# What exactly is the Flash Technique? An open letter in response to some FAQs

*Dr Derek Farrell, former President of the EMDR Association UK & Ireland, asked some important questions concerning the Flash Technique in a JISCMAIL post on 5 December 2018. Dr Philip Manfield and Dr Lewis Engel respond below.*

Dr Derek Farrell's post read as follows:

*Dear colleagues, I would welcome a discussion, and colleagues' thoughts surrounding the 'Flash Technique' by Phil Manfield. I'm fortunate to have known Phil for a long time – and like his work. I've spoken with him several times about the 'Flash Technique'. I've also used it several times with C-PTSD clients – and it has been very useful and helpful.*

*However, I have a few questions:*
*1. Is it a Phase 2: Preparation – Stabilisation and Resource device only?*

*2. Is it a Trauma Confrontation piece: Phases 4, 5 & 6 – after all there is a reduction in the SUD of a Trauma Memory (symptom reduction)?*

*3. The theoretical underpinnings of the 'Flash technique' – and why it works, does it fit 'Adaptive Information Processing' or is it a 'Habituation / Extinction Model'. So, another way of framing this question – Is it EMDR or is it CBT? A secondary component to this would be 'does this matter?'*

*4. Is it a form of 'Dosed Exposure' to a particular Trauma Memory?*

*5. If it is a Trauma Confrontation piece then the logical research consideration is to compare it with the EMDR Standard Protocol using pre, post and FU psychometric measures to ascertain its effectiveness.*

*I would welcome colleague's considerations.*
*Best,*
*Derek*

We asked Dr Manfield if he would be interested in responding and he very kindly agreed. The following is an open letter in response to the questions raised above.

Derek,
Thank you for your thoughtful inquiry into the Flash technique (FT), how and why it works. Of course, we can only speculate about many of your questions, but hopefully we can shed some light and clarify some misconceptions.

## 1. Is it a Phase 2: Preparation – Stabilization and Resource device only?

Like many techniques used in the preparation phase of EMDR, CIPOS (1) notably among them, there often seems to be some reprocessing that occurs during the preparation phase when these techniques are used. Less than half but over a quarter of the time FT is used, the SUDS goes to a zero. (In the presentation we did at the EMDRIA conference in Atlanta several months ago, 123 out of 370, exactly a third, got to a SUDS of zero or 1 in a 10-minute practicum involving only four sets of triple flashes.) The objective of FT is to reduce SUDs to a level that it can be easily processed with phases 3 through 8 of the EMDR protocol with minimal suffering for the client. Nevertheless, as long as SUDs is rapidly coming down, we tend to continue with three or four rounds of FT and sometimes the result is that there seems to be nothing left of the target to process. I (PM) assume that what you are referring to as a "trauma confrontation piece" is the direct triggering of a trauma memory. With FT, we like to refer to "selecting" of a memory or memories, because the disturbance is not triggered, other than when the client first raises it as a target to address, and then the client is prevented from giving details.

The standard EMDR protocol calls for cognitive distortions to be specifically identified during phase 3 and processed during phase 4, with the help of cognitive interweaves if necessary. FT does not focus on cognitive distortions directly, but they sometimes become resolved. The way we understand this is that adult perspectives develop as a client experiences distance from the memory. The vast majority of clients report, by the end of the second set of flashes (five triple blinks while focusing on a positive engaging focus [PEF]), that the memory or image seems further away. They often say it is vaguer, less vivid, fuzzy or not as clear. Typically, I (PM) tell them that my interpretation of that comment is that they are experiencing themselves less as the person the memory is happening to, and more as the observer of the memory unfolding. They almost always endorse this interpretation as matching their experience. I believe that adequately resourced clients will develop adaptive adult perspectives when they cease to reexperience

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the trauma and begin to observe it in present time as something that happened in the past. The outcome is the laying down of new pathways to adaptive adult perspectives. I think this is consistent with AIP.

The exception is where there are multiple channels and one or more of the channels are not desensitized by FT. Normally the most disturbing channel becomes less disturbing, so the client reports the entire memory as being less disturbing, and usually the disturbance level is easily tolerated. In this situation, SUDS has been reduced, and then Phases III and IV of the standard EMDR protocol identify and address these more tolerable channels. We have a listserv of over 600 active members who have taken our FT webinar or live workshops. We have been amazed at the creative and sometimes ingenious contributions some of the members have made to the practice of FT, but we have not seen any suggestions yet for how FT can be modified to ferret out and desensitize all the existing channels.

### 2. Is this just symptom reduction?

We have collected results from a total of 2014, 10-minute, self-administered practicum sessions reported by attendees at our webinars and workshops. The mean reduction in SUDs after 10 minutes is over two-thirds. When possible, we have done a four-week follow-up to see if the results obtained have held. The mean SUDs after four weeks has been even lower than the SUDs at the end of the practicum experience. Of course the "clients" in these 2014 sessions were all therapists, so we don't know what will result when we do studies with a more diverse population. We are encouraged by the fact that clinicians posting on the listserv tend to report therapeutic breakthroughs with clients, some of whom have been stuck for years. Dr. Sik-lam Wong did a small study with residents at a homeless shelter, all of whom were highly dissociative, and was able to develop a group version of FT that they responded to very strongly, and showed impressive symptom relief and reduction of levels of dissociation (*JEPR*, February 2018, in press). So, at the very least, FT gives effective symptom relief that makes EMDR Phases III and IV more tolerable and, in some cases, target resolution occurs.

### 3. Is it EMDR or CBT and does it matter?

Addressing the last part of your question first, yes, I (PM) do think it matters because understanding the Mechanism of Action helps in refining the technique. Dr. Louise Maxfield, editor of the *Journal of EMDR Practice and Research* (JEPR), required me to develop a theory for the mechanism of action (MOA) before she would be willing to publish our November, 2017 paper (2). When I settled on what I believed to be the MOA, I changed the protocol in mid-2018, based on what our theory of the MOA predicted would be more effective. I believed FT is a subliminal process, so we stopped asking clients to make any contact with the disturbing memory at all. Instead, we asked clients to only think of a positive engaging focus (PEF) and simply to blink their eyes at our signal. With this modification, the efficiency and effectiveness of FT increased.

Does FT fit the 'Adaptive Information Processing (AIP) Model' or a 'Habituation / Extinction Model'? Both Flash and EMDR have a rapid initial effect of making disturbing memories less intense before any cognitive shifts occur. The common explanation for how EMDR does it is that working memory is taxed, so there is less capacity available to maintain a vivid memory. Flash has a similar initial effect but working memory doesn't seem to be greatly taxed and the simplest explanation is that the initial reduction is a result of a subconscious Habituation/Extinction process. With both EMDR and FT, however, it appears that, as the memory becomes less intense, cognitive shifts in the form of adaptive adult perspectives fall into place.

Intuitively I (PM) have always recognized that as we do EMDR, clients go into a kind of zone in which they become less defensive and more receptive to cognitive interventions like cognitive interweaves. This is why one does not do cognitive interweaves early on in the process before sufficient BLS. I think Shapiro recognized this when she talked about "advanced EMDR," which was essentially a lot of successive cognitive interventions. In the first few years of EMDR it was included in Part II of the training, but I think it was too complicated for people to learn, so it disappeared. But I think it was recognition of the state that clients get into in which they can receive and benefit from a lot of insight and cognitive intervention that caused Shapiro to talk about advanced

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EMDR. So, I think initially in EMDR there is a working memory overload and perhaps also some Habituation / Extinction, which then causes the vividness of the memory to recede and from there on the AIP explains the rest. I think Flash has the same two phases, beginning with, for lack of a better explanation, unconscious habituation after which the AIP takes over.

A critical and distinct element of FT that we believe is responsible for much of its speed and effectiveness is that the client does not re-experience the trauma, and has minimal or no autonomic activation. The client does not feel disturbance during FT. FMRI studies have shown that the parts of the brain crucial for resolving traumatic memories (dorsolateral prefrontal cortex and the ventromedial prefrontal cortex [VMPFC]) become relatively inactive during a fear reaction (3). When Siegel showed subjects with arachnophobia subliminal images of tarantulas, they showed no increase on autonomic indicators of fear; however their fear of spiders was significantly reduced, quite a bit more so than in subjects who were able to see and recognize the image of the tarantula. It is believed that the VMPFC plays an important role in calming fears, and it acts inversely to the amygdala (4). In other words the amygdala becomes active when a person becomes emotionally volatile, and that's when the VMPFC becomes inactive. We believe that the lack of autonomic arousal with FT allows the VMPFC to remain active, and accounts for the striking speed and effectiveness of FT in reducing disturbance associated with trauma memories.

As stated above, after one or two sets of five triple flashes, clients almost always describe the memory as feeling further away or not as clear. They are usually amazed at this change, because they were not "trying" to have any particular impact on the memory. I think there is a lot we need to know about how Habituation/Exposure works on a subconscious level, but Siegel and his colleagues believe that "unreportable" (5) exposure is responsible for the tarantula becoming more tolerable for the subjects who were not aware of having seen the image of one. So, I think that is the first effect of FT after which the AIP process takes over as the intensity of the memory continues to diminish.

### 4. Is it a form of Dosed Exposure?

If it is 'Dosed Exposure,' it is subliminal exposure, and one that does not result in the client becoming activated or disturbed. A number of studies and papers have been appearing in the past few years making a case for 'implicit memory" (6). If the term "exposure" can be extended to "unreportable" working memory phenomena, then, yes, we think that is what is involved. But, if we are extending the use of the term "exposure," we will need to start thinking of an aspect of EMDR as also including dosed exposure.

### 5. The logical next step in research

We heartily agree with and support the study you are proposing. Keep in mind that often when FT is used in the processing of a natural or man-made disaster, numerous targets are likely to be processed in a single extended session. To show the advantage of FT over EMDR without FT, a study should document the time required to fully process the first, and presumably worst, target. We think that the speed of EMDR with FT compared to EMDR without FT will be what stands out in a head-to-head comparison.

Dr. Bart Rubin, Dr. Ricky Greenwald, and I (PM) attempted to do just such a study with fire victims from the huge 2017 fire in Sonoma County, near San Francisco, California. Unfortunately, by the time we got Institutional Review Board (IRB) approval and all the logistics in place, including 100 volunteer EMDR therapists, we were not able to make contact with fire victims who believed they still needed our services, and we had to scrap the study.

Over the past year, we have been searching for institutionally-connected researchers or doctoral students who have an interest in doing research about FT. We are now finally finding some researchers who are convinced from their own experience that FT is effective and safe, and are willing to argue those points with their IRB's and funding sources to get some research done.

Derek, thanks again for raising these important and thought-provoking questions.

**Phil Manfield, PhD and Lewis Engel, PhD**

*Dr Manfield is the Northern California Regional Coordinator for the EMDR International Association. He is an international trainer in EMDR. Dr Engel is a licenced psychologist with a practice in San Francisco and Marin County.*

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## References


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