptoms that she was recounting. Herman (2001) argues that general diagnostic categories are simply not designed for survivors of extreme situations. She offers an important viewpoint when she surmises that:

> The persistent anxiety, phobias, and panic of survivors are not the same as ordinary anxiety disorders. The somatic symptoms of survivors are not the same as ordinary psychosomatic disorders. Their depression is not the same as ordinary depression. And the degradation of their identity and relational life is not the same as ordinary personality disorder. The lack of an accurate and comprehensive diagnostic concept has serious consequences for treatment, because the connection between the survivor's present symptoms and the traumatic experience is frequently lost. (p. 118)

The corollary to this argument is that if survivors of sexual abuse are misdiagnosed then they are subsequently mismatched with psychological treatment. Ostensibly the survivor is made to fit existing diagnostic criteria rather than the other way around with the potential for generating further traumatization (Farrell, 2009).

Specifically it can be seen that Erin was reporting themes related to those as highlighted in Table 1. Within Phase 1 History Taking, it is important to explore these issues in more detail in order to then identify appropriate targets for assessment, desensitization, and reprocessing. In Erin's case this was undertaken using a mind map. Figure 1 highlights a mind map of the specific trauma targets in relation to those outlined in Table 1; each of these are given SUD scores.

Cognitive Interweave

The Cognitive Interweave is a proactive strategy for working with challenging clients who often enter

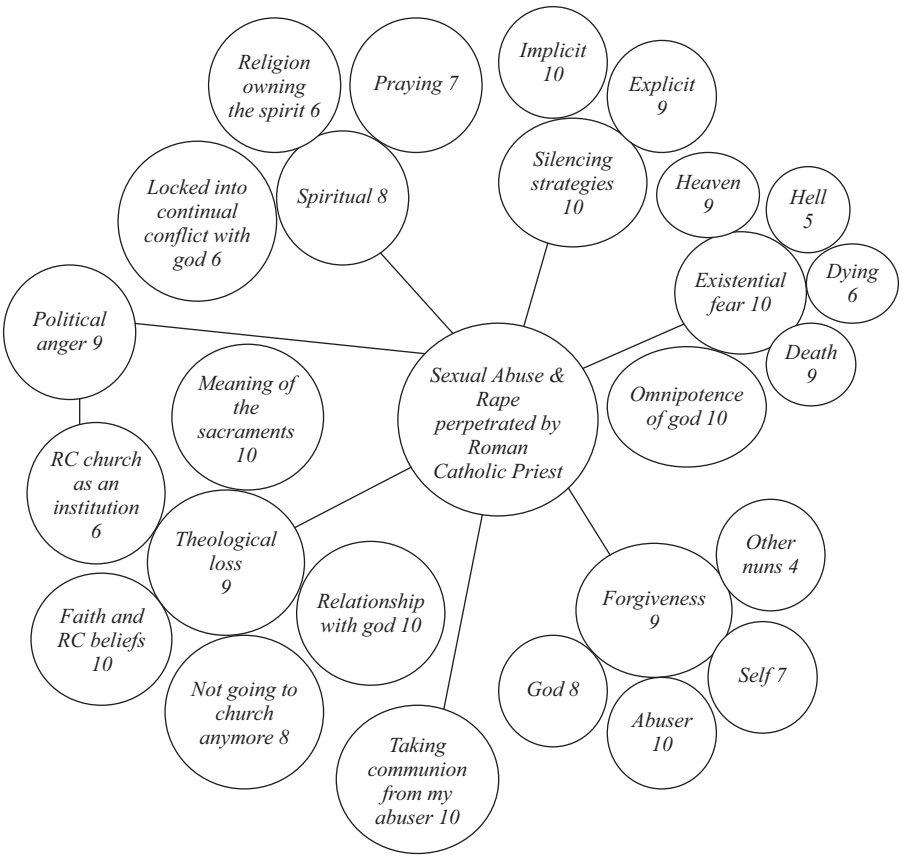

FIGURE 1. Additional trauma symptoms from history taking and case conceptualization and targets for EMDR.

into cognitive and emotional loops that are not amenable to the simpler EMDR intervention. Shapiro (2007) states:

> EMDR clinicians are trained to stay out of the way as much as possible, since the therapist does not know what the best unconscious connections are that need to be made. When change has not occurred after consecutive sets of dual attention stimulation, then the clinician may use a Cognitive Interweave and ask a question, or offer a statement for consideration, or suggest an action that is geared to elicit the next bit of information needed to continue the learning experience. (p. 78)

A good interweave brings exactly the missing information within reach of the client, no more, no less. It is not random or involving trial-and-error, but instead it is an interweave used with precision from the therapist's knowledge of the client. A content interweave can also take the form of a hypothesis on what is missing or might provide a liberating insight, or the releasing pivotal words. Table 2 outlines some of the interweaves that were utilized during EMDR for survivors of sexual abuse perpetrated by clergy.

EMDR can be understood to have three types of cognitive interweaves: (1) process interweaves to solve problems on a process level in the form of nonspecific interweaves, (2) content interweaves to solve problems on a content level by using specific interweaves, and (3) relational interweaves, which utilize the aspects of the therapeutic relationship itself (Dworkin, 2005; Spierings, 2008). In this article, we talk about content and process interweaves exploring how each of these is specifically used with clergy abuse survivors to address the issues outlined in Table 2.

Process Interweaves

Spierings (2008) refers to Ogden and Minton's (2000) "window of tolerance," which is the range of affect that the patient can tolerate. Spierings stipulates that process interweaves are used to keep the client within his or her window of tolerance, to strengthen the client's contact with the safe "here-and-now," and to strengthen the contact the client has with the EMDR therapist. It is almost like having two computer files open at the same time, the safe here-and-now and the traumatic there-and-then (dual attention). When the window of tolerance is too small, process interweaves may be ineffective, and so resorting to the two other forms of interweaves can become necessary.

An example of a process interweave, specifically developed for a clergy abuse survivor when she was drifting above her window of tolerance is:

> **Therapist:** When you were a child going to church is there a particular smell or color that evokes pleasurable memories for you?
> **Client:** When I think about the celebrations during the month of May I used to love the

TABLE 2. Themed Areas for Creative Cognitive Interweaves Within EMDR & Specific Trauma Characteristics

Theological Trauma	Spiritual & Existential Trauma
• "I don't know who God is any more, or for what he stands or represents." • "What I do know is that now I no longer believe what I used to believe, and that bothers me greatly." • "Was my sacrament of confession really sacred and holy?" • "Is he really a forgiving God? If so will I meet my abuser in Heaven if he repents?" • "If God is meant to be so good, why didn't he intervene and stop what was happening? Why didn't he help and protect me?" • "I was taught to believe that for a Roman Catholic priest his hands are holy and sacred; yet these same hands molested me. How do you make sense of that?" • "The next day after sexually abusing me, he would be saying Mass." • "After abusing me he would tell me that I needed to go to confession."	• Difficulty praying • Discomfort with religion assuming ownership of the spirit • Generalized sense of inner emptiness • Locked into continual conflict with God • Inability to engage in any of the sacraments • Political anger • Dissonance in accepting inner freedom and direction within life • Fearful of death and/or dying • Being robbed of an important philosophy of life • Generalized uncertainty surrounding the purpose of life itself • God = omnipotence = collusion = powerlessness = insignificance

smell of the flowers. The church used to be full of them.
Therapist: Is there a particular smell or color?
Client: The beautiful, pink lilies
Therapist: Can you remember that smell now?
Client: Yes, very clearly
Therapist: As we go back through our target I'd like you to just be mindful of the smell of those pink lilies. Keep remembering that it is just an old memory. We'll do another set of DAS.

This interweave was used for the purpose of keeping the client within her window of tolerance so that processing could continue.

Content Interweaves

Specific "content interweaves" pertinent to survivors of sexual abuse frequently involve interventions around fear, anger, evil, a reluctance to feel, silence and secrecy, displaced loyalty, guilt, complicity, physiological responses, being believed, victim mode thinking and behaving, over-responsibility, shame, and worthlessness. However, for survivors of sexual abuse by clergy more specific content interweaves seem necessary. These include addressing issues such as God, Heaven, omnipotence, the holy sacraments, forgiveness, holy hands, prayer, mass, transubstantiation, death and dying, existentialism, spirituality, the church as an institution, and political anger. Examples of existential and spiritual points of stuckness are outlined in Table 2.

The following is an example of a specific content interweave that was effective during psychotherapy work with Erin. During an EMDR session Erin was struggling with the emotion of anger and consequently processing had become blocked. Process interweaves had been ineffective. The therapist asked her to look at a painting that was on the wall of the therapist's office. It was a painting by a Croatian artist Vlaho Bukovac entitled "Isus pritjatelj malenih"; its translated meaning "Little Friends of Jesus." The poignancy of this painting portrays Jesus Christ; people are bringing their little children for him to lay his hands on them and say a prayer and his disciples are depicted turning people away. Jesus has his hand outstretched, rebuking the disciples. In the interweave, the therapist stated, "Look at this picture. Jesus clearly made his thoughts and feelings known. Anger has its place. Maybe yours does too? Think of this during this next set of eye movements."

Another example of a content interweave is to consider Robin Shapiro's (2005) Two Handed Interweave. This is a useful strategy within EMDR when addressing two, opposing positions that create a stuckness for the client. Within the two handed interweave the client anchors one conflicting feeling, thought, choice, belief, or ego state in one hand and then in the other anchors an alternative feeling, thought, choice, belief, or ego state, to which the therapist then initiates DAS.

Therapist: So what you are saying is ALL priests are rapists?
Client: Yes.
Therapist: So all priests want to sexually exploit and rape young novitiates?
Client: Well, that's what Fr. Jones did.
Therapist: What about Fr. Martin?
Client: He was a really good priest, so kind and spiritual. I really liked his sermons. He was good.
Therapist: And he didn't rape any of the nuns as far as you know?
Client: Not as far as I know.
Therapist: So I'd like to you be aware of that statement you made "all priests are rapists." In one hand I want you to be aware of Fr. Jones and in the other hand be aware of Fr. Martin. Go with that (DAS).
Client: They were different priests, very different in fact. Actually Fr. Martin really was a priest, Fr. Jones … well he was just a rapist.

Discussion

When considering overarching aspects for psychological treatment with survivors of sexual trauma, the following areas should be monitored: responsibility, accountability, legality, safety, choice, control, adult/child thinking, trust, self-esteem, interpersonal relationships, dependence/independence issues, sexuality, intimacy, and contribution to chaos. These issues are also pertinent for survivors of clergy abuse. However, Farrell's research (2009) has highlighted some idiosyncratic aspects that also need to be considered for survivors of sexual abuse perpetrated by clergy. Table 2 outlines some of the key aspects; it is possible that any of these could become potential targets for EMDR intervention. It is the intention of the authors to expand on these areas for future articles.

Sexual abuse perpetrated by clergy and religious appears to generate unique trauma characteristics that have to be taken into consideration when working with this particular client group. If these attributes are not ascertained during History Taking (Phase 1) then a potential mismatch may occur once Desensitization (Phase 4) commences. Initial

findings appear to indicate that EMDR as a treatment intervention appears extremely useful for this client group; however, during Desensitization (Phase 4) when processing becomes blocked the integration of creative cognitive interweaves around themes such as theology, existentialism, spirituality, and political anger may need to be utilized. The need for further research in this area is extremely important for the future.

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