Accelerated Resolution Therapy (ART): Clinical Considerations, Cautions, and Informed Consent for Military Mental Health Clinicians

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Disclaimer: This document reflects personal notes of the author and is not an official position of the U.S. Army or institutions listed above. The term "client" is used throughout, rather than "patient," consistent with ART training, although ART is intended for use only in clinical treatment settings.

I. Introduction

This document provides information to help put ART in context with other trauma-focused therapies, as well as clinical considerations, safety, and information concerning informed consent for prospective ART clients being treated in military treatment facilities.

Although there has only been one randomized controlled clinical trial of ART for the treatment of PTSD[1] and several case reports/case series,[2-5] ART has firm roots in trauma-focused psychotherapies that have an extensive evidence-base.[6,7] ART also received a high-level evidence statement from SAMHSA for PTSD and depression.[8] Though the structure and protocols of ART are distinct, the principles, techniques, and theory underlying evidence-based trauma-focused therapies, particularly EMDR, fully support the approach ART takes to trauma recovery. ART incorporates the same core components of A-level trauma-focused psychotherapies accepted as standard of care, such as CPT, PE, and EMDR, including desensitization through imaginal exposure, in-vitro/in-vivo exposure, cognitive restructuring, and relaxation.[6,7] ART delivers these components in a unique way that appears to be consistent with evolution in the development of trauma-focused therapies, capitalizing on recent knowledge on memory reconsolidation.

Like other trauma-focused therapies, ART treatment sessions can sometimes produce abreactions as part of the healing process, including accessing primitive emotions and physical sensations, as they were experienced at the time of earlier life traumas. ART procedures are designed to assist the client in finding relief from these reactions during the session. Nevertheless, clinicians who utilize ART techniques should have the training, knowledge, clinical experience, and comfort in delivering trauma-focused psychotherapies in which such reactions may occur.

As long as mental health clinicians are licensed to practice independently (or are trainees working under direct supervision of licensed independent practitioners) and are comfortable delivering more established exposure-based or trauma-focused therapies in which strong emotional reactions may arise during or between treatment sessions, there is no reason not to consider ART techniques within the range of acceptable options for delivering the core-components of evidence-based trauma-focused treatment. Clinicians

must be comfortable addressing high emotional states / abreactions resulting from processing traumatic memories. The same cautions and clinical considerations that apply to other therapies apply to ART.

II. Why Choose ART?

ART, developed by founder Laney Rosenzweig, offers a novel way of delivering trauma-focused therapy components, and the potential for more rapid and lasting resolution of symptoms in a safe and effective manner. ART attempts to clinically apply evidence that suggests that conditioned responses to traumatic memories can be permanently modified during the brief period shortly after traumatic memories are reactivated, known as the reconsolidation window.[9,10] This offers potential advantages over classical exposure techniques in which desensitization/extinction effects can degrade over time or be rekindled by exposure to a novel stimulus or novel context. Initial research suggested that ART may offer significant resolution of PTSD symptoms in less than five treatment sessions (mean 3.7 in the clinical trial[1]), which, if confirmed, offers the potential to reduce the time needed to treat PTSD and improve clinic workflow. Whether or not the brief course of treatment is confirmed in further trails, the structure of the ART procedure also allows it to be integrated with other modalities and utilized when needed to help address specific problems over a longer course of treatment. Because there is resourcing and positive visualizations built into the process clients almost always leave each treatment session feeling measurably better than when they started the session. Clinicians also experience satisfaction of seeing immediate relief and measurable benefits in mood, functioning, and health, which in turn could lead to less clinician burn out.

III. Comparison Between ART and EMDR

ART can be considered a direct derivative of EMDR, drawing from the extensive EMDR evidence-base. Like EMDR, ART relies on guided visualizations and eye movements to facilitate desensitization and processing of distressing memories, in-vitro exposure to future feared triggers, practicing future preferred behavior through visualizations, and eliciting improvements in physiological arousal, emotional reactivity, and beliefs. Both EMDR and ART may be used for a variety of mental health problems, not just PTSD, based on the fact that a great many problems can be traced to events that were encoded as traumatic, often in childhood, even if they did not meet the formal Diagnostic and Statistical Manual (DSM) A-criterion definition. Both EMDR and ART have been reported to be capable in some patients of producing rapid resolution of long-term distress stemming from trauma or other adverse life events, sometimes within just a few, or even at times a single treatment session.[1-5,11] The mechanism of action for both EMDR and ART is likely to be overlap. The EMDR adaptive information processing model is consistent with the approach that ART takes to memory processing, and all of the core ART techniques, such as holding attention on the body sensations, rescripting, and Gestalt interventions, can be found in EMDR protocols (although these are usually reserved for situations according to clinician judgement in which the patient is not responding well to the basic EMDR protocol).

Procedural differences that distinguish the core ART protocol from the core EMDR protocol offer the potential to improve processing of traumatic memories, achieve rapid results more reliably, and lower the risk of experiencing heightened trauma-related distress shortly after beginning treatment or between treatment sessions (well-known to occur with EMDR and other trauma therapies), although additional research is needed to confirm this.[1-5,11] Most important in ART is holding the focus of processing on the body sensations and emotions, whereas in EMDR routine processing involves a more free-associative approach. While both ART and EMDR techniques facilitate clients coming to their own solutions/resolutions, and both incorporate and conclude treatment session with positive imagery or resourcing, ART has a simpler more experiential body-centric approach to desensitization and reframing (what EMDR calls "installation").

Key differences between the EMDR and ART approaches are as follows:

1. During the desensitization phase in EMDR, the target traumatic material is represented by what Dr. Shapiro refers to as three narrowly focused "laser beams," the single image that best represents the trauma (e.g. worst part of the event), the negative cognition about oneself associated with the event, and the emotions/sensations (including where the client feels this in their body). (One exception to this in EMDR is for recent events protocols; if traumas are recent, within the past 3 months, clients may be asked to visualize the entire event.) In ART, the client is asked to visualize the entire traumatic event from beginning to end (as defined by the client) whenever it occurred without such representations. Immediate attention is directed to resolving any strong emotions or physical sensations that arise when the memory is activated. When there are gaps in memory, which is common, the client visualizes everything they can remember, even if only a single image. Eye movements are used to facilitate both the visualization of the traumatic event as well as finding relief from the immediate emotions and physical sensations that occur as a result of the visualization.

2. EMDR relies to a large degree on a free associative desensitization process prompted by attending to the three target representations (traumatic image, negative cognition, and emotion), and clinicians are discouraged from repeating the client's words (so as to avoid intonations that may subtly change the meaning) or exploring the meaning of what comes up during the free-associative process. EMDR uses repeating sequences such as, "I'd like you to bring up that picture and those negative words (_____negative cognition) and follow my fingers…. Take a breath and let it go. What comes up? (or What do you notice?, What do you get now?) Think of that/notice that/go with that and follow my fingers… Take a deep breath and let it go. What do you get now?", etc. This is repeated multiple times until changes remain neutral or positive for two sets of eye movements; then the client is asked to go back to the original image/cognition, again with a free-associative approach, "when you go back to the original memory, what are you noticing now?" In contrast, in ART, desensitization is facilitated and reinforced through sequences that bring immediate awareness (and relief) to the physical sensations and emotions directly connected with the traumatic material. The ART desensitization procedure is less open ended and more body-centric. A typical ART sequence would be, "Start seeing your scene (from beginning to end) and follow my hand… Take a deep breath. Forget the scene (or put the scene aside). Check

your body from head to toe. What sensations do you have right now? Notice those sensations and follow my hand." Only after the client has found sufficient relief from the distressing emotions/sensations will they be asked if they are comfortable picking up where they left off and continuing to visualize their scene. Two times through the entire scene, combined with processing out all physical/emotional sensations, is usually sufficient to achieve desensitization, and considerable relief. The ART approach has a natural flow. Within the structure of the basic protocol, conversation and exploration of insights between eye movements often occurs spontaneously and facilitates the process.

3. The more free-associative approach used in EMDR, compared with ART, typically requires a high level of clinician training and experience, 90 minute sessions, and not infrequently results in clients getting stuck in distressing memories or emotions during sessions, requiring more advanced procedures to facilitate progression and avoid harmful effects of the intervention. It should be noted that EMDR practitioners may shift the focus of processing to physical sensations when there is high abreaction, but this technique is usually reserved for these situations and used according to clinician judgment, whereas they are part of the core ART protocol. This original EMDR approach to processing can leave original traumatic experiences half-processed at the end of a session resulting in the emergence of distressing memories, images, or emotions during the intervals between treatment sessions, especially in clients who have suffered significant childhood traumas or have an underlying dissociative disorder. This can lead to clinical instability between treatment sessions. In contrast, the ART procedure, which keeps attention on the sensory experiences, is simpler to learn and master, more procedural in its approach to targeting traumatic memories (though clinician skill and experience are still very important), and can usually be safely and effectively delivered within 60 minutes (though sometimes longer sessions are needed). The goal is to sufficiently process the targeted memory during each session, and thus clinical distress from continued processing of traumatic material between sessions is less likely to be a concern with ART (though the client still needs monitoring).

4. EMDR has a strong cognitive focus, whereas the primary focus in ART alternates between the visual imagery and the somatic/emotional sensations that are closely paired with the traumatic material. In EMDR clients are asked to identify a negative and positive cognition for each target event at the beginning of the session, with the specific goal to install the positive cognition at a high level of validity (7 on scale of 0-7). More advanced EMDR techniques are necessary to address blocks, stuck points, or "looping" distress, which occur relatively commonly. This include the "cognitive interweave," involving brief statements that subtly point to the illogical nature of the how the client may be viewing something like the source of responsibility or "fault" for maladaptive beliefs (e.g., "I'm confused, how old were you when that happened?" "Let's pretend…") Although clients are often asked in the EMDR sessions to notice where in their body they feel negative emotions/sensations, a full body scan is not routinely done until the end of each session, after the positive cognition has been installed. In contrast, ART sessions always begin with the equivalent of a body scan, and continue body scanning repeatedly throughout the session, without asking clients to focus on specific cognitions. Attending to and eliminating uncomfortable body sensations are first and foremost throughout the entire ART session. Changes in cognitions also routinely occur in ART, but are not the primary focus, and are

allowed to evolve more naturally in the context of continually attending to processing of the physical sensations and emotions linked to the traumatic imagery. Clients, for instance, would never be directly asked to assign responsibility or "fault," though this topic frequently emerges during ART sessions, and clients routinely experience insights and shifts in their perspective, including letting go of self-blame and guilt, as soon as the desensitization process is complete and they come to a suitable resolution using the re-scripting paradigm. Significant reduction in trauma-related guilt was documented objectively in the ART randomized clinical trial.[1]

5. Reaching a state of resolution for a specific traumatic memory, including "installation" of a positive cognition with a high degree of certainty, is expected to emerge spontaneously in EMDR through the free-associative process over the course of multiple sequences of eye movements or other forms of bilateral stimulation. However, Shapiro reports that this occurs only approximately 40% of the time using the basic EMDR protocol, and more advanced techniques (e.g., the cognitive interweave, changing direction/speed of eye movements, returning to the original image, pausing to resource) that also require high level of clinician skill are often necessary to achieve lasting positive changes. While EMDR clients may at times be asked to modify an image (e.g., shrink it, change it to black and white, put up an impermeable barrier), this is generally only used in the event of high reactivity ("over-accessing" memory pathways). In contrast, in ART, after the initial desensitization process, the client is always asked to actively re-script the targeted traumatic images in whatever way they find most suitable, using a procedure similar to Imagery Rehearsal Therapy[12] used in CBT treatments for insomnia and repetitive nightmares or suicide-related CBT,[13] but in this case facilitated with eye movements. This process (which the ART founder refers to as "Voluntary Image Replacement") encourages clients to actively develop their own solution(s) for whatever images and emotions are being processed during each session, and is based on the theories of traumatic memory reconsolidation.[9,10] The active re-scripting is a creative visualization process, facilitated by the therapist, that can incorporate grief resolution, Gestalt, metaphorical interventions, and other techniques that empower the client to find their own solutions. This rapidly produces positive emotions/sensations, and reframing of negative cognitions and additional insights frequently occurs. While healthy reconsolidation also occurs in successful EMDR sessions, the more actively rescripting in ART sessions is designed to ensure that this happens consistently within the brief reconsolidation window. The re-scripting is a key distinguishing component of ART that appears to facilitate clients experiencing a high likelihood of achieving a sense of mastery at the end of each session. By the end, clients frequently report feeling calm and relaxed. They are often able to recount the details of their trauma without experiencing the visceral sensations they experienced previously, and they experience a change in the cognitive appraisal of event.

6. EMDR and ART have parallel but different approaches to determining which events to prioritize for treatment. While both require a comprehensive clinical evaluation (and therapeutic alliance) before proceeding, including consideration of the number and severity of prior traumas, they differ in their approach to working through them. When there is a history of multiple traumas, an EMDR treatment plan is developed (typically over many sessions) involving stages beginning with establishing resources, and carefully

compiling and prioritizing a list of the most significant past traumatic experiences[11] (using a floatback or affect scan technique to create a map of touchstone events). These are gradually worked through (and associated events that emerge) before concentrating on strategies to address present triggers or future preferred ways of responding differently. In contrast, ART starts with where the client is now and what symptoms/problem the client wants to work on currently. If a specific traumatic event is clearly linked to the current level of distress (e.g. PTSD symptoms causing impairment), this event is targeted for processing. If the origin of current distressing symptoms is less clear, and the core ART relaxation techniques do not rapidly attenuate the current level of symptoms, a technique similar to floatback/affect scan called "scene match" is used to identify the most salient early traumatic event(s) connected with the current problem for immediate processing. Furthermore, at the end of every ART session, an in-vitro visualization technique is utilized to allow the client to gain practice being able to respond differently to their current problem or future triggering situations. Similar to processing past traumatic events, processing the distress related to feared future events that are visualized can help clients better cope with future situations, and this is a core technique for every session.

7. EMDR often involves a relatively detailed discussion of the traumatic event to ensure that the optimal image, cognition, and emotion are targeted for processing, with frequent return to the image and ongoing assessment of what changes are occurring throughout the session, however subtle. In contrast, ART does not require clients to narrate in any way their traumatic experiences to the therapist, which some clients find very helpful, for example military personnel who experienced traumas as part of top-secret missions, or rape victims who do not want to verbalize horrifying details to the therapist. The desensitization phase can be accomplished without any verbalization of the specific content of what the client is visualizing, other than to report where they are in their scene (e.g., beginning, middle, or end) and the physical sensations or emotions they are experiencing in the moment. Paradoxically, once the initial desensitization has removed the affect-laden charge linked to the traumatic images (and the client finds relief from the corresponding physical sensations and emotions), there is often a greater willingness to talk about the event in a linear manner.

8. In EMDR, clinicians are expected to vary the direction and number of eye movements or other forms of bilateral stimulation according to client responses, whether the target is a resource or a distressing memory, and according to their clinical judgment, whereas in ART eye movement sets are fixed both in direction and number, with minor adjustments for comfort (height, closeness to client, speed of eye movements) for all processing, including both negative images and positive resources. This also contributes to ART being simpler to learn and apply more consistently. The vast majority of clients do very well with the fixed format. The only potential disadvantage of ART is that it currently does not have alternative forms of bilateral stimulation available for individuals who have visual impairment or a medical conditions exacerbated by eye-movements.

9. There are no homework requirements in ART, and the in-vitro visualization approaches to feared triggers or phobias are generally so effective that in-vivo exposure assignments between treatment sessions are not necessary.

10. Lastly, for most PTSD cases in combat veterans, the research suggests that ART can be delivered in ≤5 60 minute treatment sessions (mean 3.7 sessions in the clinical trial[1]) compared with 10-12 90 minute sessions for EMDR and other trauma-focused therapy packages. However, this is still an empirical question that requires further research.

Caveat: The comparisons noted above relate primarily to the core basic protocols of ART and EMDR, and it should be noted that many of the distinctions between these treatments become less obvious in the hands of skilled clinicians. Since all of the core ART techniques are contained in EMDR protocols, skilled EMDR clinicians often naturally apply similar procedures, particularly when working with patients with complex trauma, to move trauma processing along efficiently and effectively.

IV. Important Clinical Considerations and Elements of Informed Consent

1. Understanding the evidence basis for ART.

Experts will disagree as to whether the current level of evidence for ART is sufficient to warrant including this as an option for treatment in addition to other better-established trauma-focused approaches like Prolonged Exposure (PE), Cognitive Processing Thearpy (CPT), Narrative Exposure Therapy (NET), and EMDR. To date, there have been only a few case reports / case series[2-5] and one randomized controlled clinical trial of ART versus an attention control condition (similar to wait-list) (DoD funded, conducted by University of South Florida) in approximately 60 combat veterans with PTSD, including many with refractory symptoms.[1] Based largely on this trial, SAMHSA recently designated ART as evidence-based, giving it their highest level evidence rating for both PTSD and depression.[8] The study was of at high risk of bias (e.g., relied on PTSD checklists rather than CAPS, 3 month follow-up with cross-over design), but showed 94% treatment completion and striking reductions in PTSD checklist scores and a high effect size after only 3-4 sessions that persisted for 3 months (17-20 point PCL average reductions), as well as significant improvements in numerous other outcomes (depression, anxiety, anger/aggression, trauma-related guilt). Although this was a promising initial trial, further research is necessary, particularly head-to-head trials with more established treatments to confirm the rapid clinical benefits suggested by the studies to date, and confirm that the benefits last beyond 3 months. Nevertheless, ART involves the same core components as other trauma-focused therapies, particularly EMDR, and clinicians who have expertise with other trauma-focused therapies will be able to apply ART techniques once trained. Consequently, it is reasonable for clinicians to offer ART as one trauma-focused therapy option, provided that they ensure their clients are properly informed as to the range of available options, and understand that ART is a newer form of therapy with less robust evidence than other treatments.

2. Important Clinical Considerations.

ART is not suitable for all clients, and carries the same clinical concerns as other trauma-focused therapies. It is important for clinicians to conduct a comprehensive clinical intake

interview, establish rapport, and gain a clear understanding of the key concerns and goals of treatment, life traumas/stressors, diagnoses, co-morbidities (physical, mental, substance use), and bio-psychosocial dynamics before proceeding with ART. Although there are no absolute contraindications for initiating ART, particular attention should be given to:

a. Early childhood neglect or abuse, history of significant dissociation or presence of a dissociative disorder, poor ego strength or affect tolerance, h/o complex trauma, and/or current or past suicidality/homicidality. These are especially important to consider in creating a safe and effective treatment plan that might incorporate ART techniques. Clinicians should ensure appropriate clinical management and levels of safety, and should not initiate ART if they are not comfortable working with these types of concerns.

b. Mental health diagnoses, substance use disorders, physical health co-morbidities, medications, past hospitalizations, and past mental health treatment are all relevant to the decision to utilize ART, and which problem(s) to focus on first. An active substance use disorder, for example, especially with signs of physical dependence (tolerance, withdrawal), will undoubtedly impede the effectiveness of ART, as with other trauma-focused therapies. However, more advanced ART protocols offer potential strategies for addressing co-morbid conditions, including substance use disorders, and may be incorporated into treatment plans for co-existing conditions, depending on the clinical judgment of treating providers.

c. Any pertinent medical conditions that may increase risk during high emotional/abreaction states, such as a history of cardiac or respiratory disease, cerebrovascular disease, seizure disorder, or possibly pregnancy. None of these are absolute contraindications, but caution and consultation with appropriate medical professionals is advised. For example, with pregnancy, the clinician and client may elect to delay trauma-focused therapy, such as ART, until after delivery, or may determine that the potential benefits of immediate treatment outweigh risks due to the severity of current symptoms and potential risks of alternatives (e.g. medications).

d. Ocular disorder that may impair eye movements, or be exacerbated through use of eye movements, or eye pain during eye movements. For example, certain types of laser eye surgery may result in inability to track lateral movements of the hand, thus requiring a different approach (ie, using "goal posts" to anchor the movements). Eye movements should <u>not</u> be continued if eye pain occurs as a result of the movements. There is at least one case report from many years ago of ocular injury and blindness apparently resulting from an EMDR-related eye movement treatment that was continued after consistent pain was reported.[11] EMDR practitioners also report that eye-movements can sometimes exacerbate headaches after traumatic brain injuries (particularly moderate and severe TBIs).

e. Level of social support, current stability of environment, and available resources and strengths.

f. Level of motivation for treatment, and any secondary gain issues that might interfere with treatment success.

g. Pending or potential legal processes related to the trauma or condition being processed. For example, when ART treatment eliminates strong emotions that occurred when narrating the details of a rape, this might have various effects on the outcome of a trial involving testimony of a victim against a perpetrator. The lower level of distress could unintentionally lead to a perception that the trauma was not as severe as it was, thus diminishing the victim's testimony. Alternatively, the lower level of distress could lead to the victim being able to more accurately present a detailed account of what happened, which might enhance the victim's testimony. In addition, while there is legal precedent for use of EMDR in court proceedings, there is none for ART, and testimony that occurred after treatment with ART could be excluded if it is perceived by the court that ART has any similarity to hypnosis. Consequently, clinicians should carefully discuss these concerns with the client (who in turn may need to consult their legal representative) before proceeding with ART.

h. Safety considerations (suicidality/homicidality). As with all other trauma-focused therapies, clinicians should ensure that safety is assessed before proceeding with ART, as well as at end of sessions that involved strong emotions, and that appropriate clinical steps are taken, as indicated, according to existing guidelines.

i. Integration of ART with other treatment modalities. While an individual session that involves ART techniques should adhere to the ART protocol and not mix techniques from other approaches, ART can be easily incorporated into ongoing treatment strategies. For example, ART sessions may be utilized to target specific traumas or current problems interspersed with other CBT, present-centered, supportive, or psychodynamic interventions in other sessions, depending on the needs of the client and clinical judgment of the clinician. Additionally, clients undergoing ART treatment with one provider may continue receiving other forms of treatment (e.g., medication management, supportive therapy, group therapy) from other providers.

j. Psychotropic medications. As with other psychotherapies, many clients will be taking psychotropic medications at the same time that they are receiving ART treatment, and in general this will not interfere with ART. However, there is a possibility that certain anxiolytics, particularly benzodiazepines, may blunt the emotional or physiological responses during the ART desensitization procedure, or interfere in some way with the reconsolidation process, leading to lower effectiveness. In certain cases, there may be benefit in advising clients to avoid as-needed doses and/or delay taking a scheduled dose close to the time of an ART appointment. However, before doing this, mental health clinicians are advised to consult with the appropriate medical authority on the treatment team. It is also conceivable that certain biological treatments, like stellate ganglion blockade, could blunt the autonomic nervous system response to the degree that it interferes with the body-oriented desensitization process used in ART.

3. Key Factors to Consider in Providing Informed Consent.

In addition to the above clinical considerations, it is advisable to consider the following key points in providing informed consent for a prospective ART client, and refrain from using ART, as appropriate, when it appears that risks might outweigh potential benefits:

a. Possibility of experiencing intense emotions or physical sensations during treatment sessions (or sometimes between sessions). It is important to explain that strong emotions/sensations are often part of the healing process, especially during the initial visualization of a traumatic experience, and to provide information on what the therapist will do to help facilitate guiding the client through this. It is also helpful to reiterate that clients will always be in control of their sessions (and that ART is not hypnosis), and that the therapist will not proceed until the client is comfortable moving forward. In addition, clients should be informed that mental fatigue is common after treatment sessions. In the published military trial, a rate of 2.2 adverse events potentially attributed to the provision of ART were reported per 100 treatment sessions, including heightened anxiety and nightmares[1]. All were reported only once and showed subsequent resolution. As with EMDR and other trauma treatments, it is important to ensure that the client has resources (e.g. positive visualizations, relaxation techniques, social supports) available to ensure a sufficient level of distress/affect tolerance for this type of treatment.

b. Importance of not leaving before the end of the treatment session. If clients become overwhelmed by strong emotions/sensations and decide to leave before the full desensitization process is complete, it is very likely they will experience ongoing intrusive images, emotions, and sensations outside of the therapeutic environment that may be at a higher level than when they started the session. As with other trauma-focused therapies, when this occurs, this could have safety implications.

c. Warnings / clinical cautions related to medical/mental health conditions that could be exacerbated by high intensity emotions (per section IV 2 above). Although there are no absolute contraindications for ART, careful assessment of the risks/benefits and appropriate consultation with medical professionals is necessary when there are medical conditions, such as a history of cardiac disease, cerebrovascular disease, respiratory disease, seizures, pregnancy, or ocular problems, and when there are certain mental health conditions that might make ART visualizations more challenging (e.g. a dissociative disorder) (See above section for more details.)

d. Possibility of ART affecting ongoing legal processes (as noted above, IV 2 b).

e. The need for follow-up evaluations. ART is not a quick fix and it is important to ensure appropriate follow-up and re-evaluation. In addition to discussing with clients the importance of not leaving a session during the middle of processing, it is also advisable to ensure that they agree to return for follow-up re-evaluation, even if distress was substantially reduced and the client believes that follow-up is no longer necessary. It is important to assess the direct effects of the previous session(s) (preferably using objective outcome measures), as well as the indirect effects, such as the impact of resolving

childhood trauma on the current stage of development or current relationships. For example, while ART might alleviate immediate reactivity associated with a traumatic event, the client may be stuck in an earlier developmental stage and not have the necessary skills to successfully navigate these changes. As another example, ART may lead to PTSD symptom improvement (e.g. hypervigilance, anger, and nightmares), but the improvement in these symptoms may expose a deeper underlying depression that requires further therapy.

4. Addressing Abreaction.

Emotional abreaction, as well as strong physical sensations, should be expected during ART treatment sessions, as in other forms of trauma therapy, and are an important part of the healing process. When the emotions/sensations become visible and palpable, that opens the door for being able to immediately attend to them and find the path to relief. Furthermore, they signal full activation of the original traumatic memory, opening the window of opportunity for these memories to be permanently reconsolidated in a healthier manner.[8,9] (More traditional narrative exposure approaches may not yield as full reactivation of the memory physiologically and thus not make take full advantage of what the reconsolidation window may offer.) When strong emotions and physical sensations occur, clinicians should remain calm, compassionate, and unsurprised, and should trust the eye movements and ART procedure to facilitate the client obtaining relief from these reactions. Abreaction usually resolves quickly, and there are a number of ART techniques described in the manual and accompanying scripts that can facilitate this process. Clinicians can also apply, if necessary, any other skills or resources they routinely utilize for similar responses that occur during other trauma-focused therapy approaches (e.g. diaphragmatic breathing, grounding, mindfulness, safe-place or comforting visualizations, ensuring appropriate social supports, etc.).

5. Medical Record Documentation and Outcome Measures.

ART requires no different clinical documentation than other trauma-focused therapies. As in other trauma-focused therapies, it is particularly useful to briefly document that informed consent was provided, how the core-components were applied, what the client's response to the process was, any important concerns that other clinicians on the treatment team need to know, and the safety assessment. It is also useful to obtain baseline assessments and then monitor progress using validated clinical measures, such as the PTSD checklist, PHQ-9, and GAD-7 on a reasonable schedule (e.g. once per month).

Other Resources:

RCRR website: www.acceleratedresolutiontherapy.com

IS-ART website: www.is-art.org

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