TREATING ADOLESCENTS BY EXTENDING THE APPLICATION OF BILATERAL STIMULATION

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From Freud (whose therapeutic approach was to make clients aware of their unconscious, emotionally-powerful processes) to Seymour Epstein (who in 1994 summarized the research that demonstrated the existence of two parallel interactive modes of information processing – a rational system and an emotionally driven experiential system) to the present emphasis in cognitive psychology that studies the neurological processes related to such phenomena as the implicit versus explicit memory of experience, there is a theoretical line that needs to be drawn to connect the dots. Indeed, it is an important line because it may enable us to understand why certain new psychological strategies (that at present seem a bit mystical) are, as research continues to demonstrate, indeed proving successful. Even more important is that theoretical understanding of these strategies (EMDR is one example of such a strategy) enables clinicians to extend the underlying principles to other areas of treatment that need to be better addressed.

In 1989, Shapiro introduced EMDR as a treatment for trauma related disorders, specifically PTSD. EMDR is an exposure treatment that involves cognitive restructuring. Two main distinguishing factors of EMDR are short exposure times and eye movements. Clients simultaneously focus on both traumatic material (exposure) and an external stimulus using saccadic eye movements of alternating bilateral stimulation (e.g., following therapist hand movements from side-to-side with the eyes). They are also taught to identify and cognitively restructure problematic beliefs related to the traumatic event(s) in order to process the traumatic affect and produce more adaptive thinking. These procedures are repeated until there is a low level of distress associated with remembering the traumatic event.

Research has demonstrated that eye-movement is not what is crucial in this strategy. Any process that facilitates the alternate stimulation of the left and right hemisphere will suffice. In my own work, I have been using a "thera-tapper" whose strength and frequency of pulse I am able to control as my client holds in his or her hands the "pulsers." Traumas have been effectively reduced and even eliminated with the help of such bilateral stimulation, but the important question is why. Simply stated, bi-lateral stimulation would seem to better enable the emotional system to interact more effectively with the cognitive system. In the case of traumas, this is dramatically helpful because traumas would seem to be locked into an emotional cycle that resists any logical reasoning or distancing to modify it. In modern terms, the implicit experience of a traumatic memory that keeps recurring in the same agonizing way will not easily allow a path by which it can become more explicit and therefore easier to handle.

In my earlier work, I suggested that an information process model that does not include both the cognitive and experiential emotional systems could not adequately explain the learning process, and, with the help of others, developed a molar model of learning process that included the parallel systems.

Many adolescents who are not experiencing trauma or PTSD still can profit from procedures that incorporate bilateral stimulation into treatment. Most of the teens I work with are struggling with the internal pressures of hormones, incomplete brain development, the external pressures of peer, family and school expectations and the anticipation of significant change. They are frequently "emotionally seized," and find it hard to melt their strong feeling to distance from the issue in order to approach it more rationally and appropriately. I have found that in relaxing teens and then discussing the "issue" with the help of bilateral stimulation, I have been better able to help them confront and consider their situation and options. I have also found bilateral

stimulation helpful in working with youngsters who are struggling with such disorders as, for example, social phobia.

There are others who are also adopting this view and are extending its use to other areas. One of these is John Omaha, Ph.D., who has been focusing on emotional regulation with clients of all ages.

We have many strategies that have been developed to help us in our delicate and important work with clients. Exposure, psychodynamic insight, and the structured homework of cognitive-behavioral therapy (in which experiences develop new feelings that counter condition the feelings that are causing problems) are evidence-based and extremely useful. I employ them all. To build and maintain mental health, one cannot have enough tools in his satchel.

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