

THEORETICAL ARTICLE

Affect-Focused EMDR: Clinical Strategies for Working with Relational Trauma

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In eye movement desensitization and reprocessing (EMDR) therapy, various strategies are employed by therapists to identify touchstone memories or other important memories linked to present symptoms. However, affect-focused EMDR posits that the reprocessing of affect is central to EMDR, rather than the reprocessing of memories or mental representations. Utilizing memories as gateways to affect is just one approach to reprocessing the underlying feelings; there are many other avenues to access the affect. This is particularly relevant when addressing the effects of childhood relational trauma, where a patient's identity, along with their defensive structures, has been shaped in chronically toxic environments. Children often need to shield themselves from the unbearable pain of disconnection, isolation, and unmet fundamental needs. As a result, childhood relational trauma can leave a child feeling helpless and alone, which hinders the development of a healthy sense of self, a basic sense of safety, and an essential sense of agency. According to Francine Shapiro, problems in these 3 domains are the primary consequences of traumatic experiences and express themselves as negative feeling states, with negative self-thoughts emerging only later. Affect-focused EMDR aligns with Shapiro's affect/valence theory in asserting that targeting affect is crucial in EMDR since negative affect is what binds dysfunctional networks together. It offers various methods for accessing affect and considers the use of memories as just one approach to activating feeling states. In this way, AF-EMDR is intended to increase therapists' flexibility in addressing the needs of diverse client profiles.

Introduction

For decades, eye movement desensitization and reprocessing (EMDR) has been recognized as an effective therapy for treating post-traumatic stress disorder (PTSD) and trauma-related disorders in adults, with its efficacy well-supported by over 30 published randomized controlled trials [1], several meta-analyses [2,3], and a recent network meta-analysis [4]. This analysis found that EMDR and cognitive processing therapy were the most significant therapies, demonstrating large effect sizes in both short-term and long-term follow-ups.

However, critics have pointed out that demonstrating efficacy is much easier for PTSD treatment resulting from simple trauma, while doing so for patients with chronic childhood trauma using EMDR is more complex [5]. Relational trauma, especially in childhood, gives rise to an entirely different category of symptoms. Over the years, several clinical strategies have been developed to treat patients struggling with the debilitating effects associated with complex PTSD [6–10]. This suggests that while the standard EMDR protocol may be effective for simple trauma, we need ways to better serve patients who have experienced relational trauma.

This article introduces affect-focused EMDR (AF-EMDR) as both a clinical elaboration of standard EMDR procedures and a way of thinking that foregrounds affect as the primary entry point for processing, particularly in adult survivors of childhood trauma. Ontologically, AF-EMDR can be understood as an integrative clinical framework: it incorporates the standard EMDR

protocol while expanding its application through the premise that targeting affect—rather than memory—is the central organizing principle of therapeutic change in EMDR. While clinical experience suggests that AF-EMDR may accelerate change in clients with relational trauma, further empirical research is needed to validate its efficacy and mechanisms.

Theoretical Underpinnings of AF-EMDR

How AF-EMDR defines affect

Drawing on affective science, “affect” is defined here as a comprehensive construct that includes bodily sensations, emotions, and feeling states. This viewpoint is consistent with theories such as the James-Lange theory [11] and the Somatic Marker Hypothesis [12], which emphasize the essential role of physiological responses in shaping emotional experiences. Additionally, research on interoception and embodied emotion reinforces the idea that our internal bodily states and our awareness of them are crucial to how we experience and interpret emotions [13].

Affect is described in the circumplex model [14–16] as comprising 2 axes: the valence axis (a continuum ranging from pleasure to displeasure) and the arousal axis (varying levels of activation). All affective states emerge from a combination of these 2 independent neurophysiological systems [15]. Emotions, on the other hand, are the subjective interpretations of these affective states. A key characteristic of affect is that it represents an unconscious response to events in our lives that touch and influence us. AF-EMDR focuses on these affective components

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of experiences stored in implicit memory, which unconsciously influence our behaviors and reactions. In AF-EMDR, we often initiate the associative process from a feeling or sensation that can trigger episodic representations in the declarative memory system, a method AF-EMDR defines as “bottom-up processing”. In contrast, “top-down processing” begins with episodic memory, as is commonly done in the standard EMDR protocol where a memory or mental representation of a past experience is used as a starting point.

When addressing affect, we leverage the concept of state-dependent memory, which suggests that a patient's ability to recall information improves when they are in the same physical or emotional state as when the information was encoded. Since similar affective states are often present in various life experiences, patients frequently experience a whirlwind of memories emerging based on shared emotions and feelings.

Shapiro's affect/valence hypothesis

The exact reasons why EMDR works remain unclear, and numerous hypotheses have been proposed to clarify its therapeutic effects [17–29]. In the second edition of her foundational textbook, Shapiro introduced an additional hypothesis to explain how EMDR functions, which she calls the affect/valence hypothesis [30].

Shapiro theorizes that the intensity of the affect/valence may explain why information becomes trapped within isolated networks. The model she proposes seeks to elucidate how this information can shift from a dysfunctional to an adaptive state.

Shapiro asserts that “associative networks (and their cognitive content) are organized, in part, by affect, so that once an affect is activated, the related network tends to settle into a stable pattern that primarily accesses memories and associations linked to that particular affect. The stronger the dysfunctional affect, the greater the network's stability and the more difficult it is for the network to shift out of its habitual set of associated memories and feelings. Therefore, the target trauma is prevented from linking with more adaptive information by the high resistance of the neural network to perturbation” ([30], p. 360).

The idea that information is dysfunctionally stored in separate associative networks is a fundamental aspect of the adaptive information processing model. Shapiro's hypothesis suggests that networks are organized around affects, and the more intense the affect, the more stable the corresponding network of associated information becomes. This stability prevents connections to more neutral or positively valenced material within separate adaptive information networks, explaining why triggers repeatedly elicit the same behavioral, cognitive, relational, and affective responses.

Shapiro not only suggests the existence of different information networks but also proposes that these networks are separated from one another due to their distinct affective valences around which memories are organized. Consequently, the patient possesses networks characterized by high negative valence, containing dysfunctionally stored information, as well as networks defined by high positive valence, referred to by Shapiro as adaptive networks. These adaptive networks “contain memories of positive material such as mastery experiences, compliments, and information from self-help books” ([30], p. 361). Shapiro views resources as positive affect states ([30], p. 248).

The standard EMDR protocol is designed to activate and process dysfunctionally stored information, linking it to more

adaptive information networks. Research has systematically demonstrated that rapid bilateral stimulation reduces the vividness and emotionality of a memory [20,21,31–33]. If rapid bilateral stimulation effectively lowers the intensity of negative affect, it may enable the brain to form and strengthen associations with networks that are progressively less negative and eventually more positive, incorporating the adaptive information stored within them ([30], p. 248).

Bodill [34] uses the strong gravitational pull in our solar system as a metaphor to illustrate this process. The sun's gravitational pull keeps the planets from drifting into other solar systems, locking them into a closed system that allows astronomers to accurately predict their behavior. If, for some reason, the sun's gravitational pull weakened, the gravitational forces of other solar systems could attract the planets, pulling them into orbit around a stronger star.

The affect/valence hypothesis underscores the centrality of affect in Francine Shapiro's thinking. Furthermore, there are numerous other instances in her writings where the significance of affect aligns with the concept of AF-EMDR.

The unbearable pain of childhood

In AF-EMDR, we aim to address the overwhelming pain of loneliness, worthlessness, powerlessness, and insecurity that children experience due to chronic relational disconnection.

We believe that complex trauma symptoms primarily stem from relational trauma in childhood. This trauma can arise from verbal, physical, or emotional abuse, as well as from neglect, where the child fails to receive the connection and love it needs. Such experiences fundamentally impair the development of a healthy self-image and thwart their basic trust in others and the world around them. We concur with Timulak [35], who asserts that every child has psychological needs, and when these needs are unmet or violated, emotional pain ensues. This pain, which Shapiro ([30], p. 42) refers to as “the pain of childhood”, continues to be triggered in the present.

Eisenberger and Lieberman [36] showed that there is a connection between social pain and physical pain in the underlying neural circuitry, which means that individuals perceive the pain of rejection as genuine physical pain.

Shapiro notes that “childhood events can have a lasting negative effect on the self and psyche and can be conceptualized as encoding negative affects and sensations that spontaneously arise when triggered by present conditions” ([30], p. 47). She further notes that activating the traumatic memory brings the dysfunctionally stored affect into awareness, at which point the negative cognition expresses its underlying meaning ([30], p. 49).

While identifying negative cognition is considered a critical aspect of phase 3 in the standard protocol, it is crucial to note that Shapiro [30] considers negative beliefs to be verbal expressions of distressing affect. She argues that the underlying affect is the key element in understanding pathology.

This suggests that affect is more fundamental than negative cognition. Just because affect is not verbalized does not mean it is absent. Young children may lack the words to articulate their feelings but can still experience negative affect. This highlights that the primary goal of phase 3 of the standard protocol is to access the affect triggered by the memory. To achieve this, we seek to identify the image of the most disturbing moment of the memory, uncover and articulate the often subconscious belief activated by this moment, and find words that resonate emotionally with the patient.

Even when searching for a positive cognition, the validity of cognition scale may reveal to the patient that such positive belief feels distant, which can intensify the negative affect. If the patient can name the emotions and feel the bodily resonance, we have sufficient affect to begin processing.

This raises an intriguing question: do we need the memory to access the affect, or is the memory merely one method to reach the affect, with other approaches available to facilitate this connection?

Memory-Focused EMDR versus Affect-Focused EMDR

The fundamental principle of AF-EMDR is that the primary target for treatment should be the affect, rather than just the memories associated with it. Our treatment plans should thus allow access to the affect through various pathways, not solely through memories. In many cases of simple trauma, a clear link exists between a symptom and a specific causal experience, making it logical to address a clearly disturbing memory. In such cases, the affect can easily be accessed through the memory and treated effectively using the standard protocol, which often results in what can be described as “miracle cures”.

However, when working with relational trauma, therapists may find themselves overwhelmed by the numerous memories presented by the patient, leaving them unsure of where to start. Conversely, some patients may struggle to recall specific memories, instead expressing a pervasive sense of threat or a feeling of not being loved or respected. In situations where numerous negative experiences have occurred from childhood into adulthood, it may be more effective to address the underlying affect directly—specifically, the intense pain of loneliness, unlovability, and lack of validation. In AF-EMDR, we refer to this as “the jam”, which represents the resultant feelings stemming from multiple negative experiences, sometimes spanning a lifetime. Rather than searching for the oldest or most traumatic memory, we propose to focus on identifying the common affect that underlies all these memories. To continue with the metaphor, instead of identifying which type of red berry (strawberries, cherries, raspberries, or red currants) the jam was made from, we concentrate on the resulting jam itself and how it manifests in therapy.

Thus, AF-EMDR suggests that in some clinical populations, particularly those with relational trauma, prioritizing affect over memory may enhance therapeutic outcomes. Is EMDR truly about memory processing, as suggested by current definitions? Is the objective of utilizing EMDR treatment protocols to reprocess memories that contribute to the client's presenting issues [37]? Is it about working with pathogenic memories, with EMDR offering strategies to effectively access and transform them, resulting in symptom relief or resolution [38]? In her foundational textbook [30], Shapiro employs the term “information processing” more frequently than “memory processing”, emphasizing the significance of processing information that is organized around an affect.

Following Francine Shapiro's insights, the rationale behind AF-EMDR is that when the information network becomes locked due to the intensity of the affect, we must access and desensitize that affect using bilateral stimulation. This approach enables the brain and body to form new associations with more adaptive networks, allowing for the transmutation of the information to occur.

Target plan: Vertical axis in AF-EMDR is depth, not time

Our aim is to allow patients to delve deeply into their feelings and then experience whatever unfolds. While memories can be a valuable route to accessing affect, they are just one of several ways to engage with it. Often, the most painful memories are also the ones that patients defend against, allowing them to provide intellectual responses without truly connecting to the affect during phase 3 of the standard EMDR protocol. If we limit our exploration to the chronological axis of memories in search of a touchstone memory, we risk overlooking many other useful pathways to access the affect. Even when using techniques like the Affect Scan [30] to identify early childhood memories linked to certain feelings, those memories may remain obscured.

Memory does not need to be the sole entry point into the dysfunctional network, as Shapiro observed: “Based on clinical observation, it seems that any manifestation of stored information can be used as a target for EMDR processing. Thus, a dream, a memory, and current behavior are all useful foci because they all stimulate the specific neural network containing the disturbing information” ([30], p. 47). AF-EMDR aligns with this perspective and expands upon it by introducing the “trauma-octopus” metaphor, emphasizing that although there are 8 arms, any of them can lead to the core of the octopus. In AF-EMDR, we are not confined to just 8 entry points for accessing affect (see Fig. 1).

We can engage with affect through memories, triggers, or future fears. Patients might be guided to focus on a physical sensation, simply “go inside”, or pay attention to a dominant emotion. We can also utilize dream imagery or symbolic representations that evoke strong feelings. Clients may hold a highly emotionally charged core belief in mind and let whatever arises unfold while engaging in bilateral stimulation. Additionally, we can work directly with emotional defenses, which are closely linked to pain, or prompt the client to envision themselves as a child, observing the pain reflected in the child's eyes—a technique utilized by Jim Knipe in his Loving Eyes Protocol [39]. Any method that provides access to affect is valuable. Once the client begins to associate, new memories may surface, representing what AF-EMDR describes as bottom-up processing. We can reverse the traditional approach of starting with the memory to get to the affect, by taking the affect as the starting point and moving toward memory.

Basic Principles of AF-EMDR

Facilitating the client's connection to the pain is essential

The depth represented on the vertical axis of Fig. 1 means that once an emotion is activated, the therapist encourages the client to go even deeper, fully experiencing the almost unbearable pain of loneliness, worthlessness, powerlessness, and insecurity. The patient is invited to venture into the darkest recesses of their psyche, using suggestive affect-deepening language, such as “go inside, go as deep as you can; feel that pain, feel that pain in your body”. Such interventions are only used when a strong enough therapeutic alliance is in place and when the patient has demonstrated readiness to access these deeper layers of experience. This process requires considerable courage from both the client and the therapist. Clients need to feel secure enough to confront their pain, while therapists must be willing to remain present

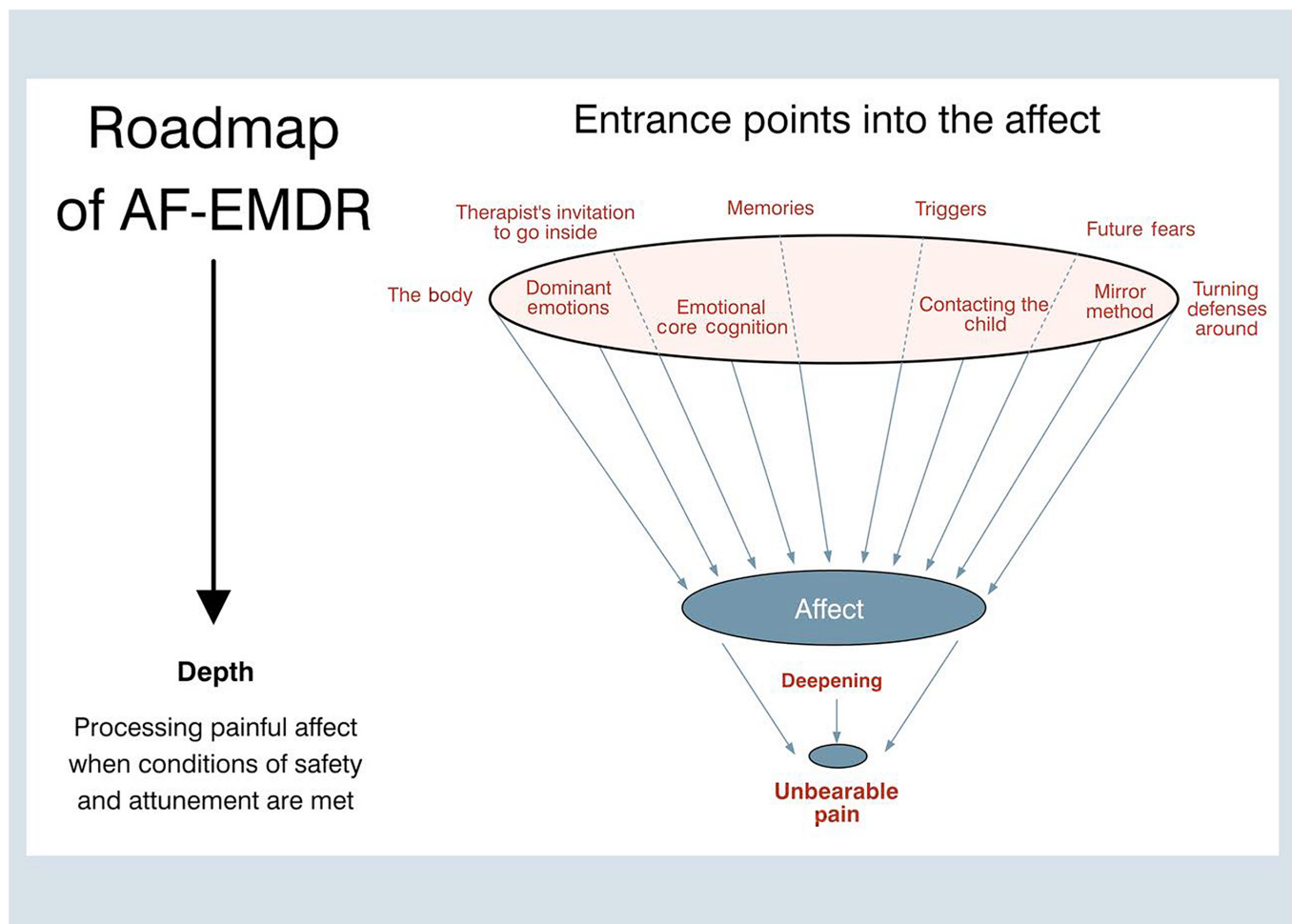


Fig. 1. The roadmap of AF-EMDR showing multiple entry points into affect.

with that pain, maintaining a connection even when their own deep-seated painful affects are triggered.

If we succeed in helping the patient access their feared and often fiercely defended childhood pain, the transformative potential of experiencing these emotions can be profound, often leading to a rapid and intense change process rather than a gradual one. As Fosha states, "...transformation is an almost invariable by-product of intense affective experience" ([40], p. 20).

The therapeutic relationship: Creating safety to handle unsafety

One of the most crucial elements of AF-EMDR to achieve its goal of processing negative affect is the therapeutic stance. Throughout their lives, patients have learned to protect themselves from unbearable pain. The idea of confronting feelings they wish to avoid can create intense fear. In AF-EMDR, we view fear as the foundation of every defense or survival mechanism: fear of being alone and unloved, fear of being deemed unworthy, fear of feeling powerless, and fear of feeling unsafe. To survive, people unknowingly expend considerable energy avoiding the pain of their childhood. However, the cost of this defense is monumental; by shielding themselves from the pain, they risk losing connection with their true selves—the person they genuinely are or could become.

While the therapeutic goal of helping the patient rediscover their real self is commendable, the patient will never feel safe enough to engage with the painful affect without a strong therapeutic relationship. This principle is well-known among therapists and is considered a fundamental aspect of any psychotherapy. Extensive research has clearly demonstrated the vital role that the therapeutic relationship plays in effective psychotherapy. A recent comprehensive meta-analysis of 295 independent studies involving over 30,000 patients reaffirmed the strong correlation between therapeutic alliance and positive outcomes [41]. We know that one important function of attachment is to reduce anxiety and encourage exploration [42]. Consequently, one way to motivate patients to delve into their pain is by fostering a trusting connection with the therapist. The therapist must embody trustworthiness and maintain the connection in any circumstance. In AF-EMDR, we emphasize the significance of establishing relational safety in order to manage feelings of unsafety. Both the patient and the therapist are involved: a lack of trust can hinder change, and an inability to maintain contact can lead to re-traumatization. The therapist is meant to be perceived as a stable rock in a turbulent river or a reliable lifebuoy in a stormy sea, while the patient should be viewed as a brave soul, needing the therapist's support. A strong therapeutic alliance encourages clients to openly express their feelings, including negative ones. Research indicates that when clients feel safe sharing their negative affect, it fosters trust and

deepens the therapeutic relationship [43]. Such an environment allows for the deeper exploration of painful experiences, resulting in greater emotional awareness and resolution during EMDR processing. Implementing AF-EMDR requires the therapist to trust the process, as well as to have trust in the patient and themselves.

People come to us to change how they feel

The transition from memory processing to affect processing is a crucial aspect of AF-EMDR. Patients do not come to see us to alter a memory; they seek to change a feeling. We emphasize the central importance of the negative affect to the patient by illustrating it with the image of a bowtie (see Fig. 2).

The left side represents a multitude of individual experiences that come together to form a knot—an intense, recurrent, unbearable affective state—at the center, from which the consequences or symptoms of present-day distress emerge on the right side, including both resurfacing pain and the survival strategies activated to avoid or numb it [44]. AF-EMDR posits that therapists do not always need to invest excessive effort into pinpointing memories of the original traumatic experiences and determining the order of processing. If we can go directly to the knot of the bowtie, we can start addressing the painful affect sooner. For example, if a patient arrives in a distressed state because they have recently been triggered and are experiencing old pain, searching for memories is not really needed as the feeling is already present in their body. The same applies to a patient who arrives feeling angry, crying spontaneously, or presenting with chest pain or other somatic symptoms. Of course, if a patient comes in with a clearly negatively charged memory, that memory can serve as our entry point.

AF-EMDR starts reprocessing as soon as possible

Patients seek our help because they are suffering and want assistance as quickly as possible. In our outpatient trauma center, we typically begin reprocessing affects in the second or third session. Therapists can lose patients when they become demotivated due to a lengthy intake process or an excessive emphasis on stabilization. The phrase “as fast as possible, as slow as necessary” is often misinterpreted as a directive to slow down. We align our views with the Dutch research group [45–47], which

indicates that therapists often overemphasize stabilization even when it is unnecessary, thereby risking patients being denied or delayed in accessing conventional evidence-based treatments that could benefit them [45]. However, the ongoing discussion about the balance between stabilization and direct trauma work is not new. Over 20 years ago, Diana Fosha [40] wrote:

“I realized that assumptions about the fragility of patients often are rationalizations for ineffective technique. Fragility should not be assumed or used to inhibit clinical action; it is a clinical assessment to be made in the course of -not prior to- dynamic interaction with the patient... for the well-trained clinician, the danger of ineffectiveness and avoided action looms much larger than the danger of damage from direct intervention” ([40], p. 16).

With AF-EMDR, we can introduce greater flexibility in reaching reprocessing sooner.

Emphasis on tactile bilateral stimulation

Another element that extends current practice of EMDR is that AF-EMDR does not use eye movements; instead, tactile bilateral stimulation is employed using devices known as “buzzers”. This enables patients to keep their eyes closed during processing. By minimizing external distractions, clients can engage more deeply with their internal experiences, memories, and feelings, which can facilitate the processing of traumatic memories. For many clients, closing their eyes offers a sense of security and comfort, particularly when recalling painful or distressing memories. This often makes it easier for them to visualize their memories, feelings, or bodily sensations. For some trauma survivors, keeping their eyes open can provoke feelings of hyper-vigilance or anxiety; conversely, closing their eyes can alleviate this heightened alertness and foster a sense of calm. However, this is not universally true; for some dissociative patients, closing the eyes might heighten feelings of danger. In such cases, keeping the eyes open while holding the buzzers can help them stay grounded in the present while exploring their inner world. Therapists must tailor their approach to each client individually. Research does indicate that working with eyes closed affects the way the brain functions. Costumero et al. [48] found that higher functional connectivity occurs between the brain’s default mode network (DMN) and sensorimotor networks when the eyes are closed. The DMN is linked to self-referential processing, as well as autobiographical and episodic memory retrieval. It activates when the mind wanders or when one envisions the future [48]. As Chen et al. ([49], p. 562) noted, “When one closes his or her eyes, one never ceases feeling and thinking, unless under adequate anesthesia, in a dysfunctional mode of coma, vegetative state, or death”.

Using the de-arousal effect of bilateral stimulation

Although there remains considerable debate regarding the necessity of bilateral stimulation in EMDR [50,51], we know that it can have a calming effect on the body [52,53] and can be employed with or without the standard protocol. We have built upon Elan Shapiro and Brurit Laub’s [54–56] concept of telescopic processing, originally used to modulate the focus of associations when working with memories using the Recent Traumatic Episode Protocol [R-TEP] (see Fig. 3). It should be noted that the intermediate *EMDr* strategy was attributed by Shapiro and Laub [54, 56] to Roy Kiessling in the form of a personal communication in 2008.

The feeling bowtie



Fig. 2. The feeling bowtie.

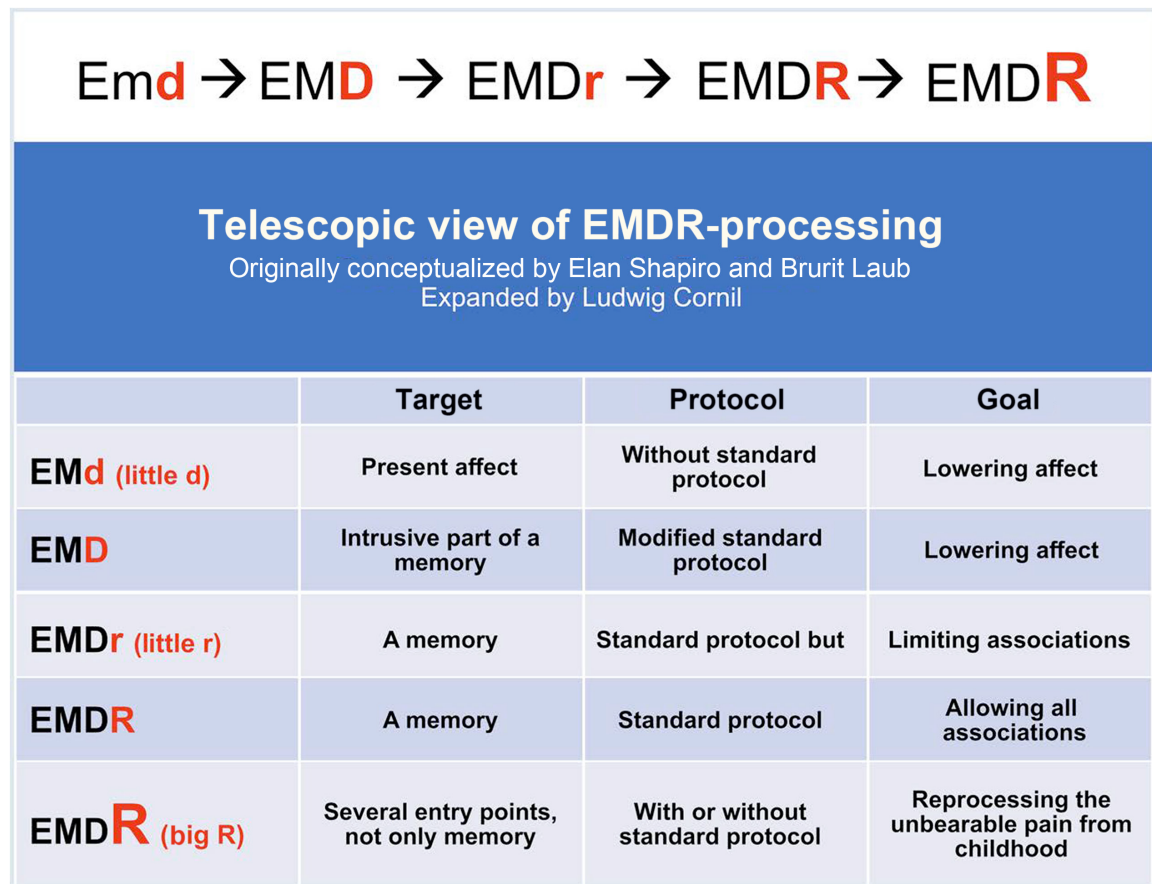


Fig. 3. Expanded telescopic processing.

In the EMD protocol, no associations are permitted, and the aim is to diminish the emotional impact of the target memory. In EMDr (EMD little r), the standard protocol is utilized with restrictions on associations. In contrast, the standard EMDR protocol imposes no such limits. AF-EMDR introduces 2 additional approaches. The first, EMD (EM little d), involves using bilateral stimulation as a means to calm the body when an affect arises, without seeking associations. Sack et al. [52] and Elofsson et al. [53] demonstrated that during the initial seconds of bilateral stimulation, a clear bodily de-arousal occurs, evidenced by increased parasympathetic tone and decreased heart rate, which is attributed to the elicitation of the orienting response. Thus, we can apply the buzzers similarly to how we do in the EMD protocol, but without a target memory or a specific protocol. This EMD approach to calming the body is also useful when employing bilateral stimulation during affective reactions, such as when a client reads a letter addressed to the person who caused relational trauma (Dellucci's letters protocol) [57]. This method focuses on bodily sensations, slows down the process, and limits associations to keep the patient stable. Many EMDR practitioners use EMD for themselves when feeling stressed and needing to calm down.

Finally, by adding EMDR (EMD big R) to our framework, we open up the possibility of applying bilateral stimulation to any entry point—not just the memory—either with or without the standard protocol, to process negative affective states. This flexibility provides more avenues for reprocessing the overwhelming pain stemming from childhood experiences.

Allowing patients to surf on the waves of affect for longer periods of time

In AF-EMDR, we introduce the concept of gradually extending the duration of sets of bilateral stimulation, allowing patients to reprocess for several minutes, gradually building up sometimes even up to 6 min or longer. By refraining from interruptions every 30 or 40 s and asking, "Take a deep breath, what do you get now?" we enable the processing to continue for longer periods of time, allowing patients to follow their associations freely. We prioritize following the ebb and flow of sometimes intense feeling states, while minimizing our interference, providing support only when we believe it is important for the patient to sense our presence and hear our voice. Given that AF-EMDR involves processing very painful affect, our perspective on the window of tolerance differs somewhat from that of many colleagues. We support patients in riding the waves of the affect until they gradually subside. In AF-EMDR, getting out of the window of tolerance means that the patient indicates he can no longer continue; only then do we stop. People are often capable of handling much more than they anticipate. When fear arises, we encourage patients to push through, using supportive phrases like "You're doing great; this will benefit you!" or "It's okay to experience as much discomfort as you need to while you're in this office, so you don't have to feel it outside these walls". We might also ask, "What would you like to scream? What would little John want to scream? Clench your fists and scream as loud as you can!"

EMDR as a primarily body-oriented form of psychotherapy

During processing in AF-EMDR, the focus is less on the content and more on the bodily experience of the affect that arises in waves, gradually diminishing or flaring up with new associations until the body is able to relax. This is why we actively seek out negative feelings, even if a patient reports feeling better between sets. A common mistake made by inexperienced EMDR therapists is to rush toward positive feelings, often driven by their own discomfort with difficult affect. If a patient reports both positive and negative material after a set, we have learned not to say “go with that” but instead temporarily set aside the positive response to encourage focus on the remaining negative aspects. We reassure patients that their positive gains will remain, even after addressing the difficult feelings. We apply the same principle when returning to the target, which in AF-EMDR can be any entry point, not just a memory. Our goal is to reset the body to a clean slate, enabling it to manage life without unresolved reactions that distort perceptions of reality.

Limitations

AF-EMDR is not appropriate for all patients. As this approach often evokes challenging emotional states, patients must be capable of tolerating negative feelings without becoming overly destabilized. The potential for temporary symptom exacerbation and destabilization is particularly pronounced for patients who are highly dissociative, acutely suicidal, or have personality disorders like borderline personality disorder. While Hafkemeijer et al. [56] found that EMDR can lead to temporary increases in psychological distress and suicidal thoughts among patients with personality disorders, these occurrences were less likely during EMDR therapy compared to no therapy at all. In our practice, we observe temporary destabilization, but the risk of re-traumatization seems to be rather small, despite intense emotional expressions. This may be because (re-)traumatization requires not only feelings of helplessness but also a sense of isolation. As long as the therapist maintains contact, provides support, and anchors the patient in the present, there is little to fear. However, caution is advised with highly dissociative patients, as maintaining this connection to the present can be challenging.

For unstable populations, ensuring sufficient stabilization before initiating AF-EMDR is part of the ethics of a responsible therapist. Since AF-EMDR originated in private practice with a more stable patient population than typically seen in residential psychiatric settings, the feasibility and risks of applying AF-EMDR in more complex situations require careful evaluation.

Another caveat is that, currently, there is no scientific research supporting the notion that affect is more important in EMDR than the processing of memories. The authors base their model on 10 years of experience developing AF-EMDR, during which they observed systematic and often rapid improvements in symptoms. However, this is not equivalent to proof of efficacy. Currently, AF-EMDR is primarily supported by anecdotal evidence, and randomized controlled studies are necessary to confirm the claim that AF-EMDR contributes something significant to the EMDR field.

Some preliminary data, however, do support the claims made in this article regarding the efficacy of using negative affect as the target. In a recent article published in this journal, Carbajal

et al. [59] examined the effects of an adaptation of the standard EMDR protocol, where the only modification was initiating phase 3 with a Negative Affect instead of an event (EMDR-NA Protocol). Although this study was small, involving only 3 patients who were first responders and veterans with co-occurring mental health issues, the results seem to reinforce the claims made by AF-EMDR. The authors acknowledge that there is an increasing body of literature indicating that negative affect serves as the driving force behind cognitions [60,61], a position also supported by Shapiro [30]. Carbajal et al. ([59], p. 153), in relation to the 3 patients reported in their post-treatment interviews, noted “that their emotions were processed first, and then, cognitions ensued”. More notably, one patient, who had previously worked on pathogenic memories before receiving the modified protocol targeting negative affect, concluded that her processing was more accelerated when starting from the emotion, allowing her to remember more than she had before.

In the next section, we include a few case examples from our own experience to illustrate what AF-EMDR can entail.

Case Vignettes

Maria, a 42-year-old teacher, sought therapy for chronic shame and emotional numbness. Although she could not recall specific traumatic events, she described feeling “invisible” throughout her childhood. In the third session, using the phrase “I don’t matter”, we activated a tightness in her chest. Through tactile bilateral stimulation and prompts to deepen her affect, tears flowed as she accessed a forgotten memory of being left behind at school.

Rather than focusing on the memory itself, we focused on the feeling of abandonment and invited Maria to fully experience the pain of loneliness. Over several sessions focusing on this familiar feeling of abandonment and following the associations while allowing her emotions to ebb and flow, Maria experienced changes in her self-perception, gained greater emotional awareness, and established stronger boundaries in her relationships. As a result, her depression lifted, and she rekindled her passion for painting.

A young woman in her 20s said she has been carrying a painful feeling of insecurity in her heart area for all her life, at least as long as she could remember. The negative felt affect was very palpable during the initial session. She could describe the physical aspect and emotion but was not able to give specific memories or specific triggers. We choose to start applying bilateral stimulation asking her to focus on the heart area and to let whatever happens happen. After just a few seconds, spontaneous memories came up (bottom-up), and the longer the process continued, the more we got into her childhood. After this one 90-min session, the disturbing feeling had weakened and she indicated she was more confident in life. More work was done on this in succeeding sessions, and she was happy to feel liberated from this familiar disturbing feeling, that was replaced by feelings of confidence.

A 25-year-old man, who had experienced childhood sexual abuse, had previously tried standard EMDR therapy elsewhere but found it ineffective. Whenever the abuse was discussed, he felt his body tense up, despite his conscious wish to confront the pain. He also expressed feelings of inferiority and loneliness. We guided him to focus on his body and immerse himself in whatever sensations he was experiencing. After a few minutes, the traumatic experience unexpectedly resurfaced. This time, his body did not

tense up, enabling him to process the trauma fully. Following the session, many of his symptoms substantially diminished.

A woman in her mid-60s asked for help with a very specific trigger. Since her Italian husband died the year before, she had been unable to listen to Italian music.

Since the trigger was very clear, we deliberately choose to use it as a gateway to her pain. We played Italian music; meanwhile, she was stimulated with bilateral stimulation with her eyes closed. After an hour of heavy crying, the grief subsided and more and more beautiful memories of her husband emerged. The woman indicated afterwards that the music had given her a “soundtrack” to recall all the necessary images playing out in her mind. After this one session, she was once again able to listen to her beloved Italian music.

Conclusion

In AF-EMDR, we want to expand on the common practice in EMDR of looking for memories or mental representations to create the target plan. In our work, we find affect to be more important than memories, because it serves as the binding element of a memory network. While memories are one important pathway to access affect, numerous alternative routes exist to engage with the negative affect, which can be processed through extended periods of tactile bilateral stimulation. The patient is encouraged to confront the unbearable pain of childhood, navigating through the waves of affect until that affect is ultimately resolved. Therapists must assess whether their patients are stable enough to confront and navigate the often intense emotions they experience. In our experience, most individuals in our outpatient practice have encountered relational trauma, and most of them are capable of processing what they perceive as the unbearable pain of disconnection. This is feasible only if the therapist can serve as a reliable anchor for the patient, trusting in the self-healing abilities to address the negative feelings that influence every aspect of their lives.

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Affect-Focused EMDR: Clinical Strategies for Working with Relational Trauma

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In eye movement desensitization and reprocessing (EMDR) therapy, various strategies are employed by therapists to identify touchstone memories or other important memories linked to present symptoms. However, affect-focused EMDR posits that the reprocessing of affect is central to EMDR, rather than the reprocessing of memories or mental representations. Utilizing memories as gateways to affect is just one approach to reprocessing the underlying feelings; there are many other avenues to access the affect. This is particularly relevant when addressing the effects of childhood relational trauma, where a patient's identity, along with their defensive structures, has been shaped in chronically toxic environments. Children often need to shield themselves from the unbearable pain of disconnection, isolation, and unmet fundamental needs. As a result, childhood relational trauma can leave a child feeling helpless and alone, which hinders the development of a healthy sense of self, a basic sense of safety, and an essential sense of agency. According to Francine Shapiro, problems in these 3 domains are the primary consequences of traumatic experiences and express themselves as negative feeling states, with negative self-thoughts emerging only later. Affect-focused EMDR aligns with Shapiro's affect/valence theory in asserting that targeting affect is crucial in EMDR since negative affect is what binds dysfunctional networks together. It offers various methods for accessing affect and considers the use of memories as just one approach to activating feeling states. In this way, AF-EMDR is intended to increase therapists' flexibility in addressing the needs of diverse client profiles.

Image

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