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EMDR THERAPY QUARTERLY

Treating Compulsive Sexual Behaviours with EMDR

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Themes at EMDR Europe's 20th Anniversary Conference

EMDR Europe celebrated its 20th Annual conference in Kraków in June this year. Sadly, Francine Shapiro could not be there to join in the celebrations but in her final communication with EMDR Europe she reiterated her commitment to the alleviation of suffering, reminding members that their work will reverberate for years to come across generations. Ad de Jongh, one of the founders of EMDR Europe pays tribute to Francine in a moving obituary in this issue of *ETQ*.

As we know, trauma experienced in one generation can visit those to come, whether through coping behaviours and their impact on the children of traumatised parents, or as Hélène Dellucci in her presentation on transgenerational trauma suggested, via deeper neurological routes.

Attachment ruptures in childhood and the problems that manifest later in affected adults also featured strongly in the Kraków presentations. Maria Zaccagnino and Deany Laliotis among others stressed the importance of therapists having a good grasp of attachment theory if they are to work well with complex trauma.

The ramifications of childhood trauma are only too visible in the case studies of compulsive sexual behaviours that illustrate Silva Neves' lucid account of treating CSB using EMDR.

Many attendees of the Kraków conference (myself included) took the opportunity to visit Auschwitz. Although I have read about the genocide perpetrated there, I was still unprepared for the stark facts and distressing displays that told of millions of lives brutally cut short. If only one could believe that we have moved on. In a year in which refugees under UNHCR's mandate exceeded 20 million for the first time, it is clear that for many people, conflict, persecution and civil strife continue unabated and it is difficult to believe that much has changed. It makes Francine's message to EMDR Europe, congratulating it for its humanitarian programmes and their implications for world peace, all the more urgent and apposite.

Omar Sattaur

EMDR Therapy Quarterly

EMDR Therapy Quarterly (ETQ) is the official publication of the EMDR Association UK & Ireland. It offers coverage of Association news, regional, national and European EMDR conferences and articles on the clinical practice and research of EMDR.

Full guidelines for authors of original practice and research articles are given on the inside back cover.

News articles covering presentations at EMDR research or clinical practice meetings and conferences are welcomed. These may be submitted to editor@emdrassociation.org.uk Please note that all articles are subject to editing and publication at the editors' discretion. We welcome inquiries.

Editorial Policy

The Journal is published for members of the EMDR Association UK & Ireland (EMDR Association), to promote research and innovative practice among its members, to provide a resource and forum for contributions from the membership and to promote knowledge and understanding of EMDR Therapy more widely in the therapeutic community. The contents are provided for general information purposes and do not constitute professional advice of any nature. Whilst every effort is made to ensure the content is accurate and true, on occasion there may be mistakes and readers are advised not to rely on its contents. The EMDR Association and the Editor accept no responsibility or liability for any loss which may arise from reliance on the information contained in ETQ.

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The Association's work within EMDR Europe

NEWS

Mike O'Connor reports from Kraków

Brexit or No-Brexit the EMDR UK & Ireland Association remains firmly connected to EMDR Europe. We are now one of 31 countries who make up the largest trauma-focused organisation in the world with a combined membership of over 27,000 members. Over the past year four new EMDR National Associations joined EMDR Europe: Malta, Iceland, Lithuania and Georgia and 2250 new members joined from across Europe. Understandably the work of the various Committees that make up EMDR Europe has increased in volume and complexity. As you might expect EMDR Europe has a formal structure to facilitate this work including a number of Committees and a Board comprising representatives from EMDR national associations.

How is EMDR UK & Ireland represented in Europe?

EMDR UK & Ireland has been instrumental in developing EMDR Europe as an effective organisation to advance the theory and practice of EMDR not just in Europe but worldwide. Currently, we are represented by:

- Richard Mitchell: Chair of the Standards Committee and EMDR Europe Board Member
- Derek Farrell: Chair of the Practice Committee, President of Trauma Aid Europe and EMDR Europe Board Member
- Alexandra Dent, Member of Child & Adolescent Section
- Maeve Crowley and Mike O'Connor: Members of the Practice Committee and EMDR Europe Board
- Lorraine Knibbs, Vice-President, Trauma Aid Europe.

The Committees meet face-to-face every six months with additional meetings, via Skype etc., as needed. In addition to those already listed there are other Committees with specific roles: Executive Committee; Research Committee; Nominations Committee; Conference Quality Assurance Committee (CQAC); Organisation Development & Constitution Committee (OD&C).

What do the Committees do?

Examples of key work streams include:

- **Reviewing the Constitution of EMDR Europe and developing a new Conflict Resolution Process.** This work is ongoing and the next draft of these documents will be presented to the Europe Board in November for ratification.
- **Planning and Evaluating the Annual Conference.** The 20th Anniversary EMDR Europe Conference in Kraków was attended by 908 delegates representing 58 countries. Ninety-five delegates were from the UK&I. The 21st EMDR Europe Conference will be held in Berlin 4-7June 2020. In 2021, the EMDR Europe Conference is to be held in Dublin.
- **Promoting research, deciding research streams and allocating research funding.** The most recent report from the Research Committee outlined how the €75,000 budget for 2019 had been allocated. Of the eight applications received, four were funded: a Dutch study on dementia; an Italian study on multiple sclerosis; a Spanish study on dual disorders and a Swiss study on acute coronary syndrome.
- **Monitoring and reviewing the Governance of and Standards in EMDR practice.** One of the key tasks of the EMDR Europe Practice Committee (EEPC) is the regular review of the Competency Framework Documents (CFD) for Practitioners and Consultants. Over the past year a slightly revised version of the Practitioner Competency Framework has been approved by the Board which has paved the way for the introduction of the algorithm version of the Practitioner Competency Framework, subject to the approval of the Board at the autumn meeting of the Board in Budapest.

The EEPC is also responsible for organising the EMDR Europe Consultant Day held prior to the Europe Conference. The theme this year was "Supervision Dilemmas in EMDR: Collective Exploration". The workshop was opened by Derek Farrell who set the scene with a presentation on 'Supervisory Theory and Practice'. Members of the Practice Committee then led the participants in exploring different models of supervision and various scenarios that might emerge in the supervisory process. 151 Consultants from across Europe attended the workshop.

A recent initiative has been the introduction of a 'Country Mentoring' scheme. The rationale for this is that there is a nominated EEPC link person with each country to liaise about all matters regarding accreditation. This is especially important for newly formed National Associations who need support to establish their Accreditation Committee.

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NEWS

• **Monitoring and Reviewing EMDR Training standards.** This year the Standards Committee has accredited four new Trainers and has re-accredited three Trainers. Eight EMDR training courses were accredited.The Committee has also addressed the issue of EMDRIA Trainers seeking to provide EMDR training in Europe. The Board has now agreed that EMDRIA trainers must undergo the EMDR Europe Accreditation process before they can provide EMDR training in any EMDR Europe member country. They will also be required to join the National Association of the country in which they wish to offer training. The Standards Committee is also responsible for organising the EMDR Europe Trainers' Day. This year 58 Trainers attended the day which was dedicated to reviewing the 3rd edition of Francine Shapiro's book "EMDR: Basic Principles, Protocols and Procedures" – "What is new and what are the implications for Trainers".

• **Monitoring the Governance procedures for the running and formation of Committees.** The Board has formed a Nomination Committee to further improve the democratic process of elections of Officers and Committee members.

• **C & A Committee.** The role of C&A Committee is to raise the number of C&A Practitioners and to strengthen the communication between the representatives and the Board. Key issues under consideration are:
– National Associations to identify ways to increase the number of accredited C & A Practitioners in Europe;
– Integrating procedures for the Training of Trainers regardless of whether the 'Trainers-in-training' work with children or adults;
– Improving research opportunities between countries;
– Disseminating the Competency Framework Document (with C & A Addendum) to member countries;
– Child Trainer Training: revision of the Training Programme still ongoing.

• **Trauma Aid Europe (TAE)** Congratulations were offered this year to the recipient of the Trauma Aid Europe Humanitarian Award 2019 Dr Isabel Fernandez. Isabel has received the award for her distinguished and outstanding service and humanitarian work in the field. TAE provides an opportunity for participants of various humanitarian projects to attend the EMDR Europe annual conferences for the purpose of networking, developing collaborative partnerships and the dissemination of research, EMDR practice and development.

More than 20 participants from the following countries around the globe were supported by TAE to attend the EMDR Europe annual conference in Krakow, Poland, 2019. They included participants from Armenia: Bangladesh; Bosnia-Hercegovina; Cambodia; Indonesia; Greece; Jordan, Lebanon; Madagascar; Sousse; Thailand; Tunisia; Zimbabwe. Trauma Aid Projects are supported currently in Africa, Europe and the Middle East and Far East.

EMDR Europe: A Broader Reach

One of the strategic aims of EMDR Europe is to develop close links with EMDR organisations across the world via reciprocal arrangements to attend International Conferences and respective Board meetings. In addition, the Europe Board participates in events that bring EMDR to the attention of Goverments, politicians and organisations that try to address the growing needs of traumatised populations across the world and the positive contribution already being made to these tragedies by EMDR.

Advocacy Activities: The EU Parliament and the EU Commission

This advocacy work is ongoing. Some of the key objectives of this work include raising the political awareness of EMDR to ensure that:
– EMDR Therapy has access and may be involved in policies and interventions in fields relevant to EMDR Europe, such as the Public and Mental Health.
– Trauma and trauma-related disorders become a national health priority in different member states;
– There is an accurate understanding of trauma & the experience of people with trauma related disorders;
– Increase visibility of EMDR Europe in Brussels in the short, mid- and long term;
– Become an active and trusted stakeholder of the EC (create more impact in the outside world, through policy makers and EU agencies).

These are just some of the activities of EMDR Europe. If you have any queries or questions please contact your national representatives, Mike and Maeve via Dawn Damni, Administrator at: info@ emdrassociation.org.uk

Mike O'Connor is our EMDR Europe National Representative

EMDR Europe's Founding Members Honoured

It's 20 years since the first EMDR Europe Conference in Milan and the current President, Isabel Fernandez marked the occasion at this year's Annual Conference in Kraków with a trip down memory lane. Mike O'Connor was there

It is, perhaps, no surprise to find the themes of past, present and future echoing through the presentations at an EMDR conference and so it proved to be at the formal Welcome and Opening Address of the EMDR Europe 20th Anniversary Conference in Kraków. Following a warm welcome to delegates from Marzena Oledzka, President of EMDR Poland, EMDR Europe President, Isabel Fernandez, asked participants to think about the journey that has led EMDR to its 20th Anniversary Conference; a journey that began in 1996 in Amsterdam and resulted in the first EMDR Europe Conference three years later, in Milan. Fernandez introduced delegates to the founding members of EMDR Europe, many of whom were present. Those present were introduced in person and via a series of photographs charting the location of the Conferences around Europe as well as the aging process of these members! - beginning with photographs of the very youthful looking 'founders' including our own Richard Mitchell, the first President of EMDR Europe. All this activity was by way of conferring the David Servan Schreiber Award on each of the founding members. The recipients were: Richard Mitchell, John Spector, Ad de Jongh, Arne Hoffman, Birgit Schultz, Joany Spierings and Franz Ebner. The contribution of the late Des Poole was also acknowledged.

Founder members receive the David Servan Schreiber award (left to right): Richard Mitchell, Arne Hofmann; Ad de Jongh and Kerstin Bergh Johannesson. (The David Servan Schreiber honorary award given by EMDR Europe in recognition of outstanding achievements in the field of EMDR Therapy. It was instituted in 2012 in memory of the late David Servan Schreiber, psychiatrist, researcher, EMDR Trainer and internationally acclaimed author of Healing Without Freud or Prozac*)*

Fernandez brought delegates up to date with the research papers featuring EMDR and EMDR-related themes, published in influential scientific journals over the past year. Journals such as *Nature*, *Neuron* (journals with a very high impact factor) and *Frontiers in Psychology*, the second largest and most cited psychology journal featuring 22 articles on EMDR with 175,700 views. While there has been much discussion surrounding the position taken by NICE in relation to EMDR and PTSD, Fernandez reminded participants of the position taken by the International Society for Traumatic Stress Studies (ISTSS). In its guidelines (*The ISTSS PTSD Prevention and Treatment Guidelines. Methodology and Recommendations and Position Papers on Complex PTSD (2018)*), there is a strong recommendation for the use of EMDR in the treatment of children and adolescents and for adults with PTSD.

Fernandez reported that four new countries had joined EMDR Europe during the past year (Malta, Iceland, Georgia and Lithuania) and that several more were due to follow over the coming year. She added that overall membership had increased to more than 27,000 members. She concluded by summarising her mission over the next four years of her time as President to help EMDR "....to have even more prestige in the academic, scientific and mental health field".

In opening the conference, Marzena Oledzka, President of EMDR Poland, highlighted the position of Kraków as a city that has symbolically connected people, cultures and histories over the centuries and, bringing delegates back to the

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OBIT

So much more than a walk in the park

Ad de Jongh remembers Francine Shapiro (1948-2019)

Francine Shapiro, the founder of EMDR therapy, died on Sunday 16 June 2019. She was 71 years old and had been ill with cancer for many years. Nonetheless her death has come as a shock and has touched millions of therapists and patients around the world.

Who was Francine Shapiro?

Francine was born in Brooklyn, New York. Her father was a car mechanic who owned a garage and, with his family, ran a taxi company. Francine had a brother and two sisters. One of

Francine Shapiro: a passion for literature

her sisters, Debra, died at the age of nine when Francine was 17 years old. We do not know how she reacted to this loss but it seems that it affected her and encouraged her later in life to help others. But in her youth, Francine's eyes were fixed on literature. She loved to read about what moves people, the reasons why people behave the way they behave. After obtaining her Master's degree she became a secondary school teacher in Brooklyn. But she wanted more.

Francine was passionate about 19th-century literature and the poetry of Thomas Hardy and wanted to obtain a PhD in that field. Alongside this she developed an interest in behavioural therapy. Reading the books of Joseph Wolpe, who developed the SUD scale that she would later include in her EMDR protocol. She once said about her interest in psychology: "The idea of a focused, predictable, cause-and-effect approach to human psychology seemed fully compatible with the concepts of literary character and plot development".

Illness as a source of inspiration, recovery as a source of inspiration

After being diagnosed with her cancer, she began a search for the causes and the cure for it and became interested in psycho-neuro-immunology, a field that was just being developed. She began to see a connection between body and mind, between illness, stress and trauma. And when her cancer healed, she studied psychological therapies and how these might contribute to health and recovery. This became the focus of her future life. She decided to leave her life in New York. She sold everything she owned, bought a Volkswagen camper and embarked on a search that led her through the United States. In the course of her studies, she met people like the psychiatrist Stephen Levine and holistic physician Emmett Miller, experts on guided imagery, self hypnosis, and meditation. Her curiosity in this area led her to register for a PhD program in clinical psychology at the Professional School for Psychological Studies in San Diego, California. Francine's dream was to start a non-profit organisation to bundle what was new and well-known in the field of psychology and to combine it with related areas such as business, motivational psychology,

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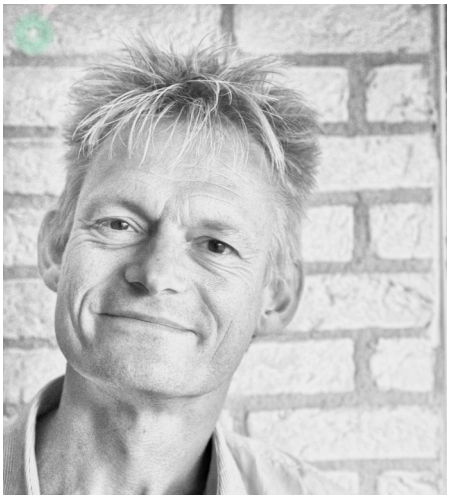
"The idea of a focused, predictable, cause-and-effect approach to human psychology seemed fully compatible with the concepts of literary character and plot development."

present, commented that this was the first EMDR Europe Conference to be held in a Central European City.Of course, when the preparations were being made for the Conference in Kraków no one could know of Francine Shapiro's passing shortly before the Conference began. Yet, she had written a letter to the President of EMDR Europe on 29 May 2019, shortly before her death. She expressed her regret at not being able to be present but in her message to EMDR Europe wished to convey her spirit of optimism about the future of EMDR Therapy and its place in the future of universal mental health care. Her final message was to emphasise the continuing need for high-quality training in EMDR and EMDR practice. EMDR Therapy is Francine Shapiro's gift to the world.

Mike O'Connor is an EMDR Europe Accredited Consultant & Training Facilitator, Child & Adolescent Consultant and President Elect EMDR UK & Ireland

creativity, and psycho-neuro-immunology all for the benefit of humanity. Her organization was called Meta Development and Research Institute.

Not everyone would have taken the step to leave the familiar behind and investing



Ad de Jongh: "Something very important happened which would change my life forever"

everything they had for a vision.

The walk in the park

Just when Francine was looking for a subject for her dissertation, she made her famous discovery during a walk in the park. She noticed that distressing thoughts disappeared just as suddenly as they came up. Fascinated by this discovery, she started paying attention to what exactly happened. She noticed that when distressing thoughts entered her mind, her eyes spontaneously moved back and forth very quickly in an upward diagonal direction. She then deliberately started making eye movements, concentrating on difficult memories, and discovered that these thoughts also disappeared and lost their emotional charge. Many others would have been satisfied with this relief of complaints, but Francine would not have been Francine if she did not question further. She was well aware that she had made a significant discovery and in the following months she developed a protocol for a therapy that she called Eye Movement Desensitization (EMD). She started working on it by conducting a survey among a group of people who had experienced a distressing event and wrote a scientific article about it that appeared in the 1989 Journal of Traumatic Stress . Shortly thereafter, she contacted the Mental Research Institute (MRI), in Palo Alto, with the intention of collaborating with a number of pioneers in the field of short-term therapy, including Paul Watzlawick. She became a Senior Research fellow at this organization.

In March 1990, Francine gave her first two-day workshop with 36 therapists who had heard of her work. Then more quickly followed. She learned during teaching EMDR therapy and the feedback she received from therapists who she had trained that information processing was much more complex than she had previously thought. She also noticed that, not only did desensitization of memories take place, but also that cognitive changes occurred that spontaneously changed the subjects' views on themselves. She therefore chose to rename the procedure in Eye Movement Desensitization and Reprocessing (EMDR).

As more and more people trained in EMDR, the so-called EMDR Network was set up to keep clinicians up to date. The Network organized meetings where people could come together for questions and peer review. The EMDR Network Newsletter that resulted from it was hugely popular. But gradually it attracted criticism. The method had not yet been properly investigated and the possibility that EMDR was no more than a complicated form of exposure could not be excluded. This criticism was sometimes aggressive and contemptuous, and here lies the origin of Francine's emphasis on the importance of research into EMDR. It took until 1995, when Sandra Wilson, Robert Tinker and Lee Becker published the first randomized study whose article appeared in the renowned *Journal of Consulting and Clinical Psychology*. In the same year, the first edition of Francine's long-awaited book about EMDR Eye movement desensitization and reprocessing was published: *Basic principles, protocols and procedures*.

The start of EMDR in Europe

My personal story and commitment to EMDR starts in 1992 when I went to the US to Stanford University to follow Level 1 training there. I slept on campus and I followed the plenary part in a lecture hall. I was really thrilled. The first time in America and also in Stanford where all those world-famous professors had been teaching! Francine Shapiro was far away; I was just one of about 50 participants. But when I did the Level II training in Chicago in 1993 it was different. In Chicago, it emerged that I was only the second non-US citizen to have taken the EMDR therapy course. And then something very special and very important happened to me, which would change my life forever. Someone asked me if I would like to have lunch with Francine Shapiro.

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I remember well entering the room where the lunch was served. In the middle, there was a large table where she sat surrounded by her supervisory team. I sat down at the table beside Francine Shapiro and thought: Wow! I am sitting next to THE Shapiro, who invented and developed a totally new therapy that might become one of the major therapy schools in the world. It dawned on me that I was sitting with a major influencer, akin to the founders of existing therapies such as Freud, Perls, Erickson and Rogers. Of the founders of the major psychotherapies, only Aaron Beck was still alive. And then she said: 'I want to bring EMDR therapy to Europe. Can you help me with that? And, of course, I said 'Yes!'. This led to Francine Shapiro's first training in Europe, at the Krasnapolski hotel in Amsterdam, in 1994. This training attracted many enthusiastic therapists and was a great success. EMDR started to grow, and at this moment EMDR Europe has more than 25,000 members. I am very grateful to have met her at that critical time and we remained friends ever since.

EMDR worldwide

Francine Shapiro had a deep belief in the good in every person, fully realizing how much this core can be damaged by trauma. Victims can become perpetrators through unprocessed trauma, and perpetrators in turn make victims, who can then become perpetrators. The tragedy of passing on trauma from generation to generation was an urgent theme for her throughout her EMDR life. She saw a role for EMDR therapy in breaking this vicious circle not only on a personal, but also on a social level. Her hope was based on processing trauma as a turning point in the endless tragedy of violence and counter-violence, revenge and more revenge. To this end, Francine saw EMDR in a humanitarian context. Every EMDR project and every EMDR mission in conflict areas, but also in developing countries and disaster areas, could count on her strong moral and financial support. Almost every time she spoke at a conference she put the importance of this work into words. She strived to make humanitarian EMDR projects possible and was one of the founders of HAP, the Humanitarian Assistance Program. There is now almost no country in the world where EMDR is still unknown. Hundreds of projects have brought EMDR to every corner of the globe.

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Getting to know the parts that grow over attachment wounds

John Henry heard of the importance of attachment history as the basis for working with eating disorders in Maria Zaccagnino's workshop

For EMDR therapists working with patients suffering from anorexia nervosa, a good knowledge of Attachment Theory is important. Maria Zaccagnino, an EMDR Facilitator and Consultant who heads Milan's Center of EMDR Therapy for Eating Disorders, showed how it provides a framework for the history taking and case conceptualisation. The questions asked of the client are informed by the Adult Attachment Inventory and the Adverse Childhood Experiences Study.

For example, who did you go to for comfort when you were distressed? Did the adults looking after you take you to a doctor when you were ill or injured? In addition, looking out for evidence of episodes of rejection, neglect or pressure to achieve. The purpose of the detailed history taking is to try and understand the function of the eating disorder in the person's life so that treatment can be tailored to addressing the person's past traumas.

If the patient struggles to provide a narrative of their childhood, it is worth asking them to bring photographs, diaries and their parent's written letters to use as targets. The patient should be encouraged to use their imagination to fill in the missing history.

With eating disorders, control is an important factor. It is important to work to achieve co-consciousness with parts to enable the work to progress. The therapist needs to be curious: is the part visible? Where did she learn control What is the task assigned to the part? Is she protecting someone? If the part were not there, what would happen? Can you see and describe the part that she is protecting?

Transgenerational trauma

Transgenerational trauma may also be relevant and should be actively considered. The cases that Maria Zaccagnino presented in her workshop illustrated how a dissociated part in a parent can be seen to ignore the daughter's/son's suffering because of a denial or diminishing of their own hurt when they were a child. This prevents the patient from perceiving the suffering in their own children.

In the clinical case example, Zaccagnino showed how she uses the Standard Protocol to process the triggering event. She warns that there may be a self-harming part that denies the trauma and therefore access to the memory for reprocessing. She stressed that it is also important to address the dissociated parts of the parent that may cause strain or ruptures in the therapeutic process through denial or diminishing of the trauma. Resolution of these dissociated parts in the parent's history can allow the parent to support the child's therapeutic process instead of supporting the blocks to the process. One method she described was the 'board-room table meeting' with all the parts being invited to participate in a discussion about the child's symptoms. The vulnerable parts of the parent need to be validated and integrated.

It is hard to do justice to a workshop in a relatively short report. The take home message from this workshop is the importance of attachment history as a basis on which to build your picture of the client. When dealing with a younger age group, parental influences can be great and need to be considered, offering them help with their difficulties, especially when they may be on the dissociative spectrum.

John Henry is an EMDR Consultant with a private practice in London

We welcome your words

Have you seen, witnessed, read, developed something in the EMDR field that would be of interest to others? We know that EMDR Practitioners are curious, creative and reflective. If you wish to share your discoveries, experiences, views, comments or thoughts related to reflective practice, we would like to hear from you. Or even if you just want to share your views about EMDR-related or Association matters, we'd still love to hear from you.

Write to:
editor@emdrassociation.org.uk

New protocol for EMDR treatment of depression

Omar Sattaur summarises a new approach to depression treatment developed by the EMDR Institute, Germany and presented at the Kraków conference by Drs Arne Hofmann and Maria Lehnung

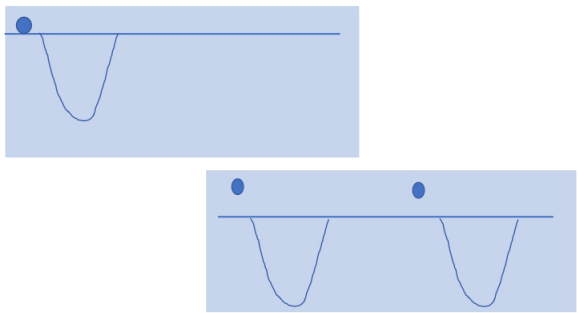
Researchers in Germany, led by Dr Arne Hofmann, have developed a new protocol for the treatment of depression using EMDR. Summarising the new work at the European conference in Kraków, Hofmann reminded us of the relapse problem – half those diagnosed with major depression will relapse within two years and risk factors include the number of previous depressive episodes and incomplete remissions following the last episode. Yet ongoing medication and psychotherapy reduces the risk of relapse by 50 per cent.

A meta-analysis of 25 studies in 2009 showed that whilst gene or gene interactions with life events are unrelated to depression risk, there is a positive correlation between risk and the number of events. The new protocol, called DeprEnd, comprises five steps. Crucially, it focuses on the recent stressful life events as primary targets for EMDR processing, followed by addressing belief systems and memories and fears of the depressive state.

Hofmann took us through the five steps: first get an overview of the problem 'wearing your AIP glasses'. This will involve plotting a timeline of the client's depressive illness (see Figure 1). Drawing a symptom-memory map pulls the information gleaned from history taking onto a simple graph. This graph shows the course of the illness, including periods of remission, but is crucially linked to the client's memory of significant life events around the onset of each depressive episode (see Figure 2).

Step 2 addresses the need for and provision of stabilisation. In Step 3, one looks for 'episode triggers': these are usually recent life events occurring in the two months prior to a depressive episode. They may resonate with previous 'traumatic' memories and may be intrusive. They have typically high SUDs and are often to do with loss, shame, humiliation or material loss. They are apparent in the history taking and are usually well remembered by clients. Work first with the trigger of the last episode, or with the strongest trigger. Hofmann says that you will often find an improvement in depression following this Step. Step 3 takes up the bulk of the EMDR sessions in DeprEnd.

Fig 1: Timeline of depression with disturbing life events



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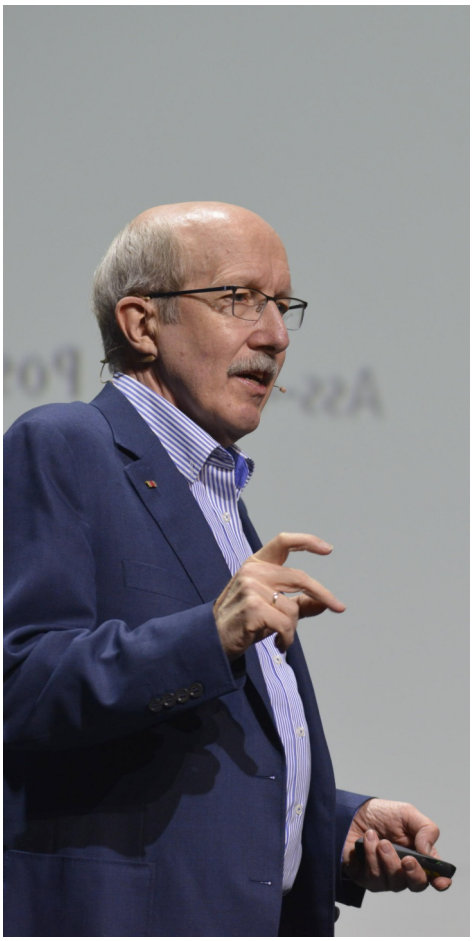

Arne Hofmann: "Painful memories of depressive states should be seen as rich in potential targets for processing"

In step 4, negative belief systems are processed. You will recognise these, Hofmann says, as they are often intrusive cognitions such as 'I am worthless' or 'I will never succeed'. SUDs are typically high and they may appear as negative cognitions in Phase 3. You can look for memories in two main ways: Cognitive Search and Affect Approach. In the cognitive search you are looking for proof memories: for example, what in your life proves that you are worthless? List the answers which will later become targets for processing.

In the Affect Approach, look

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A case report using the DeprEnd Protocol to treat depression

By Maria Lehnung

When we treat depression with EMDR, we work with the pathogenic memories. We start by focussing on 'episode triggers', the event that triggered the current depressive episode. Mostly it is a stressful life event that precedes the depressive episode by a month or two and which is usually easily identified by the patient. The episode trigger is rarely criterion A (direct or indirect exposure to death, threatened death, actual or threatened serious injury or sexual violence). It is more often an event that results in feelings of loss, shame or humiliation. Typically, SUDs are high and it may be intrusive.

Maria Lehnung: Episode triggers are commonly events that lead to feelings of loss, shame or humiliation.

The case of Mrs G is typical. Mrs G is a CEO. She is 59 years old and arrives for therapy because her doctor can find no somatic cause for her severe back pain. She suffers from depressed mood, low energy and poor sleep. She sums up her symptoms with the bald statement: "that's not me". And truly, that is not her. As a well-respected CEO she had been regarded as very energetic.

When we start working together, we find no trauma in her history so we ask ourselves what happened before she got depressed.

This is what we find. Mrs G was the CEO of a health company that merged with another company. During the merger the way of treating staff changed. She learned that she was to be replaced by a younger, ostensibly more dynamic, CEO. During this process she became aware that she had not been invited to an important meeting concerning the future of the company. It turned out that the episode triggers were to be found in events that preceded her dismissal.

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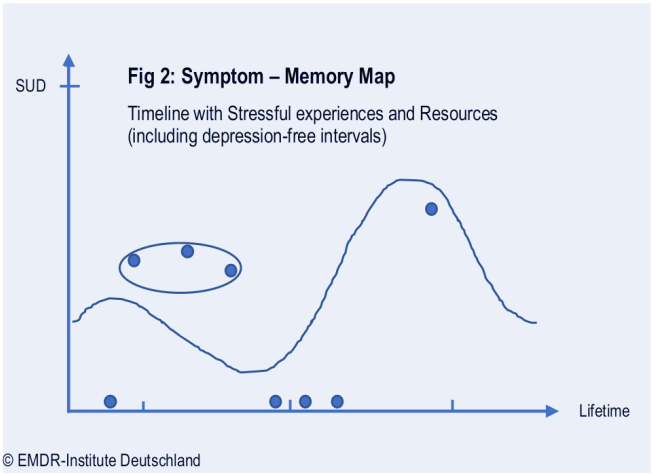
for the touchstone memory. Use the present trigger and use floatback to find the touchstone. If the touchstone memory has SUDs higher than the proof memories, it should be processed first. Next process the proof memories followed by triggers and future protection.

Step 5 is to do with processing the depressive 'state'. Hofmann reminded us that suicide attempts, for example, represent trauma and therefore a traumatic memory that can be processed. Painful memories of depressive states should be seen as rich in potential targets for processing – for example, the 'low mood on waking', the image of the client's depressed face in the bathroom mirror.

Hofmann says the take-home messages of his presentation are: current standard treatment of depression has only a limited impact in chronic depressive patients. Stressful memories are key factors in triggering and maintaining depressive episodes. Treating depressive patients with EMDR DeprEnd leads to better long-term outcomes. Above is a case report of the protocol in use, by Maria Lehnung, a co-researcher and co-presenter in Kraków.



Omar Sattaur edits this publication

We chose as our first target the phone call in which she realised that she had not been invited to the important meeting. Her negative cognition was "I am a loser". Her positive cognition was "I am successful". The SUD was high, at eight. Processing this target went well and SUDs fell to zero. The next two targets concerned other negative experiences during the merger.

Following these sessions, Mrs G felt better and less depressed but, in a later session, she reported a resurgence of depression after driving past the administrative HQ of the newly merged company. Prior to her redundancy Mrs G had been instrumental in initiating the construction of the new building. The new company HQ became our next EMDR target.

Finally, we made a future template focussing on the inauguration ceremony for the new building. Her NC was, again, "I am a loser" and SUDs were 7 – 8. The stress resolved completely and ended with the PC "I am successful".

Mrs G rediscovered her strengths and regained her quality of life as a result of therapy. She was able to sleep restfully and work again. She felt full of energy and decided to recommence in an entirely new field. Her back pain had disappeared and she was in full remission of depressive symptoms.

Maria Lehnung is a Clinical Psychologist in private practice. She helped to research and develop DeprEnd with Arne Hofmann and others.

Healing attachment wounds with EMDR

Susan Darker-Smith attended Deany Laliotis' workshop on 'The Dance of Attachment' and was reminded of the critical importance of therapist self-care

Trauma affects us all. It is a universal human experience – whether it is the terror of experiencing a physical or sexual assault, the pain of losing someone we hold dear or the agony of growing up in a family and never feeling seen or heard by those who are meant to care for us.

Best known as a treatment for PTSD and childhood trauma, the role of EMDR in treating attachment wounds is still a relatively new concept for most non-EMDR therapists. Laliotis, a Trainer and EMDR Consultant, began by exploring how this myopic view of EMDR as being only a treatment for PTSD minimises its value in helping clients heal from attachment wounds.

Attachment wounding

Attachment wounds are those that occur when fundamental needs in infancy and childhood have not been met. Emotional neglect during a child's pivotal developmental stages can lead to the internalisation of blame and shame. It is well to remember that the term trauma comes from the Greek for 'wound, a hurt, a defeat'. Perhaps that myopia also explains why it is so easy to miss the wounds caused when a person has never been seen, heard, loved or valued.

The impact of such wounding is captured in the words of psychologist and author Shahida Arabi: "A child that's being abused by its parents doesn't stop loving its parents, it stops loving itself" (Arabi, 2016). And this is often what we see in our clients who have sustained attachment wounds in early childhood: that deeply held sense of being unlovable.

Laliotis explained that the self of the therapist and our relationship with the client is central to treating attachment wounds. In infancy, the process of exploration is only possible once the child has confidence in a safe place (the parent) as a secure base that remains steadfast and reliable: something that many of our clients, wounded in their relationships with their caregivers, have never had (Bowlby, 1988). Thus clients who have never had their developmental needs met may be unable to explore traumatic events; lacking a safe base they were deprived the chance to learn how to titrate the anxiety they feel associated with exploring the larger world. And safe place resourcing in the preparation phase may not be enough to address this. Such clients need the therapist to be that safe base – that steadfast and reliable anchor point – if they are to heal their attachment wounds. The relational dynamic between therapist and client is critical in affording the wounded client stability in the here and now while exploring their traumatic past.

In a remarkable presentation, Laliotis helped us to get in touch with our somatic responses and encouraged us to be aware of these when she presented a video of EMDR processing by a woman who had experienced the loss of two children through suicide. In the

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video, the woman becomes distressed and Laliotis paused it, asking us to identify what we were feeling at a somatic level. By repeating this process, it became clear that, in order to attune fully and relate from a position of authenticity with our clients, we must also be aware of what becomes activated in ourselves.

Bringing our best selves to this work requires an ability to track our own somatic and feeling-state experiences moment by moment as well as tuning into our client's emotional responses in order to navigate the real-time shifts in processing. Attunement, Laliotis argued, is key.

Yet we often miss the opportunity to bring the relational dimension into our practice. In a more relational model of EMDR, the relationship between the client and the therapist creates something Laliotis refers to as 'Active Attunement'. Active attunement is not merely tracking the client's experience – but means relating actively to what the client is experiencing: being 'in' that experience alongside the client while remaining open and curious about their journey and inviting the client to be similarly open and curious.

Laliotis describes the dynamic between therapist and client as a coemergent process; that is, it is configured organically through the attunement (Bloomgarden & Mennuit, 2009). To the extent that the therapist can hold in their awareness what is happening in the moment determines the extent to which the therapist can meet the client in their experience. Thus, bringing the 'self' of the therapist, resolute with an innate understanding of our own attachment styles and somatic responses, Laliotis explained, is a necessary part of the client's healing journey.

Deany Laliotis: Being in relationship with our clients requires self care

She concluded her workshop by summarising that being 'in relationship' with our clients in order to meet their needs requires a higher level of self-care if we are to prevent burnout and maintain best practice. Moreover, protecting ourselves from burnout requires an awareness of our own attachment styles and emotional states as therapists.

EMDR and world peace

Francine Shapiro believed that human suffering is largely a result of untreated trauma. As such it is far greater than the wounds caused by external life events. And as therapists, we must consider the longitudinal suffering caused by attachment wounding in childhood for adult and child clients alike.

In Francine's final communication with EMDR Europe, she sent her apologies and said: *"Your steadfast commitment to the alleviation of human suffering has resulted in an unparalleled union of 31 countries upholding the highest standards of clinical practice. The ongoing humanitarian programs are a wonderful reflection of your dedication to ensuring that no one is left behind... [and] this has important implications for reconciliation and world peace...The results of your actions will continue to manifest themselves through countless generations.'* (internet citation).

EMDR has far reaching implications that impact people all over the world. Through attuning to our clients from a position of respect, curiosity and openness, we have the capacity to help repair the wounds caused by unmet early developmental and attachment needs and in doing so, take an active role in helping Francine in her quest for world peace.

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Susan Darker-Smith is an EMDR Consultant and Child & Adolescent (C&A) EMDR Trainer. She is a founder member of the Trauma Response Network UK and is a member of the Association's C&A committee. Contact her at: https://www.://childtraumatherapy-centre.com

EMDR and working with transgenerational trauma

Jutta Brayne reports on Hélène Dellucci's presentation on healing wounds rooted in familial, cultural or collective pasts

Some clients come to therapy with an explicit awareness that they don't want to pass on to their children what they or a family member has struggled with. And on my own journey as a psychotherapist, I've become increasingly aware how many of the deep, long-lasting and often puzzling issues that we encounter working with EMDR are not traceable to touchstone experiences clients have had themselves, but turn out to be rooted in their family and cultural, or collective histories.

Hélène Dellucci talks of 'transmitted trauma'

Transmitted trauma

To find out more about what's increasingly referred to as transgenerational or intergenerational trauma, I attended Hélène Dellucci's presentation on EMDR with Transgenerational Trauma at the EMDR Europe Conference in Kraków in June. A psychologist, family therapist and EMDR Europe Consultant based in Geneva, Dellucci describes transgenerational trauma, or TT, as a Transmitted Trauma because the individuals were not themselves exposed to the initial traumatic experience yet are affected by it, similar to vicarious or collective trauma.

Dellucci hypothesises that Vicarious Trauma can perhaps be explained in part by mirror neurons, activated as she puts it without the mediating influence of the ability to differentiate between one's own experience and that of others.

This might go some way towards explaining traumatic contamination from parent or grandparent to child, but raises questions about the mechanisms at play when such direct transmission was not possible. Whatever the route, a whole range of presentations in psychotherapy can have their origins in transgenerational experience, from relational difficulties and lack of emotion and connectedness to compensatory enmeshment, phobias, psychosis, dissociation, treatment-resistant depression or anxiety and complex grief.

Goal-oriented brief therapy that targets a touchstone memory in the client's life does not necessarily resolve the client's distress, or prevent it from being passed onto the next generation. And when SUDs don't go down, and triggers or touchstone memories don't resolve, it is likely, she said, that transgenerational trauma is acting as a feeder memory. Transgenerational issues, Dellucci told us, need to be addressed specifically, and reprocessed.

She made suggestions for target identification such as a genogram during Phase One history-taking, stressing the need for psychoeducation on relational wounding and the value of imagination in resolving what needs to be resolved.

Speaking to an enthusiastic group of us at her well-attended workshop on day two of the Kraków conference, Dellucci said that clients can present with inexplicable psychosomatic problems, whether or not they are aware of family histories or narratives. It's therefore important for therapists to ask them about family members and cultural heritage, and their own or relatives' psychosomatic symptoms, as well as being alive to how such issues can arise spontaneously in session.

Parent's birth trauma

Based on her client work, Dellucci offered practical interventions and interweaves; for example, if a parent's birth trauma is known about or suspected, she suggested encouraging the client to imagine what the parent's foetus might have experienced and felt in the womb. This would, of course, warrant dropping the negative cognition while facilitating the emergence of a

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positive cognition.

In particular, Dellucci promotes what she terms a "double protocol" that addresses the client's and their relative's issues in parallel. She recommends following the Standard Protocol's sequencing for both the trigger and the past - step-by-step, in tandem - identifying a target image for the trigger, then an image for the transgenerational past, then the NC of the trigger, then the NC of the past, SUDs for both and so on.

Letter writing

Among Dellucci's other helpful ideas, the therapist can invite the client to write a letter to the emotional part, using EMDR's bilateral stimulation for targeting not only hotspots but what she intriguingly and logically describes as coldspots, where there has been an emotional nervous system shutdown. If necessary, an imaginary giving-back ritual can be added (with BLS at appropriate places) where the client hands the trauma back to those from whom it was received.

Dellucci spoke of the essential place of psychoeducation, helping clients understand the concept of parts and dissociation and the importance of careful resourcing for those parts. At the same time, she cautioned us to address a client's fear and /or initial rejection of an emerging emotional part before processing the trauma.

Noting work by Hanne Hummel and Michael Hase on murder and suicide, and how these often indicate transgenerational trauma, Dellucci suggested the same might hold true for psychosis, incest and domestic violence. She spoke to us of her conviction that transgenerational trauma is healable and that, provided the touchstone relational wound has been identified and reprocessed, its continued transmission in family systems can be prevented.

I found Dellucci's double protocol intriguing, as my partner Mark Brayne and I, with other colleagues not previously aware of Dellucci's work, have been experimenting recently with reprocessing transgenerational trauma by separating out the client (usually a child ego state) from the triggered parent in the client's memory. We then address the remembered parent directly through the client's imagination, floating or bridging back to a touchstone memory in that parent's own childhood. We then process the memory by giving what is in effect by-proxy bilateral stimulation via the client in the room, as she or he imagines that BLS being experienced by the parental introject.

Once the parent is in a soothed and positive state, both parent and child ego state are invited back to the initial target scene, where, in the client's imagination and memory, their parental introject is no longer compelled to continue acting as they did in reality, but how they might have responded to their child had they had a more secure attachment themselves.

Inside ICE - the Kraków Congress Centre - on the bank of the Vistula

We find this can help integrate a client's past, and reinforce the necessary positive self-referencing PC belief ready for checking the Future Template. It sounds more complex than it is, but while approaching the issue from a different angle to how Dellucci works, the effect seems to be similar.

Dellucci's presentation had particular significance and resonance given the proximity of beautiful Kraków to the termination camp at Auschwitz, close by.

Auschwitz resonance

I think all conference participants were acutely aware of the extreme violence and suffering that was experienced at Auschwitz and its disturbing potential to reverberate on through nations and generations. Like many other participants, we visited Auschwitz before the conference started. Our guide told us he was himself a descendent of Auschwitz survivors and that working there was his life's mission. His hope? An end to genocide and suffering. Perhaps with our own EMDR work on transgenerational trauma, we too can make a small contribution to that goal.

Jutta Brayne is a registered psychotherapist and Accredited EMDR Practitioner in private practice in Norfolk. Jutta and Mark Brayne will be presenting their work on transgenerational trauma in October at a conference of the Parnell Institute in San Francisco

BOOK REVIEW

The power of shame

Unshame: healing trauma-based shame through psychotherapy
By Carolyn Spring

Carolyn Spring Publishing, 2019
ISBN: 978-1-9998646-1-3

UNSHAME

healing trauma-based shame through psychotherapy

CAROLYN SPRING

author of *Recovery is my Best Revenge*

Reviewed by Omar Sattaur

Shame is the conviction we have of being wrong, defective, damaged. It is something we feel in relation to others, particularly to a group whether that is a family, a friendship group or the society in which we live. Its function is to de-escalate conflict by adopting an inferior position in relation to the 'other'. Whilst this can confer the protection of the group or other – shame signals my acceptance of my 'wrongness' in relation to the other's 'rightness' – it can also exact tremendous costs on an individual. Carolyn Spring's book shows how her experience of abuse as a child sowed the seeds of shame and how these germinated, grew and flourished in her adult life causing her unremitting distress and repeatedly bringing her to the brink of suicide.

This is not a book about EMDR therapy, and you may legitimately wonder then why I have selected it for review in this publication. It is because of the relationship of shame to trauma, particularly childhood trauma, and because of the power of shame to derail therapy of any kind, including EMDR therapy.

Many survivors have written accounts of their experiences and their healing journeys. But not many have Spring's courage, honesty, understanding of trauma and patience to unpick the helpful conversations she has had in therapy. Nor have many gone on, as she has, to help others escape the psychological burden of trauma – she is the founder of PODS, Positive Outcomes for Dissociative Survivors. Her book is a reflective account of the milestones and turning points in her own recovery journey and it makes for interesting reading for any therapist who is aware of the power of shame and the critical importance of the therapeutic relationship.

Reading it I was struck many times by its stamp of authenticity. "These are not verbatim accounts", Spring writes, "they're narratively true rather than historically true: these sessions didn't happen exactly as I present them, and yet, in essence, they absolutely did happen" (p1). She recounts many therapeutic moments, the like of which many of us will have recognised, but rarely have been afforded the client's perspective. It reminded me of clients I have worked with and made me reflect on how my interventions might have been received. Most of all I found it a valuable reminder of the power of what Dave Mearns and Mick Cooper call working at 'relational depth' (Mearns & Cooper, 2005); when the provision of empathy, authenticity and compassion paves the way for a level of attunement that brings lasting change. Of her therapist, Spring writes: "I can't describe how she responds. She's not silent, but she doesn't use words either....I feel heard. I feel understood. I feel held. And just for a moment, the pain eases, and moves back a few inches. It's still there but it's muffled. It's more bearable, less intense and its edges blur. I don't know how she does it, especially without words. It's something about presence. It's some silent communication between her nervous system and mine. It feels primitive. It is wordless", (p172).

There is an excellent account of careful work with Spring's various ego states (she has described how shame and trauma "resulted in a way of experiencing the world that is called dissociative identity disorder"). Following a dissociative episode during a therapy session, the therapist asks whether Spring remembers what just happened. She responds angrily that she can't remember when she is in other parts. "Hmm", the therapists says, "I think sometimes you can, and that you could if you wanted to". Spring then gives an account of her internal process, taking her through angry indignation at her therapist's 'provocative' assertion, an intimation on the edge of Spring's awareness that, perhaps, there is the hint of freedom in the frightening prospect that, if she wished, she perhaps could remember some of what her other parts

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experience and the realisation that her therapist is: "...absolutely right. I could know if I wanted to know. It's exactly because I think it's too overwhelming, too unbearable, too shameful, that I don't want to know". ....There aren't words big enough to describe this feeling. It is the sense that I would rather be anyone other than myself. It is a belief that I am fundamentally and impossibly flawed, that I will never change, that there is no-one in the universe as unacceptable as me. It is an expectation that I must cling to the edge of the room because if I dare to take my place in the world, to show my face, to announce my arrival, I will be rejected. I am only allowed here as long as no-one notices me, as long as I don't get in the way, as long as I don't need or demand anything".... "You're ashamed of being you?" "Yes", (pp91-93).

The ensuing thoughtful, deep exploration of the shame associated with dissociation, the injured parts, and the daily toll of distress that this exacted on her as an adult is the heart of Spring's book and makes painful but very worthwhile reading. Spring gives us a client's experience of grounding, barriers to keeping safe, mindfulness and mentalisation. But above all, of how shame works to create barriers that imprison traumatised clients and prevent therapeutic change.

Reference

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Omar Sattaur practises EMDR at the University of Manchester Counselling and Mental Health Service. He also edits EMDR Therapy Quarterly

A letter to Association members from Rolf Carriere, Director of the Global Initiative for Stress and Trauma Treatment

GIST-T
GLOBAL INITIATIVE FOR STRESS AND TRAUMA TREATMENT

Dear Membership of the EMDR Association United Kingdom & Ireland,

An estimated 500 million people worldwide suffer from trauma and its adverse consequences. The Global Initiative for Stress and Trauma Treatment (GIST-T), serves to meets the needs of people traumatised by natural disasters or violent conflicts, in low- and middle-income countries. The aim of GIST-T is to reduce the global burden of Stress and trauma and in doing so promote healing, health and hope and foster resilience, peace and productivity.

Last April 2018, GIST-T, jointly with ATDL, organized a conference on EMDR Early Intervention (EEI) in Boston (USA) for almost 400 participants. On that occasion the request was made that GIST-T convene an expert workshop to design an AIP-informed curriculum for trauma relief for use by humanitarian crisis workers in the global south — ranging from community health workers to frontline nurses and doctors and teachers and first responders. These frontline workers would thus be trained and supervised to provide services to meet currently unmet needs in crisis situations in Low- and Middle-Income Countries (LMICs).

May saw the completion of the first edition of Traumatic Stress Relief (TSR): Training package. The TSR training package aims to promote and extend trauma relief capacity, applying EMDR/AIP methods

All associated with the GIST-T project receive no payment—all of us offer our time and energy pro bono.

The late Francine Shapiro, herself, contributed to the work of GIST-T and, just as important, encouraged the work and seeking of donorship to fund the projects.

It is in that context that we, at the Global Initiative for Stress and Trauma Treatment (GIST-T) seek financial support for continuing the next stage of the Traumatic Stress Relief (TSR) project, which takes place in August/September 2019.

Since GIST-T's financial resources are very limited, our appeal to EMDR UK & Ireland is an invitation for financial contributions that would allow us to maintain and meet expenses of projects currently.

We greatly appreciate past support from the EMDR Association for GIST-T ventures, especially the Marawi project (2017/2018).

Further information on past and current projects can be located on the website: gist-t.org

GIST-T will be pleased to keep you informed in the future.

Best personal regards.

Rolf C. Carriere
GIST-T Executive Director, a.i.

Clare Blenkinsop
GIST-T Executive Secretary
CONTACT@GIST-T.ORG

Please see overleaf for a message from Association Treasurer, Kath Norgate, on how you can support this important initiative.

EMDR EYE MOVEMENT DESENSITISATION AND REPROCESSING THERAPY

Dear Members,

I write to invite your support for GIST-T, It is a global initiative whose aim is to reduce the global burden of stress and trauma.

Your Association supported them with some funding at the beginning of 2018 when they went to Marawi in the Philippines on an Assessment mission, you can read more about them, that particular mission and their other work in the attached leaflet and letter from Rolf Carriere. It is an initiative that was close to Francine's heart and one that she contributed to, encouraged and provided financial support to.

Click here to download leaflet

They are seeking further financial assistance for the next stage of their Traumatic Stress Relief project. Your Association has already made a donation of £5000 but they need more. The Trustees have agreed that further funding needs to be driven by the membership and to that end, it has been agreed that we will match any funds donated by individual members. Just send a screen shot of your donation and we will pay the same amount into the GIST-T account. I also urge you, if you belong to a Regional Group that has a reasonable bank balance, to encourage the managing committee to consider making a contribution, no matter how small, to this very important initiative.

Beneficiary Account Name: GIST-T , Chemin du Chateau 15, 1246 Corsier GE

PostFinance BIC (SWIFT code): POFICHBEXXX
Beneficiary Account number IBAN: CH12 09000000 8975 2201 5

Beneficiary Bank Address: PostFinance Ltd, Mingerstrasse 20, 3030 BERNE, Switzerland.

Thank you for your kind attention.
On behalf of the board

Kath Norgate
Treasurer and Trustee

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Treating Compulsive Sexual Behaviours with EMDR

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Abstract
The psychological presentations of compulsive sexual behaviours are often misunderstood and mistreated. In this article, I aim to clarify the confusion regarding the term 'sex addiction' for the more accurate and scientific diagnosis of compulsive sexual behaviours, based on robust sexological science.

Compulsive sexual behaviour (CSB) is a complex condition. It is important to have a solid assessment and a unique clinical formulation of the patient's difficulties, if the clinician is to choose the appropriate treatment.

The next stage is sex education in preparation for EMDR treatment to reduce sexual shame, which not only motivates CSB but also blocks processing.

The clinician may then choose whether the Standard Protocol, the DeTUR protocol or the Feeling State protocol is most appropriate based on the assessment. I illustrate how to use each protocol with case studies.

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Introduction

Many patients report negative consequences as a result of unwanted, repetitive, consensual sexual behaviours. In their initial consultation, they often use a 'sex addiction' language as it is the most familiar language: their behaviours feel like an addiction because they think they can't stop it.

I will answer the following questions:
1. How may compulsive sexual behaviours be recognised and how may the disorder be diagnosed?
2. How may the disorder be diagnosed in an ethical manner?
3. How may EMDR be used to treat the condition?

What is a compulsive sexual behaviour?
For years, clinicians have disputed the case for 'sex addiction'. Whilst the DSM-V has not categorized the problem as a disorder, the ICD-11 (International Classification of Disease) included the following entry on Compulsive Sexual Behaviour as a disorder:

Compulsive sexual behaviour disorder is characterized by a persistent pattern of failure to control intense, repetitive sexual impulses or urges resulting in repetitive sexual behaviour. Symptoms may include repetitive sexual activities becoming a central focus of the person's life to the point of neglecting health and personal care or other interests, activities and responsibilities; numerous unsuccessful efforts to significantly reduce repetitive sexual behaviour; and continued repetitive sexual behaviour despite adverse consequences or deriving little or no satisfaction from it. The pattern of failure to control intense, sexual impulses or urges and resulting repetitive sexual behaviour is manifested over an extended period of time (e.g. 6 months or more), and causes marked distress or significant impairment in personal, family, social, educational, occupational, or other important areas of functioning. Distress that is entirely related to moral judgments and disapproval about sexual impulses, urges, or behaviours is not sufficient to meet this requirement.

The WHO (World Health Organization) clearly states that there is no clinical evidence of an addictive component to sex therefore the disorder is classified as an Impulse Control Disorder. This should give clinicians enough confidence to stop using the term 'sex addiction', as it is neither clinical term nor diagnosis. The science simply does not support the addiction model.

Patients are commonly misdiagnosed as 'sex addicts' or as exhibiting 'compulsive sexual behaviours' due to a lack of knowledge or from a

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basis of 'sexual morality'. Clinicians must avoid this if their practice is to remain ethical. We must be diligent in formulating a robust conceptualization of patients' presentations. Failure to do so can cause harm to patients. There are a few important considerations when assessing a patient following the diagnostic criteria:

- The patient must decide on which sexual behaviours are problematic . A patient may, for example, say that their repetitive visits to sex workers is a problem but their pornography use is not. It is not for clinicians to decide for patients what is problematic and what is not. We must observe the ethical guidelines of honouring patients' autonomy and not tell them what to do with their sex lives.
- When a client reports feeling shame after engaging in a pleasurable sexual behaviour, it is the shame that requires treatment and not the behaviour.
- Many people do not attempt to reduce their repetitive sexual behaviours until after they are caught by their partner or at high risk of being caught. In this case, a psychosexual and relational investigation of the couple is needed.
- If a patient judges their sexual behaviour as 'wrong' from the perspective of their partner, religious morality or society, the diagnosis of the disorder must be ruled out. In such cases it is a problem of shame rather than of sexual behaviour.

The psycho-sexological assessment

Given the considerations above, many patients will not meet the criteria for the disorder. Many however will present with a sexual health behaviour problem. EMDR is effective with both populations. An effective treatment is underpinned by a robust psycho-sexological assessment which is framed by a sex-positive philosophy.

The six principles of sexual health (Braun-Harvey & Vigorito, 2015) (see panel) is a good guide for patients to assess their own sexual behaviours as it is principle-focused rather than behaviour-focused. The rationale behind this is that if we are behaviour-focused, we can easily insert our own sexual morality. For example, if the clinician doesn't agree with group sex, he is more likely to assume that the patient practicing frequent group sex may have a problem. However, if we are guided by the sexual health principles, it is easier to assess problems non-

The six principles of sexual health

(Douglas Braun-Harvey & Michael A. Vigorito, 2015)

Consent. A voluntary cooperation and the permission to reach sexual satisfaction and intimacy with oneself and willing partners. Consent is a balance between one's autonomy to give clear unambiguous consent for sex in combination with everyone's right to engage in sex with whomever he or she chooses. Safe, consensual sex is a human right and the essential sexual health principle that makes mutually positive sexual interactions possible.

Nonexploitation. Exploitation can be seen as leveraging one's power and control to receive sexual gratification from another person, which compromises that person's ability to consent. A person can increase the likelihood of nonexploitative sex when he or she remains highly motivated to ensure he or she is not taking unfair advantage to gain access to a sexual partner or sexual activity. Nonexploitative sex is likely when each person considers the risk of exploitation as it relates to the consent between partners, the potential of harm, and the mutual advantageousness for each person to enjoy the sexual situation.

Protection from HIV, STIs and unwanted pregnancy. This sexual health principle is evident when those involved in the sexual activity are capable of protecting themselves and their partners from an STI (including HIV) and unintended or unwanted pregnancy. This includes access to testing and medical care and to scientifically accurate information regarding disease transmission, reproductive health and contraception resources.

Honesty. Sexual health involves direct and open communication with oneself and one's partners. Self-honesty involves being open to sexual pleasure, experiences, and sexual education. Honesty is a crucial building block for sexual relations with others and is necessary for effective communication to uphold all of the sexual health principles. Honesty in sexual relationships varies based on the relational factors and contexts and is not to be confused with complete transparency and unlimited candidness.

Shared values. Sexual relations between partners involve clarifying motives, sexual standards, and the meaning of specific sexual acts for each person. This principle promotes conversations between sex partners to clarify their consent for sexual relations, discuss their sexual values, and articulate motivations for having sex.

Mutual pleasure. The mutual-pleasure principle prioritises the giving and receiving of pleasure. There are many ways for both giving and receiving sexual pleasure. Each moment of heightened pleasure can have many meanings that can change over time and with different partners. Valuing the pleasure of sex as positive and life-enhancing aspect of sex is vital for ensuring mutual pleasure. Mutually pleasurable sexual activity invites clients to consider their bodily, erotic, and emotional sensualities for themselves and their partners.

Sexual Health is the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. (WHO 2006).

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judgmentally. Viewing their behaviours through the lenses of principles is good because it helps to reduce sexual shame.

Clinicians can have powerful conversations with their patients about what a breach of sexual health principles means, thereby guiding them towards good sexual health. I think it more useful to discuss a patient's sex life rather than what is 'healthy' or 'unhealthy' where we may fall into polarized views that are potentially pathologising.

A psycho-sexological assessment also includes the following understanding:

1. A compulsive sexual behaviour is not an addiction.
2. It is neither an illness nor a character defect.
3. A thorough understanding of the patient's erotic mind and arousal template is crucial.
4. The CSB seeks to resolve unmet needs, either emotionally, relationally or sexually.
5. The CSB seeks to resolve an attachment problem.
6. The CSB can be completely resolved with appropriate treatment.
7. The problematic sexual behaviours are symptoms of underlying disturbance. If we treat the behaviour alone, we don't treat the problem.
8. A 12-step fellowship programme is not recommended. Abstinence is not recommended as it can increase sexual shame exponentially.

Exploring the erotic mind and identifying the arousal template

Some of the central enquiries are: What is your sexual memory that leads to peak arousal and what is it that makes it a peak 'turn on'? What is your sexual fantasy that leads to a peak 'turn on' and what makes it a peak 'turn on'?

Such exploration enables patients to identify the ingredients of their natural arousal template. For example, some of these ingredients can be: 'In the office, dominant'; 'Connecting, looking into each other's eyes, in bed'; 'Stranger, anonymous, in a park at night'.

You might be surprised that the first of the ingredients listed above is part of a female patient's arousal template and the second is a male patient's. I am pointing this out because it is easy to let our sexual, relationship and gender biases cloud our vision and misdirect our clinical considerations. When it comes to the erotic mind, there are no real rules; everybody is different and specific about what turns them on. This process of inquiry often reduces the patient's sexual shame. It is a clinically crucial step because when we begin EMDR processing, we must not process any of the materials that are parts of the patient's arousal template as it can be harmful and unethical.

Trauma and Erotic Timelines

Doing a timeline with a patient will indicate what might cause the compulsive sexual behaviour. There is usually a trauma or a series of traumas. Alongside the trauma timeline, it is important to do an erotic timeline to understand a patient's erotic history: the first time they had sexual urges and fantasies, their sexual history, their relationship history, how they felt about it, their sexual 'script'. The Erotic Timeline is important because, in some cases, the compulsive sexual behaviours can arise from sexual immaturity rather than trauma. Often, there are both elements at play.

The identification of the underlying problems is varied and unique to all. It may be that monogamy is not a good arrangement for the patient and they need to find a relationship setting that is more appropriate to them. (This requires much courage and a deep exploration of their erotic mind). It may be a one-off or multiple childhood traumas: sexual abuse, physical assaults, parental neglect, disruption in attachments, traumatic loss and so on. Most patients will harbour negative core beliefs: 'I'm worthless' 'I'm unloveable', 'I'm alone in the world', 'no matter what I do, it always turns bad', 'I only have myself to rely on'.

We should be mindful to work towards shame reduction continually, from the first meeting, throughout the assessments and until the end of the treatment. The clinician should inform the patient through accurate sex education, normalising sexual behaviours and sexual fantasies as well as highlighting that the problem is not a chronic disease but the symptom of erotic and relational conflicts for which permanent positive change is possible.

Compulsive sexual behaviours are complex behaviours and they are unique to each patient. I use different EMDR protocols depending on the presentations and root causes.

Clinical Pathway One

If there is a clear starting point trauma identified, the clinician can use the standard EMDR protocol.

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Clinical Pathway Two

If there isn't a clear starting point trauma identified, the clinician can use the DeTUR protocol, which is focused on reducing urge. One must be mindful to process only the urge triggers that are typically non-sexual and away from the patient's arousal template, for ethical and safe practice. It is important not to desensitize urge triggers that are typically sexual as they are most probably functional. We must remember that it is usual and normal to feel sexual arousal with sexual cues.

Clinical Pathway Three

If clear urge triggers are not identified, when sexual behaviors have gone out of control in a generalised way, the clinician can choose the Feeling State protocol. When using this protocol, it is important not to focus on the sexual behaviour but on the psychological benefit of the behaviour, for example not 'visiting sex workers' but instead: 'feeling seen and wanted'.

A case study using standard EMDR Treatment

Presentation

Tom is a 22-year-old man presenting with compulsive pornography use. He loses hours every day to pornography use, neglecting other areas of his life, including study and self-care. His

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shame about his behaviour caused problems in his relationship and made him turn away from his girlfriend. He made several attempts to stop but failed each time. He has had these behaviours since the age of 12, but the problem became unmanageable since living on his own.

History

A clear trauma starting point for his behaviour was identified - his mother died of cancer when he was 12. Nobody in his family discussed his mother's illness and death, which created a rupture in attachment that remained and was never addressed. He felt unable to express his intense sadness, anger and other grief-related emotions to anybody. He discovered masturbation and pornography, and this became his sole means of successfully soothing his pain.

Preparation

Shame reduction: watching pornography is not 'wrong'. Masturbation is a good soothing strategy.
Validation: The goal is not to stop masturbating and watching pornography, it is to expand Tom's self-soothing capacities as well as healing the grief of his mother passing.
Stabilisation: Emotional regulation. Safe place installed.
Psychosexual education: There are various ways to have sex, including solo sex. Pornography is entertainment, not sex education. Connection with girlfriend is different from solo sex.
Reframe: pornography and masturbation can be a good quality time with self, provided it is well-boundaried in a way that it doesn't affect other areas of life.
His erotic mind: Tom had a fetish for pierced tongues, long nails and 'bukkake'. It is the materials he watches on porn mostly.

EMDR Treatment

Standard EMDR protocol targeting the memory network related to the death of his mother.
SUDs: 9/10; NC: 'I am alone'; PC: 'I have connections' = 1/7
We had three session of psychosexual and relationship therapy to help him have honest conversations with his girlfriend about his erotic mind, his turn-ons and his functional use of pornography.

Outcome

Four sessions of bilateral stimulation (BLS).
SUDs: 1/10 (ecological); PC: 'I have connections': 7/7. Appropriate sadness when thinking about his mother's death in voluntary memory. Able to recognise sadness and anger.
Pornography use decreased significantly, only at appropriate times and with no consequences to the rest of his life. He was much more productive with his studies as he had more time and energy to engage with it. His connection with his girlfriend improved. He was able to have honest conversations with her based on the six principles of sexual health. Tom's fetish was

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discussed and understood by both; his girlfriend accepted that Tom would watch pornography as quality time for himself in addition to spending quality time engaged in sexual activities for their mutual pleasure.

Review

At six- month and one-year post-treatment evaluation the positive outcomes were maintained. He realised that his career path would lead to lone working. This was in line with his previous NC 'I am alone' but no longer fitted since his PC 'I have connections' was successfully installed. He decided to re-train for another career.

A case study using DeTUR

Presentation

Gary is a 40-year-old man married to his husband in a monogamous relationship. Compulsive behaviours included having sex anonymously with men in secret, mainly in sex clubs and public toilet cubicles. He does not get satisfaction from his behaviours and feels worse afterwards. He feels much shame as well as guilt for cheating on his husband. Gary reports that he is in love with his husband and sex with him is satisfying; he is unable to identify a significant issue with his relationship. The idea of sex in sex clubs excites him but the behaviour does not. He derives no pleasure from sex in public toilets.

History

Good enough childhood with no significant trauma. Usual sexual development. No significant issues with attachment identified. Third relationship: it is the first time he finds himself being unfaithful. He doesn't understand why. The behaviours started one year after getting married.

Preparation

Shame reduction: compulsive sexual behaviours are a sexual health behaviour problems, not a disease or character defect and positive and permanent change is possible.
Validation: Compulsive sexual behaviours seek to meet sexual needs, attachment needs or emotional needs. We can figure it out together.
Stabilisation: Emotional regulation. Safe place installed.
Psychosexual education: The six sexual health principles.
Sexual Health: recommendation to have a STI check-up at a sexual health clinic.
Erotic mind: he finds group sex with strangers very exciting. It is the not knowing and the anonymous body contact that he finds thrilling. If he is in a dark room, it heightens his bodily senses. He does not know why it is so arousing for him.
Relationship: He finds all aspects of his sex life with his husband satisfying and arousing. He describes his husband as sexually open and adventurous. They have sex once or twice a week, which he is satisfied with.

DeTUR Protocol

External resources: Gary has good friends. He goes to two yoga classes, exercises regularly and has a good diet and good sleep hygiene. He lacks a hobby or meaningful activities but has made a commitment to himself to add one to his life. He is thinking about doing photography. I did not recommend a 12-step programme such as SA or SAA.
Internal resources: His values (six principles of sexual health, monogamy), his integrity: honesty with self and his loved ones. Practising emotional regulation and mindfulness. Practising affirmations and gratitude.
Positive treatment goal (PG): The treatment goal must be sex-positive - not 'I must only have sex with my partner' or 'I must stop masturbating'. For Gary, it was to 'have a fulfilling and diverse sex life with the partner of my choice'. PG installed with bilateral stimulation.
Positive state (PS): feeling calm, peaceful, excited, free of shame, comfortable with body and mind together. Breathing into these feelings and experiencing them. Install PS with BLS. Anchor the Positive State, touching his wrist. Check that the anchor brings PS without BLS. Suggested to practice anchor in between sessions (it can become a new internal resource).
Desensitisation of triggers, installing PS and future template: Triggers identified that are linked with unwanted urges that are not typically sexual and away from his arousal template. Rate the level of urge (LOU). The desensitisation process to be done with EMD (returning to target for reading after each set, for less free association).
The process of desensitisation, installing the PS and future template to be done for each trigger.
T1: Smell of public toilet: LOU1: 8/10 - 0/10. Bilateral stimulation with PS and anchor with trigger: Positive state. Future template: Imagine

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handling the trigger successfully. Bilateral stimulation with any blocks. Run the scenario until clear. 'When I smell the public toilet scent, I am calm and remind myself that it is a non-sexual public place'.
T2: Image: his partner being disgusted by him: LOU2: 9/10 - 0/10. BLS with PS and anchor with trigger. 'When I want to do something sexual with my partner, I can talk to him about it and check if he might like it, rather than assume he won't. My husband is actually open-minded. Sharing sexual fantasies together is hot'.
T3: Image: stranger looking at him with sexual desire: LOU3: 9/10 - 1/10 (ecological).
BLS with PS and anchor with trigger. 'When a stranger fancies me, I can recognise my sexual arousal. It feels good. I like it. I don't have to act on it. I can remain calm and remind myself that I have a husband who fancies me. When it is the right moment, I can masturbate thinking of having sex with strangers and it is my private hot fantasy or I can choose to initiate sex with my husband'.

Outcome

Four sessions of BLS to desensitise all LOUs identified and urges came under control. Gary reported that he still had sexual desires to have sex outside of his relationship, but he was able to control his urges and no longer felt compulsive. Once the urges were cleared, there was room for Gary to identify an underlying trauma through a recurring NC: 'I'm unlovable'. The traumatic memory linked to the NC that emerged was growing up in a homophobic household, which he believed he had previously overcome.
Floatback to the first time he felt 'I'm unlovable' unlocked a memory of his father shouting at him for playing with girl's toys when he was five years old. He made the link between his sexual behaviours and an underlying need to be loved, desired and wanted, as it meant survival for him.
Standard EMDR protocol on the first memory SUD: 8/10; NC: 'I'm unlovable'; PC: 'I'm loved' – 2/7. Three EMDR sessions of BLS processing many memories in the homophobic memory network, including bullying at school, which didn't feature in the original history taking.

Outcome

After the three sessions of the Standard Protocol, SUDs were 1/10 (ecological); PC: 'I'm loved' which expanded to: 'I can love and receive genuine love': 7/7
His compulsive sexual behaviour stopped. He lost all desire for sex with strangers and felt more connected to his husband and friends like he had never felt than ever before.

Review

At six months post-treatment his CSB disappeared. Gary stayed with his values and integrity and did not have sex outside of his marriage again. He felt good about it. He reported feeling present in his marriage. He was able to reflect that the act of getting married triggered the 'I'm unlovable' which was the starting point of his CSB. One-year post-treatment he was using his PS and anchor successfully when needed. He reported a more balanced life overall, with hobbies, connections and satisfying sex with his husband.

Case study using the Feeling State Protocol

Presentation

Peter's compulsive behaviour was to engage in group sex with men using drugs, commonly known as Chemsex. He reported being unable to stop himself engaging in Chemsex every weekend, resulting in significant problems with his career (as he would experience come-downs and low moods from Mondays to Wednesdays and so could not perform well at work). He also developed difficulties in sleeping and he would neglect basic needs like eating at weekends. His sexual health was at risk too as he was having unprotected sex. He was on Prep and managed to remain HIV-negative, but he consistently contracted STIs. He went to sexual health clinics once every three months. He was aware that he didn't always know what drug he was taking, which put him at high risk of overdose and serious harm. What brought him to therapy was the escalation of the behaviour by starting to inject the drugs; he said this made him feel like a 'junkie'.

History

Peter grew up in a highly religious household where being gay wasn't accepted. He was bullied at school. He felt he didn't fit in throughout his life. He had black and white thinking which revealed homo-negativity: 'gay men don't do love', 'gay men are only interested in sex'.

Preparation

Shame reduction: it is ok to have group sex. It is ok to have anonymous sex, as long as it is safe, pleasurable and without negative consequences. It is ok to be gay. You can be gay and be a loving person in a stable relationship.
Validation: the most 'functional' part of Chemsex is a sense of 'community', 'connection' where there is no 'rejection'.
Treatment information: Chemsex is complex. It's not only a drug issue, not only a sex issue, it's both that need to be treated.
Sexual health: STI check-ups. Chemsex first-aid leaflet. Chemsex support group.
Psychosexual education: the six principles of sexual health.
Harm-minimisation: how to make sure he can reduce harm when engaging in Chemsex.
Erotic Mind: His erotic template was disrupted by the drugs in a way that it was impossible for Peter to identify what was a turn-on for him and what was a drug-induced turn-on. The lines of enquiry were unsuccessful.
Stabilisation: Emotional regulation. Safe place installed.
Feeling State protocol treatment
Although the Feeling State is behaviour-focused, I like the protocol because it does not employ an addiction stance of sobriety and aims to break the link between the positive feeling state associated with the behaviour. Although we try to break the link between a positive feeling state and a behaviour, the clinician should be mindful not to process a positive feeling state that is typically sexually arousing.

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For Peter, the most intense part of the Chemsex behaviour was walking through the door of the house party. For Peter it was associated with a positive feeling of 'I'm accepted'. Indeed, the Chemsex parties guarantee a lack of rejection. The 'I'm accepted' positive state is one that is important for Peter to protect, given that he had never felt that he fitted in.
Positive feeling state (PFS) 'I'm accepted' with walking through the door: 10/10
Locate the positive feeling state in the body: Forehead, chest, heart. Two BLS sessions with EMD: 1/10 (ecological). As the most intense positive state and the behaviour of walking through the door was desensitised, Peter immediately felt much less urge to do Chemsex. After the second session, it was the first weekend when he didn't want to go to a Chemsex party. What emerged next was grief and the NC: 'I'm nothing'.
Floatback uncovered a link between the NC 'I'm nothing' and his earliest memory of his father's face when, pointing at the 10-year-old Peter, he told his son: 'if you're gay you won't be my son anymore'.
Standard EMDR protocol
SUD: 9/10; NC: 'I am nothing'; PC: 'I am good as I am': 1/7.
Eight BLS sessions with regular emotional regulation. SUD: 0/10 – 'His opinion doesn't matter now'; PC: 'I am good as I am': 7/7 – 'There is more to being gay than random sex. I can be liked for who I am'.

Outcome

Peter's urge to engage in Chemsex parties ceased completely. He used his weekends to meet good friends that were not in the Chemsex scene. He started meaningful activities. His work performance improved instantly and he was able to look after himself much better. He started to challenge himself with his black and white homo-negative thinking and developed a new understanding of being gay.

Review

Six-months post-treatment the positive out-

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come was maintained. He struggled to find a partner. Meeting men around a common hobby (like a class) rather than using apps was suggested. Although he didn't have any desire for Chemsex, he didn't manage to find a partner for good sexual pleasure. Touching body mindfully was suggested. Butterfly hugs practised.
One year post-treatment Peter found a life partner and was just starting to feel sex pleasurable again. He found it easier to reach out to people and his PC was: 'People love me and want to be with me'.
Peter learned that he needs to connect with friends and needs to love himself in order to tolerate being vulnerable with others in a sober state.

Discussion on important considerations for ethical and safe practice

1. The treatment pathways exclude sexual behaviours that are non-consensual. The area of sex offending differs from CSB.
2. The treatment for CSB using the three clinical pathways is effective with all populations: LGBTQ , female and all heterosexual populations.
3. The preparation stage is crucial and has to include psychosexual education.
4. We do not focus on the sexual behaviours, which are only symptoms. Instead, we focus on the underlying cause which various EMDR protocols can treat well.

Although the DeTUR and the Feeling State protocols are used for addictions, it doesn't follow the traditional abstinence-based model. Abstinence is not recommended as it can be shaming and harmful. Many people in 12-step programmes become dependent on their sponsors, doctrines and meetings. The major problem with this is that patients do not become autonomous in their sex lives and they do not develop any internal resources to manage their own emotional states. All of the 12-steps resources are external, including the 'Higher Power'. In my opinion, dependence on external resources is not a good clinical outcome. The dependence is based on fear too: 'if you stop the meetings you will go down the rabbit hole', this is mainly because of a lack of sexual knowledge and a lack of proper psychological resources (12 step members are not therapeutically trained).

The entire treatment is framed with robust psycho-sexological knowledge. Science informs us that sex is not addictive. It is important not to process material that is part of the patient's arousal template for ethical and safe practice.

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Required statements

Ethical statement

I, the author, have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the American Psychological Association.
I also abide by the ethical principles of BACP (British Association for Counselling and Psychotherapy) and COSRT (College of Sexual and Relationship Therapists).
There is no ethical approval needed. This article is a summary of case studies of my own clinical work.

Conflict of Interest

There is no conflict of interest identified.
My clinical work described in this article makes a small percentage of my income. I do not financially or otherwise benefit from my particular clinical opinions. I based my clinical opinions and pathways on scientific evidence.
My patients have given consent for this article to be written. All of their identifying information are hidden to maintain their confidentiality.

Financial Support

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EMDR Therapy Quarterly
Guidelines for authors

EMDR Therapy Quarterly is intended as a practical journal combining scientific rigour, carefully selected practice updates and evaluations and innovative and novel research. The following guidelines aim to elicit useful practical applications in a structured and exacting scientific style.

1. Editorial Statement

EMDR Therapy Quarterly is peer-reviewed and aims to disseminate and promote effective research and practice. Its intended audience is practitioners, and, with this in mind, the journal publishes articles covering both clinical and professional themes. Papers describing empirical research will be considered in line with those that are practice-focused. The journal will ensure the publication of theoretical research of exacting standards together with articles accurately detailing clinical and professional matters.

2. Scope

Articles will be welcomed from those involved in the practice and/or research of EMDR. All articles must include 3 – 5 learning objectives that are achieved through reading the paper. A summary must be included at the end of the article detailing principal points and suggestions for further reading. This is consistent with the aim of the journal in providing professional development and supporting practitioners in delivering therapeutic treatment.

Articles should contain only original material that has received all required ethical approval and is not published, or under consideration for publication, in any other domain.

2.1 Practice Articles

The development of EMDR has relied on empirical research. Articles will be published that explore EMDR practices and their research base, as well as innovative practices and their outcomes. This may include the application of EMDR in new treatment areas, in novel service models or in particular clinical settings. Information regarding both successful and unsuccessful practices are valuable in the development of EMDR and are equally welcomed.

2.2 Case Studies

Case studies are sought which contribute to the development of EMDR theory and/or practice. Sufficient detail must be included for other practitioners to replicate successful treatments. The suggested structure for case study articles is as follows:

a. Abstract
b. Learning objectives
c. Introduction
d. Presenting problem
e. Course of therapy
f. Outcomes
g. Discussion
h. Summary and further reading
i. Required Statements
j. References

2.3 Original Research

Research evidence forms the basis of EMDR practice and development. Original research will be welcomed, including the investigation and evaluation of therapeutic processes and techniques and application in new treatment fields. Such investigations must be scientifically rigorous and should include the standardised outcome measures of the EMDR Association UK & Ireland. Research articles should be sufficiently brief to enable assimilation and discussion of the study's implications. Consideration will be given to quantitative, qualitative and any other approaches providing an appropriate investigation of the research question. A similar structure to that of the case studies papers could be beneficial, such as:

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a. Abstract
b. Learning objectives
c. Introduction
d. Research question
e. Methodology
f. Results
g. Discussion
h. Summary and further reading
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Articles should be 5,000 words or fewer on submission (excluding references, tables and figures). Formatting of text should not go beyond using bold or italics to distinguish between main title, headings and sub-headings. All submissions should be addressed to: editor@emdrassociation.org.uk

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1. Title Page: highlights major issues
2. Main manuscript:
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   b. Learning objectives
   c. Introduction
   d. Presenting problem/Research Question
   e. Course of therapy/Methodology
   f. Outcomes/Results
   g. Discussion
   h. Summary and further reading
   i. Required Statements
   j. References

3.2 References

APA referencing style should be followed throughout the document. http://www.apastyle.org/

3.3 Tables, Figures and Graphics

These should be submitted as separate files but have their intended position clearly marked in the manuscript.

4. Ethical Standards

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All articles should include a statement declaring that the authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the American Psychological Association http://www.apa.org/ethics/code/. Authors should also confirm if ethical approval was needed and provide the relevant reference number. If no ethical approval was needed, the authors should state why.

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All known professional, financial and personal relationships with a potential to the bias the work must be declared.

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Sources of financial support, including grant numbers, must be provided for all authors.

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