The Integration of Relational Gestalt Therapy and EMDR

In this article I attempt to show how the integration of "eye movement desensitization and reprocessing" (EMDR) techniques within a relational gestalt therapy approach results in a more powerful method than either therapeutic method alone. I describe the steps in the EMDR standard protocol, as outlined by Francine Shapiro, the founder of EMDR. I briefly discuss what we now know about how trauma affects brain functioning and EMDR's effectiveness in resolving "simple" trauma. I then explain how EMDR, within the context of a relational gestalt approach, can help to resolve therapeutic impasses, enhance the working-through process of therapy and trigger associations that neither therapists nor clients anticipate or predict.

One of the hallmarks of gestalt therapy is that its practitioners have felt free to explore other forms of therapy. All too often, however, the result is, as Yontef (2002) has pointed out, in a "gestalt therapy and (something else)" hybrid in which techniques or procedures from one form of therapy are merely introjected into gestalt methodology. The result is then a monster of disparate, sometimes incompatible, techniques without an overarching theoretical umbrella under which to subsume them. I take some credit in attempting to integrate self psychology concepts and methods into gestalt therapy (Tobin, 1982; 1983; 1985) but must include my efforts at that time as an introjective process rather than what Yontef points to as a more viable approach: assimilation of the useful techniques from one form of therapy into the theoretical system of another therapy. Yontef describes the necessary steps: "... deconstructing, assimilating and integrating that which is useful in gestalt therapy" (Yontef, 2002, p. 22).

As examples of assimilation, Bresgold and Zahm (1992), Yontef (1988; 2002), Jacobs (1992), Hycker and Jacobs (1995), Sapriel (1998), Staemmler (2002), and others have assimilated contemporary psychoanalytic observations and concepts into gestalt therapy while maintaining fidelity to gestalt principles of field theory, phenomenology and dialogue.

I am now faced with the assimilative task of integrating into my gestalt approach the powerful "eye movement desensitization and reprocessing" (EMDR) techniques discovered and developed by Francine Shapiro (1989; 1995; 2001). I have found myself being able to utilize the standardized EMDR protocol very effectively in short-term treatments of people who have suffered traumatic experiences and for specific issues such as simple phobias. I have also gradually been increasing my usage of EMDR techniques with many long-term clients and have found the therapies greatly speeded up. Growth plateaus that frequently had lasted for years have ended, with clients making important changes in their lives. Issues that I thought had been fully dealt with before using EMDR resurfaced, and when we then used EMDR techniques to work on them, a complete closure resulted.

I also began to realize that, although EMDR was known to be effective in helping clients work through trauma, a possibly even more important usage was, with the addition of other useful techniques, aiding clients to access self-strengthening resources that were potentially available to them.
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and they badly needed but lacked. I found that, with people who had been severely abused and/or neglected as children and had suffered multiple traumas, helping them develop and then internalize these resources was necessary for them to make any progress in their lives.

I shall briefly describe in this article the theory and methodology of EMDR and give an overview of how I am integrating it into my relational gestalt approach.

**What is EMDR?**

EMDR was the original creation of Francine Shapiro, who discovered, quite by chance, in 1987, that moving her eyes from side to side while thinking emotionally disturbing thoughts resulted in the disturbance suddenly disappearing. She also noticed that, when thinking the thoughts again, they were not as upsetting or as valid as before. She tried the same technique with other disturbing thoughts and memories and achieved the same result. She then began to try the technique with other people with the same positive outcomes.

After conducting a pilot study (Shapiro, 1989), she rapidly developed a method of working with clients and began to train therapists in the method in 1988. The methodology was expanded and modified in significant ways by communication between her and a network of these other EMDR therapists. She trained other clinicians to be trainers, there was continual research on the use of EMDR with various groups of trauma survivors, and the expansion of the usage of EMDR with a wide variety of emotional disorders rapidly occurred.

To date, approximately 40,000 therapists have been trained in EMDR all over the world. A number of other techniques have been developed by EMDR-trained therapists and various procedures or "protocols" have been created to be used with different psychological disorders. Because the procedure is quite straight-forward when utilized with trauma victims, its efficacy is relatively easy to study and more research has been done on EMDR than any other form of trauma treatment. Most of these studies have shown EMDR to be the most effective treatment for trauma survivors (van Etten & Taylor, 1998), and treatment usually takes only a few sessions with clients who have had a reasonably good attachment history and do not have severe personality disorders.

With clients who have more complex disorders, however, including the multiply traumatized, the treatment is much more complex and takes much longer. And it then must be integrated into more comprehensive therapeutic approaches. Shapiro herself recommends its integration into other modalities, and suggests how it can be compatible with psychodynamic, behavioral, cognitive-behavioral and experiential approaches (Shapiro, 2001, pp. 20ff.).

Because EMDR grew out of cognitive-behavioral zeitgeist, however, it tends to be rather technique-driven, and there is a danger for EMDR-trained therapists to be mesmerized by the powerful, novel procedures. In addition, Shapiro and others in the EMDR establishment wish to have EMDR recognized alongside other widely recognized, manualized approaches and tend to discourage innovators calling what they do EMDR.
I myself am finding a combination of a relational gestalt approach with EMDR techniques essential to effective treatment because of the gestalt emphasis on phenomenology, dialogue and contact. EMDR provides the complementary methods that can greatly enhance the therapy but, as much research shows, it is still the therapeutic relationship (Horvath, 2001) and the client’s own self-healing capacities (Bohart & Tallman, 1999) that are the most important factors in effective psychotherapy. Also, in conjunction with many of the classical gestalt techniques such as the empty chair work, dealing with sub-personalities in dialogue, emphasizing body awareness and process rather than content, can be combined with EMDR bilateral stimulation to “cement in” important changes and awarenesses that emerge from the work.

But in order to discuss the EMDR procedure, I first need briefly to describe what we have been learning about the effects of trauma on brain functioning.

**The Nature of Trauma and Its Effects on Memory and Functioning**

Trauma prevents the gestalt formation and destruction process to be completed in a smooth, creative, lively fashion. The un-metabolized traumatic effects exist in the person’s background as vague thoughts, anxiety, frightening images and unpleasant bodily sensations. The results can be either a rigidity in present functioning so that almost every activity is related to these unfinished figures in the background, or the person is so labile that he or she does not experience fully what is going on in the present, resulting in figural closure never completely occurring (Polster & Polster, 1973, p. 37) in common, everyday activities. I described the difficulties in achieving closure many years ago with a discussion of how hanging onto the past prevents fully living in the present (Tobin, 1971). We now know much more about the physiology of the brain, about different types of memory and why the processing of trauma frequently does not occur in many people.

One of the reasons why talking therapies, such as psychoanalysis and cognitive-behavior therapy, have not been very effective at resolving trauma, is that trauma affects implicit memory, located mostly in the limbic system of the right hemisphere of the brain (van der Kolk, 1996; Siegel, 1999; Schore, 1994). Hippocampal activity, which relays emotionally-charged information to the cerebral cortex, is suppressed. The result may be that the traumatic event is prevented from becoming a “memory” in the usual sense of the word: a piece of information about oneself that lies clearly in one’s past. Instead, elements of the past experience are unable to anchor in time. They seem to float freely, often invading the present. In the absence of hippocampal activity, memories of unresolved traumatic incidents may remain in the implicit memory system alone (Rothschild, 2003, p. 11).

The individual who has experienced trauma and not worked it through then doesn’t experience having survived the traumatic incident and realize that it is over. Instead, there are flashbacks, nightmares, anxiety attacks, etc., and continual re-experiencing of the bodily sensations, emotions and visual images associated with the trauma. It is as if the traumatic event keeps recurring. An example would be the Vietnam veteran who dives to the ground whenever he hears a loud noise.
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As examples of the effects of trauma, I shall consider traumatic events at two developmental stages. A one-year old child is bitten on the hand by a dog. This event gets encoded in implicit, but not explicit, memory because the child’s cortical development has not been completed. Later in life the individual may feel terror, vague but disturbing visual images, sympathetic nervous system physiological arousal, and even pain in her hand at the mere sight of a dog. But there is no sense of a self to which these symptoms are connected. This, of course, makes it impossible for her to process and work through her phobic reactions to the sight of dogs without the help of a therapeutic method that results in the integration of implicit and explicit memory. Another example is a woman who is raped by a violent sexual predator. To protect herself from overwhelming terror and pain, she may dissociate during the rape, imagining herself in a benign, safe environment. Once again, the experience is not registered in explicit memory. But this very survival mechanism of dissociation makes it impossible to process the events of the rape. Every time she sees a man similar in appearance to the rapist or starts to become involved in sexual activity with any man, she may begin to experience the intense affective, cognitive and sensory experiences that occurred during the rape. Dissociation then follows.

While being a survival mechanism, protecting the individual from overwhelming affect and preventing fragmentation, this dissociative outcome has very limiting effects on the individual’s contact functions. In gestalt terms, the figural formation/destruction process is severely hampered whenever even a small part of the original traumatic situation is present in external or internal stimulus situations. These stimuli then trigger the sympathetic nervous system, certain stress hormones, such as cortisol, are released and the organism is catapulted into a flight/fight mode of functioning. If neither fight nor flight are possible, both the sympathetic and parasympathetic systems are simultaneously triggered and freezing occurs. This can result in a slack-muscled response, such as mouse caught by a cat or the stiffness of a deer caught in a car’s headlights.

The trauma can be a dramatic, single event, such as experiencing a life-threatening injury, being involved in a catastrophe, such as an earthquake; or it can be the experiencing of multiple catastrophic events, such as prolonged childhood abuse or living in a country where there is continual violence or famine. Some would include as trauma early childhood deficit experiences, such as a caretaker who is cold and distant from his or her infant, but I do not believe that these experiences should be defined as trauma. They certainly have a devastating effect on emotional development, but the concept of trauma then becomes so broad as to be almost meaningless. I prefer to limit the term trauma for the presence of devastating negative experiences rather than the lack of some essential acquired during childhood. I will show later, however, how EMDR-related techniques can be instrumental in helping to address deficit.

Frequently, the person may have a cognitive memory of the traumatic event(s) but the understanding is dissociated from affective and sensory experiencing. Or the person may have the affective and sensory experience without the cognitive component. The former is the rigid, over-controlled, frequently obsessive-compulsive type of person discussed by Polster and Polster (1973), compulsively
needing to attempt closure of the traumatic event. The latter is the emotionally labile, scattered type, having difficulty in self-regulation because of the constantly competing, unfinished gestalten.

EMDR’s Effectiveness in Treatment of Trauma

EMDR provides a methodology to accomplish five things that make it a very good fit for gestalt therapy.

First, it “jump starts” the brain to process unmetabolized trauma so the person achieves rapid closure of past unfinished events. This extremely fast, often dramatic, resolution of traumatic material, often accomplished within two or three sessions, is what has made EMDR so popular so quickly. It can be seen as a way to resolve impasses between the influence of past traumatic events on the present gestalt formation-destruction process and the organismic need to achieve closure of those past influences so that they can recede into the background of memory and thereby allow new, lively figures to form.

For example, a long-term ex-client and I had spent numerous sessions working on the sequelae of a beating she had suffered at the hands of her husband thirty years before. This work was very meaningful in that she expressed much affect toward him during this work: fear, pain, anger, and shame. She seemed to know exactly what had happened and why, and what had motivated her to stay married to her husband after the beating. However, the incident was still not resolved. Consequently, she had stayed emotionally distant from her husband ever since, avoided sexual contact with him and, although he had gone to a therapist himself to work through the shame he felt and begged her to talk with him about the incident, she had refused and was still subliminally frightened of him.

She then took a five-year hiatus from therapy during which I had the EMDR training. Upon her return to treatment, we worked on the beating incident again and, in two sessions, managed to resolve her unfinished business about it completely. What seemed to make the difference between this work and our previous attempts to deal with the trauma, was that the EMDR processing catapulted her back into the event in an immediate way that our previous gestalt therapy work had not. She was able to feel what she felt at the time, see her husband’s rageful eyes and his “ugly” mouth, hear his voice and, perhaps most importantly, understand why she hadn’t fought back. Her passively giving in to his beating, about which she had felt shame for many years, she then realized was motivated by the belief at the time that, were she to resist, he would kill her. She was now able to forgive herself and even him.

Not only did we work through the incident so there was no longer any emotional charge to it, but she expressed her resentment toward her husband for the abuse, and was able, finally, to stand up to an abusive boss she worked for at the time.

Second, EMDR activates “...a whole variety of unexpected feelings, images, and thoughts that are ordinarily not accessed in conjunction with other memories” (Norcross & Shapiro, 2002, p. 341). As an example of this, Paul Wachtel, a noted relationally-oriented analyst, has described how, in EMDR treatment, he resolved an issue that had existed from the age of four that he had not been able
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to resolve in his analysis. The results of this EMDR work led to his concluding, "... something about
the experience I have reported seems to me compelling and suggests that the EMDR experience can
contribute powerfully to releasing some of the stuck locks in the darker rooms of the psyche"

Third, it can help the person to access resources within himself or herself to fill in needed back-
ground support functions. This is accomplished in EMDR via the procedure of developing resources
and then "installing" them via the use of the bi-lateral stimulation. For example, a client who is un-
able to feel nurturing toward himself or herself can be helped to acquire this ability in various ways.
One would be imagining being in the presence of a person who was nurturing, while being encour-
aged to experience a full range of emotional, physical and sensory accompaniments while the bi-
lateral stimulation is being administered.

Lest this sound unrealistically magical, I hasten to add that this might have to be done many times
with a variety of resources before the client begins to experience the presence of a nurturing internal
self. Among the most important therapeutic resources is, of course, the therapeutic alliance and I have
discussed how the self-psychological phenomenon of "transmuting internalization" can be speeded up
with EMDR (Tobin, in press).

Fourth, it helps to achieve the holistic job of integrating cognitive, emotional and sensory func-
tions. There is evidence (van der Kolk, 2002; Siegel, 1999) that it does this by integrating brain neural
networks that have been dissociated as the result of traumatic experiences.

Fifth, it fits with gestalt therapy because it is a non-linear approach that relies on the brain’s natu-
ral information-processing abilities rather than requiring much interpretive activity from the ther-
pist. Gestalt therapists have classically avoided the "whys" or interpretation of client material in fa-
vor of the "whats" and "hows" of experience. Bohart and Greenberg (2002) see EMDR as most similar
to Gendlin’s focusing and Roger’s client-centered therapy in that the therapist is cautioned against
introducing his or her own ideas into the therapy. Wachtel (2002) likens EMDR, at least in the way it’s
recommended to be conducting according to the manualized Standard Protocol, to early psycho-
analysis, with its emphasis on free association.

How can one justify using a methodology that is so different from the usual gestalt approach of
dealing with what the client brings into the session, particularly when the main focus may be, as in
the relational gestalt perspective, on dialogue and on the contact functions of the client? After all, the
therapist is introducing something the client has very probably never thought of or encountered:
moving his or her eyes back and forth or doing some other kind of bilateral stimulation.

The answer is in terms of the issue of experimentation, a hallowed aspect of gestalt therapy meth-
odology. Although many EMDR therapists seem to follow a rigid procedure that allows for little dia-
logue between them and their clients and little consideration of the individual differences of ther-
pists and clients, my focus is first and foremost on the dialogic relationship. Therefore, I always ex-
plain the rationale behind EMDR and suggest the various techniques at appropriate times as experi-
ments to see what the client can learn from them. But the client has the last word as to whether or not
we use these techniques. In addition, my use of the techniques arises from what is transpiring in the therapeutic field. For example, a client began to be afraid of me because a facial expression of mine suddenly reminded her of an uncle who had sexually abused her as a child. After helping her to experience the physical differences between her uncle and me and the great difference between his exploitation of her and my helping her, I began to process via the EMDR techniques the memory that had been triggered of the abuse.

**How Does EMDR Work?**

Nobody knows for certain just how EMDR works. Shapiro sees it as a method for providing accelerated information processing of memories that the individual has not been able to process. In the latest edition of her EMDR text (Shapiro, 2001), she discusses a number of possibilities: deconditioning as a function of a relaxation response; a shift in brain state; the enhancement, activation, and strengthening of weak associations; and the dual attention to the past trauma while, concurrently, attending to current external cues.

Some people question whether the bilateral stimulation is at all necessary. Siegel (1999), an expert on brain neurophysiology and attachment theory, and an EMDR proponent, suggests it may be that during the EMDR procedure the individual is encouraged to focus on the emotional, sensory, cognitive aspects of trauma while experiencing the support of the therapist. The result is then brain integration along horizontal (left and right hemisphere) and vertical (brain stem, limbic system, orbitofrontal cortex and neocortex) levels. The bilateral stimulation, however, may have the same result as rapid eye movements (REM) during sleep and it is well-known that PTSD patients show an absence of REM sleep. Siegel believes that cortical consolidation occurs during REM sleep and that it also occurs with EMDR processing.

In any case, the evidence is quite convincing that information processing of PTSD does occur in a more rapid and efficient and thorough fashion with EMDR than in other methods. Van Etten and Taylor (1998) found, in their meta-analysis of psychotherapeutic and pharmacological treatments of PTSD, that EMDR and exposure therapies achieve similar outcomes and were superior to other psychotherapeutic treatments. But they also found that, while exposure treatment averaged 10 sessions, EMDR treatment averaged only 4 sessions. Davidson and Parker (2001) also did a meta-analysis of 34 difference EMDR studies and also found EMDR treatment equivalent to exposure and other cognitive-behavior approaches, with EMDR again being more efficient. It has also become clear to me that, although it was originally used in short-term treatment of trauma survivors with good self strength, EMDR techniques also can be applied both in short term and longer term treatment with the multiply-traumatized, in treatment of more severely disturbed people, and at certain stages of treatment with less disturbed clients who function relatively well but see therapy as a growth process. While it is much harder to do research on therapy procedures wherein EMDR is integrated with other approaches, a large number of articles and books have been published on such integration (for example, Shapiro, 2002; Manfield, 1998). In addition, it has been adapted for working with children and ado-
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lescents (Greenwald, 2001), family therapy (Kaslow, Nurse & Thompson, 2002), transpersonal psychology (Krystal, et. al.), hypnosis (Gilligan, 2002) and even psychoanalysis (Wachtel, 2002).

The Procedure for Working Through Trauma

Shapiro divides EMDR treatment into eight distinct phases.

Phase 1 is obtaining a history and planning treatment.

Phase 2 is preparation for the EMDR processing, which requires establishing a therapeutic alliance, explaining the EMDR process and initiating relaxation and safety procedures. Part of this stage involves helping the client create a “safe place,” just one of many techniques for resource development and installation (RDI). The therapist and the client also determine the preferred mode of bilateral stimulation. With most people it is visual, but with some it is auditory and with others, kinesthetic.

The third phase is assessment of the targets to be processed and identification of the image that best represents the memory. The client is also asked to identify a negative belief or organizing principle about the self that was formed as a result of the trauma. It is usually something like “I am useless/worthless/unlovable/helpless/bad.” The client then specifies a positive belief that will later be used to replace the negative belief during phase 5, the installation phase. The client is asked to give this positive belief a score between 1 and 7 as to how valid it is. The therapist also asks the client to indicate, on a scale of 0 to 10, how upsetting the event is as she remembers it, with 0 being not upset at all, 10 being the worst she can imagine. This is a “Subjective Unit of Disturbance Scale” (SUD) originally designed by Joseph Wolpe (1990).

Phase 4 is desensitization. The client is asked to focus on the worst part of the event and to notice visual images, other sensory stimuli, physical sensations, emotions and the negative cognition. The therapist then initiates the bilateral stimulation. It is usually about 25 stimuli but can be much shorter or longer. After each set, the client just says what he experienced and the therapist usually makes no comment except something like, “That’s fine, just go with that.” The sets are repeated until the degree of disturbance level is reduced to 0 or 1. Many times the sets of stimulation are not sufficient in themselves to complete processing and the therapist has to use additional strategies and advanced procedures, as the “cognitive interweave,” which I will describe later.

Phase 5 is installation of the positive belief that the client identified in phase 4. This is done with short sets of stimulation (usually about 7) until the client experiences the positive belief as “completely true,” i.e., a score of 7. The reason that they are kept short is that, if made longer, other neural networks are apt to be activated and more negative material may arise.

Phase 6 is a body scan to see if the trauma is completely processed. The client is asked to hold in mind both the original target and to scan his or her body to see if there is any residual tension. If there is, then processing of the sensations of tension are targeted for successive sets.

Phase 7 is closure of the session. Frequently, processing has not been completed and the client is helped to return to a state of emotional equilibrium via the safe place or some other grounding and
self-soothing method that has been acquired before processing started. The client is also asked to keep a log of negative thoughts, dreams and memories that may occur between therapy sessions.

Phase 8 takes place in the next therapy session and involves reevaluation; the therapist returns to the memory targeted during the previous session, even if the SUDs level reached 1 or 0 and the positive belief was a 7. Further processing takes place until the therapist and client are convinced that it has been completed.

Note that, although I routinely use the standard protocol with short-term clients who have come to work through specific issues, such as PTSD or a phobia, and occasionally with long-term clients, I often use only part of the protocol with long-term clients.

**The Procedures for Developing and Installing Positive Resources**

A use for EMDR that is just as important as the rapid information processing of trauma is the development and installation of positive resources. Frequently, these resources need to be accessed and installed before the trauma processing can be started. For example, a client who cannot regulate affect and self-soothe needs to learn to provide those abilities for himself or herself before tackling the difficult task of re-experiencing traumatic events. Some of the other positive resources are positive self-regard, self-grounding, self-confidence, and the ability to set limits with others. Severely disturbed clients such as borderlines, the suicidal, dissociative identity disorders, and others who have suffered from multiple traumas, abuse, and childhood neglect can be helped, via EMDR techniques, to achieve self-strengthening. Korn and Leeds (in press) have extensively discussed the use of bilateral stimulation with some of Linehan’s (1993) procedures for installation of positive resources.

One very important resource is the therapeutic relationship, the importance of which many EMDR therapists underestimate. Although many effective EMDR therapists attribute their success with their clients exclusively to the techniques, I believe much of the power of their work is due to their accepting, attentive, affectively attuned style of relating to their clients.

I have found, however, that some clients who feel safe and secure with their therapists and have a very positive alliance with them when in session, lack the object constancy to maintain a sense of their therapists’ presence when away from them. I have discussed in another article how the therapeutic relationship can be an additional, very helpful resource that can be installed via EMDR (Tobin, in press).

In gestalt therapy terms, one could see the therapeutic alliance when doing EMDR as the ground, as part of the client’s support system. The relationship can itself become figural and there are EMDR therapists who will then use the bilateral stimulation on the client’s perception of the therapist (Snyker, 1995). But I usually deal with the relationship in a dialogic way—self-disclosure, empathic immersion in the client’s view of me and our relationship—more rarely, transference interpretation.

**EMDR Techniques for Installation of Positive Resources**
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EMDR therapists have been very creative in devising methods for accessing and installing positive resources. One that is used for almost all clients is the Safe Place installation. This is used both for introducing them to the EMDR bilateral stimulation and providing a way for them to soothe themselves if they become very upset between sessions. The safe place is part of the standard protocol, described above.

It is beyond the scope of this paper to discuss all the other methods that EMDR therapists have developed for resource development and installation, but I shall refer to a few. One is the creation of a container in which the client is helped to put overwhelming traumatic material. Then the client can take out elements of the memory one at a time when ready to deal with them. Another method is to have the client remember a person in his or her life who was positive and loving and affirming. This would be appropriate for a client who has low self-esteem.

I used this method in combination with the gestalt therapy two-chair technique with very positive effects with a young man who had a very active internal top-dog shaming sub-personality. We discovered this part by my having him assume the role of his internal critic, putting himself in an empty chair and indulging in overt criticism, something that he was only vaguely aware of but was almost constantly happening to him. He became aware of the function of what we then called the “shamer,” where it came from and what its ultimate purposes were, which he was surprised to discover, were ultimately positive. He realized he did not want completely to get rid of the shamer, for it served a useful function of keeping him from making poor choices in his everyday affairs. But he also realized that it was too harsh and extreme in the way it attempted to accomplish its protective function, and he wanted to soften it.

In a later session I suggested that perhaps he could use a “praiser” to counterbalance the shamer and he readily agreed. I asked if he knew someone in his life who could serve that function and he told me that the headmaster at the prep school he went to had been very fond of him and very supportive and encouraging. So we installed with short sets of eye movements the felt sense of this man’s presence with him. This headmaster had been a wrestler and I was amused to hear, during our next session that, when the shamer started to shame him during the preceding week, the praising resource had wrestled the shamer to the ground and pinned him there. I was impressed that the praiser accomplished the pinning with humor and even a bit of affection for the shamer.

Use of EMDR in Short-Term Treatment

Short term would be treatment of “simple trauma” (based on a single incident), phobias or performance enhancement, e.g., for an actor or an athlete who wishes to acquire resources to improve performance. For it to be short-term, the client must have had secure attachments and to be able to contain affect relatively well. I also believe that the therapeutic alliance is not as necessary in short-term therapy as it is in long-term therapy. van der Kolk (2002), one of the foremost trauma researchers, believes that EMDR even works in the treatment of trauma when the client actively dislikes the therapist. And
in short term treatment the EMDR standard eight-phase protocol seems to be sufficient and very effective.

For example, I used EMDR with a young woman who was staying in a hotel across from the World Trade Center when it was bombed on September 11, 2001. She experienced the worst of the trauma: coming very close to dying, seeing someone she knew dead on the ground, seeing body parts and people jumping to their deaths. In four sessions, we not only worked through the trauma so it no longer brought up any upset, but she was able to go back to New York City and observe Ground Zero with a feeling of awe at what she had experienced. Follow-up contacts indicated that, as this is being written, she has managed to maintain these gains.

With longer-term treatment, where clients are dealing with more severe disturbances, or more complex problems, such as interpersonal difficulties, and the developmental arrests are due to long-standing childhood trauma or neglect, EMDR must be used as an adjunct to a more comprehensive treatment approach, such as gestalt therapy. I shall next discuss how EMDR can be utilized in the context of more comprehensive, longer-term treatment. I shall discuss briefly using EMDR in working through therapeutic impasses, processing past traumatic events that arise during the course of therapy, dealing with symptoms unaccompanied by conscious thought, and helping to create positive internal resources.

Use of EMDR for Working Through a Therapeutic Impasse

As an example of the use of EMDR for working through impasses, I shall describe a session with Dick, a man in his thirties with whom I had been working for about eight years. Although handsome, intelligent, witty and charming, he had not made much progress in his goal of allowing himself to be more emotionally vulnerable with others, which had prevented him from accomplishing the two goals he most fervently desired: achieving more depth in his fictional writing, and in forming a love relationship with a woman, including marriage and children. Although describing feelings of inadequacy, pain and worthlessness, he almost always affected an attitude of cheerfulness and good-humor. He also could almost never allow himself to express anger toward anyone, no matter how justified. In session, I found myself feeling frequently impatient with him and unempathic, even when he told me of times of experiencing despair.

He tended to spend the first half-hour of his weekly sessions recounting all the insights he had had during the previous week. Sometimes I felt that these insight and experiences were important and that he needed to tell me about them. But I frequently felt somewhat distanced by him and would occasionally interrupt these discourses and attempt to focus on how he was avoiding contact with me in the present. This sometimes evoked his fear that I would reject him if he were to be real with me, and, after quite a bit of work in the session, he would begin to show the sadness and emptiness he was experiencing internally. It was only at those times that he appeared authentic to me and I felt emotionally close to him. But this greater affective depth never lasted; the next session he would
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always come in as if nothing had happened in therapy the previous week, and he would be his usual cheerful, contact-avoidant self.

I decided we were at a therapeutic impasse, and that EMDR might be helpful in dealing with it. I had utilized EMDR bilateral stimulation with him before; unlike most clients, he frequently had no cognitive awareness during the eye movement sets, but would look frightened at times, and his body occasionally jerked. It seemed to me that he was experiencing events that either had happened before he had learned to speak, or events that occurred later from which he had to dissociate.

Then one session he said in the beginning that he had nothing particular to talk about today. I suggested he did not have to have a topic, that he could just bring himself to the session. He thought about this, became anxious, and then described an image of being inside himself, seeing a pool of water — greenish yellow — that he stayed above, rather than being immersed. I asked him to stay with that image and did a set of eye movements with him. After I stopped the bilateral stimulation, he saw himself at the side of the pool, which looked shallow but he thought was really deep. He began to feel panic and helplessness. He thought of himself as "an annoyance. I'm seen as insignificant, with hostility, like an insect you'd want to brush away. I'm whatever the other person thinks I am." I asked what he would prefer to think about himself, and he said, "I can define my own worth."

During the next set of eye movements, which was thirty movements long, he seemed to dissociate after about twenty-five. He said, when I stopped, "I'm feeling very cold, feeling fear." He was afraid he would drown if he went into the pool. More eye movements. He then remembered a Stanislav Grof breathing workshop he had attended where he accessed a memory of his brother pushing him under the water at a swimming pool when he was approximately four, his brother being nine. His mother had been sitting at the side of the pool, reading.

While the next set of eye movements was being administered, he again looked frightened, followed by what looked like dissociation, with his eyes glazing over. I pointed out that he looked frightened and asked him if he were aware of spacing out. He answered yes, and his next thought was that he always has to pretend everything is okay, that he is just "irrelevant" in the world. After the next set, during which he again dissociated, he said, "I'm seeing myself in a degraded way, as disgusting." Following the next set, which I did in a circular pattern, to interrupt the dissociation, he said, "I'm pulling away, wondering how people are doing. I'm hearing their voices." He meant sounds coming from the next room. I asked him about the pool of water, and he said, "I should just go ahead and die, let myself be drowned. It's not because I'm worthless, but it would be best for the world."

After the next set of eye movements, he said, with surprise, "I'm actually feeling good now, flowing, like I was swimming. The process is over." He thought of the disaster movie, "The Poseidon Adventure," which he always loved. This movie was about a huge ship that had begun to sink into the ocean after having a big hole ripped out toward the front of it. A group of people had survived by going back inside the ship to the back, and then escaping to the surface of the ocean. During the next set of eye movements, he suddenly realized that, after struggling to come up for air, while his brother
had "playfully" held his head under water, he had deliberately sunk to the bottom of the pool and come up in a different part of it. He had surfaced very upset, enraged that his brother had tried to drown him. But both his mother and his brother had ridiculed him for being angry. He realized that his frequent thought that he should just go ahead and die was connected to this incident, that it had seemed to him at the time that his mother had actually wanted him to die, and that dying would allow him to escape from his intense shame. He also realized that he had no recourse in this and many other situations with his family, except to act in a perpetually cheerful manner, and deny awareness of anything being the matter in the way his family treated him and each other.

I suggested, since I did not have anyone scheduled during the next hour, that we continue working on this very important theme. He readily agreed.

He was going to the Southwest in the next few days, to his brother's house for Thanksgiving. His parents would also be there. His niece, a teenager, had been frequently throwing up and his mother had been very upset about this but had been blaming his sister-in-law and his brother. He imagined taking his mother aside — "with rage" — and making her "behave."

He also realized that the day of this session was the date a dog he had as a child was given away for biting the mailman. While he realized this probably had to be done, he felt it was accomplished by his parents in a very insensitive way, and that it was a message to him that it was not okay to be angry and aggressive. Behaving that way would get him thrown out of his family. But he was now feeling in the session powerful and masculine and more comfortable with being an assertive man.

I suggested we do some resource installation at this point. I asked him to experience his body and the thoughts he was having that it is okay for him to be powerful and assertive, and did a few sets of short bilateral stimulation sets. He became more and more comfortable experiencing himself as powerful. He also remembered incidents in the past when he got enraged — e.g., beating up a kid in school who taunted him until he exploded with rage — and the other kids congratulated him for asserting himself. But, when he got home and told his mother, she shamed him for his aggressive behavior.

Another event was recalled, from adulthood. He had picked up an anti-abortion protestor who had pushed a woman working at an abortion clinic, and thrown him back. He had felt proud of himself and had realized that, if he were defending someone else, he could allow himself to become angry and forceful. I again did a short set of eye movements to reinforce his feeling of power and self-confidence.

The next week he told me that he realized during his Thanksgiving trip that his mother seems to hate him, his brother and his father whenever they show aggressiveness or assertiveness, and they have all had to cover up their awareness of this fact. He also noticed that his mother got very upset when his niece came to sit on his lap during the vacation. He realized why he had never been able to get married: He always started out a new, potentially romantic relationship with a woman assuming, without awareness, that she hates him. He had had to cover up this hypothesis and his emotional reactions rather than checking out his assumption about her feelings toward him.
This session is a good example of how EMDR can help with a therapeutic impasse. As long as we kept our encounters on a verbal, linear level, Dick and I had not been able to get beyond his intellectualized way of dealing with his issues. There was obviously a good deal of transference to me as a father figure who was not really interested in him, did not really care about him and, indeed, I did have some difficulty expressing concern and interest in him because of the shallowness of his affect. Despite my best efforts, however, to deal with this impasse, we did not get much beyond it until use of the EMDR techniques. We did have to do more subsequent work on his fears of being aggressive, expressing anger and making himself vulnerable with others, but these were pivotal sessions toward working his fears through. Perhaps another therapist would have had the stamina to consistently confront Dick’s avoidance of contact, but I was able to do that only sporadically. I was grateful to have the EMDR techniques available to get through the impasse.

An Example of a More Complete Integration of EMDR and Gestalt Therapy

As an another example of a gestalt therapy/EMDR integrated approach, I shall recount a rather brief session I had with Jack, a very experienced professional, who worked with me as part of a demonstration I did on the integration of EMDR with gestalt therapy, in June, 2002. This was a very striking and successful experience for Jack and he gave me permission to use the session as an example of combined gestalt/EMDR therapy.

He chose as his EMDR target waking up early in the morning and having trouble going back to sleep. This had gone on periodically for two and a half years, ever since his girlfriend at that time ended their relationship. I asked if he wanted to start our work there or the most recent time he had trouble sleeping. He chose the most recent, about three weeks before our meeting. He preferred the audio scan, a device with headphones that presents alternate tones to the ears, after trying out both the visual and tactual stimulation.

I had him just focus on his bodily sensations when he woke early in the morning and he became aware of tension in his abdomen and chest. I did a set of auditory bilateral stimulations and the bodily sensations became more intense. After another couple of sets of stimulations, he was reminded of an important incident, either just before his ex-girlfriend left or after: the death of a very dear friend. I noticed as he said this that he looked sad. I felt touched and communicated my observation to him. He later told me that my comment and the way I delivered it gave him permission to feel the sadness, of which he had been unaware.

He had been to visit this friend a few weeks before in a hospital about ninety miles from Los Angeles, and she told him and another mutual friend that she wanted to die naturally, not have her family hurry the process along.

He then got a call early in the morning, around 3:00 a.m., from the hospital saying that she was dying, and that she wanted him and the other friend to come to see her. He called the other man and
they made arrangements to go to the hospital to be with her. This required canceling numerous appointments they had scheduled, and they could not leave until later that morning. When they got to the hospital, however, they found out she had died and that her family had given permission to the physician to have her given a lethal dose of morphine. The family said the room she was in was peaceful but, when Jack went in, it did not appear at all peaceful. Jack, who is well-trained in spiritual and meditative practices, sensed a great deal of turmoil in the environment and the expression on his dead friend’s face appeared tormented, rather than peaceful.

He was very angry that the family had disregarded his friend’s final wishes. I asked at this point if he had communicated his anger toward the family and he said he had not. We were doing sets of the auditory bilateral stimulation all during this recounting of the events. As is usually the procedure, I would do a set and, when I sensed, from the expression on his face and his breathing, that he had achieved some closure, I stopped and he told me what he had experienced. He began to become aware of feeling guilty that he and his friend had not left sooner to go to the hospital.

I sensed that he had some unresolved guilt and sadness that was connected with his dead friend, and asked him if he wanted to imagine talking to her. He eagerly seized on this opportunity, imagined her in the room with him, and communicated, with much affect, his feelings toward her and his remorse about not having been at her side when she died. I then asked him to give her a voice, which he did, and he attributed forgiveness and loving feelings to her.

I did more bilateral stimulation. His next association was when he was a late teenager, attending college, and was a counselor in a college dorm. He was down at the front desk in the dorm when he suddenly looked out the front window and saw a student’s body falling to the ground from the 19th floor. The student had committed suicide and fell directly on the car of his parents, who had come to visit him and were also in the lobby. I wondered if Jack felt guilty about the boy having killed himself, which Jack affirmed, but he also said he had felt guilty all those years about going out and looking at the body. (I had spoken during the lecture part of this workshop about the World Trade Center survivor I had worked with and had mentioned her guilt at being fascinated by the sight of people jumping from the twin towers.) Jack realized at this point that he had felt guilty for similar reasons and realized now that it is natural to feel drawn to scenes like this.

Jack said after the work was over that what made it complete for him, along with the bilateral stimulation, was my caring contact with him and my suggesting he give his dead friend a voice to talk to him. He is a long-time meditator and said he found the bilateral sounds very helpful in a spiritual kind of way. He was surprised that the earlier situation in college was connected to this more recent incident. He also favorably contrasted our work with a lecture demonstration by an expert EMDR therapist he had attended that was lacking the dialogic nature of our session. He reported, weeks later, that chronic headaches he had been having were gone and that he was sleeping better.

Discussion
Gestalt Therapy and EMDR

One aspect of this session that struck me was the fluidity of the integration of EMDR and gestalt therapy. It is important to reiterate that Jack is not representative of the typical psychotherapy client, many of whom are resistant to EMDR and not nearly as cooperative as Jack. At the same time, it is a good example of the integrative power of this combined approach. I actually thought, as we first started our work together, that the sleep problem was related to the ending of Jack’s relationship with his girlfriend. But it seemed to play no part in his symptoms. Also, neither Jack nor I could have predicted, beforehand, that an experience in college over thirty years previous to this session would be germane to his sleep difficulties and his headaches.

**Summary and Conclusion**

In summary, I am finding EMDR techniques an excellent adjunct to my work as a gestalt therapist. Because EMDR came essentially out of cognitive-behavior therapy, with rather rigid procedures, it is necessary to modify these procedures to integrate them into other therapeutic styles, and numerous theorists, including me, have been attempting that integration (Shapiro, 2002). I have found the use of EMDR techniques very helpful in speeding up the process of my work with long-term clients; in achieving a more complete resolution of unfinished, incompletely metabolized issues from the past; in increasing the internalization of what the self psychologists would term needed self-object functions; and in helping clients increase the complexity and resiliency of self-support functions.

In future articles I will discuss more in detail how EMDR techniques can be utilized in conjunction with other gestalt methods to further the growth of clients in psychotherapy, among them, an internal representation of the therapist, the use of EMDR in conjunction with the empty chair approach, and use of a combined gestalt therapy/EMDR method with various diagnostic groups.

**References**


Gestalt Therapy and EMDR


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**Author**

Stephan Tobin has been a clinical psychologist since 1963 and a certified (by Fritz Perls and Jim Simkin) gestalt therapist since 1970. He was a co-founder, past-president, trainer and chairman of the Certification Committee of the Gestalt Therapy Institute of Los Angeles. In the early 80’s he introduced psychoanalytic self psychology and intersubjectivity to the American gestalt community with articles and appearances at national gestalt therapy conferences. He serves on the editorial board of the *Journal of Humanistic Psychology* and has published articles on the integration of psychoanalysis and existential-humanistic psychology. In the late 90’s he received training in EMDR and is now certified as an EMDR practitioner. He recently moved, with his wife, to the Portland, Oregon/Vancouver, Washington area, where he practices, supervises and does online teaching at Saybrook Graduate School and Research Institute and Ryokan College.

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