EMDR UK & IRELAND

EMDR now

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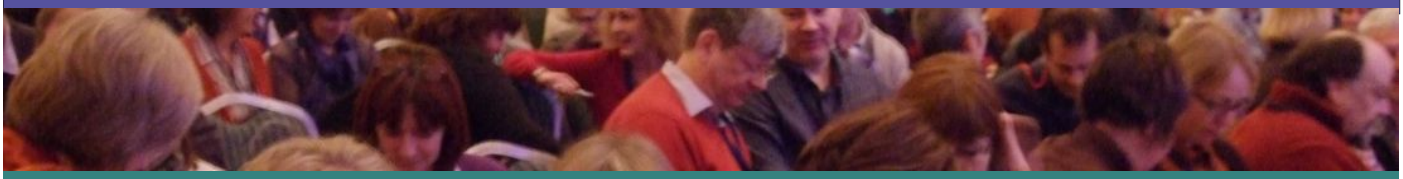

Newcastle 2013: Annual Conference highlights inside

Helping young people make sense of BLS

Russell Wharton finds a way round adolescent skepticism about safe place installation

When I first started using EMDR with adolescents I found installing the safe place testing. While some young people were perfectly happy to give the safe place a go, many seemed to find it all a little 'airy fairy'. There were those that would give it a go but their self-consciousness seemed to block any therapeutic effect.

I attempted various strategies to get them on board. I tried colluding with the 'airy-fairy' view. "I know it seems a bit woolly" I'd say, "but it does work for lots of people." Then I tried playing around with various methods of bi-lateral stimulation as if that was the problem - iPhone apps, light bars, hand buzzers. Still the predicament persisted - some adolescents simply didn't buy the safe-place.

It occurred to me that if the young person understood how the safe place worked then they may be more inclined to give it a go. I thought about Crystal healing and how this makes no sense to *me* because I simply can't see *how* it can work.

I printed a diagram of a central nervous system from Google images. I explained that when our hand touches a surface, a signal is sent from that surface through the central nervous system to the brain. I demonstrated this by drawing a line from the hand, up the central nervous system to the left and right hemispheres on my diagram. I described it as a little like turning a light switch on and off. When the switch goes down, a signal is sent through the wires in the wall to the bulb, causing it to light up.

Tapping the arms of the chair bi-laterally, I explained that each time my hand came into contact with the chair arm; a signal was sent to either the left or the right side of my brain. By doing this slowly, it helps the brain connect with what we are thinking and feeling in a positive way.

Explaining the biological process using a CNS diagram has made me far more successful in safe-place

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New Special Interest Group for Depression

Although EMDR has been widely recognised as an effective treatment for PTSD, many of us have found it effective for many other mental health problems as well. Depression, like PTSD, is often associated with negative life events; traumatic incidents that can have a detrimental effect on our state of mind. We know that when these traumatic events lead to PTSD, EMDR is very effective at targeting the memory that continues to traumatise long after the event so it is reasonable to assume that this same mechanism may help to treat depression as well. I hope that the EMDR and Depression Special Interest Group (SIG) will bring together people with an interest and expertise in this area:

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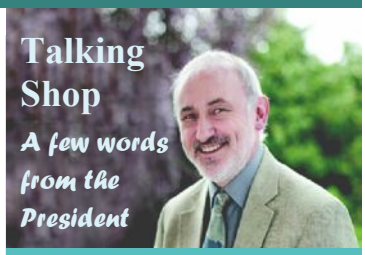

At the recent Annual Conference Workshop on EMDR and Attachment, Sandi Richman reminded me of my favourite way of understanding different attachment styles: someone with a Secure Attachment can both *feel* (access emotions) and *deal* (take action to adapt to situations). Individuals with an Avoidant Attachment can deal but don't feel. With an Ambivalent Attachment they can feel but don't deal. And individuals with Disorganised Attachment neither feel nor deal (Diana Fosha, 2000).

It struck me after the workshop how important it is for us as therapists to both feel and deal in our therapeutic work. It is vital that we can get in touch with the client's emotions. I don't mean that we should be swept away by our client's emotions but we should, in some way, be able to acknowledge what they are feeling whilst keeping our own sense of self and the fact that we have some

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responsibility for keeping them safe. But if, as therapists, we only feel and don't deal, we are not helping our clients change, move on and process their traumatic memories. So we also need to be able to *deal* as therapists and actually work with our clients on helping them to change.

Some therapies (mentioning no names!) seem to work only with feelings whereas others seem to work only with practical solutions and ignore the underlying feelings. With EMDR however, we get right in there and help the client *feel* by locating the trauma or touchstone event that is at the core of their problems and its accompanying cognition, emotion and felt sensation. But we also help them to *deal*, initially by immediately anticipating change with that PC question of 'what would you prefer to believe about yourself now?' And the whole idea of 'processing' indicates that EMDR involves helping the client to deal with their problems whilst staying connected with the feelings that they evoke. Thus the EMDR protocol builds in both feeling and dealing and as therapists we just need to be able to make that happen. As therapists, then, it is also important for us to look at our own attachment style and how this may help or hinder the therapeutic process.

My massive *Handbook of Attachment* (Cassidy & Shaver, Eds) informs me that not only are securely attached clients better able to make use of psychological therapy, securely attached therapists are better able to deliver it. Research shows that the securely attached therapist is less likely to become sucked into their client's attachment style and can be more flexible in, for example, responding 'out of style' by gently challenging a client who 'deals' to *feel* a bit more.

A study of clinical psychologists in the UK showed that 70 per cent described themselves as having a Secure Attachment (i.e. higher than the average for the population which stands at about 55 per cent). I know many psychologists and I think there might be some wishful thinking in this statistic! I wonder if many therapists, like me, are dealers rather than feelers and need to acknowledge this limitation if they are to respond appropriately to their clients.

However there are advantages and disadvantages to every attachment style bearing in mind that they develop, in the first place, as the child's most adaptive way of coping with the world. I was brought up with a (deal/don't feel) Avoidant Attachment and I don't seem to have a problem with tolerating my clients' emotions even where there is a heavy abreaction. Perhaps it is because I am emotionally cut off that I am less affected by it. It's important, however, that I am aware of this. To quote John Bowlby's son, Richard (whom I once had the pleasure to meet) when referring to his father's traumatic separation from his nanny at the age of four, he was "sufficiently hurt to feel the pain of childhood separation – but not so traumatised that he could not face working with it on a daily basis".

So when things seem to be getting knotted up in therapy or you are puzzled as to what is going on between you and your client, just ask yourself two questions: What is my client's attachment style and what is mine? Your answers may just help you to unravel the knot.

With best wishes,
Dr Robin Logie,
President

installation with adolescents. Setting the tempo by tapping my own chair arms also seems to make the young person less self-conscious (many will ask their parents to join in with the tapping if they are present). I feel that self-administered taps also foster autonomy; the young person experiences self soothing.

Pushing the idea further, I have also encouraged the young person to focus on their cue word (written in a colour and temperature of their choice), "gently moving left to right in your mind" to reinforce the notion of bilateral stimulation. I have used the metaphor of Atari Tennis to illustrate this. Unfortunately this is a cultural reference that resonates with adult clients, but is lost on the under-30s. I shared this reflection with my EMDR supervisor who rightly points out, the Atari metaphor is also very much lost on the over-50s – back to the drawing board with that one then.

Russel Wharton is a EMDR Europe approved practitioner,. He is a BABCP accredited CBT Therapist and a mental health Nurse with an interest in adult survivors of abuse. He works for the Norfolk and Suffolk NHS Foundation Trust within CAMHS and in private practice.

- Encouraging members to present both practice based evidence and research evidence at conferences and workshops, including those which are dedicated to EMDR and those that are not.
- Connecting EMDR therapists from around the world with a common interest in the treatment of depression via a Linked In Group, by liaising with the EMDR Europe SIG for depression and other international organisations sharing our interests.
- Promoting research into EMDR as a treatment for depression.
- Being a resource for researchers, EMDR therapists and anyone else with an interest in learning more about the use of EMDR with depressed patients.

The SIG has not yet been formally approved by the EMDR Association of UK&I Board but the process has begun. Formal aims and objectives will be agreed by the membership of the SIG. If you are interested in becoming a member you can contact me in the following ways

emilywood101@yahoo.co.uk
http://www.linkedin.com/pub/emily-wood/54/a77/854
or via the EMDR and depression Linked In group.

Emily Wood is a mental health nurse and EMDR therapist from Sheffield; she is currently studying for a PhD in Health Service Research at the School of Health and Related Research at the University of Sheffield, investigating the use of EMDR with long term depression.

The first cut is the deepest: EMDR and attachment repair

Omar Sattaur reports on Mike O'Connor's and Sandi Richman's one-day, joint presentation for the Association's Annual Conference Workshop held in early March in Newcastle

The attachment style we established as babies and infants affects the way that we cope with life stresses for the rest of our lives. Much of our work as therapists centres on effecting attachment repair. In their engaging presentation Mike and Sandi gave an overview of the theory of attachment and its relevance to EMDR practice.

Omar Sattaur

Mike O'Connor gave a run down of attachment styles

Mike began the 4-session workshop with a video of Ainsworth's Strange Situation experiment which clearly showed the behaviour associated with what has come to be known as secure, avoidant, ambivalent and disorganised attachment styles. If you have not seen these videos, it is well worth a search on YouTube. He followed this up with an overview of current research supporting Bowlby's original formulations.

The power of these early attachment experiences in shaping our interactions with others was brought home to us when Mike asked us to participate in some action research. We had to pair up, one person spoke, whilst the other listened. In the second half of the exercise, the speaker played the same role but this time the partner had to look away, as if ignoring the speaker. Try this with a friend and pay attention to whether the loudness and/or tone of the speaker's voice changes in part two. But pay special attention to how, as speaker, you feel when the other person is not listening. An interesting observation was the impact of psychoactive drugs on pupil dilation or contraction and the potentially confusing messages this can give to the young infant or baby. In attunement and bonding, dilated pupils *should* signal caregiving behaviour, but reacreational drugs often affect pupil dilation. It is possible therefore that a mother's pupils may be dilated by recreational drugs, but she may not be exhibiting caregiving behaviour, and vice versa.

In Session 2, Sandi showed us how the attachment styles above correspond to internalised adult narratives: Secure to Secure, Avoidant to Dismissing, Ambivalent to Preoccupied and Disorganised to Unresolved/ disorganised narratives. Sandi went on to show how these internal narratives manifest or influence the various stages of the EMDR protocol. It is particularly striking in history taking: an adult with a secure narrative is able to make sense of the past, which is presented as a coherent story. The individual is able to both access and regulate emotion while relating their story and feels okay about themselves. Sandi cited the work of Diana Fosha in summarising the correspondence between attachment styles, internal adult narratives and their influence on the way an individual talks about their past (see Box).

As might be expected, these styles impact on history taking, preparation, assessment and processing phases. For example, a disorganised client will offer contradictory information during history taking, a dismissive client will often reject RDI and a preoccupied client may find it hard to settle on one NC and one PC.

In Session 3, Mike showed touching video material of work with children in attachment repair using EMDR. He

showed how, when working with children, procedural steps might differ but treatment phases remain the same. In a case study of 9-year old 'Paul' who had a long-standing history of neglect and abuse, PTS symptoms, a history of disorganised attachment, Mike showed how through the use of story in an EMDR framework, repair was possible. He explained how the story can be structured to follow the main elements of the standard EMDR protocol and how the story corresponds to the EMDR three-pronged approach of processing past, present and future scenarios. We saw how, after installation of a safe place, Mike read a story he had written for Paul, which helped the boy to reframe his trauma experiences and strengthen links with his present carers. We saw the child in the lap of his uncle, who patted Paul's tummy (BLS) whilst Mike read the story. It was fascinating watching the change in affect and signs of attachment behaviour as the story moves from trauma to recovery.

In the final session, Sandi presented research evidence for the efficacy of EMDR in attachment repair in adults and children. The workshop gave participants plenty to think about, particularly the importance of assessing a client's attachment style at the outset as it is so influential for each of the EMDR phases. You can access these thoughtful and thought provoking presentations from the 'Delegates section' of the Association website (user name: attachment; password: trauma).

Omar Sattaur

Sandi Richman: EMDR and attachment repair in adulthood

Infant Strange Situation Behaviour	*Adult Narrative*	*Characteristics (Diana Fosha)*
Secure	**Secure**	• Affective competence • Feeling and Dealing (while relating) • Capable of auto- and interactive regulation • 'I'm ok'
Avoidant	**Dismissing**	• Not feeling but dealing • 'Goes on automatic', eradicating feelings in order to cope • Less capable of interactive regulation • 'I'm FINE. Really!'
Ambivalent/ Resistant	**Preoccupied**	• Feeling but not dealing • Being overwhelmed with feeling and unable to cope • Capable of interactive regulation but not easily soothed • Less capable of auto-regulation • 'I'm dying, help!'
Disorganised/ Disoriented	**Unresolved/ Disorganised**	• Not feeling and not dealing • Alternates between hyper- and hypoarousal • Not capable of auto- or interactive regulation • 'I'm not sure'

Attachment styles, characteristics and adult narratives

EMDR in the treatment of chronic pain

Do we target pain or the trauma that caused it? What form of BLS is most effective and how long should each set last for? Michael Tidbury heard these, and many other questions, addressed at Mark Grant's workshop on Chronic Pain, held at the Friends Meeting House in London in November 2012

Mark presented several *in vivo* videos (one was 15 years old) and it was possible to see the protocol developing over time. He had worked 'on the ground' in trauma situations abroad and in his clinical facility.

Mark has empirically adapted Francine's standard protocol over a period of more than 15 years and he described his revised cycle.

He often starts from the perspective of pain rather than trauma. Sometimes it was possible for a patient to feel partial, significant or complete relief from pain without specifically dealing with triggering traumas (even if one was known).

He employs rather pleasant auditory tones delivered through headphones as his bilateral stimulation (BLS). He invites patients to focus on a single point directly in front of them (for instance he would hold up a pen) so that BLS were auditory, without eye movements. His experience has suggested that this enhances pain reduction.

He allows tones to continue for several minutes rather than the standard 24 because he finds that interrupting BLS reduces pain-mediating effects.

He does not always introduce negative (NC) and positive cognitions (PC) since it seems that BLS is sufficient in itself for a patient's experience of pain to reduce. He speculated that this was associated with the distancing effect of BLS – it is difficult for patients to focus on pain with tones at the foregrounds of their minds.

If pain reduces then he uses reinforcing words (i.e. a form of PC) to help the client to be clearly aware of changes. He did, however, bravely present a video of one patient for whom there was no reduction and he indicated that this is unusual and speculated on reasons.

The number of sessions varies with patients. This perhaps reflects our own experiences of trauma clients who may have their trauma resolved in a single session or perhaps take many sessions.

Mark said that patients, once relieved of the pain, sometimes did not return for EMDR trauma treatment.

There were some difficulties in sound technology and distribution of correct slide sets was problematic. Mark's open and responsive style of presentation also meant that the agenda was not followed. Some delegates found these elements unsettling. Nevertheless, the content was sound (no pun intended).

Research on chronic pain relief using EMDR is in its infancy and therefore there are no randomised control trials (RCT) available. Mark's work has been bottom-up and evolved on the basis of many hundreds of hours with patients.

I have undertaken a straw poll of some delegates and there is an intention to try out Mark's pain protocol if opportunities arise. Questions from the hall highlighted that chronic pain is something that we all meet from time to time and Mark's ideas provide a model within which we can all work.

John Spector's Q&A

In the interests of confidentiality, names and addresses have been withheld. Please send your EMDR questions to the editor: o.sattaur@gmail.com

Q *When a client is processing they sometimes go on a very long journey which becomes increasingly difficult to see the relevance of. The reported material is still changing but seems more and more irrelevant to the original target or issue. When there are a limited number of sessions are there criteria for deciding more effectively then just waiting, whether the client is off track rather than processing in a complicated way?*

A In Phase 4 (Desensitization) we are guided by the AIP model which is about movement of information. The general principle is that if the information feedback is moving or changing, we stay out of the way and "stay with it" – even when we don't fully understand the relevance of the client's feedback or associations. In contrast to Exposure Therapy, in EMDR clients feedback may often be directed to associated material or channels we have not been aware of or don't at first understand. Some psychodynamic therapists call this "Accelerated Free Association" and it is a legitimate and usually fruitful way of processing.

However, there is one caveat to this. Very occasionally we get a strong intuitive feeling that long and remote feedback is not so much processing as avoidance. This is the exception, and a matter of clinical judgement when you know your client well. But where this appears to be the case, the correct procedure is to take the client back to the original target and to repeat this as necessary till emotional processing is observed.

Q *Could you please clarify the speed of BLS during Resource Installation? I was trained to do it at the same rate as when processing, then later heard it should be done more slowly. I have recently heard that it should be the former. I am confused and would be grateful for an explanation.*

A My observations from supervising confirm your experience of some confusion around this issue, perhaps in part because I note that there is no clear instruction on the *speed* of EMs or BLS during Installation in any of Shapiro's published work. The answer is that the speed of EMs in the Installation Phase is as fast as in processing (Phase 4, Desensitization) because the client should be considered as still processing. However, the sets of EMs or BLS are short (perhaps six to nine back and forth movements) because the main processing work has already been done and we are now primarily interested in installing the Positive Cognition to full strength. If we cannot get the VOC up to a seven or at least a six, then whatever is blocking should be targeted with further sets of BLS because a new unprocessed feeder channel may have been accessed.

Q *What do I do with a client who so strongly represses all memories of past emotions and body sensations that he cannot get in touch with any target traumatic memory in the Assessment Phase (e.g. death of father, aged 4) or via BLS? He remembers being very angry only twice in the past, but only as thoughts, though he is clearly capable of emotions in the present (e.g. anxiety, guilt).*

A The fact that your client can connect with emotions in the present is good news - at least the client is not alexithymic. And let's assume that your client is not very dissociated because that would require a different more cautious approach. Then the best way of getting to old trauma is through present trauma or disturbance. You should take a present trauma or disturbance and take an assessment protocol around it, and then floatback to the first time that the client ever had those experiences e.g. of the anxiety or guilt that you report. Wherever the floatback takes you-start there. If the client cannot locate an earlier thematically linked experience, or one that you think should be relevant, then stay with present disturbance and future template work. Needless to say, you cannot take clients where they do not want to go until and unless they are ready.

Regional News

Midlands Regional Support Group Meeting and Workshop: The EMDR Protocol in depth

Date: Friday 5 April 2013, 9.30 am until 4.30 pm
Venue: Queen Alexandra College, Birmingham, Court Oak Rd., Harborne, Birmingham, B17 9TG
Directions: The 24 bus stop is right outside the College, this can be caught from Colmore Row in Birmingham City Centre. If coming by train, get a taxi from New St. Station. The nearest railway station is Five-Ways from there you can catch the buses: 21, 22, 23 or 24 to Queen Alexandra College, check train times at RailTrack.

Map here: Multimap.com There's a canteen on site. or the Court Oak Pub is just up the road and the Old House at Home also do lunches. Both are within five minutes' walk, or bring your own lunch.
Cost: £20 for EMDR Association members, £30 for non-members.

The Workshop

We will be re-visiting the EMDR Protocol in depth. A group of Consultants have very bravely offered to present the phases of the protocol under the watchful scrutiny of Dr Derek Farrell. This will be a great opportunity to get a really solid grasp of the Protocol.

We will focus on:

1. The AIP model, neurobiological aspects, memory and case conceptualisation
2. History taking, risk assessment and contra-indications (including pharmacology)
3. Preparation and resource building
4. Target sequence planning (including EMD, EMDr, & EMDR)
5. Desensitisation and Reprocessing (including cognitive interweaves and blocked processing)
6. Re-evaluation

There will also be opportunities to network and to develop specialist groups.

Tim Young , EMDR Association UK & Ireland Midlands Regional Representative.
Tel: 01905 354819

These words could be all yours!

Have you got an idea for this newsletter? Have you a burning question to ask? Have you some clinical experience you'd like to share? Did you read an interesting paper or book or attend an interesting meeting that you think readers of EMDR *Now* would like to know about?

If so, then I'd really like to hear from you. We can discuss your idea and I can help guide you on content, word count and style if you wish. Write to Omar at: **o.sattaur@gmail.com** I'd love to hear from you!

This space could be all yours!

EMDR *Now* reaches all members of EMDR Association UK & Ireland. We aim to publish four quarterly issues per year and consider advertisements relating to: book sales; EMDR equipment for BLS; courses and workshops relating to EMDR and conferences on mental health. Adverts for events organised by EMDR Association (including Regional Groups, Sections or Special Interest Group Events) and HAP UK & Ireland are free of charge. All other adverts are charged at the following rates (subject to increase): one-quarter page at £50 and one-eighth page at £25. Deadlines for adverts are: Winter: 1 January; Spring: 1 March; Summer: 1 June; Autumn: 1 October.

EMDR Wales inaugural conference: Combining EMDR with other psychotherapeutic modalities

Date: Friday 17 May 2013
Venue: Paradise Farmhouse, Presteigne, Powys, Wales, LD8 2NH
Food: Bring and Share lunch. Coffee/tea – provided by Paradise Farmhouse. **CPD Credits:** 4
Schedule:
10:00 - 10:30 Arrival/signing in time to meet, greet, refreshment.
10:30 - 11:30 Session 1: Karen Beswick – EMDR and the use of Art Therapy. Techniques with Adults and Children
12:00 - 13:00 Session 2: Diane Cook/Sue Thorogood – EMDR with Eating Disorders and Trauma
13:00 - 14:30 Lunch and time for walking around the lovely woods and grounds
14:30 - 16:00 Session 3: Gloria Howard/Tania Dolley/Sally & Richard Worthing-Davies - EMDR and Family Therapy with Parents and Children
16:00 - 16:30 Reconvene – Tea/Coffee, Discussion and Feedback before finishing at 16:30.
Cost: £25 Bookings, payment: to Annette Wyndham. Annettew67 @hotmail.co.uk
For more information: sally@familytherapy.uk.com or call 01793 642702

Success for Northwest mini conference

EMDR North West Region's Inaugural Mini-Conference took place on a cold January day in Manchester. David Blore presented his research on Post Traumatic Growth and Positive Psychology. A lively question & answer session with an expert panel including Robin Logie and Lynn Keenan followed. Lieutenant Matt Wesson shared experiences of using EMDR with military personnel, giving a touching case study. It was good to hear that EMDR is increasingly recommended by other nations to help military victims of trauma. The conference was a big success, raising £155 for HAP.

Elaine Beaumont