EMDR*now*

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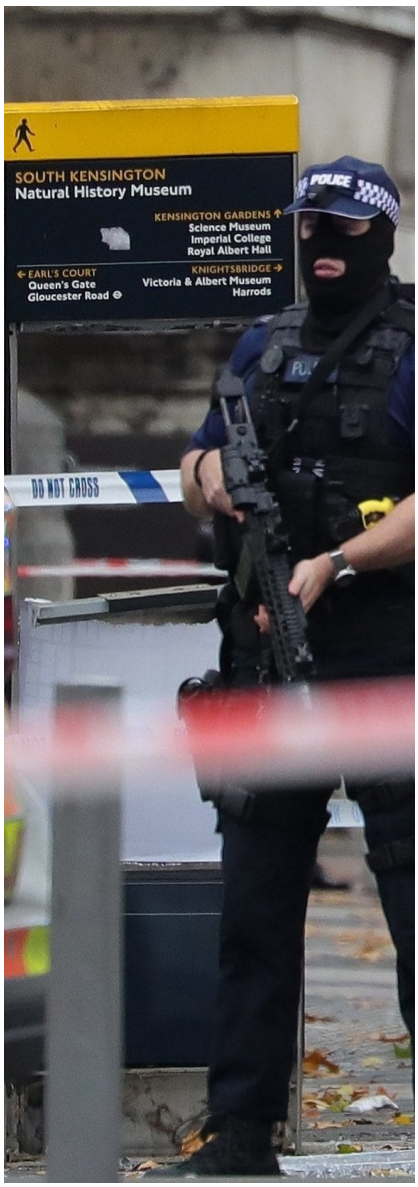
Early intervention training gets 'up close and personal'

Clinicians attending a two-day training event at Imperial College in Central London on Saturday 7 October 2017 on how to respond to mass trauma events were shocked when one took place just a short walk from the training venue. Eleven people were injured when a car ploughed into them in a road traffic accident - initially suspected to be an act of terrorism. Colin Brazier was there

What are the chances of being traumatised by a random event and receiving trauma training and treatment in the same day? During the lunch break, I was out and about in Central London and had the harrowing experience of getting caught up in what was initially suspected to be a terror attack. Soon afterwards, at the R-TEP/ G-TEP training event and to the sound of nearby ambulance sirens and police helicopters, I had the good fortune of receiving treatment from an excellent practicum team overseen by Soraia Crystal. This team had only just learnt the theory of R-TEP before the lunch break - yet they were able and brave enough to practise on a real, fresh active trauma, within an hour of the event!

I had unwittingly arrived on the scene seconds after a black car had left the road and ploughed into a crowd of tourists queuing outside the Natural History Museum. I was badly shaken by what I had witnessed.

The crowd had scattered



Armed policeman outside the Natural History Museum

in panic, some people falling and getting trampled, several people displaying obvious bodily injuries. I did my best to usher a few of the fleeing pedestrians through a side gate into the garden of the museum where it seemed safer, before calling the police. I understood from the police that I was one of the first to report the incident. At the same time I was scanning for men with knives/guns/ suicide bombs. I remember being curious that I was not feeling any fear. I then continued to the training venue, walking through the wreckage of three cars and several people with injuries who had been unable to escape. I vaguely saw other people lying down, and it occurred to me in that moment that they could be dead. A solitary uniformed policeman was standing close by, frantically shouting for people to get away as there may be 'another wave' of attack. I saw a man (was he the terrorist, I wondered) being held down by a larger man. I remember hesitating, as memories of my time as a war journalist resurfaced. I felt an urge to assist and to document what was happening, but I decided to heed the policeman's instructions and move away.

My life is different now. I have a wife and seven-year-old daughter and I wanted to get home to them safely. I reasoned that the emergency services would no doubt be there at any moment. As I passed beyond this scene, I tried to divert pedestrians away from the area towards safety, but there were scores of people and only me doing this. After a while I desisted. At this point the shock and fear kicked in and I struggled to hold it together. I wanted to burst into tears, but forced myself to just get back to the training. As I arrived at the conference venue, Sian Morgan, President of Trauma Aid UK kindly attended to me at the door to our room. I was unable to make any sense of Elan Shapiro's words nor what I could see on the power point slides.

Images of the injuries I had seen were randomly flashing into my

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mind's-eye, the man being held on the ground and, I think, other 'made up' images of men with long knives seeking to kill. I was extremely anxious and wanted to know what was happening outside: were there any fatalities, were we locked in the building, were any of our group missing? I was worried that my wife would be seeing all this on the news, knowing I'm here.

The group practicum session came as a relief as I trusted my peers enough to be able let it all out. I was very upset. They were brilliant and brave in how they handled me. I did originally have some reservations about whether EMDR R-TEP would have much effect very soon after an incident, but it was extremely impressive. I don't remember much but was later told I had initially reported a SUD 9. As a result of the treatment I received this dropped to SUD 0! I lost track of time so I don't know how long I was doing the R-TEP, perhaps 90 minutes? I remember first talking through the whole episode whilst doing BLS, and then scanning for 'fragments' and BLSing those. I felt something happening and was able to report what speed of tapping seemed to work best. Some of the material that came up was surprising, personal and emotionally powerful; I remember even feeling murderous for a while, but this shifted to a felt sense of having power,

Colin Brazier experienced the power of R-TEP first hand

control and choice and of having some ability to protect. The quality of this felt new. My level of anxiety and vigilance did not drop completely, but then I became more aware of others and that they were also concerned by what was going on outside. This was adaptive and appropriate and therefore 'okay'. I felt a profound connection with the group. I felt good.

Later that day we learnt that the event I was caught up in had been a road accident. I studied the news reports online, but the event itself soon seemed almost boring. The following morning, I returned to the scene to check how I would be, but was not triggered or distressed at all. The blood on the pavement had dried up and the police and media people had gone.

From this whole experience I have richly benefited, not just from a simple trauma recovery, but from proper post-traumatic growth. A gift! I am especially grateful to Elan Shapiro, to Soraia Crystal, and to my small practice group of three (all called Jane!), especially Jane Chugg-White, who courageously took on the therapist role.

This was second training in early intervention in the UK sponsored by TAUK, in the hope that newly trained clinicians will offer their pro bono services to a national rapid response network . Amanda Roberts gave a presentation of how the Trauma Response Network (TRN) operates in the US. The details of a UK version of this - Trauma Response Network UK - are still being worked out.

Colin Brazier is a Gestalt Psychotherapist and EMDR Consultant with a private practice in Devon

Gus Murray honoured for developing EMDR in Ireland

Gus Murray was the recipient of the Carl Berkeley Memorial Award for 2017 honouring his outstanding contribution to the development of the counselling and psychotherapy profession in Ireland and for his work in developing EMDR there. The Irish Association for Counselling and Psychotherapy (IACP) presented the Award on Friday 20 October 2017 at its annual conference in Kilkenny.

Gus Murray, left, receives the Carl Berkeley Memorial Award

Gus received a dual nomination for this award. In the first instance, the nomination came from the staff team in the Counselling and Psychotherapy training programmes at Cork Institute of Technology (CIT). A separate nomination was put forward by the Counselling and Psychotherapy Graduate Association at CIT.

Murray said he received news of the award in a phone call from a former colleague at CIT who had been contacted by IACP with the news. He told EMDRNow that his initial response was a mixture of shock and disbelief, which included asking his colleague if she was pulling his leg. The following day, he received a further call from IACP to confirm that he had also been separately nominated for the award by the Counselling and Psychotherapy Graduate Association at CIT. "It means a lot to me to have been nominated for the award both by the staff team and the graduate association", Murray said. "And indeed, as I said at the presentation ceremony, both these groups richly share in the award."

Murray said it was also very gratifying that the citation recognised his more recent work in the development of EMDR in Ireland in addition to recognising his work in the Counselling and Psychotherapy programmes at CIT over 25 years.

Gus Murray was Programme Director and Lecturer in Counselling and Psychotherapy at the Cork Institute of Technology for more than 25 years and now represents the Republic of Ireland on the Boards of EMDR UK & Ireland and EMDR Europe

Online discussion explores the pros and cons of online EMDR therapy

Responding to a Jiscmail question on EMDR therapy online, Mark Brayne, EMDR Europe Consultant, organised an online discussion on the topic – in the process introducing most of the participants to the professional, online platform, called Zoom. Deborah Fish reports on the proceedings

Seventeen EMDR therapists (one of whom was based abroad) participated in this online event. They ranged in experience and qualification from the very recently trained to (mostly) accredited Practitioners and a sprinkling of Consultants. Some were venturing into online EMDR with trepidation, focusing upon resourcing, whilst others were enthusiastic and experienced, with many successes behind them.

Participants discussed the following key points:

To offer online EMDR therapy or not?

Online EMDR therapy helps to overcome geographic and logistical constraints. Whilst some therapists might find it less satisfying than in-person sessions, experienced participants said it can nonetheless feel very close and intimate and, from a client's perspective, facilitate an effective treatment outcome.

As with in-person EMDR therapy, client

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readiness, stability and risk need to be carefully assessed to determine the most suitable treatment option. For containment, the client needs to feel safe, both with technology and relationally.

What online platform to use?

Although Skype is familiar to therapists and clients, with encryption now acceptable to the UKCP, the connection quality can be inconsistent. Skype also uses more bandwidth than Zoom and VSee, which can be problematic at midday in certain countries such as Germany and Finland. WhatsApp is encrypted, and popular with younger clients, although connection quality can also be variable. Facebook and Facetime were considered less appropriate, although professional and personal accounts can be separate.

What form of bilateral stimulation to use?

The participants had tried and tested various options including: the butterfly hug, asking clients to tap on their own knees or the table in front of them (with eyes following from side to side). Some watched a moving dot via YouTube on a phone or tablet app. Others used headphones, with the client stopping and starting BLS from an app such as BSDR Player. With couples work, clients could face each other and do knee taps.

How to get started?

Experienced practitioners said it is essential for your technology and apps to be up to date, and that you are able to coach a client to use a particular platform. Therapists should consider what will be visible around them. Ideally the backdrop should be neutral. Also agree contingencies; is the telephone the standby plan, if needed?

Participants discussed the need to address safety procedures and expectations for treatment. Therapists should find out specifically where the client will be located during the session. What equipment do they plan to use and what size of screen? Therapists should discuss with clients how they plan to ensure uninterrupted confidentiality for the session as well as space for them to unwind quietly afterwards. Participants drew attention to whether therapists might also want an agreement with the client not to record or share session content with others, e.g., via social media.

What about professional liability insurance?

Towergate includes indemnity for online clients in the UK and abroad, provided the therapist is UK-based. Balens also cover online work, although they exclude clients in the US and Canada. Participants recommended checking individual cover providers.

Additional considerations to explore

- If working internationally, might you be liable for tax in the jurisdiction where the work is being done?
- One participant recommended the Association of Counselling and Therapy Online as helpful for best practice guidance: https://acto-org.uk.
- If the client were to dissociate how could you deal with it?

This online event was engaging, informative, motivational and validating. Thanks to online technology and Mark Brayne's generous involvement and expertise in making it possible, we were able to feel connected, despite being geographically dispersed. Thanks to everyone who contributed to this stimulating discussion.

Deborah Fish is a Psychotherapist and EMDR Europe Consultant providing EMDR therapy and supervision in private practice. She also practises within NHS Secondary Services in Dorset

Flash Technique a rapid means of preparing clients for reprocessing trauma

Repeated rapid exposure to a traumatic image for a fraction of a second from a resourced state can painlessly reduce the distress associated with a disturbing target memory, according to new research by Manfield et al. (Journal of EMDR Practice and Research, Vol 11, No 4, p195). The researchers suggest that the technique, which they call the Flash Technique, during the preparation phase of EMDR can facilitate therapy with clients so apprehensive of accessing their traumatic memories that normal EMDR therapy is jeopardised or processing brought to a standstill.

The Flash Technique (FT) requires that the client is able to access a relaxed state, such as a 'safe place', in which the client is resourced, more resilient and emotionally stable. From this state the client is asked to flash on the memory just for a fraction of a second and to inform the therapist when they are back in the resourced state. The therapist provides BLS before and during the 'flash' to guide the client into making slow eye movements lasting 2-3 seconds for each left-right-left pass. A full set may be 4-5 passes with the client flashing the traumatic memory after the third or fourth pass. This is repeated twice and SUD level associated with the disturbing memory noted. The whole thing is repeated until the SUD level is low enough for normal EMDR phases 4-8 to proceed. It can take 10-45 minutes to reach this stage.

The paper outlines four case descriptions using FT, all of which were successful in reducing the distress associated with the clients' traumatic memories.

Manfield et al. draw attention to three processes which they believe underpin the success of EMDR in desensitising traumatic material: erasure of the traumatic quality of a memory via a prediction error during the process of memory reconsolidation. They posit that the Flash Technique (FT) may fast-track these processes making this client group ready for the last four phases of EMDR more quickly and painlessly.

In memory reconsolidation, memories are retrieved from the long-term memory into the working memory. They are modified by the encounter with new information; this updated information is then returned to long-term memory. When the memory is of traumatic experience, the new, updating, information results in overturning the original prediction error. For example, if the traumatic memory was maintained by the prediction 'I will be harmed', the experience of retrieving the memory, however fleetingly, during FT and remaining safe seems to overturn the prediction error, changing the cognition to e.g. 'I'm safe now'. This in turn results in permanent erasure of the traumatic quality of the original memory.

FT builds on the somatic experiencing pendulation technique of Levine which Kinowski adapted in her paired titration, the researchers say. The difference in FT is that the exposure to the disturbing image is titrated. The researchers liken the extremely brief flash of contact with the memory as similar to passing a finger quickly through a candle flame. This duration of contact is what seems to be critical – it must be long enough for the memory to be accessed and brought into working memory, but not long enough for the client to bring up a clear memory or to think about the memory. "We believe that this aspect of FT interrupts conscious defences against accessing the memory", they say. The technique is not a substitute for EMDR, they warn, but "most useful for clients who are not highly dissociative but resist fully accessing intense disturbance".

Omar Sattaur edits EMDRNow and counsels at the University of Manchester.

Thinking big and imaginatively among the Californian redwoods

More than 100 delegates from across the US met for the recently established Parnell Institute's first Annual Conference held at the 1440 Multiversity Conference Centre deep in the majestic redwoods of California's Scotts Valley, just south of San Francisco. Mark Brayne reports

The choice of venue could not have been more appropriate. Named for the 1440 precious minutes that make up each day, the 1440 Multiversity enabled us to use our time well, with plenaries and workshops facilitated by Dr Laurel Parnell, my now-fellow PI trainers and facilitators and Somatic Experiencing luminary Maggie Phillips.

Themes explored ranged from the body and spirituality in EMDR and the challenges of working with gender identity. Speakers explored how EMDR can rewire the way in which dysfunctional early attachment experiences are stored in the brain to processing the primal wound of adoption and strategies for when EMDR sessions go off the rails.

As many readers will know, I am an enthusiast for Parnell's development model of what she calls Attachment-Focused EMDR, emphasising the importance of resourcing clients not just with a safe or calm place but also with Nurturing, Protector and Wise figures, allowing for simple modifications to Phase Three of the Standard Protocol and encouraging the forensic and central use of bridging (which some prefer to call floatback or the affect bridge) for identifying the target memories that most effectively shift dysfunction.

My enthusiasm for her work has led me to bring Laurel Parnell to the UK where, over the past three years, she has trained more than 200 practitioners in an approach which has attracted criticism from some quarters for perceived deviation from the Standard Protocol - a discussion perhaps better left to the EMDR UK & Ireland Association's 2018 Annual Conference next March where I'm presenting a paper to explore this

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subject more fully.

EMDR, as I believe we all understand it, involves establishing safety in the therapeutic relationship and resourcing the client appropriately, accessing a distressing memory, identifying the components of image (if possible), cognitions, emotions and body sensations. Then, simply summarised, EMDR Therapy stimulates this disturbing memory bilaterally using Dual Attention which facilitates the client's awareness during their processing of the present as well as the past. The aim is to access and integrate the felt right-brain and often limbic-system memory - somatically in terms of subjective disturbance, and psychologically in terms of meaning – and so liberate clients from their traumatic past.

Parnell now has a richly-skilled team of colleagues helping her deliver her EMDRIA-accredited Parts One and Two trainings in the US, as well as the Part Three Advanced EMDR workshops which she brings to the UK. In many a spirited and inspiring discussion in the Californian redwoods, we discussed the essential importance of new trainees internalising the standard procedural steps of EMDR, rather as anyone learning to dance properly must have the basic rhythms of Salsa, Waltz, Foxtrot and the rest, without which dance can be a mess of spills, confusion and trodden toes.

There was so much to find stimulating; here are a few of the gems I brought home with me:

- How, with proactive and imaginal interweaves at appropriate moments in Phase Four processing, a client-attuned EMDR therapist can help a client creatively repair even the very earliest attachment wounds.
- Successful therapy relies not just on what the therapist does and what the client says but how the client talks and what they do inside their bodies. We can search for more nuanced meanings - for example the sorrow in sadness;
- From Somatic Experiencing, the extra question: 'How present ARE you?' 'How do you know you feel distressed?' Or, when relaxed, 'How do you know it's pleasing to you?' The explicit reconnecting of body and mind with the goal of therapy, restated at the beginning of every session, can make such a difference.
- Orient to the body, and - such a lovely interweave - 'Bring your awareness to what you've just said, and let's spend some time (or just hang out) with that.'
- And, how about just inviting a client to 'Notice your adult body,' or to 'Let that thought/awareness seep into your body like a slow rain…'
- At the end of a powerful session, therapists might offer to place their stockinged feet gently over the client's feet to ground them back to present reality – tender, and powerful.
- Or to regulate arousal, clients might be encouraged to press their knees outwards with the palms of each opposite hands. Or, when processing, to stand up with tappers/buzzers under their feet.

And did you know a basic fact of evolutionary biology, that females when in danger orient to a person, where males orient to the source of the danger? The setting at Fourteen-Forty as the locals call it (financed by rich internet power-couple from Silicon Valley, just up the road – this is after all California) inspired us to think bigger, to revel in the power of the imagination.

Many of the techniques advocated by experienced trainers and facilitators seemed to have at their roots a wonderful and liberatingly holistic view of life, of the true nature of our mind-bodies or body-minds.

At the heart of attachment rupture is a splitting of that body and mind, and Parnell's Attachment-Focused EMDR has become, to me, a central way of using our amazingly powerful therapy to facilitate the essential repair work of trauma therapy.

Mark Brayne is an EMDR Europe Consultant and Parnell Institute Facilitator

EMDR brings peace to child traumatised by domestic violence

A case report by Ghada Berbari

AM is a 7-year-old boy who is the eldest brother of four siblings. He is in the first year of primary education and resides in a suburb of the city of Tunis, Tunisia. He is the son of a Tunisian father and a Moroccan mother. We were able to interview AM when his mother and brothers visited the Centre for the Care of Battered Women in order to access psychiatric care. AM was a victim of domestic violence. He was subjected to physical and psychological abuse by his father in front of his older brothers. He had also witnessed his mother being abused by his father, from an early age. He had not attended school despite being of the legal age for school attendance.

AM exhibited psychological disturbance due to the disintegration of the family from repeated violence and neglect. He presented with symptoms of hyperarousal, poor emotional regulation, aggressive verbal and nonverbal behaviour and lying, characteristic of a history of disturbed attachment. The trauma of domestic violence and abuse hindered proper psychological development, behaviour and socialization which were likely to influence his future psychological health significantly.

We had attempted a psychodrama approach with AM as a way of helping him to express his emotion and overcome the considerable deficits in his childhood. I started by strengthening trust through play and creative graphics. AM took this as a form of entertainment but, at the same time, it helped us to assess the degree of his psychological disturbance. With time he grew more confident that the therapeutic environment was stable and secure and once he began school we decided to start treatment.

Following an initial improvement, he suffered a setback. His teacher had asked the pupils to give their home address. AM replied that he lived near the school, but another student interrupted him saying 'not true' and telling the class that he lived in the Centre for the Care of Battered Women, meaning that AM was homeless. AM became disturbed by these words nodding his head in agreement with the student, and started to cry. This incident caused a relapse after a surprising initial improvement on using psychodrama. This gave me the chance to persuade my supervisor to allow me to use EMDR as I had completed my Part 1 training in April 2017. After taking a full history and making sure that the child's condition had stabilized, we decided to start using EMDR therapy.

The first session

We started BLS through tapping and I asked AM to draw a picture after each set. The violence he had witnessed was immediately evident in every image he produced. The violent scenes clearly and accurately depicted his father's abuse of his mother. He had witnessed all of this and the pictures he drew both expressed his fear and his desire to defend his mother. After several sets of BLS he was able to draw beautiful and peaceful paintings of the Centre for the Care

Photo 1: How father taunts mother

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of Battered Women, which were free of violent elements and served as a safe place for him.

Photo 1 illustrates how his father taunted his mother (slapped and kicked her and tries to stab her with a knife); the same image expresses AM's fear and his attempt to defend his mother.

The NC was: I am helpless; PC: I'm a hero who can defend my mother. His overriding emotion was fear.

Photo 2 shows a seaside scene where his father assaulted his mother (pulled her by the hair, punched and kicked). AM explained that he is absent from the image as he was swimming at the time. His friend stopped him from going to the beach to prevent him

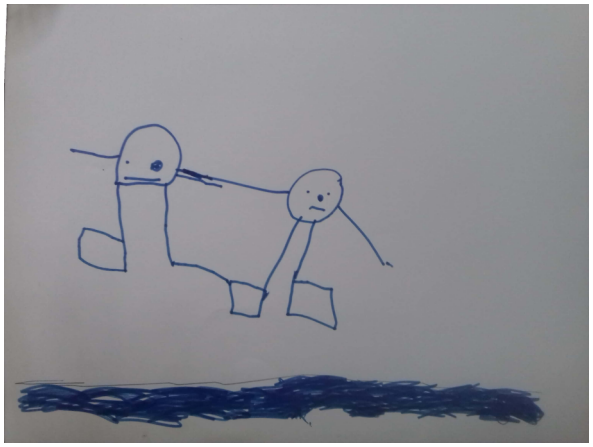

Photo 2: Father assaults mother at the seaside

witnessing this horrible and violent scene.

The NC and emotion were the same as before. The PC was *I can help and defend mother*.

Photo 3 shows a picture of his father and the games: Spiderman and Batman. He said that his father wanted to control him just like the player of a game controls the characters. In discussing his picture, AM said that he wanted to add his name in Arabic.

Photo 4 shows a smiling child at the Centre for the Care of Battered Women. The characters in the picture are AM's friends and the picture shows his strong attachment to them. AM said "the picture is beautiful". We decided later to use this picture as the safe place for EMDR therapy.

The second session

We chose this time a story that represented his situation. His mother attended and contributed to the session as we asked her to put her son on her lap and give BLS by doing a 'butterfly tap' on his shoulders while we recounted the story he had told us of the physical violence that he and his mother had experienced up to the present safety now that the parents had separated and his father was no longer a threat. We then asked him to draw another picture.

Photo 5 shows him at a summit of a hill where there is a door leading to many treasures. The hill is in the desert and the summit is in a beautiful place where there are a camel and a Cheetah. We asked AM why

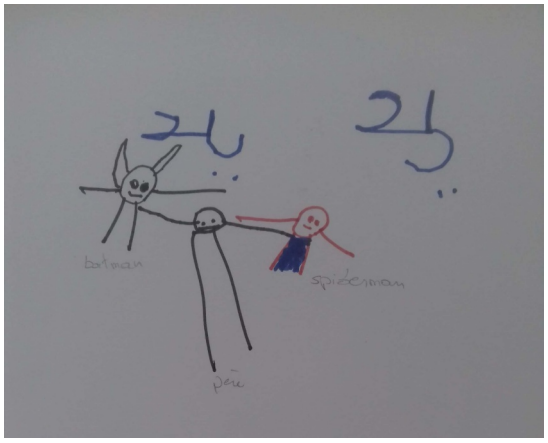

Photo 3: Father and the Batman and Spiderman games

the Cheetah is present in the desert as it is usually

lives in the woods. He said that the cheetah is dangerous in the wood but when it is in the desert it never poses a danger.

The third session

Our story was told again while AM's mother provided BLS by tapping on child's shoulders. The story this time was about animals and we aimed to modify his apparently violent behaviour towards others, especially towards the other children in his class. It is worth noting that AM is fond of boxing and karate; his father was a boxer and had been teaching him some techniques which AM had begun using against his classmates and children at the Centre.

Through the story we were telling him, we *Contd. p10*

him to address the problem of violence. The story explained to him that while his hobbies are acceptable and good he should not use them against others to hurt innocent people and that this behaviour is rejected by everyone. Then we asked him to draw for us and he drew the picture shown in Photo 6.

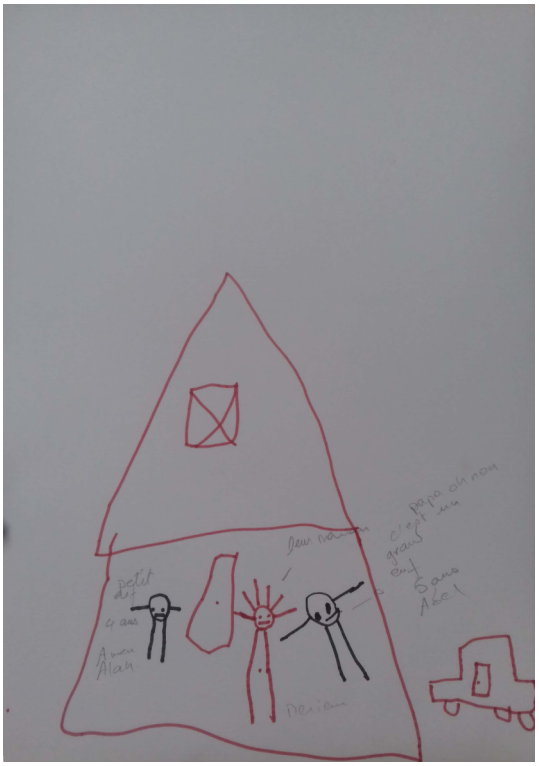

Photo 5: AM's friends at the Centre for the Care of Battered Women

Photo 6 depicts houses which he coloured with all available colours until the picture was beautiful. He explained that the houses were old houses on Mars which will get dumped and broken and be re-built. It seemed that he was wrestling psychologically with his aggressive and destructive impulses, inherited from his violent and traumatic history but which he sought to eventually abandon.

In conclusion, EMDR has helped this child to access his long suppressed feelings and emotions. It also contributed to creating a feeling of safety and reduced the fears and aggression that besmirched his behaviour and his actions towards others. EMDR also seems to have reduced the former sense of danger associated with the memory of his father.

Photo 5: The door to many treasures at the summit of the hill

Photo 6: The old houses on Mars, due for demolition and rebuilding

For further information on the use of 'stories' in EMDR with children, see *Trauma-Attachment Tangle: Modifiying EMDR to help children resolve trauma and develop loving relationships*, by Joan Lovett (2015).

Ghada Berbari is a Psychologist at the Shelter for Women Victims of Violence in Sidi Thabet, Tunisia. She attended Part-1 EMDR Training in April 2017, conducted by Sian Morgan, Trainer and President of Trauma Aid UK