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Emdr: Eye Movement Desensitization and Reprocessing a New Method in the Treatment of Performance Anxiety for Singers

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EMDR:
EYE MOVEMENT DESENSITIZATION AND REPROCESSING
A NEW METHOD IN THE TREATMENT OF PERFORMANCE ANXIETY
FOR SINGERS

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I would like to dedicate this thesis to my lovely wife Natalia Rivera and to my three-year old daughter Adriana Elizabeth Feener. This thesis holds within its pages varying levels of passion, dedication, discipline, stress, exhaustion, love, and the overall desire to help those in need. The completion of this work could not have happened without the support of my family.
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ABSTRACT

The purpose of this thesis is to provide information and exposure for EMDR therapy as it relates to performance anxiety in singers and other musicians. Since EMDR therapy is a relatively new approach to relieving issues of anxiety, this thesis provides a description of its discovery, background, development, and proper procedures and protocols. In 1987 Francine Shapiro discovered and began to develop a new method in the treatment of trauma using guided eye movements. These guided eye movements were theorized to create bilateral brain stimulation, which through the simultaneous component of recalling one’s trauma both physically and emotionally, an individual’s trauma can be processed toward a state of mental health. This is similar to what is theorized to happen during REM sleep. Francine Shapiro states that every human being possesses an innate information processing system that guides each individual toward a balanced state of mental health, similar to the way our bodies heal physically. Once an individual experiences a trauma, the events become locked into the nervous system into its own separate neuro-network, unable to be accessed by the individual for positive processing. Our ability to process the traumatic experience is hindered and the trauma relives itself through nightmares, flashbacks, disturbing or intrusive thoughts, anxiety, or any number of life hindering events.

The theory of EMDR is that through guided eye movements, or other sources of bilateral brain stimulation such as hand taps, alternating lights or sounds, or hand buzzers, the traumatic information held in its separate neuro-network is able to bridge itself to more positive information stored in the individual’s memory. EMDR not only helps to desensitize our traumatic memories but also helps to reprocess our thoughts and feelings regarding the trauma with positive statements and beliefs such as “I am in control” and “I deserve this”. One of the most impressive aspects of the therapy is the rate in which patients improve. The success rate of EMDR is between 84 and 90 percent effective in one to three sessions or less, depending on the severity of the trauma. EMDR began treating patients suffering primarily from PTSD (Post-Traumatic Stress Syndrome) but has expanded over the years to include a wide range of pathologies, traumas, and anxiety disorders. Francine Shapiro is continuously striving to enhance the
protocols and procedures of EMDR in order to better understand and improve its effectiveness. I discovered EMDR only a few years ago and realized that it was being used by therapists across the country in the treatment of performance anxiety, but very little had been written on this topic. Therefore, my goal is to expose both singers and instrumentalists to this new method as a new option in the treatment of performance anxiety.
CHAPTER 1
INTRODUCTION

Performance anxiety has plagued the artistic world for many years. There have been numerous attempts to alleviate the unhealthy levels of stress and anxiety performers experience, with varying levels of success. Whether it is through years of conventional psychotherapy, self-help books, or the sometimes-inevitable action of removing oneself from the performance arena altogether, the search for relief is ever present.

In 1987, a new form of relief was on the horizon. Francine Shapiro, a graduate student in psychology, discovered and developed a new method in the treatment of trauma called EMDR, Eye Movement Desensitization and Reprocessing. Her discovery is based on the idea that within each of us is an inherent physiological system tailored to process information to a state of mental health, similar to the way in which our physical body heals itself. As we experience displeasing events, we think, discuss, and even dream about the event in order to process and learn from the incident. When a traumatic moment occurs, there is an imbalance in our inherent processing system and the trauma becomes locked into our nervous system. Our ability to process the traumatic experience is hindered and the trauma relives itself through nightmares, flashbacks, disturbing or intrusive thoughts, or any number of life-hindering events.

EMDR therapy targets the traumatic memory along with the thoughts, feelings, emotions, and physical sensations associated with the individual trauma. Through the combination of guided eye movements and mental image of the targeted negative memory, EMDR stimulates our inherent information processing system and allows the traumatic experience to be properly processed, thus returning balance to our state of mental health. EMDR not only helps to desensitize our traumatic memories but also helps to reprocess our thoughts, beliefs, and feelings regarding the trauma to more positive cognition’s such as “I am worthy,” or “I deserve good things.” Though EMDR first used guided eye movements during processing, (similar to REM sleep), clinicians have found other means to expedite processing. This includes processing with alternatively tapping a patient’s hand, the use of hand buzzers, or the use of alternating tones via headphones,
(for patients who are blind). These are similar to the guided eye movements in that they stimulate the brain bilaterally while the client focuses on his/her targeted memories. The patient rates his/her level of disturbance for a specified memory and rates it on the zero to ten SUD scale (Subjective Units of Disturbance), with the goal to reduce his/her rating on to zero. A patient is also asked to rate the validity of his or her positive beliefs on the zero to seven VOC scale (Validity of Cognition), and increase his/her rating to seven. Both are accomplished through the processing of targeted memories, beliefs, images, and physical sensations with EMDR. These scales are tools to assist the clinician in assessing the patients and developing a treatment plan.

This revolutionary therapy was originally used and tested on victims of major trauma such as rape, stress related to war, childhood physical and sexual abuse, and other PTSD related traumas. Today, however, EMDR is used to treat a plethora of disorders, which include low self-esteem, learning disabilities, dissociative disorders, and many types of anxieties. An impressive aspect of EMDR is the rate in which patients improve. The success rate of EMDR can vary from client to client depending on the severity of the trauma and the number of years a patient has lived with the trauma. However, EMDR has been observed to be 84 to 90 percent effective in one to three sessions. This effectiveness is compared to traditional therapy, which has achieved no more than a 55 percent success rate in seven to fifteen sessions, often times lasting for years with little or no success.

The exciting new possibilities that EMDR offers are endless. The continuous research and studies of EMDR will no doubt enhance its use and application to help millions for the future.

The purpose of this treatise is to examine the potential benefits of EMDR to singers and other performers suffering from a wide range of performance anxieties, and through this research bring EMDR to the attention of the musical world. My interest in this topic has stemmed from my own experience and success with EMDR. The high levels of stress, expectation, and competition found within the arts often assist in generating many possible anxieties towards performance. An anxiety can begin at any age and the cause can be rooted deep within the subconscious, therefore needing more advanced treatment. EMDR offers that next step in the treatment of performance anxiety.
EMDR can be the treatment that helps bring performers back to the stage, renew their joy of performing, unlock the potential of an individual’s learning and success, or just replenish the spirit in order to embrace the love of performing once again.

Most of the current literature on EMDR focuses solely on the creation, development, and procedures of EMDR and its treatment of PTSD (Post Traumatic Stress Syndrome). This is mainly due to Francine Shapiro’s need in the early development of EMDR for a controlled study of a homogenous group of people who suffered from anxieties of old memories. Patients suffering from PTSD were prime subjects due to their intense negative cognitions and the high number of patients suffering from PTSD. Much of the information regarding the use of EMDR with performance anxiety has come from alternative sources due to the current infancy of this new therapy and ongoing research. Therefore I have included an interview with a licensed practicing therapist who has had experience using EMDR with musicians, Dr. Ellen I. Carni, Ph. D. I have presented her with questions that pertain to the use of EMDR with musicians, such as: Are there standard symptoms that performers with anxiety issues have in common?; Are there EMDR clinicians who specialize in performance related disorders? Her professional perspective is invaluable to this thesis.

I will also be discussing the many aspects of performance anxiety. This will be an overview of the information found in many of the current self-help books on performance, such as “Power Performance for Singers,” “The Inner Game of Music,” and “The Audition Process: Anxiety Management and Coping Strategies,” to name a few. Some of the more inventive applications and uses of EMDR have been made by Dr. David Grand, Ph.D. Dr. Grand has developed a more in-depth method of using the process of EMDR to enhance performance, creativity, and to help actors develop deeper character background and history.

EMDR is constantly and meticulously being researched and reevaluated by Francine Shapiro to ensure its efficacy and professional standing in the realm of psychology. There have been many critics, but there have also been millions of satisfied patients over the years. Francine Shapiro offers several levels of specific training for all licensed psychologists interested in expanding their practice of psychology. This thesis
will present several guidelines and resources in the appendixes for any reader interested in pursuing either training or treatment.
CHAPTER 2
EMDR: DISCOVERY AND BACKGROUND

In 1987, Francine Shapiro, a 38-year-old clinical psychology student in Palo Alto, California, made a chance discovery that would revolutionize the field of psychology. She discovered and developed a new method of treatment for patients suffering from a wide range of cognitive traumas and anxieties such as PTSD (Post-Traumatic Stress Disorder). For patients who spent years on standard talk therapy with little improvement, the new approach resulted in a staggering 80 to 90 percent recovery rate after approximately three ninety-minute sessions or less. This amazing development sparked both ebullience and controversy in the field of psychology.

In the spring of 1987 Shapiro was taking a stroll around a lake in Los Gatos, California, pondering some disturbing thoughts, when she noticed that the thoughts had instantaneously vanished. As she revisited these thoughts she noticed that the intensity of their disturbance had been greatly diminished. She, as an inquisitive psychology student, began to reexamine the situation, recalling more disturbing thoughts in order to determine the causality of their reduction of disturbance. She soon noticed that her eyes were moving spontaneously and rapidly from left to right in an upward diagonal pattern. Shapiro found that with her every attempt to combine the rapid eye movements with a disturbing thought, the level of anxiety and validity of these thoughts were consistently being reduced. She wondered if this was something that could be used in the field of psychotherapy? To test her new discovery, she experimented with the eye movements on a few of her friends and colleagues, who were all dealing with various disturbing memories, beliefs and overall frustrations. She found that the muscle coordination of the eye movements to be too difficult for most patients to sustain on their own. She instead decided to facilitate the eye movements by guiding them with her own hand. The patient would follow Shapiro’s fingers with their eyes with the same rapid left and right diagonal movements she had previously discovered in the park. Over the next 6 months, Francine Shapiro worked with approximately 70 people with the intent of using the eye movements to reduce a person’s anxiety. Through these early experiments she...“developed a standard procedure that consistently succeeded in alleviating their
complaints.” Shapiro states that “because my primary focus was on reducing anxiety (as that had been my own experience with the eye movements) and my primary modality at that time was behavioral, I called the procedure Eye Movement Desensitization (EMD).”

Francine Shapiro’s serendipitous discovery was precipitated by an emotional prologue of events that helped to place her in its path. In 1979 Francine Shapiro had been working on her doctorate in English Literature at New York University. She was about to begin her dissertation on the poetry of Thomas Hardy when she was diagnosed with cancer. Doctors informed her after surgery and radiation treatments that her cancer was gone. However, the doctors had also informed Shapiro that there was no guarantee that the cancer would not return. This single event catapulted her into a crusade not only to help heal her own illness, but to assist others suffering from serious illnesses as well. Through her research into several disciplines, she began to discover concepts that stress could be a main contributor to many diseases, such as cancer. Shapiro had always enjoyed psychology and the readings of behaviorists such as Andrew Salter and Joseph Wolpe. However, now the behaviorists’ theories on “physiological cause and affect” began to materialize for Shapiro in an entirely new light. The turning point was when she found that certain types of colitis, specifically the type from which her nine-year-old younger sister had died, were now considered stress-related.

The idea that there is a connection between disease and stress now seemed obvious to me, but what to do about it was another matter… Now the question of which psychological and physiological methods actually worked to enhance physical health became primary. I believed there had to be some useful psychological and physiological approaches already developed, but why weren’t they well known? Suddenly, finding these methods and disseminating information about them to others with life threatening illnesses became more important to me than studying and communicating about 19th-century literature. I left New York in search of workshops and seminars on mind, body, and psychological methods to enhance physical and mental well being.

Shapiro eventually received her doctorate in clinical psychology at the Professional School of Psychological Studies in San Diego, California. After her initial discovery and early development of the procedures of EMD, Shapiro decided to conduct

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a controlled study with a homogenous group of people having difficulty with old memories. This first study was comprised of 22 people who fell into the category of suffering from Post Traumatic Stress Syndrome (PTSD). The PTSD individuals selected for the study were victims of rape, molestation, or Vietnam combat, who suffered from a wide range of symptoms such as nightmares, flashbacks, low self-esteem, intrusive thoughts or persistent traumatic memories.\(^3\) Shapiro randomly divided the individuals into two groups: a treatment group and a control group. The treatment group used the EMD procedure while the control group was asked to recall the bad memory or trauma, discussing it without the use of EMD.

“The treatment group showed two marked changes: Anxiety levels decreased, showing a pronounced desensitization effect, and there was a marked increase in the subjects’ perceptions of how true their positive beliefs were, showing a strong cognitive restructuring.”\(^4\) She found the same to be true after a one-month and three-month follow-up. The control group, which did not receive EMD, showed both an increase in their anxieties and a decrease in their sense of self-efficacy. The control group was then administered EMD for ethical reasons and they too showed positive results. This controlled study was published in the *Journal of Traumatic Stress Studies* in 1989, becoming one of the first published controlled studies of PTSD symptomology.

Since Shapiro’s first study there have been a wide range of case and controlled studies broadening its understanding and effectiveness, as well as its applicability. EMDR has treated a plethora of populations such as combat veterans; panic disorders; phobias; mental or physical assault victims; victims of sexual dysfunction; clients of chemical dependency; dissociative disorders; personality disorders; performance anxiety; and many PTSD disorders. After years of observing cases and developing the procedures of EMD, Shapiro witnessed not only the desensitization of bad memories or anxieties on a simply behavioral level, but observed the reprocessing of negative experiences on a more adaptive, multidimensional state, emotionally, cognitively, and physiologically. Patients were not only lowering their anxiety levels, but were spontaneously...

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\(^2\) Shapiro, *Eye Movement Desensitization and Reprocessing*, xii.

\(^3\) Laurel Parnell, *Transforming Trauma: EMDR* (New York: W.W. Norton, 1997), 40.

reconfiguring both their negative and positive perceptions of themselves and their relationship to the traumatic experience, past, present, and future. This observation led to Shapiro’s renaming of the process in 1990 from EMD to Eye Movement Desensitization and Reprocessing. The main principle of EMDR is that there is an inherent system in all of us that is physiologically geared to process information to a state of mental health. This system is similar to the process in which our body processes physical trauma, such as cuts, scraps, or bruises, toward a state of physical health.

The system may become unbalanced because of a trauma or because of stress engendered during a developmental period, but once it is appropriately activated and maintained in a dynamic state by means of EMDR, it can rapidly transmute information to a state of therapeutically appropriate resolution. Desensitization, spontaneous insights, cognitive restructuring, and association to positive affects and resources are viewed as by-products of the adaptive reprocessing taking place on a neurophysiological level.

This idea of an unbalanced system of mental health has its roots with both Freud and Pavlov. In 1927 Ivan Pavlov hypothesized that “there was an excitatory-inhibitory balance in the brain that maintained normal functioning. If something caused an imbalance to occur (as when something caused overexcitation), a neural pathology resulted.”6 Shapiro created the theory of the Adaptive Information Processing Model that guides the procedures and protocols of current and future EMDR sessions.7 Shapiro’s Adaptive Information Processing Model holds the view that most pathology is created from negative earlier life experiences, or traumas. These traumas are then stored dysfunctionally and locked into the nervous system, in a sense, freezing the traumatic memory into a non-adaptive state, carrying with it all of the negative thoughts, feelings, physical sensations, and beliefs experienced at the time of the original trauma. Thus as people grow older and find themselves in similar situations to that of their earlier traumatic event(s), they will often experience the emotional, mental, and physical sensations of the past. In regard to trauma, the past is literally present. “Unless the cause

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5 Shapiro, Eye Movement Desensitization and Reprocessing, 15.
7 The model was originally titled the “Accelerated Information Processing Model” due to the rapidity of the patient’s processing of old memories when compared to that of traditional therapies.
of the problem is organic, or biochemical, everything we feel or do, every action we take, is guided by previous life experiences, because all of them are linked together in an associative memory network. A person often attempts to use logic to intellectualize his or her perceptions of the trauma, or cope with the memory through personal or spiritual means, often with the understanding that their beliefs, behaviors or responses regarding their traumatic memories are logically inappropriate. The theory behind EMDR however, is that the traumatic event has been locked into the nervous system in its own state-specific neuro network and is isolated from other neuro-networks which contain therapeutic information. Instead of being processed into our narrative memory, in which we would simply recall the event, a trauma is processed into our motoric memory, thus retaining all of the negative emotions, feelings, sights, sounds, and overall sensations associated with the original trauma.

The obvious example of unprocessed events contributing directly to current dysfunction can be found in clients suffering from a distinct trauma such as rape or combat—the Criterion A events needed to diagnose post-traumatic stress disorder. The intrusions necessary for the diagnosis of PTSD in those who have experienced a rape may include intrusive images of the rapist, often along with the smell and touch of the rapist’s body. In addition, the person has feelings of terror, possibly alternating with feelings of shame and numbness. Unhealed, those who have been raped are trapped in the event of the past, truly unable to choose their present attitude. Even if a beloved and trusted partner unexpectedly touches them in the same way the rapist did, they may startle, cringe, and be flooded with the feelings associated with the rape. For the EMDR therapist, the present dysfunction is caused by a lack of processing of the event.

It is not that they “learned” to feel helpless. In the present moment they are helpless because the perceptions (the stored experience) of the earlier event override them emotionally and physically and trap them into being reactive rather than appropriately responsive to their partner’s touch.....Regardless, inappropriate fears of abandonment, lack of love, fear of failure, and all the ubiquitous psychic pains that mar a person’s present existence can generally be traced to early childhood experiences physically stored in the brain. Those individuals who have PTSD are comparatively the lucky ones. They have the intrusive images that allow them to be aware of the genesis of their fears. Other clients have only the thoughts, emotions, or associated physical sensations released into consciousness; they are gripped by the past without knowing how or why.

8 Shapiro and Forrest, *EMDR: The Breakthrough Therapy for Overcoming Anxiety, Stress, and Trauma*, 66.
Through the protocols and procedures of EMDR and the Adaptive Information Processing Model, the isolated neuro networks are able to link up with one another facilitating proper information processing and adaptive learning, in regard to the associative memories and sensations of a specific trauma. This in turn gives the patient the ability to function in the present with the proper tools for the future.

An individual experiences millions of events in his/her lifetime that result in positive or negative emotions, ideas, or beliefs within that individual. “When an event has been sufficiently processed, we remember it but do not experience the old emotions or sensations in the present. We are informed by our memories, not controlled by them.” However, as stated earlier, most pathology is the result of negative earlier life experiences that have been dysfunctionally stored into an individual’s nervous system. EMDR breaks the negative earlier life experiences into two categories: big “T” traumas and small “t” traumas. The big “T” trauma deals with the more standard PTSD group of Criteria A, as defined in the Diagnostic and Statistical Manual, (DSM-IV). In these cases the individual has observed or been associated with something beyond normal human experience; events that elicit reactions of overwhelming fear, helplessness, or terror. Throughout their lives these individuals very often experience symptoms such as flashbacks, nightmares, insomnia, panic attacks, obsessive thoughts, social isolation, substance abuse, irritability, hypervigilance, and even difficulties with concentration. They also may find themselves avoiding the activities or situations that might arouse memories of the trauma. Through time and research, EMDR has found that an event need not be as serious as incidents of murder, rape, or combat to cause an event to be categorized as a trauma. The ubiquitous events of daily life that effect one’s confidence and self-efficacy such as humiliation, disappointment, or rejection can cause long lasting negative effects for the individual. This is often due to the intense personal significance or association to one’s self and the event. These are called small “t” traumas and the sights, sounds, emotions, and even physical sensations experienced at the time of the incident become locked into the nervous system, infelicitously coloring one’s current

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10 Shapiro, *Eye Movement Desensitization and Reprocessing*, 3.
perceptions, ideas, and beliefs. A few examples might be overhearing a remark that one is stupid, unattractive, or untalented; forgetting the words to a song during a live performance; or failing an important test or project. These small “t” events are obviously not as graphic as many PTSD-related traumas might be, but can be just as severe and debilitating for the client. Many psychotherapists have downplayed the importance of these events, not recognizing the possibility that the smaller ubiquitous events may be categorized as a trauma. The dictionary definition of trauma is “an emotional shock following a stressful event; a distressing or emotionally disturbing experience; something that severely jars the mind or emotions.” By this definition many life experiences previously not thought of as traumatic may be placed into this category. EMDR distinguishes between big “T”, and small “t” traumas only in the sense that EMDR focuses on how the stressful events or traumas are dysfunctionally affecting the client in the present.

Any memory or series of memories that affects a patient’s ability to function in a state of balanced mental health is of high priority. “An indication of the dysfunction is the fact that the memory of the event still elicits similar negative self-attributions, effects, and physical sensations as existed on the day the memory was originally created.”

An example of a “small t” trauma might be the emotional disappointment or overwhelming sadness a child may experience after their pet has run away from home. Due to the child’s intense personal attachment to the animal (and possible detachment or apathy from parental figures or loved ones), the loss of the pet may be quite intense. This may cause the child to develop beliefs of, “It was my fault,” or feelings of abandonment from the only “friend” they really knew. From the outside looking in, the situation may seem to be a minor incident in relation to the bigger picture. Adults, who are normally able to view the situation through more experienced eyes, usually assess this “bigger picture.” Although they recognize the child’s grief, parents may unwittingly, through any variety of apathetic, sarcastic, or uncaring responses, fail to address a possible trauma that may then appear throughout the child’s adolescence and adulthood. One reason that

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11 Shapiro, *Eye Movement Desensitization and Reprocessing*, 43.
children are inherently more susceptible to trauma is due to the early development of both the nervous system and the brain.

The human nervous system develops incrementally, which means that children are less protected against trauma than adults. An infant responds to stimuli with his or her reptilian brain, or hindbrain, the primitive part of the brain that regulates breathing, blood flow, and all the other basic life functions. The limbic or mid- or mammalian brain is also active from the start, generating the beginnings of the fight-or-flight response, later developing as the seat of the emotional self. Gradually, the thinking brain, the neocortex or forebrain, comes online, enabling us to think, to reason, and to understand abstract ideas and observe ourselves. PTSD has not been observed in mammals other than primates; less-developed creatures seem to have been spared the glitches that can occur with a highly developed brain—a thinking brain.\(^\text{12}\)

In Shapiro’s Adaptive Information Processing model, any event that occurs in a child’s life that stands as a self-defining moment in regard to the contribution or creation of one’s negative beliefs or feelings about one’s self is termed a “node.” Throughout the child’s development into adulthood, any event similar to that of the first (the runaway pet), the memory and the emotions of guilt or personal responsibility will attach itself to the associated channel of the node. Thereby over time the accumulation of these associated channels creates within the adult a dysfunctional reaction to present or future events similar to the first event or node. Since the event was so intense or “traumatic” for the child, positive information will not link with the neuro network of this specific event due to the fact that the node itself is defined by the negative experience and is locked into the nervous system. This does not mean that the child has not assimilated positive information in regard to the event, only that it has been stored separately into its own neuro-network. That is where EMDR comes in. EMDR stimulates the person’s information processing system through a method of dual stimulation. The first, being the bilateral brain stimulation through the use of the guided eye movements (or other stimuli such as lights, hand taps, or sounds) by the clinician. The second would be the client bringing the picture of that first incident into his or her consciousness with all of the

emotions and physical sensations that accompany the event. Through this process (along with the standard protocols and procedures of EMDR discussed in the next chapter), the separate neuro-networks are able to link up with one another, allowing the negative information to adapt its stored memory, emotions, and physical sensations to a more functional and healthy mental state.
CHAPTER 3
INSIDE EMDR: STAGES OF HEALING

Since her discovery in 1987, Shapiro has striven to develop and enhance the protocols and procedures for EMDR. She has also attempted to thoroughly comprehend and describe the rapid therapeutic changes elicited by the EMDR method. Through thousands of observations of EMDR sessions and the effects of the eye movements, as well as several scientific studies, Francine Shapiro developed the Adaptive Processing Model to help explain and govern the procedures of EMDR.

This model, as stated in chapter one, is based on the theory that there is an information-processing system inherent in all human beings that facilitates the processing of information toward a positive state of mental health. The system is believed to be adaptive due to the consistent progression patients’ experience from a negative dysfunctional mental state toward a more positive balanced outcome at the end of each session. The reverse scenario has not been witnessed in an EMDR session, thus strengthening the idea of an inherent physiological system naturally tailored toward mental wellness. The balance of this system is often jeopardized due to any number of negatively charged daily occurrences. An individual may logically process many of these negative events with no obvious residue of dysfunction. However, what is believed to happen with a physically or emotionally overwhelming situation is that one’s natural information-processing system becomes impeded, thereby cutting off its ability to process the event. The traumatic event is then stored or locked into its own separate memory or neuro network within the nervous system. This neuro network is referred to as a target or node and is considered the root of any future similar associations that might attach themselves to the original event. The goal of EMDR is not only to desensitize the impact of the target or node, but all of the associated channels as well. (Figure A)

Clinicians have discovered that many times a general wave of healing will often occur during a session. “Since the information is linked associatively, many similar memories can be affected during the treatment session, and it is possible for the new positive affect and positive cognitions to generalize to all events clustered in the memory network.”  

13 Shapiro, Eye Movement Desensitization and Reprocessing, 48.
Patients suffering from PTSD are generally easier to treat due to the availability of very specific images, memories, and time period of the traumatic event. However, many patients find themselves in therapy without having the benefit of knowing the specific reasons why they experience reoccurring negative thoughts, emotions, or physical sensations that dominate their consciousness.

During an EMDR session the information-processing system is activated by the use of bilateral brain stimulating eye movements (use of other stimuli will be discussed later in the chapter). This coupled with the client focusing their attention onto the target or node rapidly brings the dysfunctional material to a more adaptive state. “Each set of eye movements further unlocks the disturbing information and accelerates it along an adaptive path until the negative thoughts, feelings, pictures, and emotions have dissipated and are spontaneously replaced by an overall positive attitude.”

Though this may seem like an extremely simple process, the overall procedures and protocols of EMDR are specific and must only be applied by a licensed therapist trained in EMDR. The process of EMDR holds with it a series of eight stages that directs the therapist through a typical EMDR session, as well as an individual’s psychological road to resolution. EMDR is primarily a client-based therapy and the client never has to participate in the personal verbal interchange with a clinician that typifies traditional talk therapy. The client has the power to keep the specifics of disturbing memories to themselves. The client is only asked to hold the targeted memory in their mind while the clinician directs the eye movements. The role of the therapist is to guide each session from beginning to end through the development of treatment plans, patient history, facilitating bilateral brain stimulation through eye movements or other stimuli, cognitive interweaves (discussed later), closure, and reevaluation of each session. After each set of eye movements the therapist gives very little instruction or verbal communication in order for the patient to stay focused on his/her targeted emotions, thoughts, or physical sensations. The therapist’s goal is primarily to guide the patient through the session and occasionally, if the processing has stalled, to provide small amounts of information to the

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14 Parnell, *Transforming Trauma: EMDR*, 55.
client, in the form of imagery or verbalizations, to assist in restarting the process. This is termed a *cognitive interweave*.

“...the goal of the intervention is to mimic spontaneous processing as closely as possible and then get out of the way so that clients can continue following the internal pathways necessary for resolving their dysfunction...The more closely the deliberate activation mimics spontaneous processing, the more productive it is. In fact, a general rule is that when processing stalls, the clinician can restart it by deliberately promoting what occurred spontaneously for other clients during unimpeded processing.”  

The therapist must also have knowledge of other psychological treatments and therapies in order to be better prepared for the spontaneity of each individual EMDR session. EMDR is considered an integrative approach or synthesis of many traditional therapies. As we will see through the eight stages of EMDR, many of its elements have similarities based in other traditions such as hypnosis, cognitive therapy, classic behavioral therapy, psychodynamic therapy, and multimodal therapy to name only a few.

“It is not that any one element is credited for healing but rather that the complex and integrative procedures and protocols incorporate elements of all the major psychological traditions...The net result underscores the need to synthesize the wisdom within the overall field of psychology by combining the extant modalities within an integrative framework. The information-processing model is an attempt to move in that direction, since all treatment effects highlighted in the various orientations either arise spontaneously or are deliberately orchestrated.”

The primary goals of EMDR are summarized within a three-pronged protocol that serves to both treat and educate the patient in regards to their relationship and reactions to the trauma in the past, present, and future. Therefore, EMDR targets 1) past traumatic events and related emotions, thoughts, and physical sensations; 2) present negative stimuli causing dysfunctional reactions that may be rooted in earlier traumatic events; 3) and also presents patients with the tools or templates to prepare themselves for the future. This 3 Pronged Protocol guides the eight phases of EMDR, which include:

1. Client History and Treatment Planning
2. Preparation

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15 Shapiro, *EMDR as an Integrative Psychotherapy Approach*, 43.
16 Shapiro, *EMDR as an Integrative Psychotherapy Approach*, 42.
3. Assessment
4. Desensitization
5. Installation
6. Body Scan
7. Closure
8. Re-evaluation

The first phase is the Client History and Treatment Planning Phase and initially consists of a discussion of why the patient has decided to seek therapy. It is then followed by an in-depth assessment of the client’s history in order to determine the appropriate therapeutic path on which to place the patient. In EMDR, approximately 10 to 15 percent of patients intensely re-experience the trauma within a session. Therefore, patients with health risks such as cardiac or respiratory problems, pregnant women or the elderly must first consult a physician before continuing treatment. In this initial phase the therapist will assess the entire clinical picture, determining the dysfunctional behaviors, symptoms, and overall characteristics experienced by the patient. This will allow the therapist to prioritize a list of events, behaviors, images, symptoms, etc., either past, present, or future, into a series of targets to be addressed with EMDR at a later phase. The assessment of an individual’s positive inner and outer support structure is also important in determining a patient’s compatibility to withstand the intense emotional shifts often experienced during an EMDR session. Often therapists will ask patients to come up with a list of their top 10 most disturbing events from their childhood. The therapist will then ask the patient to recall each of the events and then rank the level of disturbance based on the SUD scale (Subjective Units of Disturbance) developed by Joseph Wolpe in 1958. A ranking of 0 is considered no disturbance, and 10 being an extreme level of disturbance. This will assist the therapist in determining what additional memories may be either in need of processing or contributing to the patient’s specific target. By asking the patient to describe their feeling or emotions regarding any of the 10 events, the therapist can gauge which memories are dysfunctionally stored and in need of processing. For example, if a patient claims that, “I am a failure,” or “The audience hates me,” and not “I can succeed,”
or “The audience supports me,” then the therapist will assume that these memories may need attention and will be prioritized along with the other targeted memories. Again, EMDR treats the comprehensive memory network, which may include a labyrinth of associated channels needing to be processed to a functional state.

The second phase is the Preparation Phase and is geared toward thoroughly preparing the patient for EMDR treatment. The therapist should explain how the nervous system stores traumas and what the patient can expect in an EMDR session, along with the theory and background of the method. This phase educates the patient in several relaxation and safety procedures such as “Safe Place,” “Lightstream,” or even hypnosis or other guided imagery techniques to ensure the safety of each client, both during and in between sessions. A therapist may need to apply one of these techniques to calm a patient who has trouble letting go of disturbing images. Teaching these techniques to the patient before actual processing takes place gives the patient a sense of control to be able to stop the processing at any time and return to a safe environment. Many therapists, such as Maggie Phillips, Ph.D. author of Finding the Energy to Heal, 17 have begun using eye movements to process positive images during this phase of the treatment.

...I test the procedure with a positive target image. This image represents a recent time free from the health symptoms we will be working on. An example of this kind of positive target is the conflict-free image...a sensory image that contains an experience of mastery related to the client’s therapy goals. Not necessarily a visual image, it can represent a special event or an interlude of time before the symptoms began or when they were in remission. The goal here is to find an image that evokes only positive feelings that can be sustained or even strengthened and expanded over several EMDR sets. We also experiment with the speed, angle, and number of eye movements to make sure they are a “good fit” during this phase. If we are unable to install a positive target image of a time when the health symptom was absent, I introduce other types of strengthening experiences. 18

Another element to be addressed is the possible loss of Secondary Gains that are being experienced by the patient as a result of years living with the trauma and its associated emotions and personal beliefs. Many may be faced with the real possibility of

18 Maggie Phillips, Finding the Energy to Heal, 7, 8, 12.
personality, identity, or occupational changes or losses due to the treatment received by EMDR which can severely impact a patient’s life. Often a traumatic experience defines an individual and all that he/she believes about himself/herself. The loss of this identification framework can create a serious dichotomy in regards to a person’s support structure. One may be searching to experience the elation of being free from all the symptoms and constraints created by a trauma, while at the same time being afraid of the uncertainty it creates in the stripping away of one’s personal beliefs, identities, life styles, and support groups that one may have grown to depend on over the years.

Phase three is the Assessment Phase, which will identify several key components necessary for EMDR processing: Target; Image; Negative Cognition; Positive Cognition; Physical Sensations; SUD and VOC Scale Ratings. After the first 2 initial phases of EMDR the patient and therapist have discussed and identified several negative memories or events to be targeted based on the individual’s complaints and symptoms. Whether it is the single event itself, as with a person who has suffered a humiliation on stage during a public recital, or the plethora of memories of childhood abuse, the correct selection of a target is of the utmost importance in order to process, successfully and rapidly, the patient towards a functional state.

In attempting to resolve a trauma, the clinician should target all of the following: (1) the memory of the actual event; (2) any flashbacks, since they might be different from the actual traumatic incident; (3) any nightmare images; and (4) any triggers, such as certain loud noises, that bring back feelings of fear and confusion associated with the earlier trauma. Triggers are any stimuli that elicit the dysfunctional images, cognitions, emotions, or sensations, either as full flashbacks or as partial arousal of the dysfunctional material.  

The therapist then asks that the client recall one image, either a detailed portrait or a blurred representation, that reflects the most striking aspect of the targeted event. “The goal is simply to establish a link between consciousness and where the information is stored in the brain.” The portion of the brain that controls sight in the brain is the occipital cortex, which is stimulated by recalling the most disturbing image of the event

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19 Shapiro, *Eye Movement Desensitization and Reprocessing*, 77.

to be targeted. Once the clinician and patient choose the image, the clinician asks the patient to articulate both a negative and positive cognition in relation to that image. The negative cognition is an interpretive statement that underlines the clients inappropriate beliefs in regards to the event and self, such as “I’m helpless, I am worthless, I am powerless.” These statements are all current self-diagnosis’ that are colored by the events of the past. However, if a client were to make a factual statement such as “The audience didn’t like me,” or “My father hates me,” this type of statement cannot be useful due to it’s valid nature. The patient must also create a positive statement that best defines their belief in how they view themselves in relation to the event, “I’m in control, I did the best I could, I learned from it.” The positive statement, however, cannot be one that is out of reach for the client in the sense that the goals to be met would be physically, emotionally, or mentally unrealistic; “My father will love me,” or “I will be the greatest singer in the world.” “The client has no real control over other people’s thoughts and actions. The goal should be that the client will be able to maintain a sense of self-worth and equilibrium regardless of external forces instead of resorting to rationalizations or false hopes of the future.”  

The patient’s level of “believability” toward the positive cognition is measured through the VOC scale, the seven-point scale in which one stands for completely false and a seven being completely true. The patient should be directed to rate the believability based on how they currently feel, not how they should feel. It is quite normal for a client to know logically how they should feel, even though they are currently struggling with overwhelming and intrusive emotions which are in direct opposition to logically formulated beliefs. EMDR makes use of the positive cognition during the installation phase in order to link up with the negative memory network and help in the processing of both the negative targets of the past and present as well as to enhance a stronger sense of self for the future.

If a client has trouble formulating a positive or negative statement, the therapist may present a list of statements during a session to assist them. (Refer to an extensive list of both positive and negative cognitions in Appendix A)

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To determine the level of current emotional disturbance being experienced by the patient, the client is asked to hold both the image and negative cognition in his or her mind while rating it from zero to 10 using the SUD scale (Subjective Units of Disturbance). The client should answer using their inner “gut” feeling for how valid their current beliefs are regarding the targeted event: the higher the number the more emotionally disturbing for the client. Along with the image and negative cognition, a patient may also be asked to report any associated physical sensations within the body. Since the mind and body work together as a system, it is important to observe the physical cues that are generated from the body. Emotional tension may cause a patient’s physical sensations, or the sensations may represent an earlier physical trauma. “EMDR presents constant opportunities to access meaning through the body and in some instances to treat emotions that are preverbal...Experiences that are reminiscent of the original trauma will trigger an adrenaline release by the brain that is felt primarily in the body. From brain to body to body to brain is a loop that has no true beginning or end.”

The intention of assessing all of these elements is to reduce the SUD rating to zero and increase the VOC rating to seven through the processing of EMDR.

Stages four, five, and six are the actual stages where the directed eye movements occur. The therapist is encouraged to experiment with varying types of formations with a “test phase” of eye movements, which may include: 1) the comfortable distance in front of the patients eyes; 2) the rate of speed from left to right; 3) the ability of the patient to follow the hand movements; 4) the direction of the movements (diagonals, circles, or figure eights); 5) the type of bilateral stimulation which best suits the patient (hand taps, sounds, hand buzzers, lights, etc.); 6) the number of sets of eye movements used during the session. All of these factors should be taken into consideration before proceeding.

The therapist first asks the client to bring the image, negative cognition, and the physical sensations into consciousness. The therapist then attempts to activate the information-processing system by directing left-to-right horizontal eye movements with two fingers similar to a “scout’s honor” formation.

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Through the dual stimulation of sustaining the conscious images coupled with the rapid eye movements, the processing begins. However, the client is not required to retain their attention on the original targeted images, negative cognitions, or physical sensations after the initial set of eye movements. The patient is encouraged to allow whatever comes to mind to surface during following sets. After each set, which could number anywhere from 24 to 36 sets of left-to-right-to-left horizontal movements, the patient is asked to “blank out” or “let go”, take a deep breath, and then is asked by the therapist “What do you get?”. Since our memories are stored associatively, many memories attached to the original target or node will surface, sometimes very unexpectedly. Abreaction can be a standard element of the EMDR treatment. The goal of EMDR is to process all of the channels of associated emotions and physical sensations. This continues until the patient seems successfully to have processed the information and is no longer suffering with dysfunctional memories and symptoms. The goal is for the SUD rating to be dropped to a 0 or another low rating appropriate to the severity of the trauma. There are times when a number cannot be processed lower than a 1 due to the valid reality of a patient’s trauma, such as the death of a loved one. At this point in the treatment, when the SUD rating of the targeted event or trauma has reached 0, phase five is incorporated, the Installation Phase. The patient is asked to recall their positive statement, “I can succeed, I am worth
“it,” which is then processed with a series of eye movements. This stage is used to plant the positive statement in place of the negative cognition or self-belief, as well as to use the positive cognition as a useful tool for the future. Stage six, Body Scan, is used in the same similar fashion as the previous 2 phases. The physical sensations associated with the negative image or event are targeted during this phase. The patient focuses on the area of the body where the sensation is occurring with several sets of eye movements directed by the therapist. The goal is for the sensations to reduce in severity by the end of processing.

People carrying emotional burdens will usually feel them bodily, although the body can dissociate from physical sensations the way that the mind does with emotions. Depression is often accompanied by sensations of heaviness and feeling slowed down. Anxiety brings on a tightening in the chest, a burning in the stomach, or back pains. PTSD yields hypervigilance and sensitivity to sounds and smells associated with the trauma. There’s no line between the effect of trauma on the mind and on the body. Nevertheless, body is sometimes “only” body, and any reasonable psychotherapist will make sure that body symptoms are checked out first to determine if the symptoms have a physical basis. 23

Phase seven, Closure, was developed to ensure that the patient is returned safely to a state of emotional stability directly following treatment, expectantly in a better state of mental health than when first assessed. The patient should also receive a thorough and comprehensive description of the client’s current affects of the EMDR session, especially if the processing of a target was not fully completed during the session. The patient is also informed of the possible activity or continued processing that may occur between sessions, for example: recurring or additional disturbing thoughts, emotions, triggers, or images. The therapist must be extremely sensitive during the closure phase in preparing the client for the possibility of spontaneous memories, directly or associatively related to the original target, which may arise while outside the safe environment of the therapist’s office. The clients may also be unable to remove themselves from the highly emotional state brought on by the accessing of past childhood memories, traumas, or associated material during or immediately following a session. “As with any trauma treatment, unless the clinician appropriately debriefs his EMDR client, there is a danger of

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23 Grand, Emotional Healing at Warp Speed, 148.
decompensation or, in an extreme case, suicide, which can occur when the client gives her disturbing emotions too much significance or views them as indications that she is permanently damaged.”

This is accomplished through the use of the previously mentioned relaxation techniques, such as hypnosis or the “safe place” exercise (see Appendix A). The therapist might also ask the client to record a journal of inter-session activity. This could include any repeating symptoms of the targeted memory, or new material that may have surfaced during the interim that may have been uncovered by the processing. This journal or log of events allows for the emotional distancing between client and stressful material: nightmares, past events, emotions, images, fears of the future, etc. The patient is directed to merely observe the information and to document it as it occurs, giving the patient a better sense of control as the “neutral observer.” This process is also recommended for any positive occurrences that might also surface.

The final phase of EMDR is called the Reevaluation Phase and does not transpire at the conclusion of the session, but at the beginning of the succeeding one. This is generally a recapitulation of the previous session and an evaluation of the stabilization of the SUD and VOC ratings in connection to the target. The therapist also discusses any new pertinent information and deciphers the patient’s logged information to validate and evaluate the direction of the treatment plan before EMDR processing can continue.

As stated earlier, EMDR is considered a “working hypothesis” due to the fact that the success of EMDR is primarily based on Francine Shapiro’s ongoing observations, research, and theories of the EMDR process as a whole. Her development of the Adaptive Information Processing Model is an attempt to explain the physiological inner workings of pathology within the human nervous system as well as the development of one’s personality. We all possess an innate information-processing system working to keep a balance in regard to our mental health and are defined by much of our earlier life experiences. However, there is still no concrete explanation or understanding of how and why EMDR works, even though eye movements have been used in healing practices such as yoga, hypnosis, and reichian therapy for centuries. There are several theories presented

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by Francine Shapiro herself and other psychotherapists in the field, as well as critics who state that the treatment is nothing more than a snake oil. One theory proposes that the alternating bilateral stimulation enhances the communication between the left and right side of the brain. Another theory is the idea that EMDR creates a constant distraction with the eye movements, which brings about a continuous startled response within an individual, allowing the dysfunctional information to be susceptible to adaptive treatment and resolution. The similarities between EMDR and the REM stage of a person’s sleep cycle provide the foundation for one of the most popular and more accepted theories.

During sleep, a person goes through several stages to complete a sleep cycle. The REM stage alternates with the NREM or Non Rapid Eye Movement stage several times during the night. The rapid left to right movements of the eyes characterizes the REM stage while a person is sleeping. It was once thought that the movement was a result of a person following the events of a dream with their eyes. Freud also speculated that our dreams were mere unconscious thoughts or wishes that surfaced during sleep, while others thought the images were just random brain activity. In 1953, Eugene Aserinsky and Nathanial Kleitman, were the first to identify the REM and NREM stages and their research pointed out that when an individual is awakened during REM, patients report very vivid and descriptive dreams. Research has indicated that there may be a correlation between the rapid eye movements during the sleep cycle and the processing of information within the brain and body. One observable indication is with the variable speed of the eye movements in relation to the emotional content of the dream: the higher the level of disturbance, the faster the eye movements. Another is the rapidity in viewing or processing the content of a dream. The REM stage only lasts approximately 20 minutes, yet many people report experiencing many hours or an entire day while dreaming. This rapid process is also observed in the EMDR process. This seems to indicate that there is an information processing system operating during our sleep cycle.

Jonathan Winson conducted research with animals and their processing of survival information during REM sleep. He suggested that “during REM sleep, what the animal has experienced during the day is synthesized and stored in memory to help it survive in

24 Shapiro, *Eye Movement Desensitization and Reprocessing*, 75.
the future.”  

Research has also found that when an individual is awakened continuously during REM, several symptoms may result: increased anxiety, irritability, disorientation, as well as the loss of a recently learned skill or information.

...studies have shown that depriving subjects of REM sleep after they have learned a specific skill results in loss of that skill or retarded learning. Therefore, it seems reasonable that dreams generally indicate the adaptive integration of material, whereas nightmares indicate insufficiently processed events. It is clear that trauma negatively affects sleep and can, perhaps, damage the hippocampus, the part of the brain most closely identified with memory. In turn, it is interesting to speculate that the eye movements in EMDR reopen an apparently crucial window of REM-like activity needed for integration and learning to take place.  

More than 40,000 professional therapists trained in EMDR around the world have used the therapy, though still a “working hypothesis,” to help more than two million patients suffering from a plethora of conditions. Many psychologists and others have criticized EMDR, stating that the eye movements have no real therapeutic affect on the patient. Others criticize Francine Shapiro by suggesting she has exaggerated the treatment benefits and success rates reported in her studies. As with any new idea, creation, or invention there will always be critics and skepticism focused toward the challenges the new discovery presents toward the old and familiar. There must always be opposition to encourage growth and determination in any field. The goal of EMDR is to help those who suffer and long for resolution. Whether the eye movements, blinking lights, or hand taps are just a distraction and considered superfluous, millions of people have claimed that EMDR therapy achieves positive results. The most important aspect to consider is Francine Shapiro’s constant dedication and research toward the improvement of EMDR for the sole purpose of contributing positively to an individual’s balanced state of mental health.

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CHAPTER 4
PERFORMANCE ANXIETY AND EMDR

In the musical realm of the arts, the term anxiety has become unmistakably intertwined with the fabrics of practice and performance. A person who embarks on a career in music performance will no doubt experience an element of anxiety of one form or another during their lifetime. The levels of anxiety experienced by any individual can range from mild to extreme, causing a state of intense body-mind arousal. This increased alertness is hardwired into our system, and is known as the *fight-or-flight* response. When an individual is presented with a situation that is perceived as a threat, the body and mind automatically reacts in survival mode: higher heart rate, hypervigilance, sweaty palms, tension, nervous shaking, etc. The individual then decides in an instant to remain and fight, or to run away. This natural defense mechanism has served humankind for centuries, giving soldiers the courage to fight in battle during overwhelming opposition; others the strength to flee from an attacking animal; and still others to confront daily fears of public speaking, or other social events. However, anxiety also has the power to consume one’s perceptions to the point of dysfunction and sabotage.

Though players of all instruments, styles, and backgrounds are subject to dysfunctional levels of anxiety, singers, for purposes of this treatise, will be examined in this chapter. The vocalist faces a wide range of obstacles, pressures, and challenges throughout his/her lifetime that are both similar to and unique from other disciplines in the arts.

The average person begins his or her tenure as a singer/musician through the public school system: elementary school general music classes, Jr. and Sr. High Choirs, and/or individual piano or voice lessons. Most singers do not begin their studies at this level with a realization that they will pursue and undertake a career in vocal performance, but rather as an extra curricular activity, social opportunity, or primarily because one enjoys making music through singing. Young students might view the activity of singing as a relaxing alternative or even escape from the daily stress of academics and certain social or parental pressures. In comparison to other disciplines, such as piano, where
many young children might begin piano lessons at the age of five, singers rarely begin
dividual voice lessons until they are in high school. This is due to the developmental
process of the vocal cords. The singer’s instrument experiences a great deal of change
from youth, through adolescence, to adulthood. The period of adolescence for the singer
is the most important time in vocal development. Though the male and female vocal
cords will continue to develop into adulthood, they have reached their overall adult length
by puberty. The male voice is often noted for its characteristic vocal “break” when the
adolescent speaks. However, the female voice also experiences changes, but not to the
extreme levels as that of the male voice. During puberty the female vocal cords grow by
about three-to-four millimeters, whereas the male vocal cords have grown up to ten
millimeters, double that of the female voice. This dramatic increase in length and
thickness explains the sudden shift from the light soprano tones of the young boy to the
lower adult vocal quality. These changes can occur at varying stages for both the male
and female, usually beginning around grades four to six through the seventh and eighth
grades in Junior High School, and sometimes into the first years of High School. Due to
the degree of changes and vocal instability that often accompanies the singer during this
time, intense vocal training is often discouraged. Singing is, however, greatly encouraged
at a young age in order to develop good musicianship skills. This is often accomplished
through general music classes, choirs, etc. Vocal studies intended to gear young students
for the performance of classical vocal repertoire is generally avoided until the vocal cords
have developed through puberty and are therefore more stable.

Hence, singers decide fairly late, in comparison with other instruments, whether
they will pursue a career in voice performance. The student is often unprepared for the
high degree of academic study and preparation needed to succeed in this particular field,
not to mention the overwhelming levels of competition that accompany the rigors of
performance. Young students often embark on a curriculum of vocal performance
without understanding the intricacies needed not only to succeed, but also merely to
survive. This not only includes the intense academic study of music theory, music
history, foreign languages (grammar and diction), classical vocal repertoire, and vocal
pedagogy, but the strong sense of self needed for the constant barrage of critiques,
assessments, and judgments toward one’s vocal/musical abilities. These critiques or judgments may come from teachers, stage directors, conductors, audience members, parents, fellow classmates, and worst all, one’s inner self.

The act of singing is typically very personal for any individual and requires a great deal of confidence and mental vigor. If a singer is unable to create or develop this ability to accept criticism, judgment, or competition with a confident and rational perspective, the chance of succeeding above one’s peers diminishes. “A combination of hard work, skill, and talent will continue to form you into a singer of quality. However, if in the future you wish to stay ahead of the pack, it will not be enough to perform consistently at a very high level. To be a winner, to remain in the zone of performing excellence as a singer, you will also need to refine your mental preparation and training. You must, in short, become mentally tough.” 27 This alone is one of the premier causes for performance anxiety: The realization that the personal experience of singing can be openly exposed and susceptible to a wide array of criticisms, critiques, judgments, and often academic pedantry, which may determine your future success. In other words, singing is no longer just for recreation.

Besides the realization that the performing world is extremely competitive, and the fact that the average singer begins his/her vocal instruction quite late in comparison with other instruments, there are a few other elements to consider that might contribute to the development of performance anxiety. The following elements will begin with the more obvious contributors to anxiety and move toward aspects that may be deeply rooted within one’s experientially personal framework.

One of the more prominent aspects of a performer’s career that might play a vital role in the development of performance anxiety is found in the art of practicing. Similar to other musical disciplines, singers must adhere to a practice schedule that will efficiently and effectively prepare them for an upcoming performance, not to mention a long-term career. However, what often occurs is the singer’s inability to predict the physical, mental, environmental, and emotional rigors experienced before, during, and

after a performance. The intense (or not so intense) practice sessions normally focus on the meticulous details of the music and the proper vocal technique required. However, what is often overlooked during one’s personal practice time is the unexpected intensity and spontaneity of a live performance.

How a performer processes the music both emotionally and physically while alone in a practice room or in the voice studio is extremely different than what is to take place on stage in front of a live audience, especially if the performer’s personality is not conducive to the emotional freedom required to communicate to the audience. This, coupled with insufficient practice time, the requisite memorization of text (often in a foreign language), and the possibility of dislike or disdain for the repertoire, can create a highly anxious singer. These issues, however, are fairly simple to remedy due to their tactile nature. A well thought out rehearsal schedule, recital program, and several practice performances can help to eliminate many unnecessary anxieties. The act of immersing oneself into every musical, physical, mental, and emotional aspect of an imaginary future performance will often help to facilitate both a focused and organic presentation.

The art of practicing, beyond learning the notes and rhythms, is often overlooked or neglected during the teaching of young singers. Young college-level singers are often expected to have already mastered this art, and must fend for themselves during their initial stages of study. A lack of attention geared toward the preparation process during the undergraduate years can result in a great deal of anxiety associated with performing.

Since many senior high school students do not perform solo voice recitals to the extent of a college vocal performance major, many undergraduate student singers develop anxiety-related problems. The proper amount of education toward performance preparation can significantly reduce the inevitable physical, mental, or emotional levels of anxiety around a performance.

Several authors and psychologists state that our anxieties are a plain result of our perceptions of the event and coping strategies, not the event itself. “An event may be stressful, not because it is inherently dangerous, challenging, or taxing but because it
makes demands that we are not well equipped to handle.” 28 One of the world’s most famous psychiatrists, Sigmund Freud, in one instance describes anxiety through his signal theory, with the view that anxiety is a response to impending danger either from within or outside the body. This is referring to “real” danger, the threat of physical harm. Freud also described a subtype of anxiety called neurotic anxiety, which is an exaggerated response to inner feelings and sensations misconstrued as threatening. An individual’s perception of a performance as being threatening, fearful, or dangerous is seen as illogical. There is obviously no real physical danger in singing for an audience, except the occasional trip on the stage, or the rare possibility of falling props/scenery. A singer’s preoccupation with his/her performance ability, audience reaction, teacher satisfaction, parental acceptance, or level of preparation will inevitably lead to a state of anxiety. These factors, though real, are often elevated to a level of misconstrued threats to one’s personal sense of self. Salmon and Meyer in their book, Notes from the Green Room call it self-absorption, which can result from the need for self-protection.

When we feel threatened, we naturally tend to protect ourselves from the perceived source of danger. When physically threatened, for example, we become preoccupied with protecting ourselves and escaping. Sometimes, however, the perceived threat is to our sense of psychological well-being. The heightened self-consciousness and anxiety that many performers--among them seasoned veterans--report experiencing often stems at least partly from becoming too focused on oneself, rather than on the music, during a performance.29

The psychologist Peter Lang created a model that states that anxiety is the result of an interaction of cognitive, behavioral, and physiological components which may be individually or collectively activated depending on the severity of the anxiety.

The key to this model lies in evidence that our thoughts contribute to anxiety when we appraise situations and conclude that there is danger. Over time, anxious people tend to develop an automatic response to situations that, although potentially stressful, do not pose much objective threat. The perception of risk may center on a specific event, such as performing in public, giving a speech, or taking an examination; on the other hand, it may be less focused, entailing a vague apprehension that “something terrible is about to happen.”30

29 Salmon and Meyer, Notes from the Green Room, 11.
30 Salmon and Meyer, Notes from the Green Room, 128.
Many of the theories regarding the treatment of performance anxiety center on our ideas, thoughts, or beliefs about an event. Many psychiatrists, such as Rollo May, believe that anxiety is a normal function of the human system and cannot be eliminated, that it should be embraced and the focus should be on the underlying contributors. These contributors, many believe, are just our irrational beliefs toward an event. Rod and Eversley Farnbach state in their book *Overcoming Performance Anxiety*\(^{31}\) that the **Activating Event**, recital, audition, or jury, stimulates the **Belief**, “I’m a terrible singer; they are going to hate me,” which then stimulates the **Consequence**, a tentative performance, or memory slip. If our beliefs are irrational in regard to the activating event, then the consequence is often manifested into forms of depression, anger, or anxiety.

The Farnbachs’ book describes **REBT**, or Rational-Emotive Behavior Therapy, created by Aaron Beck and Donald Meichenbaum. The REBT theory “maintains that if we feel disturbed and/or are behaving contrary to our reasonable interests, we need to make our thinking logical and rational in order to feel and to perform better. Distressing emotions such as anger, anxiety, and misery are caused by irrational thinking that defies fact and logic.”\(^{32}\)

Salmon and Meyer view the treatment of anxiety in the manner of developing one’s awareness of one’s self during both a practice session and performance to be more rational and positive. They speak a great deal on the prevention of anxiety rather than the alleviation of symptoms. In their book, *Notes from the Green Room*\(^{33}\), they describe the **SIT** therapy, which contains three phases: Self-Assessment; Learning Stress Management Skills (Relaxation, Imagery, and Cognitive Restructuring); and Implementation. They place a great deal of emphasis on one’s reactions, beliefs, or perspectives toward the event rather than the event itself: “...stress has more to do with how you evaluate and react to events than it does with the events themselves.”\(^{34}\) They also make the point that from the earliest days of our childhood, performers have relied on the assessments, opinions, and feedback from others about their performances both in life and on stage.

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\(^{32}\) Rod and Eversley Farnbach, *Overcoming Performance Anxiety*, 2.
\(^{33}\) Salmon and Meyer, *Notes from the Green Room*.
\(^{34}\) Salmon and Meyer, *Notes from the Green Room*, 25.
This makes it difficult for singers/performers to have the confidence about themselves and their performance skills.

We have discovered that one of the factors that contributes to tension and anxiety during performance is difficulty in evaluating one’s own performance skills. Performers who anxiously turn to listeners, irrespective of the latter’s musical credentials, for reassuring or validating feedback are often very unsure of their own capabilities. It is important for performers to cultivate sensitivity to their own performance skills and to learn how to evaluate their own musical efforts.\(^{35}\)

They have developed a four-phase assessment process to help performers develop better self-evaluation skills of their performance. It is called **SOAP**: Subjective Rating, Objective Rating, Assessment, and Plan. This plan assists the performer in subjectively rating his or her feelings during the performance, his or her more objective ratings of technical, interpretive, and expressive issues, an overall assessment of the entire performance, and a future plan based on the individual’s observations of the previous three phases. Again, this is another treatment based on the exercise of self-assessment and the conscious effort in shifting one’s negative belief or perspective in regard to the anxiety-producing event.

However unfortunate, singers often develop into their own worst critics due to the nature of the singing/learning process. Most academic institutions require the standard vocal performance major to prepare a selected amount of repertoire for each weekly voice lesson. During each lesson, the teacher or vocal coach scrutinizes, analyzes, and assesses the singer’s preparation, vocal ability, attitude, and performance. The situation requires the singer to open himself to accept (hopefully) constructive criticism and to develop techniques to improve on his/her vocal development. As many teachers and singers know, this process can be extremely difficult for both the young inexperienced voice student as well as the experienced professional. One of the main issues contributing to this and one that is unique to the singer, is the fact that the singer’s instrument is housed inside the body. The singer must rely primarily on his/her own physical sensations and external feedback from others for proper assessment. A perfect example is the common reaction singers have after hearing their recorded voices. The usual reaction

\(^{35}\) Salmon and Meyer, *Notes from the Green Room*, 30.
is: “That isn’t my voice,” or “Do I sound like that?” Singers learn, and rightly so, not to trust what they hear so much as the sensations experienced in the body, head, or vocal tract. Therefore, the act of creating the “self talk” toward one’s vocal ability is inherently built into the system. “Having bad thoughts and feelings usually results in feelings of inferiority which originate not so much from the ‘facts’ or ‘experiences’ themselves but from our EVALUATION of these experiences. This feeling of inferiority comes about for one reason: we judge ourselves, and measure ourselves not against OUR ‘norm’ or ‘par’ but against some other individual’s ‘norm’. When we do this, we always, without exception, come out second best.”

One of the more familiar of the self-help books is Barry Green’s *The Inner Game of Music,* where he separates the self-talk into Self 1 and Self 2. First, Greene describes our participation of both an outer and inner game in almost every aspect of our lives. The outer game is basically that which is external: the concert environment; the abilities of competing singers; difficult musical passages; demanding conductors; etc. The inner game is the internal aspects of the mind: desire; nervousness; self-doubt; excitement; the overall “thinking” state of mind. He states that we are participating in both games simultaneously, but there can be a copious amount of problems that can occur if the individual pays little attention to the workings of the inner game. If we allow self-interference, or negative self-commentary to be filling our minds during a performance, our natural abilities will be hindered. “Our performance of any task depends as much on the extent to which we interfere with our abilities as it does on those abilities themselves.”

That is where his Self 1 and Self 2 come into play. The Self 1 represents the interference: thoughts focusing on “should” or “shouldn’t,” or “could have been” or “if only” and can be absorbed from the expectations of others such as teachers, parents, and friends, as well as our own need to fulfill or reject those expectations. “It includes everything we ‘think’ we should be doing or about what we should be worrying.”

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38 Green, *The Inner Game of Music*, 12.
Self 2 contains the natural talents and abilities of an individual and includes the infinite amount of potential they may possess. Self 2 has access both to our entire nervous system and the wealth of information that is stored in our past experiences, yet can be difficult for us to recall. Our Self 2, with its vast memory bank, contains all our past musical experience, everything we have ever heard, learned from others, or experienced ourselves. It even contains knowledge that we assimilated directly from others without any specific instruction being given...As we discover the value and utility of having relatively fixed ideas, attitudes, and opinions, the gap between our “critical” and “creative” selves becomes wider, and our spontaneous ability to tap the resources of Self 2 gradually disappears.  

Green’s idea is that when Self 2 is able to operate without the distractions of Self 1 (negative self-interference), a performer is able to access his full potential of music making and reduce any anxieties that may occur. He has even created a formula to represent this idea:

\[ P = p - i \]

Performance = potential - interference

Green gives many examples of exercises throughout his text to remedy the overbearing Self 1 interference: giving oneself permission to fail, increasing the simplicity of a task for instant success; being aware of the internal and external distractions and accepting them; simply trusting one’s abilities; and more. According to *The Inner Game of Music* the simultaneous development of potential with the reduction of interference will inevitably bring one closer to his or her potential.

Many of the general anxieties experienced by singers can be dealt with through several of the techniques described in self-help books for treating performance anxiety. Self-help books dealing with performance anxiety state a shared belief that through a series of techniques and exercises, a singer/performer can change his/her negative perceptions toward an anxiety to a more adaptive and logical state. The common denominator is that one’s anxiety stems from a performers perceptions, beliefs, or interference in the performance rather than the event itself.

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However, there are some issues that have a much firmer grasp on the singers’ psyche. Many performers have suffered from extreme emotional pressure from their peers, parents, or teachers, which creates issues of low self-esteem, perfectionism, or other symptoms of general anxiety. Others, however, may have experienced events more severe or traumatic, such as being physically or emotionally abused by parents, the victim of rape, the witness of a murder, or other traumas such as being diagnosed with vocal nodules or experiencing a particularly humiliating performance. These events can have long lasting psychological effects on individuals and can often be suppressed to the point of dissociation. When singers are unable to function on stage due to overpowering sensations of anxiety and fear, and are systematically and logically unable to alter their irrational perspective and reaction to performing through the use of self-help literature, EMDR, then, would be a definite option to consider. EMDR was first used for the treatment of PTSD patients, but the populations have expanded to include daily ubiquitous events such as disappointments, and childhood humiliations, stress and anxiety disorders, and even for performance enhancement. A singer may be dealing with dysfunctional levels of stress before a concert, panic attacks, and possible physical reactions such as losing his/her voice the closer he or she comes to the performance, while never honestly knowing or understanding the underlying causes for his or her anxiety. EMDR works on the belief that present personality and sense of self is influenced by early life experiences. If one experiences a traumatic event, the trauma is locked into the nervous system in a state-specific form, inaccessible to our innate information-processing system to be moved toward a balanced state of mental health. One’s trauma may or may not have anything to do with performing, but the symptoms of anxiety and stress which surface during a public recital can be signs of deeper issues that may need professional therapeutic assistance. Symptoms of a trauma can surface immediately after the traumatic event or may lie dormant for months or for several years. We may also experience what is known in psychoanalytic terms as, “a screen memory, something that in and of itself does not seem particularly significant but that, like a dream, disguises deeper, more significant material lying underneath.”

As we experience

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similar situations to that of the original traumatic event, the sights, sounds, emotions, beliefs, and physical sensations arise and activate themselves in the present, often attaching to the stored traumatic event in the nervous system as associated channels. Many times an individual is unaware of the reasons for his/her anxieties, negative emotions, physical sensations, or reactions to an event, person, or situation. The difference between EMDR therapy and the use of performance anxiety self-help books is that EMDR can target either the actual event, a specific memory, a person in one’s past or present, physical sensations, or any number of negatively charged memories that may have a connection to their present anxieties. As explained in the previous chapters, one of the most important aspects of the EMDR session is taking the patient’s history. Through this stage the therapist determines what events from a patient’s past is negatively coloring or affecting his/her present. There can be a plethora of memories that a therapist can use, but the primary source should be the most negatively intense memory available. Francine Shapiro often asks three questions to track down the source of a patient’s negative feelings: When was the earliest time you had the feeling; when was the worst time; and when was the most recent time? After the memories have been targeted, the patient is asked to imagine the worst time and to develop a negative cognition regarding the event. The negative cognition is the irrational beliefs that patients hold about themselves, “I am worthless, I have to perform perfectly,” Another significant difference with EMDR and other self help books is that EMDR views the irrational beliefs as a link to deeper issues. This material is derived from past experiences and is subconsciously defining the patient’s personality and sense of self in the present.

The initial targeting is an effort to “light up” the part(s) of the brain where the image or memory is “stuck.” The bilateral stimulation will act as a kind of cerebral pacemaker, activating and moving thought. Scientists know from brain scans that depression, anxiety, panic, and trauma correlate with increased blood flow on the right side of the brain. As trauma and its symptoms heal, the scans show activity balances more equally for both sides of the brain. Ultimately, EMDR normalizes activity. Through bilateral stimulation, the unprocessed memory or image does not remain frozen in state but proceeds from being a traumatic memory (feeling as if it just happened, is happening, or is going to happen) to being a memory experienced as from the past. And once it’s released,
the patient will never go back and reactivate the same image or its emotional charge.\textsuperscript{42}

EMDR’s goal is to “clean out” all of the associated channels or memory networks surrounding the specific target. The singer suffering from anxiety onstage may experience a wide range of associated memory networks in his/her subconscious: the image of a parent humiliating the singer after a past performance; the physical sensations of being slapped or beaten if the practice or performance was not up to par; the memory of being told by a friend, parent, or role model that he or she is not intelligent or talented; images of sexual abuse by a parent or guardian; and many more.

The average person suffers from low levels of anxiety or depression that may last a couple days or even a week. These types of issues can often be logically dealt with through the use of many self-help books such as the ones mentioned earlier. The singer’s beliefs or attitude toward their anxiety are viewed as adaptable through a series of physical and mental exercises. However, if the anxiety begins to completely overwhelm the singer to the point of dysfunction on and off the stage, and the efforts to reduce the anxiety through one’s personal effort of changing irrational beliefs is unsuccessful, there may be other issues hiding beneath the surface.

An example that was presented in David Grand’s book, \textit{Emotional Healing at Warp Speed}, was of an older woman at the age of fifty-seven who had been a professional singer in her twenties but had lost her upper range and consequently was forced to end her career. She visited Dr. Grand for reasons of depression and low self-esteem. Dr. Grand took a history and asked her what had been going on in her life at the time she gave up her career. Her answer was stress, financial problems and a verbally abusive and critical mother. This, however, didn’t seem to Dr. Grand to warrant the loss of her voice. After a few weeks of treatment she finally revealed she had been raped at age twenty-seven and had become pregnant. She also stated that she had an abortion soon after and had to deal with it alone. As Dr. Grand treated her with EMDR, several

\textsuperscript{42} Grand, \textit{Emotional Healing at Warp Speed}, 28.
associated channels began to surface and reveal themselves related to the target of being raped and the negative cognition of “I asked for it.”

...she felt a tightening in her throat and associated it with her mother grabbing her larynx when she told Sylvia to “shut up.” The rapist had choked her so hard, she lost consciousness. During the abortion, she had been given anesthesia through a mask. She had panicked and tried to speak, but the anesthesiologist had held the mask over her face, and she couldn’t make a sound. When, thanks to EMDR, the emotional dissociation lifted, the reasons for the loss of her singing voice came together for her.\textsuperscript{43}

After several sessions of EMDR, her upper register returned.

Another interesting case was that of a 30-year-old woman who began experiencing lack of concentration, tension, and debilitating anxiety while performing. The inner voices of, “You just missed that note; I’m sure everyone heard it; I bet they think I’m terrible; watch out, don’t mess up,” would plague her mind during a performance. This barrage of self-criticism was severely interfering with her professional career and social life. She would often ask loved ones (significant others, friends), not to attend her performances because she believed they would not “love her” if they heard her mistakes. She came to the realization that if she didn’t seek help she would be forced to give up her performing career. She eventually visited a therapist who was an EMDR specialist. After taking a thorough history, the patient began describing past performances when she was a younger singer. When asked by the therapist when this negative self-talk and fear of performing began, a specific incident came to mind. She recalls making a few mistakes during a performance and thinking at the time that it was not that significant. The following afternoon she read the newspaper critique of her performance that stated rather severely that she, “was lacking in technique,” and “she performed with little musical feeling.” One might think that this would be enough reason to establish a pattern of anxiety or low self-esteem. However, she soon discovered that the trauma was not in the performance, or in the critique itself, but in her parents’ reaction to the critique and to her. They were embarrassed with the negativity of the critique and directed it toward their daughter. This single incident colored every future performance, creating a series of

\textsuperscript{43}Grand, \textit{Emotional Healing at Warp Speed}, 186, 187.
negative performances that were based on conditional love if she didn’t perform “up to par.” After one session of EMDR in which the therapist targeted the memory of her parents’ reaction, she began to view her future performances with anticipation rather than fear. She grew more confident with every performance thereafter. EMDR allowed her mind to process the traumatic event and heal itself gradually.

Over the past 17 years the applications of EMDR has expanded to a wide array of pathologies as well as more creative ventures such as performance enhancement for athletes, actors, and musicians. One of the leading developers in using EMDR for performance enhancement is Dr. David Grand. Dr. Grand presents a similar concept to that of the previously mentioned self-help books, that the most important element of one’s anxiety is based on perception: our perceptions about ourselves as well as those of our audience. “When we project our own negative perceptions onto those observing us, we activate our anxiety, shame, and inhibition, undermining our performance. When we view ourselves positively, our performance is enhanced.”

As I have stated earlier, many external forces such as parents, friends, teachers, media, and other significant personalities influence us as singers (and human beings). From birth, the type of feedback we receive following any of our accomplishments will begin to determine our personality and self-image. If our lives happen to be full of criticism and negative responses, the chances of a person developing a sense of trust and a positive self-image about his/her abilities will be severely reduced. Clifton Ware states in his book Adventures in Singing, that “learning to sing occurs first in our imagination. ...But imagination cannot work alone. Because emotion and thought precede action, our attitudes also determine what we decide to see and how we interpret what we see as we undertake any activity.” He goes on to say, “…the habits we bring to speech and singing are largely influenced by other people, greatly influencing our ability to imagine (image) new outcomes.” This concept is rooted in the EMDR process, that current pathology is based on earlier life experiences.

Dr. Grand goes on to discuss how many professional performers must master the art of adaptive dissociation in order to deal with such distractions. This is the ability to

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44 Grand, Emotional Healing at Warp Speed, 160.
consciously block both the internal and external forces that might hinder one’s level of performance: an audience of two thousand; the presence of media coverage; an infamous critic in the front row; thoughts of both failure or success that might distract one’s concentration; racing heartbeat; etc. Some athletes refer to this as being in “the zone.” However, maladaptive dissociation is usually not far behind. Many performers can adaptively dissociate themselves from the standard distractions of performance, particularly when they are performing well. However, some find themselves unable to dissociate, especially during periods of poor performance levels. This can be related to the performer’s negative earlier life experiences. A baseball player in a terrible hitting slump was unable to reverse his poor-hitting streak. It seemed that the longer he was in a slump, the more difficult it was for him to escape it. During treatment, Dr. Grand asked him where he felt the negative energy in his body, the player replied, “It’s in my stomach...but I don’t feel it.” Dr. Grand determined that this meant that he was dissociating from his body. After using EMDR, the baseball player realized that his dissociation from his body was his way of protecting himself from the memory of his abusive father. His current perception of himself, “I can’t hide it. I really am worthless,” was connected to the memory of his father, thus contributing to the longevity of his batting slumps. After EMDR, his batting average improved and was able to deal with future slumps without the negative effects of the dissociative memories of his father.

In order to enhance performance, the therapist needs to find the source of the problem instead of treating the symptoms found on the surface. A performer will never be able to improve his or her performance, or reach his or her potential until the deep-rooted issues currently coloring his or her perceptions of self are resolved. “The nature of the solution is defined by the nature of the problem.”

In general, performance enhancement is the discovery and removal of distorted internal beliefs that color our perceptions of self. This allows the individual to continue the discipline of practice and performance without the influence of the underlying trauma. Dr. Grand also discusses Creativity Enhancement. This, through EMDR, is the release of spontaneity and openness within an individual in order for creativity to flow. It

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does not necessarily need to be attached to the improvement of a specific task or function, but merely the individual’s ability to freely access his or her creativity. Dr. Grand has also expanded the use of EMDR to facilitate better character development with actors. Through the standard protocols of EMDR and the bilateral brain stimulation, an actor can dive into a character’s past with intense specificity. For example, an actor is asked to think of his or her character, and is asked something along the lines of, “What is bothering you now?” The actor replies with a negative statement about himself/herself while playing a specific character, and then bilateral stimulation is administered. Through a series of sets of stimulation, the character spontaneously moves through the characters past experiences with great detail and emotional attachment. There are also physical sensations as well. This is the actor’s enhancement of creativity through the use of EMDR.

EMDR is a new technique to treat performance anxiety. It is client-based, efficient, and thorough. It has the capability to be incorporated into many types of psychotherapy and should be used as a tool to help unlock the trappings of trauma. EMDR has its skeptics that view EMDR as a snake oil, claiming there is no neurological evidence that any changes occur in the brain due to EMDR. However, there have been millions of witnesses to the fact that their own traumas and anxieties have been revealed and processed to a positive outcome. Therapists and researchers are constantly reevaluating and studying EMDR in order to improve our understanding of its effectiveness and to refine the procedures and protocols.
This chapter is an interview with Dr. Ellen I. Carni, Ph.D. Dr. Carni is a licensed psychologist whose Manhattan-based practice includes performing and other creative artists. A graduate of New York University, City University and Columbia University, she holds postdoctoral certificates in psychoanalysis and EMDR. This writer contacted Dr. Carni in the summer of 2000 after reading her article “Eye Movements and Memory” in the January/February issue of Piano & Keyboard. This was one of the first resources I had found that discussed the use of EMDR specifically with musicians and performance anxieties. I soon formulated the idea of calling on the expertise of an actual licensed psychologist to include in my treatise. My goal with this chapter is to give the reader an insight into the realm of performance anxiety and its treatment with EMDR through the perspective of an experienced clinician.

The following is a series of questions that I created and sent to Dr. Carni to be answered in an informal interview format. The questions deal with several issues of performance anxiety experienced by singers and instrumentalists alike, as well as the proper use of EMDR in the treatment and diagnosis of performance anxiety-related issues.47

1. Are there standard symptoms that performers with anxiety issues have in common?

The short answer is, “Yes.” The bigger picture is that, psychologically, musicians who experience performance anxiety are caught between a desire to demonstrate their unique style of musical expression in public and a competing fear of appearing inadequate in that task. Ironically, the very thing performers covet, the opportunity to perform, may also be their greatest threat.

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47 Case material Dr. Carni drew from her own practice has been given with client permission or disguised to protect their identities. Other case material comes from published work that is available in the public domain.
When the performing musician feels threatened, the central nervous system responds with a “fight or flight” command. The cortex sends adrenaline through the body. But for the musician onstage there is nowhere to flee to and no tangible enemy to fight. Adrenaline runs amok because it can’t be expelled. “Symptoms” result. They are physiological, cognitive, emotional and behavioral messages about the musician’s plight – “I’m stuck; I’m in danger; I’m losing control.”

Physiologically, symptoms such as shaking, cold hands, sweaty palms, heart palpitations, difficulty breathing, nausea, and gastrointestinal problems are classic.

Cognitively, symptoms may show themselves as irrational thoughts, called “cognitive distortions” according to cognitive-behavioral psychology. Some great examples are given by Diane Nichols, a non-EMDR clinician in New York who works with performing musicians: “I missed one note. This concert is a total failure. (perfectionism)…The way I came off that fermata, they’ll never hire me again. (generalizing from an instance; catastrophizing)…I hate my vibrato, so everyone else must hate it, too. (personalizing)…I will be exposed for the imposter I truly am...(identity distortion).”

Of course, anxious musicians may hear negative self-talk that has a basis in reality: “What if I have a memory slip? … Will the audience appreciate me? … Will I live up to the success of my last performance? … Will I be hired again?” While these thoughts may not be without cause, the severity of the anxiety accompanying them and their persistence over equally realistic positive thoughts may be great enough for the musician to be considered “symptomatic.”

Emotionally, performing musicians may experience anxiety states ranging from mild agitation to outright panic, depending on the meaning a situation holds for them. Carly Simon comes to mind as someone who, at least in her youth, experienced such severe anxiety that she was once caught on video pounding her fists on a door backstage insisting she couldn’t go out and perform. Thousands of fans were waiting. The pressure was up. With enough goading from her manager she went out and sang.

On the subject of anxiety, it is important to mention that musicians may be conscious of their fears or unknowing. The more unconscious the anxiety, the more
frustrating and impotent they are inclined to feel. One of the EMDR’s greatest strengths is in bringing the unconscious sources of anxiety into consciousness so they can be reprocessed.

Depression is a symptom well known to performing musicians. When musicians feel that their thoughts and feelings are out of control; when they have actually failed at a performance or compromised it significantly; when they cannot find enough work to sustain a livelihood because of economic times or are grossly underpaid relative to their talents; if they cannot resolve core psychological conflicts to reasonable satisfaction, they can be subject to depressive states ranging from mild and manageable to agonizing, landing the musician in a mire of despair and hopelessness. In this sense, the term “performance anxiety” is somewhat of a misnomer. Although they manifest differently, anxiety and depression tend to go hand in hand.

Behaviorally, musicians may experience disturbances in eating and sleeping patterns such as over- or under-eating or insomnia. And many, as we know, turn to drugs and alcohol or other potentially self-destructive activities as ways to soothe themselves. Elvis Presley comes to mind here, Janis Joplin, Mariah Carey and endless other performing stars.

Anxious musicians may make technical mistakes onstage such as forgetting the music if they must perform without sheets, skipping notes or playing the wrong ones; becoming derailed; or over- or under-expressing the mood of particular passages of a piece or a composition as a whole. And you know that performance anxiety may begin well before the performance itself. Symptoms can begin simply from anticipating an audition!

Clinicians of the psychodynamic bent and of the more cognitive information processing ilk that EMDR draws upon look at performance anxiety as the symptom in itself, a signal representing the presence of unresolved conflictual or disturbing experience in the musician’s formative years. From this vantage point, clinicians attempt to help clients work through these underlying experiences as a result of which process all the symptoms diminish as a whole.
Bear in mind that we are concentrating only on the worst aspects of performance anxiety. Performance anxiety is not necessarily an “abnormal state.” A great many musicians utilize their anxiety as a challenge to rise to the greatest occasion of performing, bringing out the beauty of music. Used in this way, anxiety becomes part of the exhilaration of making music. When the constellation of symptoms called “performance anxiety” become debilitating, musicians may experience significant distress and impairment in performance. At worst, they may be forced to abandon or redirect their musical careers in a way that avoids performing.

Fear of professional stigma and its consequences (loss of reputation, loss of work) and personal shame often keep musicians from seeking psychotherapy that can be of great benefit to them. Hopefully, your treatise will educate the performing world about the value of psychotherapy in general and EMDR in particular in a way that will give permission to musicians to take advantage of this help without fear and shame.

2. What are symptoms that would suggest a performer needs EMDR as opposed to conventional therapy?

Thinking about how best to answer your question, I wouldn’t “oppose” EMDR and conventional therapy. EMDR is a therapeutic tool that clinicians integrate into whatever brand of “conventional” therapy they practice. There really isn’t such a thing as “EMDR treatment” apart from a therapeutic context, be it psychodynamic, cognitive or gestalt-based, in approach. EMDR gained wider use in clinical practice when practitioners discovered by experience that for certain people, the use of bilateral stimulation embedded in the technique brought to consciousness a flow of buried memories and feelings relevant to the issues at hand that were simply not accessible in the course of strictly verbal communication between the therapist and the client, or, if they were, would have taken a much longer time to retrieve. Furthermore, EMDR accelerated the processing of disturbing information. Whether this phenomenon has to do with certain individuals’ greater accessibility to their own internal world when forgoing the logical (verbal) part of the brain or with brain biochemistry in itself or for whatever reason still remains a mystery for all the research that has been done.
If a musician has already tried many techniques and therapies in attempt to vanquish performance anxiety and has not succeeded, I would definitely recommend EMDR. I have seen patients who had been in talk therapy for seven to ten years prior to trying EMDR and who gained greatly in their understanding and life functioning but whose performance anxiety or other symptoms were not budged. In three to five months of working with EMDR within my own psychodynamic context, their symptoms were disappearing. In these cases, I would have to say that, rather than looking at their prior therapies as having failed, they gave the clients a wonderful foundation that made the EMDR move very quickly. These clients came at a time in their lives when they were very motivated to get rid of symptoms. But without the EMDR, they would not have fulfilled their dream of being able to perform with pride, without either the symptoms or fear of the symptoms returning.

For musicians who have not had prior therapies or treatments for performance anxiety, I would still definitely recommend EMDR because when it works well, it is an amazing process.

I would put out just a couple of precautions. EMDR is not a quick fix method. I’ve had many people come in expecting deep-seated performance anxieties to disappear in three easy sessions. It rarely works that way and often those people drop out. One has to be prepared to do the work of going back into the storehouse of one’s more painful experiences and feeling all the old emotions. It’s not always an easy ride, especially when there has been a lot of trauma.

My other recommendation is to make sure the clinician has good solid professional training before he or she obtained the EMDR certification and that there is a good match of personality between client and clinician. Any method is only as good as the clinician utilizing it. That concept is true of performing musicians, too. Developing a therapeutic relationship of trust, safety and comfort is essential to effective trauma work.

3. What is the difference between using EMDR for Performance Anxiety and Performance Enhancement?

EMDR used for performance anxiety aims to eradicate the condition by helping performers reprocess disturbing experiences that contributed to its formation. EMDR
used for performance enhancement aims to help performers overcome stumbling blocks they encounter onstage when there is no time to think about past experiences. I like to think of performance enhancement techniques as psychological “cue cards” to help prevent musicians from making slips during live performances or to get them back on track immediately after making a slip. In my experience, once musicians resolve and integrate the underlying issues related to performance anxiety, they no longer need performance enhancement techniques.

I can share an example from a pianist who permitted me to use material from our work for publication. She had a solo recital scheduled about two months into the treatment. It was her first performance since starting EMDR. She was both excited to see how much improvement she would make in her overall level of comport and terrified of making technical mistakes. Mostly, she was concerned about bad internal voices coming into her head telling her she was going to “mess up” and reprimanding her if she did. Arguably, we could say that the voices were internalized from her father, who was perfectionistic and punitive. However, her concert being a few days away, there was no time to reprocess the voices fully with EMDR.

Using EMDR for performance enhancement, we came up with a number of devices to counter the voices. For example, she could keep her breathing going. She could rely on muscle memory instead of intellectual memory. She could use humor and not take herself so seriously. She could “normalize” things by telling herself that everyone gets nervous and everyone makes mistakes. She could hear the voices as she would see scenery from a train window, just passing by. We “installed” each device with a few short sets of bilateral stimulation.

In a post-recital session she reported that it helped her to have choices in getting rid of the critical internal voices. What helped her most was telling herself that the beauty of the music took priority over technical mistakes. “I was able to shoo away the demons…Noise and roar were reduced.”

By her second recital several months later, we had continued to use traditional EMDR trauma processing to work through deeper issues involving her projection of parental criticism onto the audience. We did not use the performance enhancement
techniques again before this concert. She reported having no anxiety and no memory slips during that performance.

In this case, I am speaking for myself. Other EMDR-trained clinicians may create different performance enhancement techniques or co-create them with their clients. The use of EMDR for performance issues is still relatively new and continuing to evolve.

**4. What are the aspects of performance anxiety that can or have been treated? – Performance on stage, practicing, memorizing, learning music, procrastinating, low self-confidence, etc.?**

Looking from the clinician’s lens, Ray, I see at least a couple of different questions here. Which aspects of performance anxiety can be treated with EMDR and which cannot? Under what conditions is EMDR most (or least) likely to be effective for performance anxiety in a specific case?

In principle, any aspect of performance anxiety that is tied to unresolved trauma is treatable with EMDR. In fact, however, many different client circumstances can influence an EMDR treatment for better or for worse. In the course of the initial period of assessment, the clinician must evaluate much more than simply the psychological underpinning of the presenting problem (stage fright, practicing, memorizing, etc.). She must take into account the severity of the client’s symptoms. She must inquire about how much trauma of any kind the client has experienced in the past and how it has affected his present capacity to cope with stress. She must examine the client’s sense of safety and trust and her resiliency to do trauma work at this time in her life.

The clinician must look at the client’s age and level of maturity. He must consider the stability of the client’s outer life in terms of employment (including school if the client is a student); economic resources; physical health; and family and social support, for example. He must appraise how much the client believes the irrationality of her negative cognitions and how motivated she is to incorporate a new positive identity and assume the responsibilities that go along with that competent sense of self.

It is also important that the clinician consider the interpersonal issues involved in an individual’s performance anxieties, concerns about rejection, abandonment, and betrayal, for instance, in terms of how they play out in the clinician-client dyad.
In certain cases, mostly in which the client feels too unsafe to process trauma through EMDR, I work with what you call “conventional” therapy until she is ready to process through bilateral stimulation of the brain. Some people need a lot more time to establish a therapeutic relationship before beginning EMDR. With others, it works best to go back and forth between EMDR and talk therapy.

I can understand that, from the musician’s point of view, you want to know what aspects of performance anxiety are amenable to EMDR. My answer is client-focused rather than symptom-focused but I hope you now know why.

What aspects of performance anxiety are not amenable to EMDR? In a short television segment on “20/20” that appeared on WABC News in 1994, reporter Lynn Scher wondered whether the much touted successes of EMDR had earned it a reputation for being “the snake oil of the ‘90’s.” Regrettfully, EMDR is not a genie in a bottle. It can’t put talent into a musician where talent isn’t there; it can’t turn a cellist into a pianist if the cellist has not studied and shown facility with the piano; it cannot make a singer fluent in Italian and German if she does not already know these languages. EMDR can’t help musicians give great performances if they haven’t learned the music or practiced sufficiently. EMDR is not a substitute for the rigors of preparation. It cannot allay a performer’s anxiety that is reality-based in these ways.

5. Is the treatment of performance anxiety by EMDR the same as the treatment of other traumas or anxiety?

Well, yes and no. One can always employ a standard EMDR protocol with performance anxiety. The basics of EMDR are the same: - the use of bilateral stimulation of the brain and the targeting of underlying trauma. Since clinicians are still experimenting with ways in which EMDR can be used effectively, there is plenty of room to develop creative ways to apply it to performance issues.

The use of EMDR for performance anxiety is a relatively recent development. Within the last five years or so, clinicians using their private practices as “closet labs” have been coming forward to the EMDR community about their adaptations of the protocol for performance anxiety. Not many, but a number of clinicians have spoken or
written about their work with artists, public speakers, airplane pilots, athletes, and people who experience anxiety around taking tests and interviewing, for example.

David Grand, Ph.D., in New York, may be one of the first clinicians to make performance issues among actors, musicians, and athletes his most cherished EMDR specialty. I am not familiar with the specifics of his current work but I know he deviates considerably from standard protocol. His book, *EMDR: Emotional Healing At Warp Speed*, is available at major bookstores. Among his present professional activities, he trains EMDR clinicians in his “name brand” techniques. For your purpose, this means that increasing numbers of EMDR practitioners are learning tools to work with performing artists.

A number of years ago, Dr. Grand adapted Watkins and Watkins work on ego state psychotherapy for performers. According to ego state theory, an individual’s psychological makeup is seen as a composite of many different psychological selves formed in the course of her life experience. These internal selves referred to as “ego states,” exist outside of our linear sense of time and are simultaneously active. For example, we can parse our identity into our experiences in different social roles such as our “inner” child, adolescent, adult, parent, musician, psychologist, etc. Likewise, we can parse our identities according to our dominant psychological experiences: - our “abused self,” “strong self,” “helper self” and “critical self,” for example. In ego state work, the clinician helps the client identify her inner selves and has them “communicate” with each other in order to heal the injured parts of the client’s ego.

I guess it was an obvious leap to adapt this technique for use with bilateral stimulation. The clinician can target any of the selves that may be working to sabotage the rest or even hold a “conference call” between and among selves while the client is under bilateral stimulation. Likewise, the clinician can target the client’s ego state at any time he experienced formative traumas.

David Grand’s creative adaptation was to identify and target the musician’s “inner critic,” that part of the musician that comments and judges him as he performs. If an “inner critic” is harsh, EMDR’s goal is to transform its character into one that is affirming, thereby facilitating optimal performance.
Personally, I will use whatever techniques I think might work and that appeal to the client, including ego state work, even during the course of one treatment. I think most clinicians would. I’d go as far as targeting the singer’s throat, the pianist’s hands, or a particular instrument (the client’s piano violin, horn, etc.), that might serve as a reservoir for the client’s memories and feelings.

With EMDR, many things happen on the spot. I worked with a performer who, in anticipation of an upcoming concert, was stuck on a piano piece by Robert Schumann (1810 - 1856), and unable to move forward with an EMDR “psychological rehearsal.” We did a cognitive interweave. I asked her to tell me something about this piece. Schumann, she said, wrote this composition for his wife, Clara (1819 - 1896), a pianist and composer in her own right, an acclaimed child prodigy, and, reputedly, the love object of the much younger Johannes Brahms (1833 - 1897) as well. The client spoke with envy and grief, that, at her present age, she knew she would never be as illustrious as the famous Clara. However, when I asked what she knew about Clara’s personal life, it became clear that Clara did not live the charmed life the client had envisioned. Engaged to Robert Schumann at seventeen, Clara later bore him seven children whom she was left to raise and support after Schumann had a nervous breakdown and was committed to an asylum where he died two years later at the age of forty-six. The client realized that, while she may not be famous, her life was quite gratifying and she would not want to exchange it for that of Clara Schumann. She knew then that she would not have difficulty with her rendition of this piece, and, in fact, it went quite well during the concert.

I do have some adaptations to standard protocol when working with performers that I keep fairly constant. I take a performance history as well as a personal history of the client. In this way, we get to look at specific performances that went poorly and those that went well to try to pinpoint where the client gets stuck and what works for him. I ask the client to set up some performances during the course of the treatment if she doesn’t have any already scheduled. There is really no other way to measure change than to get the musician out in the world performing. A “test performance” may be as simple as a house concert in front of friends or a more formal public program. I attend programs (not
house recitals) if I believe my attendance will help the client and she wants me to be there.

Often, I set up an EMDR session pre-concert to work with anticipatory anxiety and performance enhancement techniques and then a post-concert session to go over what succeeded and what didn’t. I “install” each gain the musician made using bilateral stimulation and we analyze and organize how to move forward in the processing.

I encourage musicians to complete the trauma work rather than just stop when they’re feeling the high of performing without anxiety. I mention this caveat because I had a case in which a pianist stopped treatment at that point and drove himself to perform so much so quickly that two years later he injured his playing hands and was absolutely devastated. By his own admission, he felt he needed to overcompensate to prove himself, indicating that he still didn’t feel worthy enough at the core of his identity.

6. Is there any correlation between the patient’s traumatic situation or anxiety and their choice in career/instrument?

This is an excellent and interesting question. There is no necessary correlation. However, in individual cases it can happen that a client’s traumatic situation influences his choice of career or instrument. Diane Nichols published two such cases in a 1995 article in *Chamber Music*.

In the first case, an oboe player switched to the English horn after performance anxiety with the oboe led to a disastrous performance of Mozart’s oboe concerto. With the English horn, the musician felt much more at ease and quickly built up confidence. In analyzing this curious change, he came to realize that he could not separate his expectations of himself with the oboe from his mother’s expectations of his success with this instrument. With the English horn, he felt free to develop his own musical voice. He later auditioned for an orchestra with an oboe opening with greatly diminished anxiety and won the audition.

In the second case, a violinist who reported experiencing comfort and confidence playing jazz in her string trio, expecting a positive connection with the audience, talked about experiencing the opposite feelings when playing classical repertoire. With classical repertoire, she feels judged by the respectful silence of the audience and intensely
anxious. She traces this shift to her experience with her first classical music teacher, who would often invite other teachers in to criticize her sight-reading and her playing.

I, myself, have worked with at least three musicians whose early traumatic experiences led to further trauma during or post conservatory training that resulted in their making choices not to pursue careers in performing. Two remained in the music industry and one retrained into a different industry but continued to play music as an avocation. Unfortunately, I am not at liberty to furnish details of these treatments. However, I can say, in general, that people with this type of history who have not made a satisfactory compromise with their career choices often come to treatment at midlife to see what is still possible and realistic for them in the area of performance and to make peace with themselves rather than take the burden of regret to their grave.

7. (a) What are the elements inside the performing world that help create traumatic memories or feelings within the performer who develops performance anxiety? (High competition, perfectionism, lack of support from peers or parents, negative environments – stage directors, conductors, unsupportive teachers.)

(b) What are the elements outside the performance world that contribute to performance anxiety?

Question 7 is, perhaps, the hardest to answer. Any experience that exceeds an individual’s capacity to cope can be a template for trauma and, specifically, for performance anxiety when performance demands feel excessive. Certainly, all the elements of the performing world that you mentioned will impact an individual’s experience in some kind of negative way. But why will one musician’s career be destroyed by the impact of these experiences and another’s flourish regardless?

What shapes an individual’s capacity to cope, her psychological resilience, is a complicated matter that psychologists are still trying to figure out. Psychological vulnerability or resilience is probably a product of a person’s innate temperament; biochemistry; the quality of his early relationships with his primary caregivers; and the quality of other significant psychosocial experiences in his formative years. Insofar as the majority of musicians begin training in childhood, their experiences in the performing world up through late adolescence and early adulthood may be as critical to their
personality development as their parenting. Therefore, those early experiences in the music world that the adult musician subjectively experiences as traumatic make acceptable targets for EMDR.

A good example of the complexity of traumatic substrates to performance anxiety is in the life of the pianist David Helfgott, about whom the movie, *Shine*, is based. David’s father was a concentration camp survivor and a would-be pianist who both pushed David to perform and undermined him at the same time. You may be familiar with the story. David had a nervous breakdown in the middle of a piano recital in England as a young adult and never fully recovered, ending a promising career. David’s breakdown was probably due to some combination of deep psychological conflict as a result of very mixed messages from his father -- You must succeed but don’t you dare! -- the pressures of the English conservatory and a predisposing biochemical imbalance, at the least.

For the purpose of EMDR, experiences that make a person overly sensitive to issues of competition, envy, rejection, betrayal, loss and abandonment, especially during her formative years, are most likely to contribute heavily to performance anxieties in her adult musical career. Likewise, unfinished issues of emotional separation and individuation from one’s parents can beset the performing musician with overwhelming anxiety about success and failure.

8. (a) **What are the ages of patients being treated for performance anxiety? How early can trauma originate in association with performance anxiety?**

I don’t have data on psychotherapeutic work with child performers in the music world. The earliest age I have heard of in which a child has been treated with EMDR is about two to two and a half years old. Children make wonderful candidates for EMDR for a number of reasons.

First, they haven’t lived long enough to have built up an extensive trauma histories. Second, their immature nervous systems are still developing; the earlier children are treated, the less likely trauma will become embedded. Third, children make good use of imagination. And fourth, there are many inventive ways for clinicians to utilize EMDR for children such as beating a drum in an alternating rhythm for bilateral
stimulation and having children draw pictures of their disturbing experiences and then targeting the pictures.

The EMDR Institute has designed a laminated board with ten faces expressing the saddest feeling to the happiest feeling. Children can better rate their SUDS level (Subjective Units of Distress) by pointing to the picture that best represents how they feel at any given time during the processing.

A great technique, called the “butterfly hug,” was developed especially for young children to help them calm themselves when they become distressed at home or anywhere outside the treatment room. Children as young as two can do the butterfly hug. The butterfly hug is simple. There is no conscious information processing involved. You cross your arms across your chest and tap your shoulders in alternating rhythm.

I’m not sure how a clinician would go about using EMDR for trauma processing with a child who does not yet have language, although some EMDR clinicians claim to have had success with traumatized dogs simply by waving a stick back and forth before the dog’s eyes early after the traumatic event has occurred.

My recommendation for those looking for help for child performers is to seek EMDR-trained clinicians whose primary specialty is working with children and adolescents. It is more important that clinicians have experience working with children and understand their psychological world than that they know how to work with performance anxiety per se. They can always adapt the EMDR protocol for performance issues with children or obtain supervisory assistance but if they don’t have skills in child and adolescent psychotherapy, applying adult techniques “whole cloth” will not help.

Unless the client is an older adolescent, one or both parents (primary caregivers) is always an integral part of child treatment. Children are naturally reactive to the verbal and emotional communications in their households and their caregivers are their authorities and models. Parent involvement is essential to the improvement of their children for obvious reasons.

8. (b) How early can trauma originate in association with performance anxiety?

As early as children have performance demands made on them for which they cannot adequately cope. Trauma can begin in the way a parent holds an infant or gazes at
him or her. The relationship with the parent (primary caregiver) is the child’s first human attachment. The parents (caregivers) are the child’s first mirror. If a parent is overly anxious or depressed herself, the infant learns to internalize the parent’s emotional state or develop some kind of adaptation in attempt to make emotional contact.

The infant who must learn to manipulate to get fed or hugged or cared for when a parent is not appropriately caretaking might be giving his first “performance.” Then, he learns that he is loved and cared for according to the success of how he performs rather than unconditionally for himself. Here is an early template for the development of “imposter syndrome” seen among some performing musicians, those who feel like frauds masquerading as talented artists, living in fear that their “secret” will be discovered and disqualify them from the profession.

Remember, though, that there is a lot of living that happens between birth and adulthood. One’s infancy doesn’t necessarily predict one’s future. It’s the constancy of the absent or negative mirroring during childhood that consolidates maladaptive patterning in the growing child. But parents can mature with experience and children can develop relationships outside the home that compensate them to some degree. A relationship with an affirming music teacher can be essential in helping a child with this background build self-confidence.

9. Are there EMDR clinicians who specialize in performance anxiety? (How can referrals for children and adolescents be obtained?)

If you are asking how a performing musician can obtain a referral to an EMDR-trained clinician with competence working in the area of performance anxiety, here are my suggestions:

Call the EMDR Institute in Pacific Grove, California at 831/372-3900 or the EMDR International Association in Austin, Texas at 512/451-5256 and make a specific request. Both organizations maintain lists of certified EMDR practitioners by city and state on their websites, EMDR.com and EMDRIA.org, respectively, but the practitioners’ specialities are not listed. Likewise, if you are looking for a child/adolescent practitioner, you may call these organizations.
The EMDR Institute sponsors a members’ listserv on which referral requests are posted every few days. You may ask the Institute whom to contact to post your request on the listserv. The general format is to provide your city and state; your gender and age; your mode of payment (self-pay, insurance plan, sliding scale fee); a few words about the nature of the problem (“musician with performance anxiety”, “seeking help for a child with musical performance anxiety”); any specific requirements you have about the practitioner (female, male, very experienced with performance issues, etc.) and an email address or telephone number where you may be contacted.
CONCLUSION

The role of anxiety within the realm of performance can be viewed as either assisting or disrupting the individual performer. Practically every performer has experienced some level of performance anxiety of one form or another throughout their lifetime. Many artists state that if they do not experience a slight degree of nervousness before a performance, they feel as if something is wrong and that they may not perform well. They depend on the heightened state of awareness in order to remain alert and focused on the task at hand. However, when the level of anxiety begins to chronically disable an individual’s performance, there may be a pathological cause and some professional treatment may be necessary to alleviate the situation.

Stress is one of the leading contributors to performance anxiety. According to Hans Seyle, in his book “The Stress of Life”, 48 stress can be described as disrupting the emotional and/or physiological homeostasis through the influence of a “stressor.” This “stressor” is an influence on any individual that causes tension, anxiety, or overall disruption of homeostasis. This type of stress can come from either an external source (dangerous situations, disturbing individuals or events, etc.) or an internal source (negative thoughts, feelings and perceptions). An individual’s response to any threatening situation, whether psychological or physical, is guided by their autonomic nervous system. The sympathetic branch of the central nervous system governs the well-known “fight or flight” response, while the parasympathetic branch guides the lesser-known “freeze or faint” response. The sympathetic branch produces the body response that enhances the body’s defense mechanism: increased heart rate, blood pressure, pupil dilation, perspiration, bronchial dilation and a decrease in renal output and gastrointestinal activity. The parasympathetic system opposes many of the actions of the sympathetic system and tends to be predominant during periods of calm. Reducing the level of the sympathetic branch while increasing the parasympathetic system is the strategy of many stress reduction techniques. 49 The perceived threats or “stressors” that

activate the heightened arousal in a singer are typically not physical in nature. Teachers, peers, judges, and relatives are constantly assessing the singer’s talent, artistry, and musical skills, and the more refined a singer becomes through years of study, the higher the level of scrutiny and fear of failure. Singing is a very personal act at any level. Therefore the constant pursuit of excellence through both internal and external judgments of one’s abilities can create a great deal of fear and anxiety toward one’s performance. The human nervous system perceives psychological threats in the same manner as any physical dangers, and reacts with the same heightened physiological arousal. Through this state of arousal, the singer becomes more sensitive to his/her environment, many times obsessing over past mistakes and negative experiences. This coupled with the worry of peer or teacher approval can create a negative cycle of debilitating thoughts, feelings, and emotions directed toward his/her performance. A singer’s negative inner self-talk regarding his/her performance expectations is the primary component in sustaining the heightened arousal mode.

The cognitive component (perception of threat) is central because it activates the autonomic arousal system and informs it about the degree of danger associated with the threat. The autonomic nervous system is merely responding to the threat, as it is perceived, and the intensity of the autonomic response accords with the degree to which the event is believed to be threatening. To the extent that singers exaggerate or “rehearse” threatening aspects of their performance, their bodies will respond naturally by upping the ante of arousal-inducing hormones.

Many self-help books deal with performance anxiety by addressing the negative inner voice or self-talk. They attempt to describe ways to recognize our negative self-talk and change it to a more positive cognition. This self-talk was termed The Pathological Critic by psychologist Eugene Sagan. The critic is extremely judgmental of everything an individual says or does, blaming him/her for things that go wrong, comparing himself/herself to others, and calling him/her names such as ugly, stupid, untalented, weak, etc. People with very low self-esteem tend to have more intense pathological critics. We begin to develop the voice of our inner critic at a very early age as our parents

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begin to teach us what is acceptable behavior through praise, and what is unacceptable behavior through punishment.

All children grow up with emotional residues from the forbidding gestures (punishment). They retain conscious and unconscious memories of all those times when they felt wrong or bad. These are the unavoidable scars that growing up inflicts on your self-esteem. This experience is also where the critic gets his start, feeding on these early “not-OK” feelings. There is still a part of you willing to believe you’re bad just as soon as someone gets angry with you, or you make a mistake, or you fall short of a goal. That early feeling of being not-OK is why the critics attacks seem to fit in so well with what you already believe about yourself. His voice is the voice of a disapproving parent, the punishing, forbidding voice that shaped your behavior as a child. 51

The voice of the inner critic is extremely vitriolic and is “more poisonous to your psychological health than almost any trauma or loss. That’s because grief and pain wash away with time. But the critic is always with you—judging, blaming, and finding fault. You have no defense against him. ‘There you go again,’ he says, ‘being an idiot.’ And you automatically feel wrong and bad, like a child who’s been slapped for saying something naughty.” 52

The inner negative critic is a persistent evil in regard to one’s attempt at overcoming performance anxiety, while the discovery of the critic’s roots is the answer to full recovery. EMDR is based on this notion and “regards most pathologies as derived from earlier life experiences that set in motion a continued pattern of affect, behavior, cognitions, and consequent identity structures.” 53 An individual can be aware of, and observe his/her negative critic toward performing, but not understand its origins. EMDR states that earlier traumatic life experiences become locked into one’s nervous system in a state-specific form. This event is stored into its own neuro-network and is unable to be accessed through traditional talk therapy or self help books. When a singer suffers from performance anxiety, the Central Nervous System, or fight or flight response is activated and a heightened state of arousal is experienced. This state of arousal can intensify a

52 McKay and Fanning, Self-Esteem, 16.
singer’s awareness of mistakes during past performances, which increases fear of a current performance, thereby creating a debilitating loop. The singer’s self-critic steps in and attempts to reduce his/her anxiety level, either through positive or negative self-talk. The negative self-talk is the dangerous kind, stating, “I’m not that talented, so it’s ok to screw up” or “I really don’t like this repertoire.” By devaluing his/her talent or the content of the work produced, a performer reduces the level of anxiety. This is only one example of negative reinforcement to reduce one’s anxiety. However, the goal of EMDR is to go to the root of the underlying negative cognition and reduce its level of disturbance while increasing the positive cognition regarding one’s self or the traumatic event. The clinician and patient choose a negative cognition to target that best represents the issue at hand, in this case, performance anxiety. The target does not necessarily need to be related to performing, but can be a starting point for treatment. Through the dual stimulation of the guided eye movements or other stimuli, and the recalling of the negative cognition, the neuro network in which the trauma is stored can be accessed and desensitized while a more positive cognition can be inserted into the individual’s mind. However, many times a patient must also confront the issue of secondary gains such as increased attention from loved ones, or financial compensation. “If the patient makes effective use of the treatment strategies, what might be expected of him or her? Where might success lead? Is he or she ready to go on to the next phase in a performance career, or does it remain safer to be immobilized? Which problem is honestly more terrifying: the symptom of performance anxiety or the possibility of success? What would be the consequences of resolving the immobilizing performance anxiety? The patient is asked to imagine a life in which the problem is no longer present.” 54

One of the more beneficial elements of using EMDR is the speed at which patients recover. EMDR’s success rate varies depending on the severity of the trauma, the number of years between the event and treatment, and the susceptibility of the patient. However, according to several studies, EMDR has a success rate between 80 to 90 percent in three 90-minute sessions or less. EMDR is a client-based treatment, which allows the patient to feel safe and comfortable during treatment. Though the clinician

must take a full patient history before beginning EMDR treatment, it is not necessary for the patient to disclose the details of the memories that might surface during a session. As long as the patient can visualize and feel the intensity of his/her memories during treatment, the clinician will generally not ask for any specific details.

EMDR works on the idea that there is an innate information-processing system within all human beings that moves us toward a state of mental health similar to the way our bodies heal from physical injury. If for some reason the system becomes unbalanced due to the event of a trauma, dysfunctional responses may occur. A trauma can be either classified as a big “T” trauma or little “t” trauma and becomes locked into the nervous system. EMDR, through the dual attention stimulation (eye movements and recalling of targeted memory) is able to bridge the gap between the stored traumatic event and positively stored information that will help process the dysfunctionally stored material.

EMDR is still in its infancy in comparison to other forms of psychotherapy. However, over the past 15 years it has helped millions of patients find relief. On the other hand, it has also received a great deal of criticism as being an unsubstantiated, unproven, and scientifically suspicious form of therapy with no evidence of positive treatment in regard to the eye movements. Whichever side one may favor concerning this matter, the important issue is that EMDR is an integrative psychotherapy approach that is helping people of all ages and backgrounds. As with all psychotherapies, only trained clinicians and therapists should employ the treatment technique, and with the highest level of responsibility and professionalism. This paper is intended to expose EMDR and its general characteristics to thousands of singers and musicians as another option in the treatment of performance anxiety. In cases where a singer’s anxiety is crippling to the point of adversely affecting his/her ability to perform, EMDR can be a valuable and effective step to recovery.
APPENDIX A

A LIST OF POSSIBLE NEGATIVE AND POSITIVE COGNITIONS

Negative Cognitions

I don’t deserve love.
I am a bad person.
    I am terrible
    I am worthless.
    I am shameful.
    I am not lovable.
I am not good enough.
I deserve only bad things.
    I am ugly.
    I am stupid.
I am insignificant/unimportant.
    I deserve to die
    I don’t belong.
I deserve to be miserable
I should have done something.
    I did something wrong.
I should have known better.
    I cannot be trusted.
    I cannot trust myself.
    I cannot protect myself.
    I am in danger.
I cannot stand up for myself
    I am not in control.
I am powerless/helpless.
    I am weak.
I cannot get what I want.
    I am a failure.
    I cannot succeed.
I have to be perfect/please everyone.
    I am inadequate.
    I cannot trust anyone.
Positive Cognitions

I deserve love.
I am a good person.
I am fine as I am.
    I am worthy.
I am honorable.
    I am lovable.
    I am deserving.
    I deserve good things.
    I am healthy.
    I am fine / attractive.
    I am intelligent.
    I am significant.
    I am okay just the way I am.
    I deserve to live.
    I deserve to be happy.
    I did the best I could.
    I learned (can learn) from it.
    I do the best I can.
    I can be trusted.
    I can trust myself.
    I can trust my judgment.
    I can choose whom to trust.
    I can take care of myself.
    It’s over; I am safe now.
    I can safely feel / show my emotions.
    I can make my needs known.
    I can choose to let it out.
    I am now in control.
    I now have choices.
        I am strong.
    I can get what I want.
        I can succeed.
        I can be myself.
    I can make mistakes.
        I can handle it.
        I am capable.
APPENDIX B
A LIST OF CRITERIA FOR A THERAPIST TO BECOME CERTIFIED IN EMDR.

1. The completion of an EMDRIA (EMDR International Association) approved basic training program in EMDR. (18 hours didactic and 13 hours of practicum experience)
2. Hold a license, certification, or registration as a mental health professional independently providing services.
3. Provide documentation of at least 2 years’ experience in the mental health field.
4. Document the providing of a minimum of 50 EMDR sessions to at least 25 clients.
5. Provide documentation that s/he has received 20 hours of EMDR consultation from an Approved Consultant in EMDR.
6. Provide a letter or letters addressing the quality of the applicant’s use of EMDR from each Approved Consultant in EMDR whom the applicant utilized for consultation.
7. Provide two letters of recommendation regarding the ethics in practice and professional character of the applicant.
8. Provide documentation of having completed at least 12 hours of EMDRIA credits (continuing education in EMDR) within the past 2 years.

* It is very important for a patient to understand a clinician’s background and training in EMDR in order to receive professional and thorough treatment.
APPENDIX C
EMDR RESOURCES

EMDR International Association  EMDR Humanitarian Assistance Program
P.O. Box 141925  136 South Main Street, Suite 1
Austin, TX 78714-1925  New Hope, PA 18938
USA  or
Telephone: (512) 451-5200  P.O. Box 52164
Fax: (512) 451-5256  Pacific Grove, CA 93950
Web site: www.emdria.org  Telephone: (215) 862-4310
E-mail: emdria@aol.com  Fax: (215) 862-4312
Web site: http://www.emdrhap.org
E-mail: HAPnewhope@aol.com

EMDR Institute
P.O. Box 51010
Pacific Grove, CA 93950
Telephone: (831) 372-3900
Fax: (831) 647-9881
Web site: www.EMDR.com
E-mail: inst@EMDR.com
APPENDIX D

Human Resource Informed Consent Form and IRB Approved

Informed Consent Form
For
Raymond Feener’s Doctoral Thesis
EMDR: A New Method in the Treatment of Performance Anxiety

I freely and voluntarily and without element of force or coercion, consent to be a participant in Raymond Feener’s thesis entitled, EMDR: A New Method in the Treatment of Performance Anxiety. I agree to be interviewed by Raymond Feener in the form of answering a list of questions pertaining to his thesis topic.

Raymond Feener, a doctoral candidate at the Florida State University School of Music, is conducting this research. I understand the purpose of his thesis is for its readers to better understand the use of EMDR therapy with musicians with performance anxiety. The list of questions will deal with several aspects of EMDR and the intricacies of its application from the professional therapist’s point of view.

I understand that I will be asked to answer a list of 10 questions in an interview format. I understand that the requested deadline for me to respond is April 1, 2004. I also understand that my participation is totally voluntary and I may stop participation at anytime. I understand that my name will appear on the thesis.

I understand there are benefits for participating in the project and answering the listed questions. The information collected in the thesis will help to educate many individuals who need another option to help treat their performance anxiety. EMDR therapy is a fairly new treatment and this thesis will help to expose its benefits to the world.

I understand that this consent may be withdrawn at any time without prejudice or penalty. I have been given the right to ask and have answered any inquiry concerning the thesis and the interview questions. Questions, if any, have been answered to my satisfaction.

I understand that I may contact Raymond Feener, 740-698-0101, for answers to questions about this research or my rights or contact the Human Subjects Committee, 850-644-8633.

I have read and understand this consent form.

(Signature)                                          (Date)

Contact Information:
Telephone: 212-721-2429
E-Mail: Eicarni@aol.com

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Office of the Vice President For Research
Human Subjects Committee
Tallahassee, Florida 32306-2763
(850) 644-8673 · FAX (850) 644-4392

APPROVAL MEMORANDUM

Date: 2/12/2004

To: Raymond Feener
   4166 Chesser Rd
   Albany, OH 45710

Dept.: Music

From: John Tomkowiak, Chair

Re: Use of Human Subjects in Research
   Interview with Dr. Ellen Corni-Licensed Therapist in New York

The forms that you submitted to this office in regard to the use of human subjects in the proposal referenced above have been reviewed by the Secretary, the Chair, and two members of the Human Subjects Committee. Your project is determined to be Exempt per 45 CFR § 46.101(b) 2 and has been approved by an accelerated review process.

The Human Subjects Committee has not evaluated your proposal for scientific merit, except to weigh the risk to the human participants and the aspects of the proposal related to potential risk and benefit. This approval does not replace any departmental or other approvals, which may be required.

If the project has not been completed by 2/11/2005 you must request renewed approval for continuation of the project.

You are advised that any change in protocol in this project must be approved by resubmission of the project to the Committee for approval. Also, the principal investigator must promptly report, in writing, any unexpected problems causing risks to research subjects or others.

By copy of this memorandum, the chairman of your department and/or your major professor is reminded that he/she is responsible for being informed concerning research projects involving human subjects in the department, and should review protocols of such investigations as often as needed to insure that the project is being conducted in compliance with our institution and with DHHS regulations.

This institution has an Assurance on file with the Office for Protection from Research Risks. The Assurance Number is IRB00000446.

Cc: Doug Fisher
   HSC No. 2004.061


Wylie, M. S. “Going for the Cure.” *Family Therapy Networker* 20/4 (July/August 1996)
BIOGRAPHICAL SKETCH

Raymond Feener is currently an Assistant Professor of Voice and Director of the Singing Men of Ohio at Ohio University. Mr. Feener received his Bachelors degree in Choral Education and Masters degree in Vocal Performance from Ohio University. Prior to receiving his Masters Degree, Mr. Feener was the High School and Jr. High Choir Director and general music teacher for the Monroeville Local Schools in northern Ohio.

Over the past ten years he has been pursuing a teaching and performance career. He has appeared professionally with the Dorian Opera Theatre, Sarasota Opera Company, Lake George Opera Festival, Columbus Light Opera, the Lancaster Festival, and Theatre Lancaster. Mr. Feener also performed with the Opera Theatre of Lucca, in Lucca, Italy in 1998. He has also appeared as a soloist with the Ocean City Pops Orchestra in New Jersey, the Lancaster Chorale in Lancaster, Ohio, and in Macon, Georgia performing both the Durufle and Faure Requiem solos. Mr. Feener’s recent 2003 engagements include Schubert’s Mass in G, Brahms’ Requiem, Ralph Vaughan William’s Five Mystical Songs, as well as the role of Ping in Puccini’s Turandot in July at the Lancaster Festival in Lancaster, Ohio.

A sample of Mr. Feener’s roles include: Malatesta in Don Pasquale, Figaro in Il barbiere di Siviglia, Yamadori in Madama Butterfly, Giuseppe in The Gondoliers, Captain Corcoran in H.M.S. Pinafore, Strephon in Iolanthe, A Man with a Shoe Sample Kit in Postcard from Morocco, Papageno in The Magic Flute, the title role in Gianni Schicchi, Baron Zeta in The Merry Widow, Martin in A Grand Night for Singing, Marcello in La bohème, Baron Duphol in La traviata and the title role in Gazzaniga’s Don Giovanni.

Mr. Feener recently served on faculty at the American Institute of Musical Study in Graz, Austria. He was the stage director for the AIMS Festival Orchestra Concerts of scenes from Fidelio and Carmen throughout Austria, as well as concerts featuring spanish art song. Mr. Feener was recently accepted into and completed the 2003 NATS Internship in Fredonia, New York, where he had the opportunity to work with Master Teacher Judith Nicosia. He is also serving a 3-year term on the board of the NATS Buckeye Division.
Mr. Feener has also had the opportunity to perform in master classes with Marilyn Horne, Phyllis Curtin and Craig Rutenburg as well as coachings with Stanford Olson and Lorenzo Malfatti.