The Development and Uses of the "Blind to Therapist" EMDR Protocol

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The blind to therapist (B2T) protocol (Blore & Holmshaw, 2009a, 2009b) was devised to circumvent client unwillingness to describe traumatic memory content during eye movement desensitization and reprocessing (EMDR). It has been used with at least six clinical presentations:

- Reassertion of control among "executive decision makers"
- Shame and embarrassment
- Minimizing potential for vicarious traumatization
- Cultural issues: avoiding distress being witnessed by a fellow countryman
- Need for the presence of a translator versus prevention of information "leakage"
- Reducing potential stalling in processing: client with severe stammer

This article details the history, development, and current status of the protocol, and provides case vignettes to illustrate each use. Clinical issues encountered when using the protocol and "dovetailing" the B2T protocol back into the standard protocol are also addressed.

Keywords: eye movement desensitization and reprocessing (EMDR); blind to therapist protocol; client-centered approach; shame and guilt; aphasia

Francine Shapiro (2001) has advised that divulging information is not crucial to the success of EMDR:

> Sometimes a client is unwilling to concentrate on a particular memory because of shame or guilt. The clinician should reassure the client that because the processing is happening internally, she need not divulge the details of the memory; merely reporting the fact she is withholding something is sufficient. (p. 132)

In the current authors' experiences, there is a fine line to tread between respecting clients' wishes and knowing sufficient to engage the client in EMDR. Indeed, it can be argued that this theme runs throughout several eye movement desensitization and reprocessing (EMDR) protocols and forms the foundation for the basic EMDR protocols set out by F. Shapiro (1995, 2001) that have subsequently been supplemented by an array of modifications to accommodate the individual needs of the client undergoing

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EMDR (see, e.g., Luber, 2009; R. Shapiro, 2005, 2009). This evolution supports EMDR's credentials as a client-centered therapy (e.g., F. Shapiro, 2007; see also Dworkin, 2005, pp. 8–10), which implies that the onus is on the therapist to devise methods to circumvent difficulties encountered by clients when undergoing EMDR rather than adopting an *a priori* expectation that the client should adhere to preexisting requirements of the EMDR protocol.

The blind to therapist (B2T) protocol represents one of these attempts to accommodate client's wishes, and although its current use may be predominantly with shame and guilt issues, this was not the starting point.

History of the Blind to Therapist Protocol

Problems with disclosure of target memories/images prior to conducting EMDR desensitization in the literature dates back to at least 1993 (Blore, 1997), in which an early version of the B2T protocol was used among coal miners and mines rescue workers from the Bilsthorpe, United Kingdom, Colliery disaster of August 1993. In a critical examination of the EMDR provided to the 28 clients from this disaster who received EMDR (Blore, 1997), 423 traumatic memories were treated, with 20 memories (i.e., 4.7% of the total) categorized as "anonymous traumatic memories" (Blore, 1997, p. 93), that is, targets were not described as per normal Phase 3 requirements (F. Shapiro, 2001). Blore (1997) originally attributed the reticence to disclose material as interactions between guilt and the inherently "macho" status of the coal industry in the United Kingdom at the time (p. 93). The method adopted to conduct EMDR was the standard EMDR protocol but with the following two key changes:

- Target images were labelled "A," "B," "C," and so forth rather than identified as per normal Phase 3 requirements.
- Although not clear from the original paper, no attempt was made to identify a negative (NC) or positive cognition (PC).

It was also reported that

- one image labelled "D," resulted in a spontaneous PC of "I'm convinced I did the best I could," and yet,
- the same coal miner remained unprepared to describe the original image content after successful completion of EMDR.

It is also worth noting that there was a suspicion that guilt was ultimately responsible for nondisclosure (Blore, 1997) just as F. Shapiro had predicted (F. Shapiro, 1995, p. 129; 2001, p. 132).

The problem of withholding imagery content also arose in 2001 (first author's unpublished case report; see also Blore & Holmshaw, 2009b, p. 233) in relation to EMDR treatment for a ship's captain involved in a near miss incident with another vessel. The same strategy as with the coal miners was used, but only later did the captain announce, "Everything I've been taught meant I must remain in control at all times." At the time, this comment was not followed up. With hindsight, the captain's comments were to prove important. The basic dilemma was that although he believed he "must" be in control of his ship at all times, the "evidence" for the "must" was based solely within his training manual. How was the reality of the situation that actually occurred (viz., that he'd apparently lost control briefly) being handled? First, Tedeschi and Calhoun (2004) have advised that therapists need to ". . . have some degree of tolerance and respect for the use of some benign cognitive biases" (p. 413). The captain's belief of absolutely being in control was one example. This "cognitive bias" was being held by someone who could be described as an "executive decision maker," effectively someone who had to have the confidence to make unilateral decisions when needed—someone with a strongly acquired internal locus of control, which in turn predicts resistance to influence from others (Crowne & Liverant, 1963).

Thompson (1981) has also argued that aversive situations produce attempts to reassert control. So, finally, there seemed to be a reason for the nondisclosure and whether coal miner, mine's rescue worker, or ship's captain, the explanation that seemed to fit was that the individual's training ran counter to the subsequent reality of the traumatic situation. To minimize the cognitive dissonance generated by this situation, the individual client had reasserted control by withholding information.

It was noted from 2003 onward that U.K. train crew, particularly train drivers (in the United States, train drivers are known as train engineers), were also reluctant to describe the details of some traumatic memories. The A, B, C strategy, described earlier, was used again. The obvious question was could train crew be placed in the category of "executive decision makers"? At a subsequent audit in 2004 (see also Blore, 2005) in a 1-year period, it was found that 21 train drivers had been treated with EMDR (out of 62 staff from the same train operating company during the same period). Although the choice of targets was entirely made by the train drivers themselves,

11 of the train drivers were reluctant to describe the content of targets in detail, whereas 3 train drivers (14.3%) refused outright to describe target imagery. Once again, there was a suggestion that a macho culture at work had contributed to this, but this time, it was noted that like the ship's captain, there was also a strongly held belief concerning "control" stemming from training.

A New Protocol Emerges

As experience accrued, it became clear that the following was important:

- Not to dismiss the refusal to describe imagery as "simply avoidance."
- That assisting clients to not disclose imagery in detail did not constitute collusion but generally led to disclosure and to the use of the standard protocol at a later point in treatment.
- There was a consistent difficulty in obtaining NCs, and that attempts to obtain NCs resulted in more refusal.
- Because it was not possible to ask clients for precise feedback at the ends of sets of eye movements, the only question relevant was whether there was "change or no change."
- This required a need to coach clients as to what "change" consisted of during Phase 2 preparation of EMDR.
- Using the A, B, C strategy was too cumbersome and led to confusion and processing stalling.
- PCs frequently arose spontaneously during Phase 4 desensitization.

After various modifications, the B2T protocol was published (Blore & Holmshaw, 2009a) and briefly consists of the following:

- Identification of a reluctance, or refusal, to describe events/ targets—particularly in any detail—during any of the preliminary phases of the standard EMDR protocol.
- Explanation that EMDR treatment will not suffer if material cannot be disclosed.
- Coaching the client in change prior to desensitization so that feedback among bilateral stimulation (BLS) sets only requires the client to provide feedback if change is occurring or not.
- Give the undisclosed target image a cue word (this replaced the earlier lettering system).
- In Phase 3, do not attempt to obtain an NC or PC or, therefore, a validity of cognition rating.
- Commence first set of BLS by saying "notice" (cue word), (emotion), and (location).
- Process as per normal.
- Disclosure may never occur, but PCs frequently do emerge during desensitization.
- Even *with* a PC, don't attempt to identify an NC.
- Seek a PC in Phase 5 or offer the chance to reword a PC that arose in the desensitization phase. Process as normal.
- Body scan as per standard protocol.
- Closure and reevaluation phases as per standard protocol.

Blore and Holmshaw (2006) have reported that clients who are unable or unwilling to describe target images were consistently able and willing to negotiate EMDR treatment by using the B2T protocol, frequently moving on to the standard protocol at a later stage in treatment.

Case Vignettes: Blind to Therapist Protocol's Different Uses

To date, the current version of the B2T protocol has been used among at least six clinical presentations as illustrated by the following case vignettes; the first two of which originally appeared in a poster presentation and have been updated here. The final vignette is a variation on the B2T protocol.

Vignette 1: Reassertion of Control Among "Executive Decision Makers" (Blore & Holmshaw, 2009a)

In 2004, the 38-year-old train driver of a train travelling at 125 mph (200 kph) was involved in a fatal impact with a 60-year-old man who had jumped in front of the train. Subsequent internal and external investigations exonerated the train driver of any blame. A subsequent coroner's hearing revealed that the deceased had been depressed for more than a year and, at the time of the fatality, had been attending a psychiatric outpatient clinic. The train driver who had been referred for EMDR was suffering from posttraumatic stress disorder (PTSD; American Psychiatric Association [APA], 2000) and was very reluctant to describe the "peri-impact" memories of the incident. The train driver described how—despite every reassurance from his employers, the British Transport Police, and the Coroner—he still felt entirely responsible for the fatality. It was established at the EMDR assessment that the level of perceived responsibility was closely associated with being trained to *always* be in control of the train being driven. In effect, the suicide "proved" (to the driver) that he was not in control. As stated previously, Thompson (1981) has shown that in these

circumstances, clients will attempt to reassert control, and it is likely that it is precisely what happened during EMDR history taking.

EMDR was conducted using the B2T protocol. The undisclosed target was given the cue word "27." The first few BLS sets were characterized by abreactions, but the client did not use the safe place previously installed. After several sets of eye movements, the train driver announced quite spontaneously he had applied the emergency brakes and the train had come to a halt almost half a mile down the track. He then described the various "safety-of-the-line" procedures he had enacted, finally declaring there was nothing else he could have done. On returning to 27, he described the details of what had happened and was able to provide normal feedback from that point including revealing the 27 related to a milepost he had seen immediately prior to the impact. EMDR subsequently proceeded along the standard protocol and was completed in five sessions. The train driver was asymptomatic on discharge. He was subsequently assessed independently for a return to safety critical work and returned to driving trains. Eight years after discharge, with no further treatment interventions in the interim, it was noted that he was still driving trains without any problems.

Vignette 2: Shame and Embarrassment (Blore & Holmshaw, 2009a)

A 54-year-old female survivor of childhood sexual abuse experienced between the age of 7 and 11 years had sought help for complex PTSD symptoms in the past with little success. She had been referred this time for EMDR, having her memories reignited by discovering that one of her nieces had been sexually abused. At assessment, the client revealed she was troubled by one specific memory. Apparently, the perpetrator, now deceased many years previously, had never been confronted by what had happened and, indeed, no one knew the precise details of what had occurred other than the client herself. At assessment, the client was found to be suffering from both PTSD and chronic depression and explained that she could not discuss the image because it was "too disgusting for anyone to hear." Therefore, not only did the client not wish to discuss the particular image but also did not wish to traumatize others. EMDR was conducted using the B2T protocol. The undisclosed target was given the cue word "lamp post." The first few sets of eye movements were characterized by little or no change followed by rapid change and abreactions. Eventually, "lamp post" became less upsetting and resulted in the feedback, "He's left," which was the only clue to the image content. The client identified a PC (albeit negatively worded): "I'm okay, I know it's not my fault"; and later admitted to having believed that the abuse was her fault for several decades (in effect disclosing the NC after completion of Phase 4 and identifying the PC). Treatment of the current trigger (hearing about her niece's abuse) then proceeded smoothly as per the standard protocol. The client was discharged describing herself as better than she had been in years. The client, who had not sought any further psychological treatment, was described 4 years after EMDR as "flourishing."

Vignette 3: Minimizing Potential for Vicarious Traumatization

A 36-year-old male involved in a serious and disfiguring injury at work was referred for EMDR. The injuries were mostly concealed from view and had healed well over a period of 2 years. The EMDR therapist who, coincidentally, had a close relative who had sustained an identical injury at work 10 years previously and had trained originally as a nurse, revealed in supervision that she had been very upset by the client's history. She reported in supervision that she had been having intrusive images of both her relative's injuries and one particular lecture slide of a similar severe injury that had been projected onto a large lecture theater screen during her nurse training. It was agreed during supervision to use the B2T protocol, with the intention of minimizing the potential for further distressing imagery. In addition, the therapist was advised to seek EMDR for her own memories (cf. F. Shapiro, 2001, p. 132, relating to the suggestion that the clinician self-administers EMDR after sessions).

Having coached the client into the nature of change as per normal use of the B2T protocol and identifying two targets, one allocated the cue word "paper" and a second given the cue word "instructions," treatment proceeded relatively smoothly until a point of recurrent "no change" occurred during feedback. Given that basic strategies for unblocking processing did not appear to work, and that it was not possible to use a cognitive interweave, a visual interweave was used in which the client was asked to provide a second image and place it alongside the target memory. The second image was to represent a "resolution" of the target image—in other words, an adaptive outcome.

With the two images in place, BLS was restarted. The feedback thereafter was ". . . 'paper' has receded into the background, but the new image has come forward . . ."—in other words, change had now occurred. Further processing revealed subjective units of disturbance (SUDs) ratings of 0 and a return to the standard protocol ensued by inquiring about a PC.

Circumstances prevented the therapist from obtaining treatment herself until after the discharge of the client she was treating. In subsequent supervision, the therapist reported she had still been "manufacturing" her own imagery during sessions, but that using the B2T protocol had helped enormously by "not having to listen to detailed descriptions of the client's imagery." At the time of writing, 18 months after treatment conclusion, both client and EMDR therapist reported no problems.

Vignette 4: Cultural Issues—Avoiding Distress Being Witnessed by a Fellow Countryman

A 32-year-old male Iranian, who spoke only Farsi, was a single man who had been imprisoned without trial, tortured, and publicly flogged in Iran. The client was treated in the United Kingdom with EMDR in the presence of a translator. The client reported having been in constant fear of execution and was taken in front of a firing squad on more than one occasion. He was able to speak about all of these incidents but identified an early childhood trauma that he chose not to describe. It transpired that he was reluctant to disclose the target because of the depth of emotion that describing the target generated. Crucially, the client was unwilling for the interpreter to witness his distress.

After discussion in supervision, it was agreed to use the B2T protocol and the overall situation was managed as follows: The interpreter remained in the room during history taking, preparation, and assessment phases. As per the B2T protocol, the client had examples of change post-BLS sets explained, along with the usual addressing of fears and setting expectations. During preparation, an arrangement was made to refer to targets by simple cue words and to use basic sign language to indicate change or no change following BLS. Once it was clear that preparatory phases were completed, including the assessment of the relevant target, the interpreter was asked to leave the room with instructions that he would be called back periodically.

During initial BLS sets, the client was clearly in touch with the target memory, with tears pouring down his face. Between sets, the therapist would signal an inquiry by raising her eyebrows, and initially, the client would shrug his shoulders. As the processing continued, the client's body language quickly began to signal a change and the distress on the client's face turned to one of interest until he nodded and said, "Okay." EMDR continued for another set, and then the interpreter was asked to return to the room. A short break in processing ensued in which the client was able to have his feedback interpreted into English. A new target was then chosen, and the whole process with the translator leaving the room was repeated. The client was later able to complete the standard protocol with the translator present during processing.

A year following discharge, it was reported that the client had enlisted for college to learn English. At the time of writing, he is well and adjusting to life in England.

Vignette 5: Need for the Presence of a Translator Versus Prevention of Information "Leakage"

A general medical practitioner referred a 37-year-old Libyan freedom fighter to an EMDR clinic for treatment of memories of repeated physical assaults. The referral letter included a photocopy of a second letter written in English by the client's cousin explaining need for ". . . great caution . . ." as information would in all certainty ". . . find its way to government sources . . ." and the ". . . family would be in mortal danger." The therapist, on seeing the client and explaining EMDR, offered—through the translator—to conduct treatment with the absolute minimum of information. This decision was made because it was assumed that identifying any memory content could have identified the client's family back in Libya. However, because of the need for translation, it was not possible to ask the translator to leave the room (as in the previous scenario). A safe place resource was installed relatively easily, and explanations and examples of the types of changes that often occurred with EMDR was discussed—again without reference to memory content other than their associations with "strong emotions." Particular emphasis was placed on the possibility of very small changes in memory post-BLS sets using a metaphor relating to the common competition scenario of two images, ostensibly the same, and with the caption "spot 10 differences." Demonstrations of how EMDR would proceed then followed.

The first target was given the cue word "street," and the client was reminded that when the eye movements stopped, he only needed to nod his head to indicate change in apparent experiences of the memory, shake his head to indicate no change, or shrug for "uncertain." The early BLS sets tended to result in shakes of the head. However, the client was visibly relaxing, suggesting change was happening. This seeming contradiction resulted in breaking off processing and restating the nature of change. This revealed that the client had thought change only applied to the imagery. On restarting processing, feedback after BLS sets quickly turned to head nods.

The client had several problems with "stuck processing." The therapist reported using a visual interweave strategy, which involve "stretching the images or otherwise intentionally manipulating them in some way." We have called this strategy "morphing." The effect was immediate, and the processing was restarted.

In due course, the translated feedback revealed that the client had spontaneously considered the thought, "We're safe," which he insisted was more important than "I'm safe." After this, EMDR was then proceeded more or less as per the standard protocol from that point.

To assist with the confidentialization process, it was necessary to make changes to the log of events between sessions. Initially, it was understood that anything written would be in Arabic and need translating, so instead of writing words down, he drew what looked like cartoon images of a face with varying degrees of happiness or sadness, and thus not giving any information away that could potentially also be "leaked."

The client describes himself as "happy" 1 year after treatment. The family finally left Libya 18 months after the client's EMDR was completed.

Vignette 6: Reducing Potential Stalling in Processing: Client With Severe Stammer

This case is different to the other vignettes in that only a single component of the B2T protocol was used rather than the complete protocol. Treatment commenced with the use of the standard protocol and a fully identified image, NC and PC, but then changed to the B2T protocol when it became apparent that providing feedback was hampering processing.

A 31-year-old computer technician who suffered with a long-standing stammering problem sought help for his memories of an assault at work. Unfortunately, the contract to provide treatment excluded treating preexisting problems, so the cause of the stammering was not investigated. The first target image was duly identified, and despite the very obvious problem with stammering, Phase 4 commenced unremarkably. However, a few sets into processing the stammering deteriorated markedly to the point that feedback took so long that processing continually stalled. Even mentioning "the target" seemed to make the problem worse and eventually "(name of) location" was used as a cue word in its place. Various strategies thereafter were tried to encourage brief feedback without success. Treatment was therefore stopped, the safe place exercise was used, and a discussion ensued so as to establish what might facilitate feedback. It was agreed to use the feedback method adopted in the B2T protocol. Treatment was duly recommenced, but even stating that there was, or was not, change proved too difficult. In the end, the client was encouraged to nod or shake his head to indicate change post-BLS set. This immediately helped, and a sequence of BLS ensued followed by nods/headshakes. It was less obvious that a channel of association had been cleared by processing and, with hindsight, several erroneous "returns to target" followed. Eventually, desensitization was complete, and a PC was obtained. After a return to Phase 4, because of a second target emerging, the process of choosing a cue word and adopting nods and headshakes was repeated—this time much more smoothly.

On completion of treatment, the computer technician was relaxed and able to speak more freely with only a minimal stammer. It is likely that some of the treatment effects were down to the subsequently disclosed information that "previous therapists have given up on me," thus underlining that taking a client-centered approach—as EMDR encourages us—can reap huge dividends in terms of relief of suffering. The client returned to work promptly. That was 2 years ago.

Discussion

These vignettes clearly illustrate the range of uses of the B2T protocol in what otherwise would have been complex clinical presentations that might have otherwise ruled out using EMDR altogether. There is also a clear theme of "client centeredness" in the flexibility of conducting EMDR among these clients using the B2T protocol. Although the intended reasons for using the B2T protocol varied throughout the six vignettes described and shown briefly in Table 1,

TABLE 1. Synopsis of B2T Protocol Components Used Among Six Case Vignettes

Components of B2T Protocol Used	Vignette 1—Control Issues	Vignette 2—Shame and Embarrassment	Vignette 3—Vicarious Traumatization	Vignette 4—Witnessing Emotion	Vignette 5—Leakage of Information	Vignette 6—Stammer
Therapist awareness of client reluctance to disclose information	Yes—client hypothesized to be reasserting "control"	Yes—client's request	Yes—therapist's request	Yes—client "unable to describe childhood trauma"	Yes—warning contained in photocopied letter	Nondisclosure not an issue
Explanation of reluctance	Client's training	"Too disgusting for anyone to hear"	Therapist had similar experiences	Depth of emotion and cultural issues	Significant risk of danger to family	Not applicable
B2T protocol intention	To facilitate treatment while also permitting cognitive distortions	To work within client's requested parameters	To minimize potential for vicarious traumatization	To preserve wish for translator not to witness emotional expression	To minimize risk of danger to family	To minimize the possibility of stalled processing
Client taught nature of "change" in EMDR	Yes	Yes	Yes	Yes	Yes—in considerable detail	No
Cue words for targets	Yes—"27"	Yes—"lamp post"	Yes—"paper" and "instructions"	Yes—(not stated)	Yes—street	Not needed
How client indicated "change" after BLS set?	Stated	Stated	Stated	Nonverbal signals and stated "Okay"	Nonverbal signals	Nonverbal signals
Interweaves used?	No	No	"2-image strategy"	No	"Morphing"	No
Emergence of PC or PC theme	Yes—(effectively) "I did the best I could"	Yes—(albeit worded negatively)	Yes—"I am okay"	Yes	Yes—but in second person (not first)	Yes—"I can cope"
Able to complete standard protocol thereafter?	Yes	Yes	Yes	Yes	Yes	Yes
Subsequent disclosure of target	Yes—"27" was the milepost number.	No—apparent altruistic motive	No	Yes	No—and modification to client log	Described beforehand
Outcome/follow-up	Still driving trains 8 years after EMDR	4 years after EMDR described as "flourishing"	18 months after discharge, both client and therapist "no problems"	12 months after treatment described as "well" and adjusting to United Kingdom life; attending college to study English	12 months after discharge, describes self as "happy." 18 months after discharge, family left Libya	Returned to work within a week of discharge. Still at work 2 years later

Note. B2T = blind to therapist; EMDR = eye movement desensitization and reprocessing; BLS = bilateral stimulation.

the overriding principle was that the B2T protocol did not replace the standard EMDR protocol but facilitated it.

One explanation for the unwillingness to describe imagery could be put down to lack of confidence to put into words an internal experience, or in other words, avoidance. Indeed, it is hard to argue that it isn't avoidance but given EMDR's client centeredness, the onus is on the therapist to assist the client overcome the hypothesized avoidance rather than merely defer treatment because the client isn't "psychologically minded" or prepared to fit the preexisting treatment format.

Another possible interpretation is that withholding content detail is merely coincidental. Again, this may be so, especially because none of the aforementioned vignettes has been systematically quantified; nevertheless, the issue of needing to help the client overcome their predicament remains. There is, intriguingly, a third possibility highlighted by the second vignette: altruism. Although space does not permit an exploration of this factor, the second vignette could be illustrating a form of "reverse client centeredness" in which the client is considering their problem from the therapist's perspective.

Whichever explanation(s) are correct, caution is still warranted when using the B2T protocol. This is particularly important because a relative lack of information means the basic question—"How do I know my client is well enough prepared for EMDR?"—is inevitable, yet needs answering in the affirmative. In some ways, the question can be altered to "am I prepared enough to conduct the B2T protocol?" Although the effectiveness of the B2T protocol has yet to be formally quantified, there is sufficient clinical experience to be able to issue guidelines on how to manage the use of the protocol. The following questions and answers summarize the key clinical points to consider (see also Table 1):

- Is the client indicating a reluctance to disclose material, particularly detailed information? Is there an explanation for the reluctance?

  It is particularly necessary to make a distinction among "reluctance to disclose," dissociation, and avoidance because of anxiety or lack of preparation.
- What is trying to be achieved by using the B2T protocol? In other words, what is the intention?

  Consideration should be given to both client and therapist's perspectives—see for comparison the differing perspectives in Vignettes 1 and 3. Table 1 explains the intention behind using the B2T protocol in each vignette.
- Given that the therapist will have difficulty in establishing whether change post-BLS set has occurred, does the client understand what change is?

  This is an important part of the B2T protocol. The client needs to be the decision maker, and therefore needs to know what change is beforehand. The advice is to keep explanations straightforward and include all components of the target (including reference to "negative thoughts"); for example, "Sometimes changes can be quite obvious such as the image moving away from you, or changing altogether, or the sensation in the body moves or the emotion changes or disappears, or negative thoughts you may have about yourself alter. . . ." The following metaphor is useful if there is a need to explain about subtle changes that could be easily dismissed: "You may well have played the competition in magazines that shows two pictures, which are superficially the same, but with the caption 'spot the 10 differences.'"
- What types of "cue words" are needed with the B2T protocol?

  Cue words are already used to trigger the use of an entire resource such as a safe/calm place. In the B2T protocol, the cue words need to trigger the entire target memory, not just a visual component. Provided a cue word triggers an entire memory, then they can consist of anything, although they need to be brief and preferably generated by the client (see Table 1 for examples). From trial and error, it is clear that using some form of lettering or numbering of targets merely causes confusion (see Blore, 1997) unless a letter or number is material to the target itself (see Vignette 1 as an example).
- How will processing differ to the use of the standard protocol?

  Managing this aspect of the B2T protocol requires practice. A couple of the most common questions are: Where is the end of a channel of association? How can I distinguish between blocked processing and reaching the end of a channel of association?

  This relies on the therapist establishing a finely tuned congruency between a stated "yes/no" (or nonverbal nod/shake of head) and the remainder of nonverbal signals. Where there is doubt, a second brief question is often useful along the lines, "Is what you now get better, worse, or not sure?"

Obviously, good preparation beforehand will facilitate matters.

- What interweaves are available to unblock processing?

  A second aspect of how processing may differ is the use of interweaves. By intention, the target memory content and the NC are not known, also, the content of any emerging material post-BLS is not known, so using standard cognitive interweaves is virtually impossible. However, using visual interweaves works very well, particularly two strategies:

  "Two-image strategy"—see Vignette 3 for an example.

  "Image morphing"—see Vignette 5 for an example.

  In addition, it is worth mentioning that basic strategies to unblock processing (F. Shapiro, 2001) can also be used effectively such as changing direction, speed, modality of BLS, and so forth because none of these require any disclosure of target content.

- What happens if a PC does not emerge?

  In the six vignettes, a PC arose on each occasion. On this basis, it does appear that PCs arise almost spontaneously as a general rule. There have been some occasions when this has not occurred, but either way, it has been possible to establish an appropriate PC at the commencement of Phase 5 (installation of PC). It therefore does not appear to matter if a PC doesn't emerge spontaneously.

- Can the standard protocol be subsequently completed?

  Again, all six vignettes show that it was possible to dovetail the B2T protocol into the standard protocol. The only vignette to differ was the sixth, which commenced with the standard protocol, used a component of the B2T protocol, and returned to the standard protocol from Phase 5 onward.

- What other potential uses for the B2T protocol may there be?

  It is unlikely that the six vignettes cited in this article represent the total use of the B2T protocol. In this respect, Vignettes 2 and 6 are particularly noteworthy.

  Vignette 2, relates to managing shame-related issues. Shame and its counterpart, embarrassment, are undoubtedly very common problems—if not as primary presentations, then as a secondary component to other presentations. To be able to manage these often delicate situations by facilitating the clients' wishes until they feel comfortable to disclose material—or not as in the case of Vignette 2—surely promotes the therapeutic relationship in EMDR and EMDR's credentials as a client-centered therapy. This alone warrants the investigation of the wider use of the B2T protocol; suffice to say, at present, rather than insisting that shame and embarrassment issues are sidelined for the sake of compliance to a psychological model, there can be no reason to dismiss a client as "not being psychologically minded" any longer.

  Vignette 6, despite only using part of the B2T protocol, highlights a very important client presentation, namely, aphasia—the inability to any degree to be able to express oneself (cf. Brookshire, 2003; Code, 2003; Code & Petheram, 2011). The vignette is related to a client with a severe stammer, which on the aphasic spectrum is arguably not a severe aphasic problem. However, successful use of the B2T protocol begs the question, "To what extent can EMDR be usefully employed among clients with expressive problems of any degree?" The question is important because of the prerequisite in any form of psychotherapy to be able to communicate. It follows that profound clinical presentations of aphasia among clients are not currently amenable to talking therapies and because, logically, the greater the problem with communication, the greater the difficulty in engaging with psychotherapy. A protocol that at least addresses the issue of aphasia is therefore significant. Aphasia of any cause often holds unspeakable trauma, psychological pain, and feelings of loss, hopelessness, and detachment. These are mental health issues like any other and are deserving of attention. EMDR, via the B2T protocol, appears to have a method of "opening up" this category of problematic presentations, which previously would not even have been considered for therapy. Use of the B2T protocol, or modified version of it, possibly with the aid of information technology, could therefore represent a significant step forward in the psychological mental health welfare of all clients with profound difficulties in speaking, potentially, up to and including "locked-in syndrome."

- Evaluation and further research

  Regarding B2T protocol research, all six vignettes cited have come from routine clinical experience. This account does not mean the

potential usefulness of the B2T protocol has been exhausted. Furthermore, no quantitative evaluation of the protocol has yet been made beyond individual cases. These points therefore appear to be the next steps that are required to establish the robustness and thus overall use of the B2T protocol. The following two particular areas merit research attention:

1. The use of the protocol among clients with shame and guilt issues (because this appears to be currently the most common use of the protocol).
2. The use of the protocol in the area of aphasia (because of the intriguing possibilities within a new area of client problems).

- What implications may there be for EMDR training?

  Given that it hasn't been difficult to locate vignettes and case anecdotes of the use of the B2T protocol, the protocol has been published (Blore & Holmshaw, 2009a, 2009b), its inclusion in another book on EMDR is imminent (Luber, in press), and the protocol provides a unique method of extending EMDR's use, which is not readily replicable in other forms of psychotherapy—it seems only reasonable to question whether the B2T protocol could usefully be included in the basic EMDR curriculum—and if yes, where?

  It is clear that the B2T protocol requires a thorough knowledge and working experience of the standard protocol. The authors argue therefore that it is neither likely nor indeed wise to include the B2T protocol as an early element in EMDR training. It would seem feasible that the B2T protocol could be added as a specialist component toward the end of the basic training or as a separate taught component within subsequent EMDR supervision.

Conclusions

The B2T protocol was devised by continual refinement from early EMDR treatment observations and by adopting a philosophy of modifying the treatment rather than attempting to get clients to abide by existing EMDR protocols. It has required a significant degree of flexibility, and the complete range of uses of the B2T protocol is probably yet to emerge. This article has outlined the protocol, its development and current uses, as well as posing questions concerning its further development, usage, research, and training.

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