Chapter 25
Reflections on Providing Virtual Eye Movement Desensitization and Reprocessing Therapy in the Wake of COVID-19: Survival Through Adaptation

Gillian O’Shea Brown

The spread of the COVID-19 virus has led to severe public health challenges, including detrimental physical and mental health outcomes nationwide. In this time of collective trauma, the effects of COVID-19 will undoubtedly give rise to unequal degrees of hardship, primarily impacting those who are most vulnerable to structural and systemic inequality. This phenomenon has presented many challenges for therapists, particularly those who utilize eye movement desensitization and reprocessing (EMDR) when treating populations who often present with an underlying diagnosis of complex posttraumatic stress disorder (C-PTSD). The negative effects of layered relational trauma, particularly through childhood abuse and neglect, have long been recognized as contributing factors towards the development of C-PTSD (Courtois 1988; van der Kolk 2015), a diagnostic entity included in the International Classifications of Diseases, 11th revision (ICD-11). According to the ICD-11, C-PTSD is associated with a broad spectrum of psychopathological symptoms and is conceptualized as including the core elements of PTSD such as re-experiencing the trauma, deliberate avoidance of internal and external traumatic reminders, and a sense of current threat expressed as hypervigilance and hyperarousal. The ICD-11 has also recently identified additional C-PTSD symptoms, including emotional regulation difficulties, persistent negative views of the self, and interpersonal problems characterized by difficulties forming and maintaining relationships with others (WHO 2018). Until recently, C-PTSD was never officially codified in any diagnostic nomenclature. Endorsement of the ICD-11 definition of C-PTSD will come into effect on January 1, 2022.
The chapter will first discuss the development of C-PTSD, with special consideration for how the COVID-19 pandemic may heighten the risk of retraumatization and exacerbate symptoms. This chapter will also provide an overview of EMDR as a psychotherapy modality for treating C-PTSD, specifically focusing on the application of resource development and installation (EMDR-RDI) for stabilization. EMDR-RDI refers to a set of EMDR protocols that focus exclusively on strengthening connections to positive affective states and resourceful memories (Korn and Leeds 2002; Leeds 1995; Leeds and Shapiro 2000). Additionally, this chapter will review the existing relevant literature and provide an analytical take on the ethical and clinical implications of providing virtual EMDR (V-EMDR) therapy. A composite case will illustrate how EMDR-RDI is provided via teletherapy. Finally, reflections of the practice benefits and challenges of providing V-EMDR will be discussed, including limitations and recommendations guiding future practice.

C-PTSD in the Time of COVID

C-PTSD transcends the category of posttraumatic stress disorder (Herman 1992), including both the core elements of PTSD, such as re-experiencing, avoidance, and hypervigilance, as well as symptoms of poor affect regulation, negative self-concept, and difficulties with establishing and maintaining healthy interpersonal relationships (WHO 2018). The long-term psychological impact, of both the spread of the COVID-19 virus and the restrictive policies adopted to counteract it, remains uncertain. However recent research has indicated heightened risk of trauma-related symptoms, which has the capacity to exacerbate C-PTSD symptoms for several reasons (Forte et al. 2020; Shigemura et al. 2020; Zandifar and Badrfam 2020). Social distancing, confinement, and quarantine were adopted to contain diffusion. This has altered the fabric of society, creating changes to consciousness and awakening a climate of trepidation. For many individuals who struggled to adapt to survive, strong relational bonds, community ties, education institutes, and places of religious practice were abruptly taken away. This abrupt loss of social norms has the potential to activate hypervigilance in many trauma survivors, while also creating a large-scale sense of uncertainty that is characteristic of a global pandemic (Forte et al. 2020). Social distancing, confinement, and quarantine were adopted to contain diffusion. This has altered the fabric of society, creating changes to consciousness and awakening a climate of trepidation. For many individuals who struggled to adapt to survive, strong relational bonds, community ties, education institutes, and places of religious practice were abruptly taken away. This abrupt loss of social norms has the potential to activate hypervigilance in many trauma survivors, while also creating a large-scale sense of uncertainty that is characteristic of a global pandemic (Forte et al. 2020). Additionally, for many trauma survivors, therapy represents a stable, predictable, reliable, and trustworthy foundation that instantiates a sense of trust and connection. Just like the parent-child dyad, the clinical relationship promotes the formation of a secure attachment in which the therapist demonstrates sensitivity to the individual’s emerging intentionality (Fonagy et al. 2007). This relationship requires the therapist to possess the ability to demonstrate attentiveness and mirroring, an interpersonal phenomenon in which the attachment figure adjusts the timing and content of their behavioral movements to mirror another’s behavioral and emotional cues, fostering empathy and rapport (Chartrand and Bargh 1999). Secure attachment experiences require mentalizing (i.e., the ability to understand the child’s subjectivity) and, in turn, lead to the formation of epistemic trust (i.e., the individual’s
willingness to experience the environment and consider new information as trustworthy) (Corriveau et al. 2009). An individual who has endured numerous experiences of rejection by the attachment figure has a memory network that can be easily triggered (Ainsworth 1982; Bowlby 1989). Consequently, clients presenting with C-PTSD will likely have complex relationships with themselves and their attachment figures, which should be addressed compassionately when quarantine restrictions prevent in-person therapy sessions, as these experiences could be perceived by the client as abandonment, rejection, or even punishment.

In the wake of COVID-19, clients were abruptly directed to self-quarantine, and the usual considerations for treatment planning and termination planning were unavailable. Changes to treatment which ordinarily would be carefully co-created and discussed over weeks or months were hastily made as this large-scale crisis began unfolding precipitously. Teletherapy is one potential alternative to in-person session; however, teletherapy is a privilege reserved only for those who can afford a phone, stable Internet connection, and/or a laptop, as well as a place of solitude where they can confidentially and safely process their emotions. When clients are unable to partake in teletherapy, preferring the safety and familiarity of their weekly in-person session, treatment shifts towards termination. Ordinarily at termination, a client’s symptoms have declined, and treatment can address the loss of the therapeutic relationship, culminating in the metaprocessing of emotions related to termination of the treatment. However, in the wake of this pandemic and the essential move toward quarantine, some clients were placed in a situation where they had to unexpectedly terminate the therapeutic relationship. For those who transitioned to teletherapy, the ramifications of COVID-19 became evident through expressions of reported survivor’s guilt, helplessness, emotional reactivity, hypervigilance, and in some cases, avoidance and numbing (Forte et al. 2020; Shigemura et al. 2020; Zandifar and Badrfam 2020).

The EMDR Resource Development and Installation Protocol

EMDR is a modality which addresses both the brain and body. Since its inception, EMDR has been understood by both therapists and clients as a powerful vehicle for processing traumatic experiences but only when the client has achieved stabilization (Shapiro 1995). The efficacy of EMDR therapy in the treatment of PTSD has been well established in over 30 positive randomized controlled studies during the past three decades (Ahmad et al. 2007; Marcus et al. 1997, 2004; Shapiro 2014; Wilson et al. 1997). Such research findings led to the World Health Organization (2013) stating that trauma-focused cognitive behavioral therapy (TF-CBT) and EMDR are the only psychotherapy modalities recommended in the treatment of children, adolescents, and adults who meet the diagnostic criteria for PTSD. It is important to note that most of the above study participants differ from survivors of complex trauma with chronic abuse and neglect histories in terms of symptom presentation and capacity for tolerating trauma-focused work (Korn 2009). EMDR is a trauma
resolution approach that involves a standard set of procedures and clinical protocols including specific types of bilateral sensory stimulation.

The EMDR approach incorporates the adaptive information processing (AIP) model, which posits that memories of distressing experiences are dysfunctionally stored in the brain in an unmetabolized state in the memory networks that contain perceptions, negative beliefs, affect, and body sensations that arose during the experience of trauma (Shapiro 2007). The unmetabolized memories, much like a “skipping disc,” will replay the most distressing part of the memory, which can cause intrusive thoughts, shame-based cognition, and psychological reactivity that can be activated by sensitivity cues. EMDR classically involves eight phases, which include (1) history taking, (2) preparation and stabilization, (3) assessment, (4–7) desensitization, reprocessing, closure, and finally (8) reevaluation (Shapiro 1995). Specific focused strategies and bilateral stimulation (administered through eye movements, tapping, or tones) help the client access dysfunctionally stored memories and related affect which, in turn, desensitizes the emotions and physical sensations and enables them to access more adaptive material stored in the brain. Ultimately this promotes the formation of new, positive associations with the original event, such as “the risk of harm has passed and I am now safe.”

Research has found that the treatment of complex trauma should be phase-oriented, multimodal, and skill-focused, with a core emphasis on symptom relief and functional improvement (Briere and Scott 2006; Courtois et al. 2009; van Der Kolk et al. 2005). In the treatment of complex trauma, the EMDR model is adapted to be phase-oriented, highlighting the importance of the role of resource development strategies that address the needs of patients with compromised affect tolerance and self-regulation (Korn 2009). This allows the client to operate out of deep self-awareness rather than conditioning. The preparatory steps of EMDR involve history taking and providing clients with a sense of safety so that they can begin to identify memories and communicate more openly, facilitating effective trauma reprocessing. This involves the therapist consciously observing and gathering information on the client’s background, while assessing their suitability for EMDR. The second phase of the EMDR protocol centers on preparation by providing clients with tools that will prepare them for EMDR, including enhancing their ability to independently tolerate positive affect regulation. During this preparatory phase of treatment, there is a strong emphasis on building affect tolerance and psychoeducation; this is known as resource development and installation (RDI).

Leeds (1995) introduced RDI along with the proposed principles for the use of bilateral stimulation along with positive images and memories. RDI was incorporated into the EMDR protocol early on and has been utilized to strengthen affective, cognitive, and behavioral coping skills (Korn and Leeds 2002; Shapiro 1995). EMDR-RDI refers to a set of EMDR protocols that focus exclusively on strengthening connections to positive affective states and resourceful memories (Korn and Leeds 2002; Leeds 1995; Leeds and Shapiro 2000). EMDR-RDI is used to help clients access existing resources and develop new and effective coping skills such as mindfulness, self-soothing, distancing, grounding, and emotional regulation (Leeds and Shapiro 2000). EMDR-RDI focuses on stabilizing and preparing the clients for
the next phases of treatment, when attention will turn to the processing of traumatic memories. A central feature of complex trauma is a loss of the ability to physiologically modulate stress responses in addition to a diminished capacity to utilize bodily signals (van der Kolk et al. 1996). EMDR-RDI can be very effective in increasing affect tolerance when it is used to enhance mindfulness, the ability to notice a feeling or bodily sensation and accompanying emotions (Korn 2009). Survivors of complex trauma often present with increased dissociative symptoms; therefore, establishing safety in the body is paramount to the healing process (Forgash and Copeley 2008). The efficacy of EMDR can be challenged by symptoms of dissociation and complex trauma; therefore, RDI is highly beneficial to the efficacy of treatment (Fisher 2002; Korn and Leeds 2002). When administering EMDR-RDI, Korn and Leeds (2002) recommend shorter sets of bilateral stimulation – six to twelve bidirectional movements are used – to ensure that the client is installing a positive resource and not accessing painful material as with standard processing.

EMDR-RDI offers a range of valuable resourcing interventions and exercises that can relinquish maladaptive defenses, as new coping skills, self-capacities, and resources are developed and strengthened (Korn 2009). The basic EMDR-RDI protocol (Korn and Leeds 2002) involved a range of resources that the client could choose from which included mastery of experiences, relational resource, and symbolic resources. EMDR-RDI has been further developed and adapted to include many other positive resources and grounding protocols by other EMDR clinicians including Janina Fisher PhD Fisher (2001) and Laurel Parnell PhD Parnell (1999). Korn and Leeds (2002) proposed the “Relational Resource,” which involved resourcing the client with a “supportive figure,” a trustworthy, reliable person who could serve as their imagined guide before they engaged in processing of painful material. This approach fosters a sense of safety, stabilization, and empowerment in trauma survivors. During the upheaval caused by COVID-19, utilizing EMDR-RDI might assist individuals in establishing a sense of safety in their body, even when faced with uncertainty, loss of resources, and isolation.

**Virtual EMDR**

Continued advancement in the technology domain has enhanced the development and utilization of mobile health applications, especially those using EMDR techniques to facilitate the therapeutic process. EMDR has always been tightly tied to technology, as various technological devices were created to assist with bilateral saccadic eye movements and other forms of sensory dual attention mechanisms (Shapiro 2018). With EMDR mHealth applications, the EMDR therapist can attach headphones to a mobile phone device and then use the application to administer bilateral tones to the client. In alternative versions, the therapist will play the application on a computer, providing the client with both visual and auditory bilateral stimulation (Lee and Cuijpers 2013). However, research measuring the efficacy and safety of these applications is limited, particularly for clients who may present with
complex posttraumatic conditions and associated comorbidities (Marotta-Walters et al. 2018).

As individuals adapt to survive during the COVID-19 global pandemic, the potential dangers associated with this kind of technology cannot be disregarded. At the present time, there are no federal or state agencies overseeing the confidentiality of data collected by mHealth applications, which are available in the mobile application stores. The Federal Communications Commission (FCC), Food and Drug Administration (FDA), and the Office of Civil Rights can only regulate mHealth applications when the applications interact or exchange personally identifiable data with Health Insurance Portability and Accountability Act (HIPAA)-covered entities (Marotta-Walters et al. 2018). Marotta-Walters and colleagues (Marotta-Walters et al. 2018) caution that the easy accessibility to unregulated mHealth applications for the treatment of severe mental health issues such as C-PTSD pose a number of serious risks, including a lack of HIPAA-compliant data privacy and security. These applications also have the potential to cause harm to clients if used improperly, including triggering dissociation and emotional dysregulation. In terms of EMDR mHealth applications, generally a brief description of the mechanism of bilateral stimulation using a sensory-based stimulus is provided; however, many do not provide the theoretical basis for EMDR (Marotta-Walters et al. 2018). Unfortunately, the widespread distribution of these applications also allows for individuals to access disturbing memories via self-administered bilateral stimulation without the guidance of a trained EMDR therapist.

Despite its structured protocol, EMDR therapy remains a highly relational process. EMDR therapists are formally trained to assist clients through experiencing intense reactions during processing, such as dissociation, looping (getting stuck in painful material), emotional dysregulation, and unexpected somatic responses. Shapiro (2018) has cautioned that there is a significant risk of retraumatization in the context of self-directed EMDR, postulating that memories may merely be dissociated rather than reprocessed. Furthermore, most of the mHealth applications are developed without the involvement of healthcare providers and with no assurance of security and privacy of private health information (Boulos et al. 2014; O’Neill and Brady 2012). Consequentially, in a review on mHealth applications designed to facilitate Virtual Eye Movement Desensitization and Reprocessing (V-EMDR), Marotta-Walters and colleagues (Marotta-Walters et al. 2018) recommended that applications should only be used by trained EMDR therapists as a tool to facilitate V-EMDR treatment, as long as the therapist provides an “appropriate and regulated environment” to facilitate EMDR treatment. However, the terms of “appropriate and regulated” are not clearly outlined or discussed in this review, leaving it largely open to the interpretation of the EMDR-trained therapist.

In January 2020, the EMDR International Association’s Report of the Virtual Training and Therapy Task Group was released with the intention of providing clearer direction concerning best V-EMDR practices. In this report, references to virtual delivery of EMDR therapy pertain exclusively to EMDR therapy that is administered by an EMDR-trained therapist online via HIPAA-compliant telecommunications that have a business associate agreement (BAA). References to
V-EMDR in the report do not concern companies, websites, or services that offer EMDR self-therapy without live guidance from an EMDR-trained therapist. Mirroring the concerns expressed by Marotta-Walters and colleagues (Marotta-Walters et al. 2018), self-administration of EMDR therapy is strictly forbidden in the policies outlined in this report. Additionally, this task group highlighted the necessity for EMDR-trained therapists to complete a tele-mental health certification in order to maintain a safe standard of online practice, prior to providing V-EMDR. The task group further recommended that EMDR therapists stay abreast of the rapidly changing technologies and guidelines in order to adequately maintain safety and security within their practice. Along with these technology guidelines, this task group recommended that EMDR clinicians providing virtual treatment must demonstrate online attunement, ethical integrity, and fidelity to the EMDR therapy model. While EMDR-trained therapists are guided to be attentive to the client’s safety and comfort level during reprocessing, V-EMDR may heighten the risk for misattunement because of limited eye contact, limited visual cues (noticing motor activity), and the forfeiture of the in-person connection. Furthermore, when conducting V-EMDR, there is no possibility of providing clients with a confidential therapeutic environment. Despite these potential limitations, the utilization of V-EMDR places emphasis on attunement and stabilization. The focus on connection can prove to be anchoring particularly during the social isolation caused by the COVID-19 pandemic.

Case Study

The following case study is a composite case which contains elements and techniques derived from a number of EMDR sessions. Savannah\(^1\) is a 36-year-old married Hispanic female, employed full time in the media industry. Savannah has a diagnosis of complex posttraumatic stress disorder and presented to treatment with symptoms of a trauma-related mood disorder and anxiety due to history of relational trauma including child sexual abuse, physical abuse, and emotional abuse. She has engaged in EMDR-oriented therapy for over 6 months. Over the course of her treatment thus far, history taking has revealed pervasive negative cognition, including thoughts of weakness and inadequacy. Savannah reported repeated disturbing memories, somatized symptoms related to trauma, pervasive guilt, low mood, and hypervigilance arising from childhood complex trauma. Due to the onset of COVID-19, Savannah was unexpectedly placed in quarantine, putting an abrupt end to her in-person sessions. The following paragraphs contain a reflection of Savannah’s first virtual EMDR session from the perspective of the therapist.

During this session, I was mindful to ensure that Savannah was in a quiet and confidential space in her home. I positioned myself so that I appeared in the center

---

\(^1\)A pseudonym has been used to preserve confidentiality.
of her screen, showing my face and upper torso in a well-lit room to resemble how I would appear if I was sitting adjacent to her in the therapy suite. Some décor from my therapy office was intentionally placed in the background to create a sense of familiarity, warmth, and comfort. I noticed and remarked that we could see each other’s facial expressions more closely, and she remarked that because my earphones were attached to my computer, she felt that this space was safe, intimate, and confidential. In the beginning of this session, Savannah was facilitated through processing her emotions regarding this period of adjustment. She reported feeling anxious and reported other familiar somatized symptoms of trauma, such as pervasive nausea and gastrointestinal upset. She was provided with psychoeducation and information regarding the use of technology-assisted bilateral stimulation via the mHealth applications. Savannah was guided through downloading the application and instructed to listen to auditory bilateral stimulation through her earphones attached to her cellphone, while simultaneously engaging in telepsychotherapy on her laptop. Once comfort and ease were established concerning the tempo, volume, and sound quality of the audio, she was guided through the grounding protocol. The following excerpts illustrate the process of Savannah being guided through the installation of a “relational resource” (Korn and Leeds 2002) as adapted from Fisher’s modified EMDR-RDI protocol (Fisher 2001).

**Therapist:** Sit back in the chair, connect with your body, and begin to breathe deep in to the stomach. You are seated with your feet on the ground (pause). Please think about a place that feels calm (pause). When you have the image of what represents your calm place, I want you to let me know by nodding.

**Client:** (Nods).

**Therapist:** Tell me what you see.

**Client:** I am at a house that David and I sometimes visit upstate. I am sitting on the back deck. I have just practiced yoga. I can hear bees buzzing in the distance. It’s a warm day. I feel Zen.

**Therapist:** As you think of that experience, notice what you see, hear, and feel. Notice what emotions you are experiencing and how you feel in your body (6–8 sets of bilateral stimulation).

**Client:** The air is cool. I feel calm. It is peaceful up here. I am present. I feel relaxed in my body. I feel like I can breathe easily up here. My body feels calm.

**Therapist:** Focus on your calm place and its sights, sounds, smells, and sensations (pause). Tell me more about your experience (6–8 sets of bilateral stimulation).

**Client:** I can see the sky; the greenery looks so beautiful and I hear the leaves move in the wind. The air is cool and fresh; I am enjoying the view. My shoulders are loose and I am breathing deeply and easily.

**Therapist:** Bring up the current image (pause). Concentrate on where you feel the pleasant sensations in your body, and allow yourself to enjoy them. Concentrate on those sensations. (6–8 sets of bilateral stimulation).

---

2 A pseudonym has been used to preserve confidentiality.
Client: (Shoulders drop, jaw is unclenched, client has a slight grin).

**Therapist:** What are you noticing now (6–8 sets of bilateral stimulation)?

Client: Cool and fresh air and the gentle movement of the leaves. There is no chaos up here, only harmony. My body is rested. I have deep breaths. It is peaceful up here.

**Therapist:** Focus on that. What do you notice now (6–8 sets of bilateral stimulation)?

Client: I feel calm in my body. I feel it in my chest.

**Therapist:** Is there a word or phrase that represents your calm place (6–8 sets of bilateral stimulation)?

Client: I am at peace.

**Therapist:** Think of the words “I am at peace,” and notice the positive feelings and sensations you are having when you think of those words (substantial pause). Concentrate on those sensations and the words “I am at peace,” and be curious about the sensation. What are you noticing now (6–8 sets of bilateral stimulation)?

Client: I am strong and I am at peace.

**Therapist:** Now say the words “I am at peace” and notice how you feel (6–8 sets of bilateral stimulation).

Client: I feel strong.

**Therapist:** Allow those words to metabolize in your body. (Pause). Ok wonderful, come back again to the room. Gently come back to your body and open your eyes.

Client: I am back (laughs) – I needed that!

**Therapist:** You did wonderfully. We need to find a way to support you in processing painful material. What inner strength or resource would help you feel less overwhelmed?

Client: I feel like I am always alone when I am most hurt. It scares me when people lose control and become unpredictable and crazy. Everyone is so crazy right now!

**Therapist:** Is there a reliable, nurturing figure that could serve as a supportive guide to you?

Client: My sixth grade teacher Mrs. Elgin would always remember my birthday, and sometimes she would see that I was alone and find a way to make me feel important. She was so kind; the way she looked at me – there was a warmth in her eyes I had never seen before – it felt like home. Even though home at that time was a house of horrors, when she smiled at me, I felt safe, important, and even special.

**Therapist:** That is a wonderful choice for a warm nurturing figure. I could hear the warmth in your voice as you recalled her warm nurturing presence. Close your eyes and imagine what it would feel like to have her presence as a resource (6–8 sets of bilateral stimulation).

---

3 A pseudonym has been used to preserve confidentiality.
Client: I would feel guided and protected. When I would enter her classroom, I always felt calm and heard. She has a smile on her face that reaches her eyes and I feel a smile on my face. She makes me feel safe.

Therapist: Yes, and if you felt safer, what would follow from that (6–8 sets of bilateral stimulation)?

Client: I feel strong and powerful.

Therapist: Once again, imagine yourself with Mrs. Elgin; imagine her warm presence and gentle smile. In every cell of your body, you feel safer and even protected. (Pause). Notice the feeling in your body that goes with having a warm nurturing figure available to you (6–8 sets of bilateral stimulation).

Client: (Smiling – eyes closed – head held high). My throat is open; stomach feels neutral. This is the first time my stomach has felt neutral all week. I feel very Zen right now.

Therapist: Yes, with your Mrs. Elgin available to you, you feel calmer and more peaceful – go with that (6–8 sets of bilateral stimulation).

Client: (Smiling). (Hands are placed on heart center).

Therapist: What would Mrs. Elgin say to that sensation (6–8 sets of bilateral stimulation)?

Client: You are here and you are safe.

Therapist: You are here and you are safe. Slowly, slowly come back into this room, noticing toes in shoes, tongue in your mouth, eyes fluttering, and when you’re ready I want you to switch off the bilateral stimulation. How are you feeling Savannah (6–8 sets of bilateral stimulation)?

Client: I feel safe and I am powerful.

Reflections on Proving Virtual EMDR

The EMDRIA task group for virtual EMDR advised that it is prudent for EMDR clinicians providing any treatment virtually to demonstrate online attunement, ethical integrity, and fidelity of the EMDR therapy model. Heeding the cautions of the timely EMDRIA report and being mindful of the need for continuity of care in the wake of COVID-19, I found it critical to balance the duty of care and the dignity of risk to meet Savannah’s needs for grounding and stabilization during this time of collective trauma. I initially felt ill-equipped to adapt treatment to V-EMDR without the appropriate training; however, because of COVID-19, I was forced to lean into this discomfort and venture into an unfamiliar territory. Balancing both parts of my clinical discernment, I chose to proceed with caution and listen for any signs that the new adaptation was causing Savannah heightened anxiety or distress. I was conscientious to practice online attunement, and made sure to monitor her breathing, facial expressions, eye contact, and tone of voice. I practiced self-guided grounding techniques prior to the session, being mindful of my physiological responses to collective trauma. Shared trauma as described by Tosone et al. (2012) refers to the affective, behavioral, cognitive, spiritual, and multimodal responses that clinicians
experience as a result of dual exposure to the same collective trauma as their clients. Despite our shared experience of the uncertainty related to the pandemic, I wanted to ensure that my own affective state and cognitive processing was regulated and not mirroring her uncertainty and activation. I was also mindful of the risk of blurring professional and personal boundaries, along with the increased risk of self-disclosure. In terms of attunement, I was conscious that my tone of voice and breathing were stabilized, so that I could fully focus on tracking somatic and non-verbal cues exhibited by Savannah. In my own countertransference, I later realized that I aspired to serve as her anchor in an unsettled world.

Despite its structured protocol, EMDR therapy remains a highly relational process. The foundational steps of EMDR processing involve providing the client with psychoeducation around dissociation, trauma, and affect regulation techniques. Savannah and I had had the benefit of completing these steps in person during our months of in-person EMDR therapy. Savannah became so comfortable during this time in the therapy room that she began to paraphrase me when exploring her newly acquired psychoeducation and complex mind-body relationship. Savannah was an eager and willing client, always demonstrating magnificent curiosity by asking for journal prompts and additional readings on theories that resonated with her during sessions. Even given these successful in-person sessions, I found V-EMDR particularly challenging for several reasons. For example, using this modality I could not see Savannah’s bilateral extremities, as I generally could during our in-person EMDR sessions. This is important as I had initially observed that Savannah’s left ankle would sometimes become agitated when she was processing painful material from her formative years, which served as a subtle somatic cue. As visual cues are limited when using V-EMDR, I could only observe her face and upper bilateral motor activity during these sessions, depriving me of her usual motor activity and affect regulation cues. Using this technology, I felt limited to the auditory bilateral stimulation, as eye movements directed via hand gestures presented were less effective when administered through teletherapy, according to Savannah’s feedback. This may be concerning for hearing-impaired trauma survivors seeking V-EMDR. Furthermore, Savannah’s previous EMDR processing had occurred exclusively with bilateral stimulation via a pulsar, though she appeared to adapt well to auditory bilateral stimulation. During our teletherapy session, Savannah lamented that she missed coming to my office; however, she reported that V-EMDR had provided her with the familiar sense of lightness she needed from stabilization resourcing. EMDR therapists must have the clinical awareness to know when to provide therapeutic assistance for grounding and restabilizing (Watson-Wong 2013). I wanted to provide Savannah with stabilization; however, I was reluctant to venture into potentially destabilizing territory as I felt limited in the quality of a safety plan I could put in place if needed, given the overwhelmed state of the healthcare systems during the early stages of the pandemic. In order to be prudent to the safety guidelines, I provided additional time for session closure and followed up with Savannah in terms of her wellness in between sessions. I also provided Savannah with follow-up instructions promoting her mind-body attunement and suggested resourcing homework to be completed in between sessions. While these are all
classic components of EMDR therapy, I felt compelled to be even more consistent in the application and was more conservative when it came to V-EMDR rather than in-person EMDR.

It is critical for therapists to build strong attunement and communication skills to ensure optimal connection with the client during V-EMDR. This process is ripe with opportunities for misattunement, given unavoidable technical glitches and/or unclear processing. This is especially true for clients suffering from C-PTSD, as technological malfunctions, for instance, a frozen screen, can appear eerily similar to the “Still Face Experiment.” The “Still Face Experiment” was conducted by placing an infant face to face with their nonresponsive expressionless mother following 3 min of free interaction (Tronick et al. 1978; Tronick and Gold 2020). After repeated attempts to engage their mother, the infant typically withdraws and orients their face and body away from the mother with a withdrawn, hopeless facial expression. This “still face” response, caused by connectivity issues, may inadvertently replicate this experience in emotionally vulnerable clients, which may impact the client-therapist dyad, causing undue stress and potential retraumatization. To counteract the risk of misattunement, Watson-Wong (2013) has advised that prior to beginning reprocessing, clinicians should build an alliance with a client’s adult ego state to enable helpful communication and evaluate missed or confusing cues and clues during processing. Therapists should apply their transferable clinical and attunement skills, to help clients stay engaged and connected during telepsychotherapy.

Conclusion

The spread of COVID-19 has caused many public health challenges, particularly in the domain of therapeutic treatment. During this time V-EMDR has emerged as a necessary adaptation to effective clinical practice. Despite the continued treatment afforded by this technology, much is still unknown regarding the refinement and safeguarding of V-EMDR use. There is an urgent need for V-EMDR-specific training and education, the development of technological guidelines, and specific telemental health certification to ensure client confidentially, safety, and optimal treatment outcomes. These steps should be integrated into the basic EMDR training to ensure continuity of care can be assured without compromising quality in the event of a future pandemic. Chronic traumatization can lead to internalized shame and negative cognitions; however, by compassionately witnessing clients and providing V-EMDR during the unfolding collective trauma, we can begin to unburden clients and develop their inner resources, thereby paving the way for deeper trauma healing.
References

Ahmad, A., Larsson, B., & Sundelin-Wahlsten, V. (2007). EMDR treatment for children with PTSD: Results of a randomized controlled trial. *Nordic Journal of Psychiatry, 61*, 349–354.

Ainsworth, M. D. S. (1982). Attachment: Retrospect and prospect. In C. M. Parkes & J. Stevenson-Hinde (Eds.), *The place of attachment in human behavior* (pp. 3–29). New York: Tavistock.

Boulos, M. N., Brewer, A. C., Karimkhani, C., Buller, D. B., & Dellavalle, R. P. (2014). Mobile medical and health apps: State of the art, concerns, regulatory control and certification. *Online Journal of Public Health Informatics, 5*(3), 229–229. https://doi.org/10.5210/ojphi.v5i3.4814.

Bowlby, J. (1989). The role of attachment in personality development and psychopathology. In S. I. Greenspan & G. H. Pollack (Eds.), *The course of life* (Infancy) (Vol. 1, pp. 119–136). Madison: International Universities Press.

Briere, J., & Scott, C. (2006). *Principles of trauma therapy: A guide to symptoms, evaluation, and treatment*. London: Sage Publications.

Chartrand, T. L., & Bargh, J. (1999). The chameleon effect: The perception-behavior link and social interaction. *Journal of Personality and Social Psychology, 76*, 893–910.

Corriveau, K. H., Harris, P. L., Meins, E., Fernyhough, C., Arnott, B., Elliott, L., & de Rosnay, M. (2009). Young children’s trust in their mother’s claims: Longitudinal links with attachment security in infancy. *Child Development, 80*, 750–761.

Courtois, C. A. (1988). *Healing the incest wound: Adult survivors in therapy*. New York: Norton.

Courtois, C. A., Ford, J. D., & Cloitre, M. (2009). Best practices in psychotherapy for adults. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic stress disorders; An evidence-based guide* (pp. 82–103). New York: Guilford Press.

Fisher, J. (2001). *Modified EMDR resource development & installation protocol*. Boston: Presentation at the Trauma Center.

Fisher, J. (2002) *Adapting EMDR techniques in the treatment of dysregulated or dissociative patients*. In Paper presented at the International Society for the Study of Dissociation Annual Meeting San Antonio, Texas November 12, 2000.

Fonagy, P., Gergely, G., & Target, M. (2007). The parent-infant dyad and the construction of the subjective self. *Journal of Child Psychology and Psychiatry, 48*, 288–328. https://doi.org/10.1111/j.1469-7610.2007.01727.x.

Forgash, C., & Copeley, M. (2008). *Healing the heart of trauma and dissociation with EMDR and ego state therapy*. New York: Springer.

Forte, G., Favieri, F., Tambelli, R., & Casagrande, M. (2020). COVID-19 pandemic in the Italian population: Validation of a post-traumatic stress disorder questionnaire and prevalence of PTSD symptomatology. *International Journal of Environmental Research and Public Health, 17*(11), 4151. https://doi.org/10.3390/ijerph17114151.

Herman, J. L. (1992). Complex PTSD: A syndrome in survivors of prolonged and repeated trauma. *Journal of Traumatic Stress*, 5(3), 377–391. https://doi.org/10.1002/jts.2490050305.

Korn, D. (2009). EMDR and the treatment of complex trauma: A review. *Journal of EMDR Practice and Research, 3*(4), 264. https://doi.org/10.1891/1933-3196.3.4.264.

Korn, D. L., & Leeds, A. M. (2002). Preliminary evidence of efficacy for EMDR resource development and installation in the stabilization phase of treatment of complex posttraumatic stress disorder. *Journal of Clinical Psychology, 58*(12), 1465–1487. https://doi.org/10.1002/jclp.10099.

Lee, C. W., & Cuijpers, P. (2013). A meta-analysis of the contribution of eye movements in processing emotional memories. *Journal of Behavior Therapy and Experimental Psychiatry, 44*(2), 231 239. https://doi.org/10.1016/j.jbtep.2012.11.001.

Leeds, A. M. (1995). *EMDR case formulation symposium*. In Paper presented at the annual meeting of the International EMDR Association, Santa Monica.

Leeds, A. M., & Shapiro, F. (2000). EMDR ad resource installation: Principals and procedures for enhancing current functioning and resolving traumatic experiences. In J. Carlson & L. Sperry (Eds.), *Brief therapy strategies with individuals and couples* (pp. 469–534). Phoenix: Zeig, Tucker, Theisen, Inc.
Marcus, S. V., Marquis, P., & Sakai, C. (1997). Controlled study of treatment of PTSD using EMDR in an HMO setting. *Psychotherapy, 34*(3), 307–315. https://doi.org/10.1037/h0087791.

Marcus, S., Marquis, P., & Sakai, C. (2004). Three- and 6-month follow-up of EMDR treatment of PTSD in an HMO setting. *International Journal of Stress Management, 11*(3), 195–208. https://doi.org/10.1037/1072-5245.11.3.195.

Marotta-Walters, S. A., Jain, K., DiNardo, J., Kaur, P., & Kaligounder, S. (2018). A review of mobile applications for facilitating EMDR treatment of complex trauma and its comorbidities. *Journal of EMDR Practice and Research, 12*(1), 2. https://doi.org/10.1891/1933-3196.12.1.2.

O’Neill, S., & Brady, R. R. (2012). Colorectal smartphone apps: Opportunities and risks. *Colorectal Disease, 14*(9), e530–e534. https://doi.org/10.1111/j.1463-1318.2012.03088.x.

Parnell, L. (1999). *EMDR in the treatment of adults abused as children.* New York: Norton.

Shapiro, F. (1995). *Eye movement desensitization and reprocessing, basic principles, protocols and procedures.* New York: Guilford Press.

Shapiro, F. (2007). EMDR, adaptive information processing, and case conceptualization. *Journal of EMDR Practice and Research, 1*(2), 68–87. https://doi.org/10.1891/1933-3196.1.2.68.

Shapiro, F. (2014). The role of eye movement desensitization and reprocessing (EMDR) therapy in medicine: Addressing the psychological and physical symptoms stemming from adverse life experience. *The Permanente Journal, 18*, 71–77. https://doi.org/10.7812/TPP/13-098.

Shapiro, F. (2018). *Eye movement desensitization and reprocessing (EMDR) therapy: Basic principles, protocols, and procedures* (3rd ed., pp. 243–244). New York: The Guilford Press.

Shigemura J., Ursano R. J., Morganstein J. C., Kurosawa M., & Benedek D. M. (2020, February). Public responses to the novel 2019 coronavirus (2019 – nCoV): Mental health consequences and target populations. *Psychiatry and Clinical Neurosciences.* [Epub ahead of print].

Tosone, C., Nuttman-Shwartz, O., & Stephens, T. (2012). Shared trauma: When the professional is personal. *Clinical Social Work Journal, 40*, 231–239. https://doi.org/10.1007/s10615-012-0395-0.

Tronick, E., & Gold, C. (2020). *The power of discord: Why ups and downs of relationships are the secret to building intimacy, resilience, and trust.* New York: Hachette Book Club.

van der Kolk, B. A. (2015). *The body keeps the score brain, mind and body in the healing of trauma.* New York: Viking Press.

van der Kolk, B. A., McFarlane, A., & Weisaeth, L. (1996). *Traumatic stress.* New York: Guilford.

van Der Kolk, B., Roth, S., Pelcovitz, D., Sunday, S., & Spinazzola, J. J. (2005). Disorders of extreme stress: The empirical foundation of a complex adaptation to trauma. *Journal of Trauma Stress, 18*(5), 389–399.

Watson-Wong, J. (2013, September). Poster titled, EMDR Internet Therapy presented at the 18th EMDR International Association Conference, Austin, TX.

Wilson, S. A., Becker, L. A., & Tinker, R. H. (1997). Fifteen-month follow-up of eye movement desensitization and reprocessing (EMDR) treatment for posttraumatic stress disorder and psychological trauma. *Journal of Consulting and Clinical Psychology, 65*(6), 1047–1056.

World Health Organization [WHO]. (2013). *Guidelines for the managements of conditions specifically related to stress.* Geneva: WHO.

World Health Organization [WHO]. (2018). *The ICD-11 for mortality and morbidity statistics.* Retrieved from https://icd-who-int.proxy.library.nyu.edu/browse11/l-m/en

Zandifar, A., & Badrfam, R. (2020). Iranian mental health during the COVID-19 epidemic. *Asian Journal of Psychiatry, 51*, 101990.