Put Your Best Foot Forward: An EMDR-related protocol for empowerment using somatosensory and visual priming of resource experiences[1]

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The protocol I would like to introduce is an eight-part therapy procedure called "Put Your Best Foot Forward." The name captures its spirit as well as its occasional manifestation in a therapy session when a client actually puts one foot forward. The destination of this protocol is empowerment and it uses somatosensory processing to get there. It aims to help clients locate within themselves a source of confidence when dealing with an unwanted recurrent problem. You can work through the eight sections in one therapy session but it is not a one-session treatment. Nor is it a replacement for the standard EMDR protocol (Shapiro, 2001). This protocol is an example of the application of EMDR information processing principles to a therapeutic field that has come to be called resource work.

Resource work is the systematic strengthening of elements of psychological capacity that maintain integrity of the self and assist effective functioning. EMDR applications of resource work have been developed by Foster and Lendl (1996), Kiessling (2001), and Leeds (2001), and this protocol builds on their contributions. Resource work can use the same information processing principles as EMDR trauma work, except the manifest content is different. You might ask clients to describe a time when they were able to manage a difficult situation, or to identify personal traits that could be helpful, or to analyze how an admired person might respond to a particular stress. "Safe place" is also an example of resource work, focused on strengthening the client's capacity for emotional containment during trauma therapy. Whatever positive associations the client identifies can be brought into the here-and-now, and enhanced and installed with bilateral stimulation such as eye movements or taps. This may be a goal in itself, if, for example, you wish to strengthen the client's resilience for certain stressful circumstances. Or it may be part of supportive preparation for trauma processing.

Put Your Best Foot Forward has a different structure from the resource work described above because of some clinical challenges in my own practice. I found many of my clients could not get their head around questions that asked them to recall, reconstruct, or conceptualize something positive e.g. "Can you think of a time when this went better for you?" or, "What traits, knowledge, habits etc. do you have that could help you here?" They could not access potentially beneficial resources by directing their mental faculties. I think this was because many were burnt out by accumulated stresses, or their analytical ability was compromised by depression. For some, the problem had been with them so long, they could scarcely imagine any potential benefit coming from their own experiences.

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This protocol therefore began as an alternative way to access positive experiences without requiring verbal responses or mental analysis. Instead of asking clients to think of something positive, I thought I would see if readjusting the framework of the body could lead us to something positive. The protocol uses a body position as an ambiguous priming cue for free association to imagery. The body position creates a somatosensory ground for visual projection, much like a Rorschach inkblot. This may seem a little unconventional but my background in projective testing made the use of an ambiguous cue to stimulate associations a perfectly sensible alternative to direct questions. Rorschach himself postulated that the inkblot response began as a kinesthetic experience (Exner, 1986). In projective testing, however, you have to provide the test materials for the person to respond to, whether inkblots, diagrams, pictures, or word association tests. In Best Foot Forward, clients economically create their own inkblot by altering their body posture, thus collapsing the kinesthetic experience and the test materials into one simple operation.

The results of doing resource work in this way were so intriguing and beneficial that I extended its use to many clients who had unwanted, stress-related behaviors accompanied by a distinct set of physical reactions in the body. A typical client would be overwhelmed or dysthymic, stuck in self-defeating reactions that always felt the same in the body, ruled by anticipatory cognitions that narrowed and distorted their perspective, sometimes with pre-existing vulnerability from earlier experiences. For those with PTSD, Best Foot Forward (BFF) became useful preparation for the standard protocol (SP), for example, if the client had trouble relating to the "Safe place" procedure or was acutely reactive to traumatic reminders.

Use with Standard EMDR protocol: The two protocols, BFF and SP, complement each other. Which one I start with depends on two main factors — the extent to which the client's resilience is depleted by current stress, including stress-related health problems, and the presence of long-term vulnerability. As a rough guide, if a formerly well-functioning individual has a Global Assessment of Functioning score (GAF) below 70, I start with BFF. If they have PTSD, but are still reasonably functional, then SP. If a client simply wants help with counterproductive responses related to stress, then BFF. With my longer-term clients, I tend to do the two protocols in tandem, interspersed with talking psychotherapy and perhaps art therapy. Sometimes clients come with reservations about EMDR, in which case BFF is an easy introduction to the general therapeutic process. Sometimes I will splice the two protocols together and shift into Section B., Body Position (see below) if the initial SP questions produce mounting distress and the client fears losing control. I see SP as event-focused and BFF as schema-focused, with some common variance in the issues they each deal with.

Database: The original 27 clients in the database (Kinowski, 2002), has now increased to 40, entailing 67 separate administrations of BFF. There are 28 females and 12 males, with an age range of 11 to 62. Most allowed me to videotape this experimental work and then gave permission for their tapes to be used for professional instruction. The data continues to expand with case reports from workshop attendees. The GAF score for the vast majority of all reported and observed cases, about 95%, is at or above 51. There is limited data for the protocol's use with clients at GAF 41-50. At this point, it is a very promising procedure in the early stages of wider use by other EMDR therapists. Its clinical decision points and interventions for specific populations are still being worked out on a case-by-case basis.

Clinical mandate: The protocol is useful in the following circumstances where GAF is over 51.

- A client is stuck in an unwanted behavioral repertoire that he or she cannot change despite awareness, prior therapy, or self-help books.
- A client's current depressed or overwhelmed state acts as a negative, hopeless filter for solution-focused work.
- A client wishes to change a response mode but is unable to conceptualize any alternative because the problem is long-term, or they are not especially psychologically minded.
- A client suffers long-term PTSD and there is a risk of dysregulation in the autonomic nervous system, or exacerbation of health problems, if unresolved trauma is accessed too aggressively.
- You wish to restore some functional capacity to a client in acute stress and quarantine an earlier, partially resolved trauma until resilience is stronger.

The Eight Sections of the Protocol

The protocol is four pages of questions and instructions, now at version 11. It has always had the same general structure but I have fine-tuned the wording and added practice tips as it developed. It is structured as to process but quite open-ended as to content. Clients do their own work under your guidance, following their own associational processes at a somatic level. The processing is bottom-up — using the raw data of the body to access, clarify, inform, enhance, and install the visual material that comes up from the projective process.

A. Recurrent Difficulty: The protocol begins with a few baseline questions about a problematic response mode. Examples include: "I have never been able to cope with someone getting hurt or upset." "Criticism makes me shrink to a pinhole." "My life feels like one joyless burden after another." "I am too shy and reserved in company." "Whenever I feel unwanted, I withdraw and start to eat." Grigsby and Stevens (2000) argue persuasively that habitual response modes have neural dynamics similar to procedural memory, a term more usually applied to automatic motor acts. They are almost like reflex behaviors, overly generalized to too many situations containing signal affect (e.g., anxiety, shame), and they cause inflexible repertoires that are hard to change.

The questions at the start of BFF take about 10 minutes. You quickly sketch in the schema of behaviors, affect, anticipatory cognitions and coping style that accompanies the functional problem. Then you ask clients how they feel in their body when the recurrent problem takes them over. This is typically a description of bracing, tension, shallow breathing, nausea, heavy lumps, knots, tightness, adrenalin surges etc. Without this information, the next section of BFF will lack face validity. Last, clients are asked how they would prefer to function instead. Any vague or diffident answer is sufficient to proceed.

Two of three ratings are taken during this initial interview:
1. Subjective Units of Distress Scale (SUDS), from the standard EMDR protocol, OR,
2. Subjective Units of Body Safety (SUBS), a 1 to 5 scale of escalating severity of physical discomfort, useful if body reactivity is prominent, and,
3. Rating of Confidence (RoC) – "How confident are you right now on a 1 to 7 scale that you can be like this?" (to function as preferred).

B. Body Position: This is a process shift into ambiguity to identify how clients might look in their body if the change they wanted were to occur. There is some advance warning in the introduction, which begins with, "Now that's the end of the logical questions." Clients are then asked to experiment with their posture and positioning to create with their musculoskeletal sense a physical framework for their desired solution. Many clients made tentative experiments from their chair or roamed around my office, pondering this unusual request. Some instantly repositioned themselves, as if they knew all along. Some used their knowledge from yoga or Pilates classes as they sensed into their posture. In the database, about two-thirds ended up standing, sometimes resting a hand on a piece of furniture. The atypical responses include one young woman who sat on the floor, a client who reclined full length on the couch, and an unforgettable case reported by Susan Hubbard, M.S.W, an EMDRIA certified therapist in Colorado, of a client who decided to jump off Susan's couch (Kinowski, 2003). This was her kinesthetic solution to always being self-effacing! No one has asked for advice although some clients have needed cheerful encouragement to get through their initial awkwardness. Remarkably, clients seemed able to use their body sense to physically frame and "be" a solution, even when they had trouble conceptualizing a solution.

Two general trends emerged:

- an upright, shoulders back stance, with chin parallel to floor and a level gaze, conveying a kind of steady readiness;
- a position that increased the amount of contact between the body and another surface, such as the back and arms of a chair, or the floor, conveying the use of tactile grounding and connection.

The body leads the way throughout this protocol, so you may find your clients changing their physical position part way through, as the body's energy flow shifts and changes. The most frequent change was from sitting to standing, or vice versa. The role of the therapist is not to direct the posture, but to supportively reflect what clients do in response to their own physical cues.

C. Body Scans: The therapist then introduces some form of alternating bilateral stimulation, or dual attention stimulation (DAS) as it is now called. I have used eye movements, taps, and tactile pulsers, choosing whichever method is comfortable for clients and respects the amount of interpersonal distance they seem to need. Other therapists have also used audio signals from headphones or speakers. DAS is done slowly, at a speed similar to a waltz beat. There are two or three short DAS sets in section C, around 4 to 9 saccades each. The purpose is to install a sense of the client's position as it is felt in muscles and skeletal frame, and then in the core when deep, gentle breathing is added. No difficult material is being processed. It is simply a small exercise in body awareness in its kinesthetic and somesthetic dimensions.

The therapist queries with, "What do you notice?" A common response is, "I feel relaxed." Then you redirect the client from affect cues to physical sensation with another instruction: "In the next set, focus on where that relaxed feeling is in your body and what it's like physically." If the client reports some physical tension, you can process this with a somatosensory pause (somatic interweave), one of two interventions in the protocol: "In the next set, just take a deep gentle breath, focus on the (tightness, knot etc.,) and see what happens." In this protocol, interventions are aimed at settling tension states within the body. This is an odd thing to say for someone trained in Object Relations Theory and psychoanalytically-oriented therapy. There the main intervention is interpretation. But that last SP question, "And where do you feel it in your body?" has led me to believe that the body

is the best cotherapist you could wish for and more accurate than any interpretation I might come up with.

D. Three Images: This is another process shift now into associative retrieval, with the grounded body position acting both as a projective cue and a priming condition. Priming is the presence of some unstated condition that matches a past condition, and it is a probabilistic determinant of a response mode (Grigsby & Stevens, 2000; Schacter, 1996). In BFF, the priming comes from implicit elements in a solution-oriented posture and a supportive therapeutic context. I hoped these would bridge to something from the past connected to them. Clients are cued with more instructions to free associate to an image of anything that might support their posture, and not to worry if it seemed insignificant or odd. Images surface in the spontaneous way associated with implicit memory, appearing to "pop up" out of nowhere. This associative retrieval is like a fishing expedition into the psyche and is my favorite part of the protocol.

Three images are obtained in all. After each one surfaces, it is installed in a three-step process. The first step is to enhance the emotional salience by asking clients to "zoom up" and study the image for what appeals to them. This usually shifts the client's perspective from observer position to field position (Robinson & Swanson, 1993), which is associated with increased emotional intensity. The second step is to teach the client to capture the somatosensory registration of this appeal, that is, to detect how the body signals change as the positive affect is experienced. And the third step is to give the image a somatic reference point by storing it, in imagination, someplace within the body. The structured, repetitive processing simulates self-referencing — looking inward for resources that support, encourage, balance, and stabilize. The storage of the image within the body concretizes an undeniable truth. Clients owned this valuable resource before they walked into the therapist's office. It belongs to them and, most important, it is undamaged.

Clients rediscover heart-warming experiences, supportive people, inspiring places, treasured objects, or moments in time so fleeting they would not think to tell you about them if you asked a direct question. The process brings laughter, tears, joy, and is often deeply moving. The emotional momentum tends to build over the session, from initial awkwardness to a sense of awe or wonder, sheer excitement, or an inner peace. It is not necessary to interpret or analyze these images for they have a transparent and self-evident "rightness." The therapist need only affirm and admire these little gifts from the right brain.

It was immediately apparent that the imagery obtained through this projective process might not be the functional or logical opposite of the presenting problem. For example, in a case of anger control problems in field hockey, the three images were a picture of the client's ankles in the sea, a picture of herself ready to play hockey but completely alone on the field, and a third image of herself reading in a quiet living room. Not retrieved was an example of temper restraint. In a case where the client experienced life as a series of joyless burdens, the three images were the Himalayan Mountains, an ashram, and herself on a train journey. Not retrieved was a time of non-depressed functioning. In a case of flying phobia, the images were the ceiling of a very large sports stadium seen from the ground, a picture of spinning turtlebacks, and the face of a close female friend. Not retrieved was a non-eventful flight.

Although not the functional opposite of the problem the client wanted to change, these images nevertheless seemed subtly relevant, if at first a mystery. They contained the high-octane elements of arresting perceptual features, strong somesthetic qualities, and core positive

affect, including poignancy, intrigue, joy, and pleasure. My volatile hockey player looked at her aggressive readiness to play her sport and her body signaled relaxation in her core. She had discovered what it was to find her focus in the sport, but what specifically this had to do with anger management was not entirely clear. In our next session, she casually mentioned she was befriending the younger women on the team, those same players who had previously received her wrath. The images allowed clients to speak of their lives with directness, certainty, and a felt truth. Although not the stuff of executive functioning, they proved to be the somatosensory foundation of positive change. They invariably helped clarify conflicted issues without engaging defenses.

About 75% of the images have been of real life experiences clients actually can recall. The rest had no reference in episodic memory. They came from implicit or subconscious memory, yet were not ego-alien. When they surfaced, clients would typically look puzzled, or laugh, and say, "Where did that one come from?" The images from implicit memory seemed clinically quite significant, like defining moments-in-waiting. Sometimes they contained a perceptual feature from a period when psychological development was still satisfactory, before life stresses resulted in self-defeating compromises. Sometimes they had dispositional properties that invited a certain action, which then helped the client master an area of anxiety. Sometimes the images represented safety and comfort missing from childhood, but without necessarily being a picture of a parent figure or even a human being. Under these open-ended projective conditions, it seemed clients could find and use a very broad range of healing source material.

As a group, the images from BFF contained recurrent themes that crossed diagnostic lines. This is consistent with Ahsen's (1973) view that eidetic images, when accessed in a triad of image/affect/sensation from a state of relaxed mindfulness, embody universal themes in human development. The table below shows the percentage of imagery in different content categories. The surprise for me was the significance of pets, especially dogs, and the importance of nature. Our couch-jumping client, for example, found herself floating down in a parachute (action), watching her pet ferrets play (relationships), and studying a waterfall whose droplets joined together as they decided to go on a journey (nature).

Relationships to others, past or present, including pets, friends, teachers, mentors, family	**27%**	Self-structure – three images integrated into one structure felt in the entire body framework	**7%**
Nature - an awe inspiring sight or soothing sensory contact	**16%**	Safe/soothing places such as family rooms, kitchens	**7%**
Self in enjoyable gross motor action or pleasant pastime	**13%**	Assists – images with a faint perceptual match to the problem inviting imaginal experiments	**4%**
Ego-state images – self as child, a conflicted ego-state projected onto a living creature	**11%**	Defender/protector, in cases where adult protective failure led to childhood trauma	**3%**
Significant object e.g., diamond, grand piano, teddy bear	**9%**	Discards - images with mixed emotions & unwanted aspects	**3%**

TABLE 1. IMAGE CONTENT PERCENTAGES (n=40, 67 applications of protocol)

The somatosensory registration of these positive images was most frequently reported in the upper chest, often with simultaneous movements in the shoulders and/or facial muscles. Many different kinds of sensations were reported, including expansion, softness, warmth, lifting, and movements in all directions. There appeared to be distinct physiological substrates for a broader range of positive affects than those identified by affect theorists such as Tomkins (1962). A case in point was the often-mentioned sensation of "solid" in the upper chest and shoulders. It seemed to be the substrate for emotions of pride/confidence/courage.

E. Journeys through Internal Space: In this consolidation phase, clients take mental journeys around their three images, check on how they all feel, listen to them for sounds or music, and finally consider what they might be saying. A cognition is added at this point. This is not the preferred logical opposite of a negative cognition, but an inductively-derived conclusion based on the evidence of one's own life experiences. It is one thing to say, "I would like to believe I am strong," a positive cognition common in SP. It is another thing to say, "As I look around the evidence of my own life, these images are saying I can do it." Remarkably, a client who concluded she "could do it," was not reviewing images of instrumental strength or competence, but the landing at the top of her stairs at home, herself wearing blue shorts on the 7th tee at the golf course, and a picture of the sea.

The cognitions from this work tend to be self-encouragements, often beginning with, "I can," "I am," "Life is." What is it about these simple images that leads to such broad affirmations? The engine of change seems not to be the manifest content, but the body's response to cathected life experiences that have been uniquely significant for the person. It is not the golf course per se but the self and the golf course together at a particular spot that has left a deeply powerful affective/somatosensory resonance. And other clients also found images from the general themes of nature/gross-motor action, but something special to them and to their life. In these triads of image/affect/sensation, a little part of the person's potential or essential self has been captured. Sometimes through the vicissitudes of time, the part of the self contained in the image may have become neglected, overlooked, squashed, or constrained. But the evidence of its aliveness and undamaged condition is in body sensation. It can be revisited, reconsidered, played with, and used to redefine what matters. The somatosensory messages from engaging with the imagery can then become a most trustworthy form of biofeedback. The mind may have forgotten these arresting moments but the body has not. And we can use this body memory in a positive psychotherapy as much as we use its negative counterpart in fragmented sensory imprints when doing trauma therapy (van der Kolk, 2002).

F. Paired Titrated Exposures: The three images and the cognition(s) form a collection of autogenetic resources from which to reprocess the recurrent difficulty. This is the application work of the protocol, applying not an executive skill set but a dialectic within the body. In one long DAS set, the therapist begins by talking the client through three switches in mental focus. The client first focuses on the images/cognition, then briefly flashes to a titrated aspect of the recurrent problem, and last returns to the images and body sensation. This procedure places competing somatosensory signals in a time lock represented by one DAS set. One group of signals comes from the recurrent problem, another from the resource imagery. The process is similar to reciprocal inhibition, proposed by Wilson, Silver, Covi, and Foster (1996) as one possible explanation for the treatment effects of EMDR. Figure 1 below summarizes the process.

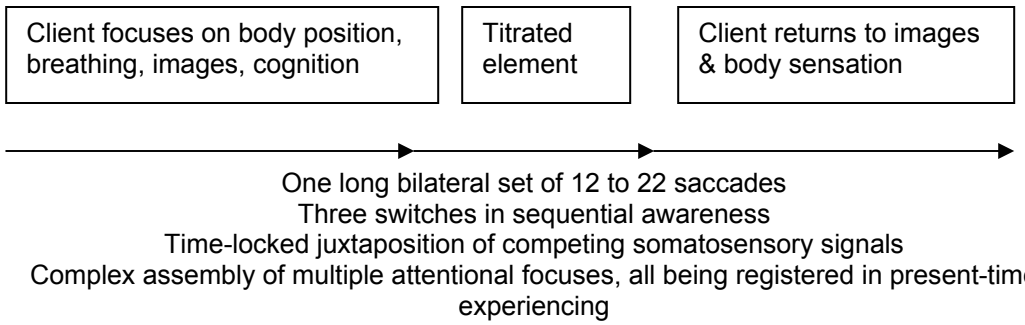

FIGURE 1. SCHEMATIC OF ONE PAIRED TITRATED EXPOSURE

Titration is the application of minimal increments of input into a system sufficient to cause a reaction. Titration can be a brief mental flash of the recurrent problem, a small content element, a vague reference, an altered perspective, or looking at a potentially destabilizing situation through a barrier or screen. There are several reasons for titration in this protocol. First, it reduces the psychological load on the client and thus may free attentional and reflective capacities for new response modes. Second, the maladaptive repertoire may be a well-entrenched reaction to intolerable affect. Titration reduces the chance that the affect will again build to aversive levels. Third, clients with long-term trauma whose fear has become conditioned to many different stimuli, can usually only handle small inputs of disturbing material. Paired Titrated Exposures thus takes baby steps, using only a small destabilizing element against a sizeable resource foundation to see if the client can remain steady under progressive increases in difficulty.

The therapist's voice gently guides the client through the three switches within the exposure, gradually reducing the structure over successive sets until the client indicates he or she can "go it alone." The client's own solutions emerge, usually reported as a different physical or verbal interaction with the representative situation being contemplated. The perceptual features of the images may change - moving, expanding, mutating – with accompanying proprioceptive changes. A series of connected insights may flow easily and naturally. The titrated trigger being contemplated may lose its charge or invite a completely different and often compassionate response.

The processing in these paired exposures is similar to the chain of associations in SP processing. Well-functioning clients can respond to SP by spontaneously associating to modulating and restorative ingredients from their own resources. This protocol seems to increase the chance of that happening by giving less well-functioning clients a helping hand from their own life experiences. On average, this section takes 3 to 6 DAS sets at the end of which many clients can picture a triggering situation with a surge of confidence. This has rarely been an action plan but an empowered stance they sense in the moment.

G. Future Rehearsal: This is similar to the future template in SP. The therapist says, "Imagine this situation occurs on …… (day). Stand (sit) in your position, collect your pictures, and then imagine how you might be." DAS "What was that like?"

H. End Ratings: The end ratings estimate within-session change and repeat those taken at the beginning. The mean SUDS change in the database was 7.5 to 3.2. The mean ending RoC was 5.9. The ending SUDS may still be somewhat elevated. The purpose is not necessarily desensitization, although that sometimes happens, but increased capacity for psychological containment in the face of felt distress. In some cases, clients were struggling with situations

where SUDS 1-5 would be normative. An ending SUDS of 5 with an RoC of 6 is virtually a definition of courage.

Outcomes

Most of the outcomes listed below were unexpected. Some were quite baffling. I thought I was doing resource work in preparation for further therapy, and found that in a few cases, the resource work itself could be enough. I also expected to obtain experiences that were a contrast to the functional problem. Instead, the body had taken a sharp left turn and had gone on a tour of nature scenes, family pets, trees, shrimp peeling, and miscellaneous objects such as speedboats, teddy bears, and precious gems.

1. Many clients spontaneously began to use their images, a body position, and breathing as self-support tools. One client developed a one-minute daily ritual out of this and reported, "it just pulls me together." Her images still retained the power to do this at 16-month follow-up. Ahsen (1973) believed that the object cathexis revealed in eidetic psychotherapy could well be lifelong. Most clients reported that the imagery popped up during the week, giving a little boost to their spirits. Some searched their house for the item that had come to mind in the protocol. There was a marked increase in the number of objects, letters, and photographs clients brought to their appointments.

2. Clients overwhelmed by stress were able to take charge of one or more unsatisfactory aspects of their lives after BFF. Their proactive stance showed determination, heart, and psychological containment without aggression towards others. This outcome has also been reported in Colorado feedback, from Nancy Battilega, L.P.C. with a borderline patient with an abuse history, and a formerly well-functioning client who had imploded into depression from acute stress. Many clients reported greater self-coherence.

3. The imagery of clinically depressed clients tended to be initially static – single concrete objects without synthesis of elements, but without morbid content or gloomy associations. Around the second or third session using BFF, images with gross motor action started to appear. Depressed clients actually "got moving" in their lives, and in the process called on a variety of executive functioning domains such as task initiation, decision-making, and cognitive framing. Increased perspective seemed to develop of its own accord, often with a clearer moral sense. Clients would then use their sessions to proudly or offhandedly report what they had already done about their problems. Sometimes they were amazed by themselves.

4. A few clients reported improvement in less important symptoms that were not the focus of therapy. One woman eliminated her speechless anger towards a family member, the focus of BFF, and then unexpectedly lost her public speaking anxiety. Several reported that their whole body felt different, lighter, and with more energy. Some reorganized their house, tackled unfinished projects, and began creative ventures such as writing and painting.

5. In trauma work, imagery could have perceptual/dispositional properties that were perfect to renegotiate trauma-related impasses in development. For example, a woman with long-term PTSD got an image of a polar bear. In subsequent somatosensory processing, this bear protected her from an abusive father (titrated glimpses through an opaque glass screen). A client with life-long anxiety for real or depicted human distress found an integrated structure made up of a column surmounted by an iridescent gazing ball with softly pleated drapery around the column. Interestingly, the salient perceptual features - color, depth, shading, and texture – changed in the processing, and these changes were consistent with Rorschach theory

to do with integration of affect. In Paired Titrated Exposures, her almost involuntary application of the drapery to an unspecified, disturbing scene on television replicated the perceptual outcome of having one's eyes shielded. This action alone brought relief, as the scene became a series of neutral black pictures. The appearance of images such as bears and columns from implicit memory did not appear to be random. The underlying process that was driving their selection from the myriad that was theoretically possible has no satisfactory explanation. Ahsen (1973) proposed that vivid eidetic images were conditioned by the light values in the original experience. My speculation is they arise from hippocampal trace matches to the priming influences (Kinowski, 2003).

6. With the polar bear client, the resource imagery originally intended to regulate autonomic arousal, became conditioned to trauma-evoking stimuli and operated independently of therapy attendance. Whenever this client felt stressed from intrusive recollections during the week, one or more of her images spontaneously "popped up" and helped her stay grounded in the present. The first evidence of an involuntary linkage between trauma triggers and her images occurred in session 21. When she was contacted at 12-month follow-up, this effect had persisted. This case is documented on videotape and is a topic all by itself. I am mentioning it here because it was a clinically significant outcome that suggested a possible way to reverse fear conditioning in long-term PTSD.

7. This counterconditioning effect has also been observed in recent work, once again with a defender/protector image - a classical male angel. In session 3 at the third return to the traumatic target event, the angel reappeared involuntarily. The client said, "It was six (SUDS) and then it went to zero when the angel came." The polar bear client said it was like having something imprinted on her subconscious (session 22). The client with the angel said it was like a short-circuit in her brain was preventing her anxious arousal for various triggers.

Discussion

The challenge was to look at these unexpected outcomes and explain what was causing them. Doing this was conceptually murky because the deceptively simple and "illogical" imagery did not fit into the usual lines of explanatory reasoning. The protocol's emphasis on somatosensory processing suggests that the answer lies in the way the midbrain processes affect and its physiological substrate. Damasio's (2000) text has been most influential in shaping my thinking here. He writes about the key functions of limbic structures such as the hypothalamus and cingulate cortex in coordinating and smoothing basic sensory and perceptual input, which in turn facilitate subsequent cortical processing. My hypothesis is that the imagery from the protocol, because of its affective potency, helps to offset or destabilize the strongly wired networks recruited by an habitual response mode. Not only is the system shaken up a little by pairing high frequency circuits with unlikely ones, the presence of the latter may even make the former unnecessary. Recalibrating the somatosensory substrate of one anxiety-related problem may also recalibrate the substrate for other anxiety-related problems that share the same neural network. This would possibly account for the treatment generalization effects.

At a non-logical, non-linguistic level of midbrain processing, the system may have what it needs for homeostasis and efficient energy usage, the superordinate functions of subcortical processes. It does not matter if the sensory/perceptual input makes no sense to a baffled therapist because the expectation that it should make functional sense is only the preserve of the neocortex. As our airborne client giggled her way through parachute practice, ferret games, and waterfall droplets, her body registered exhilaration, relaxation, springiness in her

legs, and a readiness to go and move. When these sensations surrounded a brief look at her shy and constricted self, she had a new sensation of peeling herself open to new experiences, fun rather than frightening. Using Damasio's terms, the Core Self (the neural equivalent of primary awareness) had possibly made a new neural map as the physiological state, Damasio's Proto-self, changed for the same inducing stimulus, now under the soft wing of her images. If homeostasis can be achieved as the body approves of a new response mode, then biology is on our side, rather than being a source of alarm and retreat.

Comparison with Standard EMDR Protocol The following table compares SP with BFF on some important procedural components. In general, BFF preserves many of EMDR's most potent features while restructuring them into a tighter format emphasizing somatosensory processing of projective imagery.

	Standard Protocol	***Best Foot Forward***
Main focus	unresolved traumatic events	unwanted, trait-like behaviors, stress-related body signature
Present-time experiencing (Primary awareness)	√	√
Semi-structured	√ partial	√ throughout
Associative retrieval	√ chain of associations	√ 3 projective images
Processing initiated by:	multiple elements in negative schema	promising body position with functional ambiguity
'Bottom-up' processing, (a focus on the raw data of the body)	one question initially, sometimes thereafter	systematically at different points; somatic interventions
Divided attention, bilateral stimulation	√	√
Cognitive work	NC PC obtained early	held in abeyance until imagery obtained
Evidentiary basis for cognition	NC from worst aspect PC from preference	three positive images felt in body, then applied to problem
Within-session ratings	SUDS, VoC	SUDS or SUBS, RoC
Best-fitting explanation of underlying processes	adaptive information processing (meaning integration)	adaptive information processing (system homeostasis)
Overall purpose	desensitization & reprocessing to adaptive resolution	empowerment, recalibration of affective response to stress

TABLE 2. Comparison of Procedural Components in Standard EMDR protocol and Best Foot Forward

Although EMDR is indelibly associated with bilateral stimulation, one source of its power, I think, is present-time experiencing and the forum for change this provides. This is characteristic of many good therapies such as Gestalt (Kepner, 1987/1999), Exposure (Rothbaum & Foa, 1999), Focusing-oriented (Gendlin, 1996), and is integral to somatic approaches (Kurtz, 1990; Levine, 1997; Macnaughton, 1997; Rothschild, 2000). BFF almost entirely uses experiencing in the here-and-now. Both the resources and the problem come from the past and both are read for their current somatosensory impact. The dialectic between the two is held in a present-time orientation by various techniques, including the therapist's

voice and bilateral stimulation. The main difference from SP is that BFF accesses the problematic schema only lightly, to see if the resources remain physiologically stable under graduated increases in intrapsychic challenge. This has been very helpful for clients with reduced stress tolerance related to clinically significant dynamics.

Practice Issues

The protocol appears to have a low risk profile. No damaging outcomes have occurred or been reported, even when dissociation risks are present. Preliminary reports suggest BFF reaches its end points with clients who have a powerful internal critic. They have trouble entering into it. At GAF 41-55, clients may have poor body awareness and need the body scan section slowed down and structured. In a few cases, a pleasant session ensues in which the client learns to use imagery and breathing, but there is little substantial change in the recurrent problem. Molly Gierasch, Ph.D., an EMDR Facilitator in Colorado, reports that self-conscious clients can be helped with the word "posture:" "What posture might help you be the way you want to be?" The wording of the instructions is not as critical as I once thought. Other therapists have introduced their own phrasing and variations, for example, asking what each picture is saying before storing it, or what the pictures might be saying to each other. When clients move on to SP, they are far more likely to answer, "What do you notice?" with what they notice in their bodies. This gives SP a much stronger somatosensory flavor. As well, the imagery from BFF seems to find its way into SP, popping into the client's associations like a friendly pest ("Oh, it's you again!"), bringing with it just the right kind of counterbalancing input the client needs in the moment. There have been few problems with unfinished sessions. Clients still leave my office in conscious possession of one or more internal companions. Although I explain we will not know how it helps until the next section of the protocol, the imagery not uncommonly starts to shift their perceptions and responses before they return.

Summary and Conjectures

Put Your Best Foot Forward builds resilience for current stresses by retrieving resource experiences and then applying their affective/somatosensory properties to the stressor in a process akin to stress inoculation with one's own experiential antibodies. Though not a logical process in terms of executive functioning, the protocol has strengthened access to resource domains, producing generalization effects particularly in clients too depressed or overwhelmed for organized verbal problem solving. Some clients have deliberately used their images as stress-management tools; many report they pop up spontaneously, and in two cases, the imagery has counterconditioned to trauma-evoking stimuli. What began as an intuitive experiment in resource work, accidentally tapped into a process for growth and healing.

The disparity between the in-session process and the post-session outcomes is an irresistible call for theory. My conjecture is that the guided use of affectively powerful imagery recalibrates limbic processing of the physiological substrates of problematic affect. This in turn seems to effortlessly result in more integrated cortical processing. Humanistically, the readiness of the psyche to reorganize itself under facilitating conditions speaks to almost innate capacities for self-integration held in the wisdom of the body.

The various unexpected outcomes reflect back on EMDR as a treatment method. When the overlap in procedural components between BFF and SP is analyzed, it suggests that the image/affect/sensation triad is a critical one for treatment outcome. The reason EMDR works may be the juxtaposition in present-time experience of triads with contrasting neural activation patterns. The "winner" is the pattern that enhances system

homeostasis, subjectively the physiological shift in which a destabilizing target situation suddenly looses its charge. In BFF, positive triads are systematically developed from cathected life experiences and then juxtaposed with stuck, functional problems. Clients learn from this quite transparent method how they can manage stress themselves using the somatosensory foundation of their own life experiences. Personal ownership of resources plus self-agency in using them is thus doubly empowering. This protocol extends EMDR processing principles beyond their trauma-focused research base. It is applicable to a general clinical population where GAF is over 51 and unwanted, stress-related problems have a recurrent physiological signature.

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