The Cycle Model: A Comprehensive EMDR Therapy Approach to Problem Behaviors

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Mark Nickerson, LICSW
marknickerson@gmail.com
marknickerson.com

Eight Phases of EMDR
(Shapiro 2001)

1. Client History and Treatment Planning
2. Preparation
3. Assessment
4. Desensitization
5. Installation of Positive Cognition
6. Body Scan
7. Closure
8. Reevaluation

Core Premise

Problem behaviors are often both symptomatic manifestations of maladaptive memory networks and ongoing reinforcers of these templates of response that compromise the quality of a person’s life.

• blueprints of a reactive system of response
• stored like a coiled spring

State-Based Learning

Clients often present with symptoms, not coherent verbal stories. Traumatic memory consists largely of reactivated, nonverbal memories, sometimes combined with incomplete narrative accounts that are split off from conscious awareness and stored as sensory perceptions, obsessive thoughts and behavioral reenactment.

The individual seems to “remember” what happened through reliving these nonverbal iterations of the historical traumata event.

These self-contained forms of memory do not necessarily interact with general autobiographical knowledge. Inaccessible to verbal recall, they typically remain unintegrated and unaltered by the course of time.

Van der Hart, et al

Tendencies stem from procedural memory of processes and functions, reflected in habitual responses and conditioned behavior (Shackter, 1996). They do not require conscious or unconscious mental representations, images, motivations or ideas to operate. They have the character of urges or impulses. They lie waiting a call to action, a trigger

Ogden, et al

Stored Trauma

All that went into the traumatic episode is stored in a memory node:

• Sensory impressions
• Affective states
• Cognitions
• Physiological reactions
• Action tendencies
Window of Tolerance

Activation Level vs. Time

Hyperarousal

Optimal Zone

for processing

Hypoarousal

Incident

Tension Building

Trigger

Winding Down

(Internalizing)

Back to Normal

Life “as Usual”

Alternative Action

Time Out/Time In

Incident (Nickerson 2007)
**Types of Problematic Behaviors:**

- Addictive/compulsive
- Abusive/destructive
- Emotionally driven (e.g., anger, fear, etc.)
- Avoidant/Neglectful
- Relational reenactments (e.g., co-depend.)
- Bad habits (e.g., over apologizing, being late)
- Dysregulation (sleep, eating, sexuality)

**Clinician Challenges**

- Common invisibility/ masking of problems hence a need for careful assessment.
- Clinicians often undertrained in certain areas and tend to misassess, mistreat or refer out too readily
- Clinicians sometimes avoidant and reactive to these issues

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**Common Dynamics and Considerations in Treating Problem Behaviors**

- Impact influenced depending upon: severity/ intensity, frequency, duration of incidents.
- Problematic in who’s eyes? Client/Significant Others/ Clinician
- Does it interfere with other needs being met?
- How destabilizing?

**Common Dynamics and Considerations when Treating Problem Behaviors**

- Locus of control issues
- Target of behavior: Externalized /Internalized
- Conscious/ Unconscious
- If conscious, is it “owned” as a problem by the client or “denied”
- Ego syntonic/ ego dystonic
- Dissociated ego states likely

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**Common Dynamics and Considerations with Treating Problem Behaviors**

- Trauma enhanced
- Stress Enhanced
- Emotional funneling- poor affect literacy and tolerance
- Situational Risk Factors
- Behaviors and action tendencies become part of the trauma memory

**Common Dynamics of Problematic Behaviors**

Cyclic pattern

- External or internal factors trigger impulsive/ compulsive behavior
- Compulsions are self-stimulating
- Fulfilling compulsions provides temporary relief
- Potential for negative consequences ignored
- Pattern of behavior reinforced over time
Common Dynamics of Problematic Behaviors

- Defensive behaviors built around the problem (denial, minimization)
- Preoccupation
- Secondary gain
- Co-morbidity with other problem behaviors
- Entangled with real needs
- Skill deficits

Questions to elicit problem behaviors:

“Are there behaviors you would like to change?”

- “Are there things you do that reflect your difficulties?”
- “Are there things you find yourself doing that have created problems for you or others?”

12-Step wisdom

- “Show up for your life”
- “Good things happen when I don’t drink- Bad things happen when I do drink”
- “People who drink to drown their troubles only teach them how to swim”
- “Fake it until you make it”
- “You can’t think your way into right action. You have to act your way into right thinking”
- “Move a muscle, change a thought”

Behavioral Compulsion: (working definition)

- You feel like doing something
- You know it is probably a bad idea
- You still feel like doing it
- You do it
- It feels good while you do it
- You regret it afterwards
- You forget the bad part
- Alternatives don’t work
- You do it again
- You try to justify it

The Cycle Model:
A Guide for History Taking and Treatment Planning for Treating Problem Behaviors

Additional details in handout
Cycle Model Protocol
A tool for assessment and intervention for problematic behaviors including trauma “acting out” and addictions.

- quickly builds client awareness and motivation
- guides case formulation and treatment planning
- informs strategies to stabilize, manage and resolve
- identifies appropriate EMDR protocols
- illuminates targets for reprocessing

Problematic Behavior
1. What is the recurrent problematic behavior you are concerned about?

Incident/Episode
2. Please describe what has happened in the past during an incident or episode of ________________ (the problem behavior)?

Aftermath
3. In the past, what has happened immediately after an incident/ episode of ________________ (the problem behavior)?
   What have you typically done after an incident?
   If others were involved, what have others done?

4. How have you felt afterwards? If others are involved, what have others felt?

Recovery
5. How have you recovered and gotten yourself back to normal?
### Moving forward

6. When you got back to normal, what have you done or tried to do about the problem? How has this worked for you? What has helped and what hasn’t helped?

7. Do you have new thoughts about what might help? What skills do you think you need?

### Triggers and Pre-existing Conditions

8. In the past, what triggers have activated you toward ________________ (the problem behavior)? (External triggers can include certain people, places or topics. Internal triggers can include certain emotions, thoughts, and bodily feelings.)

9. Under what pre-existing conditions unrelated to the triggering event have you tended to get more easily triggered? That is, what conditions make you vulnerable to being triggered? (This may include emotional moods such as irritable, mindsets like in a hurry, or physiological conditions such as being tired)

10. What experiences from your past do you think may link to these triggers and make them so powerful?

### Warning Signs and Urges

11. When you recall past times when you have been triggered and the tension was building, where were warning signs that could have told you that you had been triggered and might be headed toward engaging in ________________ (the problem behavior)? Warning signs can include things you certain behaviors, thoughts, emotions, or physiological reactions.

12. In the past, what urges, yearnings, or cravings have you had during the tension building phase that may have compelled you toward ________________ (the problem behavior)?

### Solutions- Alternative actions and attempted solutions

13. When triggered and the tension was building, what efforts have you made in the past to cope with the triggered reaction and divert from a tension building phase to get back to normal? How has that worked for you? When has that worked? Why do you think it worked? When has that not worked? Why do you think it hasn’t worked?

### “Positive” reward of the problem behavior

14. Even though it may not be good for them in certain ways, there is often some learned reward that a person may be getting or seeking from a problem behavior. Sometimes the reward is obvious and sometimes it’s more unconscious. Although you have identified ________________ (the problem behavior) as a problem behavior, can you think of a positive aspect of the behavior? What reward do you currently or did you once get from the behavior?

### “Positive” reward of the problematic behavior

15. When you think of a time in your life when that behavior was most rewarding, what positive sensations, feelings and thoughts did you have about yourself at that time?

16. Are there other healthier and less problematic ways you can pursue similar rewards and better meet your needs?
Meta-concerns and Motivation

17. If this cycle pattern continues, what do you think will be the consequences?

18. If you could believe right now that you are capable of change, how motivated are you now to break this cycle on a 0-10 scale?

Step 3: Establish Positive Treatment Goal

Positive Treatment Goal (PTG) should be:

- clarifying of goals
- client generated
- a meaningful stretch, but not unrealistic
- far enough away in time to accomplish goal but close enough to appeal
- magnetic in its appeal and thus motivating
- the light at the end of the tunnel

Step 4: Identifying Pathways and Obstacles

Orienting with the PTG, clinician and client:

- Identify gaps between current state and PTG
- Review information from Cycle Assessment
- Assess client strengths/ resources/ motivation
- Formulate and prioritize treatment priorities and sequences
- Reevaluate and revise treatment plan as needed

Decisions about where to start first should be based upon factors such as:

- client willingness and motivation
- stability/resources of the client
- acute needs and short term goals
- obstacles that are most problematic
- risk/benefit of destabilizing the client
- “bang for the buck” - biggest gains possible
Stages of Change

- Precontemplation (Not yet acknowledging that there is a problem behavior that needs to be changed)
- Contemplation (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change)
- Preparation/Determination (Getting ready to change)
- Action/Willpower (Changing behavior)
- Maintenance (Maintaining the behavior change) and
- Relapse (Returning to older behaviors and abandoning the new changes)

DiClemente and Prochaska

Questions to develop a treatment plan:

As you consider your Positive Treatment Goal and what we learned as we went through the phases of the cycle, let’s consider where we should focus our work together. Where can we strengthen your capacity for change and how can we overcome the obstacles that have interfered with change in the past?

Step 5: Determine Treatment Intervention and Begin Treatment

Treatment possibilities at each phase of the Cycle

Breaking the Cycle: Identifying Components

Incident

Tension Building

Urges and Yearnings

Warning signs

Trigger

Pre-existing conditions: Moods and Mindsets Current stress Past Trauma

Life “as Usual” Coping/Denial

Alternative action

Recovery

Regaining stability

Back to Normal

Breaking the Cycle: Intervention options

Incident

Tension Building

Deensitize triggers and urges

Identify and heed warning signs

Trigger

Identify and manage pre-existing conditions

Reprocess related trauma memories

Reprocess past incidents

Life as you want it Positive Treatment Goal

Reprocess consequences

Rehearse alternative action

Back to Normal

Develop resources, skills, self-regulation, motivation

Address unmet needs

Incident

Tension Building

Deensitize triggers and urges

Identify and heed warning signs

Reprocess consequences

Rehearse alternative action

Back to Normal

Develop resources, skills, self-regulation, motivation

Address unmet needs
Incident Aftermath

- Target and reprocess memories from the aftermath. Reprocessing the aftermath can reduce the phobic denial or minimization of the incident and therefore increase client awareness, support learning and increase motivation for change. Ask, What were the worst consequences of the incident? (reprocess)

Recovery

- Identify ways client recovers after an episode. Support effective coping and build skills as needed. Use reinforcing, rescripting and rehearsing protocols.

Moving forward

- Identify and strengthen core resources. Develop additional resources as needed to increase capacity to face and resolve difficulties (personal qualities, positive beliefs about self, etc.)
- Identify unmet needs that have been dysfunctionally coped with through the problem behavior. Build skills and develop ways to adaptively meet unmet needs. Use reinforcing, rescripting and rehearsing protocols.
- Address self-care, affect-regulation

Resource Development

- Safe (calm) place
- Container
- Physiological grounding
- Install (as resources) personal qualities needed to do the work. Redefine power with constructive qualities (e.g.):
  - Courage
  - Patience
  - Persistence
  - Love

Creating Behavior Change

- The Three R’s
  - Reinforcing: Strengthening
  - Rescripting (Redoing): Correcting
  - Rehearsing: Visioning and Practicing

Reinforcing: Enhancing Progress and Shaping Behavior

- Adaptive experiences/behaviors/feelings should be acknowledged and enhanced with BLS. (Especially progress between sessions!)
- “Notice how you handled that situation. What choices did you make? What do you notice now as you remember handling those situations?” (BLS)
Rescripting

Bad experiences can be rescripted with corrective “redos.”

1. “Imagine how you would have liked to have handled that situation if you could do it over.”

2. Or “Imagine how you would have handled that situation knowing what you now know.”

3. Enhance with multiple sets of BLS until fully strengthened.

Rehearsing for the Future

Future Templates:
Anticipatory Anxiety (third prong of Standard EMDR Protocol).

1. Use established Positive cognition that comes after reprocessing all memories connected to a negative cognition or...

2. Use a temporary positive cognition based upon the most positive belief the client can hold to with a VOC of 6 or 7.

What’s a positive belief you can leave here with today?

Skills Building with Imaginal Rehearsal

1. Establish and access a positive cognition, a personal quality, a skill and/or another resource
2. “Holding ______ in mind, I would like you to imagine coping effectively with______.”
3. Sets of BLS to refine and enhance.

Enhance with multiple sets of BLS until fully strengthened. Add in new skills and resources as needed.

If significant distress continues, target and reprocess memories linked to the distress.

Window of Tolerance:
learning to self-regulate

Affect Regulation:

• Affect Tolerance: A. Leeds, R. Kiessling, others
• Pendulation between calm state and an affective experience
• Target and reprocess life experiences that inhibited emotion
• Emotional reset: K. O’Shea

Processing on the imaginal level: What does anger look like? BLS

Triggers and Preexisting Conditions

• Identify Preexisting Conditions such as emotional moods, mindsets, or physiological conditions that create a vulnerability to being triggered. (Use Red Flag Trigger worksheet for times and topics)
• Identify Triggers that ignite the tension building phase
• Identify Warning Signs that client has been triggered. Use Red Flag warnings worksheet Increase client awareness.
Red Flags: High Risk Challenges and Triggers

Times/ Situations  
Topics

Red Flags: Warning Signs

Verbalizations/Actions  
Neg. Thoughts  
Emotions  
Body Sensations

Alternative Action Plan

• Develop an Alternative Action Plan to more adaptively cope with Warning Signs. Rehearse alternative strategies with BLS. Develop resources as needed to increase strength of the alternative plan (personal qualities, positive beliefs about self, new skills, etc.)

Protocols for Immediate Behavioral Change

• Skill Building
• Detailed Scripts:
  Time-Out/Time-In Procedure
  Assertiveness and Empathy Scripts
  Call your sponsor
  Going to the grocery store

Desensitize Triggers and Urges

• Target and desensitize Triggers and Urges/Yearnings/Cravings with EMD (such as DeTUR)
Addiction Protocols

Eye Movement Desensitization and Reprocessing (EMDR) Scripted Protocols: Basics and Special Situations
New York: Springer Publishing Co, Inc.
Luber, Marilyn. (2009)

Positive reward/attraction of the problematic behavior
Target the apparently rewarding aspect of the problem behavior to uncouple the link between a genuine need and the currently dysfunctional behavior.

Strategies:
• “What’s good about the behavior?” to dislodge
• Feeling-State Addiction Protocol

DeTUR Protocol- A.J. Popky
Desensitization of Triggers and Urge Reprocessing

Desensitize Triggers
1. Positive Treatment Goal (PTG) established, triggers identified
2. Picture of trigger + words, sensation, emotions
3. Identify Level of Urge (LOU) (0-10)
4. Contained processing (what do you get now, frequent back to target, frequent LOU checks)
5. However, some tolerance of accessed negative material then diverting the standard EMDR
6. When LOU is 0, link and install with PTG
7. Follow up

Target the Defense

• Acknowledge the meaning of the defense (addiction, rationalization)
  How has your ______(defense) helped you?
  How has avoiding _______ (what you are defended against) helped you?

• Invite attention to it
• Often it will clear, allowing access to previously inaccessible material.
  Jim Knipe

Dysfunctional Positive Affect (Jim Knipe)

Codependence or Obsession with Self-Defeating Behavior
• Can you think of a time you engaged in this unwanted behavior (e.g. over apologized)?
• When you think of it, how strong is the urge to repeat it?
• Desensitize
• Look for blocking beliefs/ disturbing memories: if evident use standard protocol

Dysfunctional Positive Affect (Jim Knipe)

Issue: Procrastination
Addicted to putting things off (avoidance)
1. Bring to mind procrastination problem.
2. What would you do if you really solved this?
3. Picture doing that. What is your LoU to do something different.
4. Desensitize LoU
5. Future template
Robert Miller, Ph.D.

- http://www.fsaprotocol.com

Feeling-State Theory of Behavioral and Substance Addictions

Feeling-State + Triggering Event creates urge for...

Desired Feeling + Compulsive Behavior

Target the linkage of the Feeling-State and the Compulsive Behavior

Collapse of idealization

Feeling-State Addiction Protocol

Protocol Overview

1. Imagine doing the specific behavior.

2. Feeling the specific feeling associated with that behavior.

3. Perform eye movement sets (utilizing a modified form of EMDR) to break the fixation between feeling and behavior.
Reprocessing trauma:

- Identify past Traumatic or Disturbing Life Experiences that are linked to triggers and preexisting conditions. Strategically prioritize targets for reprocessing.

Standard EMDR with managed processing considerations
- Reprocess traumatic memories from incidents related to problem behavior (Hase Protocol)

Goal: Address co-morbidity of PTSD and substance abuse

Addiction Memory (AM):
- Individual acquired memory following drug consumption
- Can be cue stimulated
- Resistant to change

- Two primary targets of addiction memories for EMDR reprocessing
  1. Memories of drug consumption or relapse
  2. Memories of intense cravings

During Assessment: Level of Urge (LoU) is used rather than SUDS

Michael Hase

CravEx

Target Selection and Evaluation:
1. Relapse and intense craving (target each)
2. Recent first (easier to access and evaluate)
3. Then first and worst
4. LoU scale (monitor)
5. Get LoU to 0
6. Installation and body scan
7. Reevaluate NC and PC

Old School Desensitization

*Now relax... Just like last week, I'm going to hold the cape up for the count of 10... When you start getting angry, I'll put it down.*
**Three Pronged Protocol**

**Identify Presenting Issue**
- Past—What memories set the foundation?
- Present—What situations trigger disturbance?
- Future Templates—What skills, behaviors, information are necessary for optimal functioning in the future?

**Preparing for upcoming challenges**
**Float Forward/ Float Backward**
1. As you imagine an upcoming challenge, what’s the worst thing that could happen?
2. What image represents the worst part?
3. What negative beliefs/emotions/body sensations go with that image?
4. Holding the felt sense that goes with that worst part image, allow yourself to float back in your life to memories that are linked to these feelings. What do you notice?
5. Reprocess.

**Phase I Target Selection:**
**Common Need for Symptom-Focused Work**
Current issues have
- high relevance and
- high activation levels
whereas old trauma may be initially denied and well buried
- Use cycle of violence model to generate targets
- Use Float Back Technique whenever appropriate and proceed with standard protocol

**Reasons for Managed Processing**
- Time constraints
- Symptom reduction focus
- Present focused
- Triggers/Urges reduction
- Contracted agreement
- Limited affect management
- Complex trauma (bit by bit)
- Staying within the window

**Processing a Disturbance (A-TIP)**
- Target image- Phase 3 Assessment.
- Begin Reprocessing BLS
- After set, say “Take a breath..., think of the incident, from 0-10, how disturbing is it now...?” Say, “Go with that.”
- Repeat 4-5 times
- Then ask: “What is different about the target?” take another SUD (0-10) and say, “Go with that”
- Repeat until SUDs no long lowers

![Breaking the Cycle: Identifying Components]

- Incident
- Tension Building
- Urges and Yearnings
- Warning signs
- Life “as Usual”
- Pre-existing conditions: Moods and Mindsets
- Current Stress
- Past Trauma
- “Reward” of behavior
- Alternative action
- Alternatives: immediate consequences
- Recovery
- Regaining stability
- Back to Normal
Behavioral Addiction: treatment strategies

- You feel like doing something (urge desensitization)
- You know it is probably a bad idea (RDI, Future Rehearsal)
- You still feel like doing it (target the urge)
- You do it
- It feels good while you do it (FSAP)
- You regret it afterwards (target worst part)
- You forget the bad part (target worst part)
- Alternatives don’t work (rehearsing)
- You do it again
- You try to justify it (Blocking Beliefs)