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The “Flashforward Procedure”: Confronting the Catastrophe

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This article introduces the “Flashforward procedure,” which is a specific application of eye movement desensitization and reprocessing (EMDR). It is used for the treatment of irrational fears, for example, when a persisting fear continues after the core memories of past events have been fully processed. A theoretical background is presented, and the procedure is explained, together with 2 illustrative case studies. We describe psychological conditions and mental health problems for which the use of EMDR aimed at client’s flashforward might be appropriate, as well as indicating which stage in the therapeutic process is most applicable for the use of this procedure. Furthermore, the Flashforward procedure is compared with other EMDR applications and similar procedures in other therapies. Some implications are discussed.

Keywords: Flashforward; EMDR; Future Template; anticipatory fears; catastrophic fears

Eye movement desensitization and reprocessing (EMDR) was developed in 1987 by Francine Shapiro for the treatment of traumatic memories (Shapiro, 2001). EMDR has since grown from a desensitization technique into an integrated psychotherapeutic treatment approach (Solomon & Shapiro, 2008). This therapy is underpinned by the Adaptive Information Processing (AIP) model, which theorizes that psychological disorders arise from unprocessed information that is dysfunctionally stored in the brain (Shapiro, 2001).

The Three-Pronged Protocol

The standard protocol for EMDR therapy consists of a “three-pronged” (past, present, and future) approach in which, initially, past events, then present issues, and finally anticipated future situations are targeted in therapy. The processing of past events would normally always be the starting point of the processing phase of EMDR therapy, and the processing of such events will usually resolve current psychological problems. According to Shapiro (2001), the standard three-pronged EMDR protocol guides the overall treatment of the client. Each reprocessing session must be directed at a particular target. The generic

divisions of the targets are defined in the standard protocol as follows. First, the past experiences that have set the groundwork for the pathology are fully processed.

Next, the focus of the therapy shifts to the second prong, which is aimed at the processing of specific triggers that currently elicit disturbance for the client. According to Shapiro (2006), some triggers could still remain active even though the original traumas were apparently processed. Shapiro hypothesizes that these triggers may be fed by some residual information from earlier events that have not been completely processed, or may be caused by second order conditioning. These triggers could be an external situation or an internal sensation (e.g., manifestation of anticipatory fear such as dizziness).

Finally, in the third-prong of EMDR, called the *Future Template*, treatment helps the client to visualize successfully managing an anticipated future event. According to the standard procedure, if there are any blocks, anxieties, or fears that arise when a client thinks about a future scene, the client is asked to focus on these blocks and several sets of eye moments are introduced. If the blocks do not resolve, Shapiro (2006) recommends providing the client with adequate information, resources, and skills that enables them to

comfortably visualize the future coping scene or to use the Affect Scan or the Floatback technique to identify old targets related to blocks, anxieties, or fears. The standard protocol is then applied to address these targets. If there are no apparent blocks and “the client is able to visualize the future scene with confidence and clarity” (Shapiro, 2006, p. 52), the third prong (Future Template) is installed. This is done by asking the client to focus on the image, positive belief, and sensations associated with this future scene and introduce sets of eye movements “to assist him/her in assimilating the information and incorporating it into a positive template for future action” (Shapiro, 2006, p. 51).

The Flashforward Procedure

This article describes the Flashforward procedure, an application of EMDR that can be applied as a technique to address clients’ irrational fears, which persist after the core memories of past events appear to have been fully processed. To this end, the Flashforward procedure can be considered an intervention that can be used within the second prong (“present”) of Shapiro’s three-pronged approach. Even though the client’s focus is on the future, the fears are experienced in the present, triggered by anticipatory thoughts, and so they are considered current fears suitable for processing in the second prong.

This article describes what a flashforward is, together with the mental health problems for which the use of EMDR aimed at the client’s flashforward might be appropriate. The article further describes the stage in the therapeutic process that is most applicable for the use of this procedure and illustrates the procedure with two case studies. Finally, a theoretical background of the Flashforward procedure is presented and explained.

Research Background for the Flashforward Procedure

It has been shown that employing eye movements and related working memory tasks typically results in an amelioration of the emotionality of memories, not only for resolving unprocessed memories underlying posttraumatic stress disorder (PTSD) but also for those in other mental conditions (De Jongh, Ernst, Marques, & Hornsveld, 2013). Two recent analogue studies have shown that intrusive images about potential future catastrophes can also be ameliorated by taxing working memory using eye movements (Engelhard et al., 2011; Engelhard, van Uijen, & van den Hout, 2010; Van den Hout et al., 2011). In both studies, participants were asked to select two

flashforwards, that is, negative intrusive visual images about events they feared might happen to them in the future (e.g., having a blackout during a presentation, the funeral of a loved one, being hit by a car). Events that had already happened to them in the past were excluded. Then the participants were randomly assigned to either “recall with eye movements” or “recall only” conditions. Next, four sets of eye movements were employed of 24 seconds each with 10-second breaks in between. Before and after the experiment, participants were asked to retrieve the image and to rate its vividness and emotional intensity. The results of the first study ($n = 28$; Engelhard et al., 2010) showed that the vividness and emotional intensity of the future-oriented images significantly decreased after recall with eye movements, relative to recall only. The second study ($n = 37$; Engelhard et al., 2011) used a sample of female students who indicated on a screening scale that they suffer from flashforwards. The results replicated those from the first study in that vividness of the flashforwards had decreased after recall with eye movements, compared to recall only. There was a similar trend for emotional intensity, but recall with eye movements did not significantly reduce vividness from pretest to posttest, a finding the authors attributed to a problem of statistical power.

Holmes, Crane, Fennell, and Williams (2007) originally used the term *Flash-forwards* to refer to suicide-related images. Engelhard et al. (2011) described the term *flashforwards* by stating that

. . . fear of future danger is common after a threatening event, and may take the form of future-oriented mental images. These may appear like “flashforwards,” echoing “flashbacks” in posttraumatic stress disorder (PTSD) and possess sensory qualities, being vivid, compelling, and detailed. (p. 599)

Thus, rather than referring to an anticipated and predictable event, EMDR focused on someone’s flashforward relates to the processing of an image of a feared catastrophe, in other words, the mental representation of someone’s “worst thing that could happen” or “anticipated doom scenario.” In fact, when a client suffers from a fear, by definition, there must be an anticipated catastrophic future event. In this respect, EMDR focused on someone’s flashforward should be conceptualized as an intervention that can be used within the second prong of the protocol because it concerns what the client still currently actively fears. It should be noted that even if the fear is of some future event, which may not occur for more than a year

(perhaps a flight or a visit to the dentist), the client may still be currently preoccupied by their anticipated fear of this event.

Previous Applications of the Flashforward Procedure

The only published description of the use of Flashforward procedures in a clinical context is by Romain (2013). She describes the successful application of EMDR on clients' flashforwards using the EMDR standard protocol in two cases. The first is a woman fearful of returning to work even after past memories are cleared. The second is a young man in early sobriety whose reprocessing of the past is interrupted by concerns of an imminent court appearance.

A similar process to the use of EMDR aimed at the client's flashforward has previously been described by Browning (1999) as the "Float-Forward Technique." Browning defines it as a technique that can be used "to address blocks, reluctance and, in some cases, resistance or secondary gain/loss issues" (p. 34). The client is asked to imagine the "worst thing that could happen" if, for example, they "do EMDR," "got rid of this problem," or "set limits with your boss about her expectations for your workload." This worst-case scenario is then processed in the usual way using the basic EMDR protocol.

When to Apply the Flashforward Procedure

In most cases, the Flashforward procedure should normally be employed once all past traumatic events, relating to the future target in question, have been fully resolved using the standard EMDR protocol. When it appears that the client still experiences anticipatory fear of confrontations with certain objects or situations, this should alert the therapist to the possibility of unexplored past traumatic events that remain to be processed. Once all memories of relevant past events have been fully resolved, or it is not possible to identify any past events that appear to be relevant to the feared future event, it would then be appropriate to use the Flashforward procedure.

If the flashforward has been fully processed (and hence the Subjective Unit of Disturbance [SUD] related to client's flashforward is zero), and the client still indicates feeling not comfortable with future confrontations with certain stimuli or formerly phobic situations, or there is avoidance behavior, then other procedures need to be used. This would include the Future Template as well as the so-called *mental*

video procedure that is part of the Phobia Protocol (Shapiro, 2001) and the use of exposure in vivo or so called *behavioral experiments* (see De Jongh, 2009). The use of these cognitive behavioral procedures can be helpful in case it is deemed necessary for the client to learn to be exposed to the feared situation until she has achieved a degree of self-mastery and feels able to handle a certain level of anticipatory anxiety and fear with confidence again.

Here are some procedures that might be used within the context of treatment with EMDR:

- Targeting memories of past events that explain client's current symptoms
- Flashforward procedure
- Future Template
- Running a mental videotape (as part of the EMDR Phobia protocol)
- Exposure in vivo/behavioral experiments

There are some exceptions to this, however: Firstly, use of the Flashforward strategy might be indicated when a future feared event is so disruptive to normal life that the client is either not sufficiently motivated to consider past events or is incapable of doing so. Secondly, EMDR aimed at targeting one's flashforward might be indicated if it is necessary to convince a skeptical client of the benefits of EMDR by first demonstrating it with some current issue with which they are preoccupied, and they are initially unwilling to accept that looking at past events may be the key to unlocking their problems. Thirdly, it may not be possible with certain clients to identify any past trauma or negative experience that appears to be at the root of their current symptoms.

How to Use the Flashforward Procedure

In its application, the Flashforward procedure is identical to the standard EMDR protocol, except that the target relates to a feared catastrophic future event rather than to a past one. For example, a client who still fears driving after the trauma of a road traffic accident (RTA), despite having fully processed the traumatic memory, would be asked what future catastrophe they fear the most. They might anticipate their own death in an RTA. This image would be used as a target.

The therapist may ask the client to say what she believes will happen to her if she is not able to avoid her fearful situation anymore. To this end, it is important to create a framework that allows and enables the client to think about the impending doom of the worst-case scenario. An example

of how to help the client identifying his or her flashforward could be as follows:

We need to figure out what kind of image is in your head that makes you scared about a future confrontation with what you fear. What is the worst thing you could imagine happening? Basically, we should look for your ultimate doom scenario. Please make a still picture of that disaster image.

To help identifying client's ultimate catastrophic fantasy, the therapist may ask additional questions, for example, "What do you imagine might go wrong if you . . . [for example: 'come across a dog']? If you had a nightmare about . . . [for example: 'driving your car to work on a busy road'] what would the most disturbing picture look like?" It is important that the therapist follows the worst scenario to its ultimate conclusion. For example, instead of accepting the client's own death as the ultimate catastrophe, the therapist asks "what would be the worst thing about you dying?" This may bring up issues about loss or responsibility, for example, "My family would be unable to cope if I died." The therapist might then ask the client to contrast the fact of their death with its perceived consequences by saying, for example, "If you were forced to choose, what would be most disturbing for you now—you dying, or staying alive but being unable to care for your family?" When the client eventually has a still picture of the worst moment of his or her catastrophic ideation in mind, he or she is asked to make it as detailed as possible.

Essential Elements of a Flashforward Suitable for Treatment With EMDR Therapy

- A detailed and still picture
- Contains catastrophic elements of what might happen in the future
- Context specific and conceptually related to client's symptoms
- Intrusive and disturbing

Next, the negative cognition (NC), positive cognition (PC), validity of cognition (VOC), emotions, SUD, and bodily location are elicited in the usual way to process the target. Because the client generally experiences a lack of control when bringing up her flashforward, she feels, in fact, powerless against this—by definition—intrusive image. Accordingly, it is the experience of the second author (ADJ) that when using EMDR aimed at the client's flashforward, it usually works best to use the NC "I am powerless" as the default NC. This would also mean that

"I am in control (of the flashforward)" or "I can deal with it (i.e., the flashforward)" should then be used as standard PC. Next, all the remaining phases of the eight-phase protocol (Shapiro, 2001) need to be used in the usual way until an SUD of 0 and a VOC of 7 has been reached.

Even if all memories of past traumatic events appeared to have previously been fully processed, the Flashforward procedure may still spontaneously activate old material. If any old material arises (either a previously processed trauma or some other memory that has not already been processed), the therapist should simply continue processing in the usual way (i.e., "go with that").

Possible Applications of the Flashforward Procedure

There are no clinical data yet from well-controlled studies about the effectiveness of focusing on individuals' flashforwards. However, the fear of future catastrophe is a key component in several psychological conditions. For example, obsessive-compulsive disorder (OCD) relates to preoccupation with, and avoidance of, future events that the client deems to be catastrophic. In one of their case studies, Böhm and Voderholzer (2010) describe using EMDR to target and successfully process a future scenario in which the client with OCD believes that she will be punished in hell.

The fear of future events is also clearly a major component in specific phobias (De Jongh, ten Broeke, & Renssen, 1999; De Jongh, van den Oord, & ten Broeke, 2002). The use of EMDR in the treatment of phobias is well established and this will often include the processing of feared future events. A fear of future catastrophe will also often be a feature of other psychological disorders such as PTSD (fear of situations similar to the trauma), anorexia nervosa (fear of consequences of eating), and several conditions in which a fear of failure appears to be a major aspect.

Examples of Situations in Which the Flashforward Procedure Might be Appropriate to Use

There is, therefore, some potential for the use of the Flashforward procedure with the following conditions, always with the proviso, however, that past traumatic events or significant experiences should be processed first.

- Dog phobia (being attacked by a dog)
- Dental and medical phobias (extreme pain, being powerless, "bleeding to death")

- Social phobia (being rejected or other embarrassing situations)
- Obsessive-compulsive disorder (being contaminated; house in flames)
- Body dysmorphic disorder (a negative remark about appearance)
- Hypochondriasis (the end phase of a terminal illness)

Case Examples

Case #1, Mary: A Phobia of Cycling

Mary is a 50-year-old married woman who was referred by her solicitors for psychological therapy with the first author (RL), funded by a personal injury claim, in relation to an RTA that occurred 18 months previously. The accident happened when she was en route to work, on a bicycle, and was hit by a car and thrown off her bicycle. On starting therapy, she has not ridden her bicycle since the accident and feels anxious as a passenger in a car.

Mary has two daughters aged 22 and 19 years as well as a 29-year-old stepson from her husband's former marriage. She has a good relationship with her husband and daughters. She is the second eldest of four siblings whose parents remained together until the death of her father 11 years previously. She does not appear to have resolved her grief about her father's death and becomes upset when she is asked about it. Her mother is in good health and Mary has a good relationship with her.

Mary tends to be a "backseat driver," leading to arguments with her daughters and husband. She avoids thinking about the accident and becomes upset if she does so. It was clear that her phobia of cycling had been caused by the accident, and the plan therefore was to start by initially processing the memory of the accident. After a session of resource installation, it took four sessions to fully process the trauma. At the next session, a Future Template was used in which she was to imagine riding her bicycle in heavy traffic past the scene of the accident. Following this, she was anticipating very low levels of anxiety and agreed to try to get back on her bicycle. At the next session, she reported that she had resumed cycling again until she saw a car approaching on a side road that had been a setback and caused her to feel worse. The Future Template was used again, but the next week she said that things had deteriorated further.

It was therefore decided to change from using the Future Template to using EMDR focused on her flashforward. Her worst-case scenario was that she would be killed on her bicycle (with the NC "I'm vulnerable"). The processing became stuck and

the level of SUD would not come lower than 4. She was therefore asked "what would be the worst thing about you dying?" She said that she would lose her family, "They're all around me; they are what I've got." She was then asked to make a clear picture of this scene, and hypothetically to choose between (a) being killed on her bicycle and (b) staying alive but being kept separate from her family forever. She preferred the former option and was instructed to "go with that" dilemma during bilateral stimulation. This produced a dramatic change. Although the SUD did not reduce lower than 2, she said at the end of the session that, "Thinking about losing my family, dying doesn't seem so bad now." This seemed to be a turning point for her. She resumed cycling and showed a marked improvement in most of her symptoms.

Case #2, Nicola: Fear of Future Surgery

Nicola is a married woman in her 30s who sought treatment for panic disorder. Nicola has a preschool daughter and an adolescent stepdaughter. She is the only child of her parents who separated when she was aged 16 years. After that, she lived with her father for 2 years because she thought that her mother was to blame for the separation. She was then informed that her father had been having an affair and she therefore chose to live with her mother and did not speak to her father for 2 years. She told the therapist that she now has a good relationship with both her parents. She has a good relationship with her husband although he finds it hard to understand what she is going through.

Nicola dates her problems back 2 years when she went into hospital for an emergency appendectomy. The anesthetic failed and she woke in the anesthetic room believing that she was already in recovery. She was paralyzed but could hear what was being said including comments that she was "fat." During this so called "awareness" experience, she felt that she could not breathe and believed that she would die. Since then, Nicola is having nightmares every night in which she relives the trauma. She experiences panic attacks and anxiety. She also suffers from bingeing and vomiting when she is feeling particularly bad. Because she was starting to feel suicidal following the trauma, her 6-month-old baby was cared for by her mother-in-law. Nicola herself works as a psychiatric nurse on an acute psychiatric ward and some clients she had worked with have exacerbated her condition. She was assessed by a psychiatrist and was prescribed medication and also received cognitive behavioral therapy (CBT) from a trauma service, but she felt that this did not help her.

It was assumed that the trauma of the operation 2 years previously was causing her current problems and this was therefore the starting point for the therapy. In four processing sessions with the first author (RL), the trauma was fully resolved. However, in the last of these sessions, she had a major abreaction in which she realized that she felt she always needed to be in control and needed to control others. Further history taking revealed that this related to when she was 16 years old and her mother suddenly left home and she began to feel responsible for her father. Two further processing sessions on this event and a great deal of discussion with both her parents brought some resolution of this issue. She then required one more session to process the original trauma. At this stage, all that was left was a residual fear of the further operation she was scheduled to have in the near future in which she still feared that her trauma might be repeated.

One flashforward session was therefore carried out on her worst fear, that she would be awake and in pain throughout the procedure. Her NC was “I’m soft.” The SUD rapidly reduced from 6 to 1 in just a few sets, most of which involved noticing different bodily sensations. She said she did not want the SUD to be any lower than 1 because she indicated that she needed to be slightly wary to ensure that the anesthetist made no mistakes on the next occasion. She also realized that it is not possible to be in control all the time and that this is something she could live with.

The Flashforward Procedure From a Theoretical Perspective

To understand what the Flashforward procedure does, it is useful to consider the theoretical perspective of classical conditioning theory (Pavlov, 1927). According to this theory, one stimulus, the conditioned stimulus (CS), can be paired with a second stimulus, the unconditioned stimulus (US)—a biologically significant and aversive stimulus such as pain or a disturbing image. The CS usually produces no particular response at first, but after it is paired with the US, it elicits the conditioned response (CR). Thus, for example, in the case of a phobia, the CS refers to the stimulus that evokes emotional disturbance, whereas the US refers to the threat appraisal, the catastrophe the client expects to happen, and which identifies the mental representation of the feared consequence. The association between the phobic stimulus and client’s prediction (i.e., as a consequence of the stimulus, a negative dangerous event is likely to occur) makes his or her anxious belief operational. The previously

neutral stimulus (CS) that has become associated with the catastrophe through classical conditioning starts to act as a predictor of the feared catastrophe (US), thereby generating anticipatory anxiety (CR). To put it simply, an individual with a phobia of dogs may believe that if she gets too close to a dog (CS), it will attack her (US), which evokes a fear response (CR). Or the client fears the situation of driving to work (CS) because she expects to be killed in an RTA (US), which evokes fear (CR). The US, in these cases, would be the imagined catastrophe of being attacked or killed which may be seen as the core of the fear network.

If someone is still fearful even after the core memories of the past have been effectively processed, it is likely that the CS triggers the core of the anticipated danger, which is the mental representation of what could happen if the client is exposed to their phobic cues, that is, his or her doom scenario. To this end, it is conceivable that successfully targeting and processing the image of being killed may produce a fundamental and generalizable change for the client. In other words, with EMDR focused on client’s flashforward, one is not targeting *what* the client fears but *what* is the *basis* of that fear.

Differences Between Flashforward Procedure and Future Template

The first case is interesting because it illustrates differences between the Future Template and the Flashforward procedure. This therapy was carried out at a time when the therapist (RL) was still learning about, and experimenting with, these different protocols. He made the assumption—probably many therapists do—that he should apply the third prong and Future Template to process future anxiety. However, when the therapist attempted to process Mary’s fear of cycling with the Future Template, her anxiety was unrelieved. This is not surprising because the Future Template is designed to install a template for adaptive positive future action; its primary purpose is not to facilitate exploration or resolve fears.

Mary’s fear of future events was an indicator that she was still experiencing current triggers. It became apparent that the therapist needed to go back to the second prong and work on the anxiety triggered by Mary’s catastrophic thoughts. The Flashforward strategy enabled Mary to look at her issues at a more fundamental level than was possible through the Future Template and made her understand what her fear was really about. By differentiating her fear of death from her fear of losing her family, it was possible for her to put the problem in perspective. This case

clearly illustrates that opening up the issues regarding clients' catastrophic ideation may enable them to see their worst fear in a new light and to process the unresolved issues that relate to it.

In this respect, the Flashforward procedure fulfills the missing link between adequately targeting memories of significant events that happened in the past (first prong) and the Future Template (third prong). This line of reasoning is supported by the experience of the second author (ADJ) that once flashforwards have been completely processed ($SUD = 0$ and $VOC = 7$), the focus on present triggers is completed. Another critical observation is that only when the client's flashforward has been properly dealt with (resolved; second prong) can the installation of a PC in relation to a future scenario with a positive outcome (third prong) occur effectively.

Catastrophic Fears

If a client still suffers from irrational catastrophic ideas about what might happen in the future, even though all past memories underlying complaints have been fully resolved, this implies that there are still dysfunctionally stored mental representations (USs) that need to be addressed. In the example of the client with a fear of awakening during an operation, the disturbance pertaining to the irrational fantasy about undergoing an operation in the future can be considered as "dysfunctional." To this end, it is realistic to hypothesize that this image stands in the way of having needed surgery. In such instances, EMDR aimed toward processing the client's disaster image to treat her fear is a useful approach. Therefore, when a client presents such a catastrophic belief, this issue can best be solved by explaining to the client that she was not born with a fear of awakening in operations and that her anticipated fearful situation is "just" based on a mental representation, a remnant of the earlier trauma, which in itself is irrational and should be targeted with EMDR. It is hoped that in this way, the client could be convinced about the usefulness of processing his or her flashforward down to an SUD of zero.

One aspect that occurred in both cases was that the clients indicated that they were satisfied with a SUD related to their flashforward that remained higher than zero. A therapist might be concerned that this indicates that the flashforward was not completely processed. This raises an interesting issue because it could be argued, for example, that most people would feel some distress at the prospect of being awake, in pain, and unable to speak during an operation even if this experience had never previously happened to

them. In which case, one might well ask why should the SUD go down to zero anyway? Perhaps having a low level of anxiety about future situations may be adaptive, allowing a person to be alert—in Mary's case to oncoming traffic and in Nicola's case to the surgery procedures. It may be that an $SUD = 1$ for flashforwards is a good outcome.

Comparisons of the Flashforward Procedure With Other Treatments

It is interesting to note that a similar approach to the Flashforward procedure has been described in the CBT literature for the treatment of hypochondriasis (Prasko, Diveky, Grambal, Kamaradova, & Latalova, 2010). These authors state that because of cognitive avoidance, clients may not go through the entire worst-case scenario, and thus can neither create a procedure for coping with the feared situation nor habituate to catastrophic thoughts. This in turn maintains and gradually increases their fear of suffering, dying, and death. In their model, they guide clients to habituate to the worst-case scenario within several exposure sessions.

The Flashforward procedure has some similarities with Marr's (2012) Adapted EMDR Phobia Protocol, which he developed to treat symptoms of OCD. He conceptualized OCD as a self-perpetuating disorder and hypothesized that the obsessions and compulsions, which he viewed as current triggers, needed to be addressed with EMDR prior to targeting historical traumatic events. His preliminary research provided promising results.

Another comparison that could be made here is with the "Desensitization of Triggers and Urge Reprocessing" (DeTUR) protocol, which is described by Popky (2005) for the use of EMDR with clients having addictions. The DeTUR protocol also relates to the client's perception of a future event in which he or she has an urge to carry out a particular behavior. However, Popky's approach focuses on the "level of urge" to carry out a behavior. In contrast, the Flashforward procedure is focused on the level of disturbance related to a feared future catastrophe.

Summary

This article provides a description of the use of the Flashforward procedure and how it can be applied within EMDR therapy. The two case examples illustrate how, for some individuals, the use of EMDR aimed at client's flashforward may be an effective approach, particularly in the case of anticipatory fears that continue after the underlying memories have

been resolved. We suggest that the Flashforward procedure has potential for assisting the progress of EMDR in situations where the processing of past events is not sufficient. Although it should never be regarded as a “stand-alone” intervention, it could exist as another valuable tool in the EMDR therapist’s toolkit.

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