EMDR*now*

April 2018 Vol 10 No. 2 The newsletter of the EMDR Association of the UK & Ireland

London 2018 Conference Highlights

Creative EMDR therapy with traumatised young people

Sara Young was inspired by Ana Gomez's Keynote Address and Workshop

As a psychotherapist working with children and adolescents, I'm inspired every day by the clients I work with so when I attend a conference I always hope to be inspired by the speakers I hear. I'm sometimes left a little disappointed but today was a noteworthy exception. Ana Gomez spoke in her keynote address about generalised wounds, attachment and dissociation in children. She guided us through a series of slides, some depicting moving images of children and parental figures. This gave clarity and understanding to the impact the parent has on the attachment relationship with the child and how the disruption of that attachment can lead to the development of dissociation in the child. Gomez also spoke about the hidden traumas that children experience, for example the parent who is not necessarily abusive but emotionally unavailable to the child. Gomez also shared with us her knowledge and experience of working with traumatised and dissociative children via recordings offering brief glimpses of her clinical work.

I was aware from the programme that Gomez planned to share with us how she works using EMDR with children and adolescents with complex trauma, attachment wounds and dissociation. I had no idea that it would be so informative and engaging but most of all illustrated through her own experience, which I loved. Gomez seamlessly wove theory and clinical practice together, to make the sometimes complex world of neuroscience easily accessible to all. Gomez's theoretical base resonated very much with my own. However, not only did her clinical work with children and adolescents echo my own experience, it moved beyond the work with children into that with adults.

Delegates at the Royal College of Physicians for the annual Association conference

Gomez began the workshop by defining complex trauma and illustrated the difference between simple and complex traumatic stress. This was followed by an account of the preparation phase through her multifactor model, in which she emphasises the importance of understanding stabilisation (emotional regulation) and direct trauma processing. Gomez broke this down into five sections: 1. state change; 2. increasing positive and negative affect tolerance; 3. meeting unmet needs; 4. Somatic, emotional and cognitive literacy and 5. dissociation: preparation strategies mentalisation. Through the five stages, I gained a greater sense of awareness and a clearer way of working therapeutically with children and adolescents, who have been exposed to trauma and who present with dissociation. I believe this area of information and knowledge to be lacking in the UK at this time, so it was so exciting for me to hear and observe how Gomez tackles this.

There were so many take-home messages from the day. I loved Gomez's interweave system model. She gave us many examples of reparative interweaves. Gomez showed through a series of recordings from her clinical practice, how you can provide distance for the child from the memory, which allows the child to stay within their window of tolerance. I loved her use of metaphor, in particular the swimming pool metaphor. She talked about the danger of jumping straight into a swimming pool, which could be traumatic for a child. Gomez advocated taking your time so you can teach the child how to swim and become confident whilst in the pool. Similarly, jumping

Contd. p2

Research as Currency in the Psychotherapy World: What does the EMDR 'bank balance' currently look like?

Matt Wesson reports on two research presentations at this year's Annual Conference and why we need much more of the same

If you're presenting at an EMDR conference you'll always be preaching to the converted. Most delegates will be regularly witnessing the amazing results this therapy can get within diverse clinical populations. So it's easy to forget the importance of published research. Practice-based evidence is essential but in today's psychological therapy landscape it just is not enough.

EMDR has survived and prospered because over the last 30 years it has been recognised by many national and international bodies as an effective treatment for PTSD. Whilst this is encouraging, many of us have been busy finding EMDR effective for many other mental health problems, particularly once you widen the definition of trauma. Unfortunately, while this has broadened our own utility of EMDR there are some worrying developments within the broader therapeutic community. The American Psychological Association, in its Clinical Practice Guideline for PTSD in Adults, has recently downgraded EMDR from strongly recommended to still recommended, but only weakly. Whilst EMDR remains a recommended treatment for PTSD in the NICE guidelines, without continued research this will not continue to be the case and will have major negative implications for the status of EMDR therapy in this country and beyond.

Thankfully, the first day of the conference had some encouraging news. Gemma Wilson presented her findings after examining research on the use of EMDR in Treating PTSD. In the 30 years since its development it seemed appropriate to return to the PTSD roots of EMDR. This review also looked at the impact of depressive and anxiety symptoms in PTSD. The report's aims were, systematically and narratively, to review robust RCT evidence examining the efficacy of EMDR Therapy.

The findings show that EMDR significantly improves symptoms of PTSD and trauma symptoms. EMDR therapy was also found to significantly improve symptoms of depression, anxiety, subjective distress, paranoid thoughts, functional assessment and fatigue

Contd. p3

straight in with EMDR can cause significant harm for children exposed to trauma; we must take time and care before beginning any reprocessing.

Gomez's use of creative media was extensive, and I heard nothing that would preclude EMDR therapists from the UK and Ireland working in this way apart from the limitations that they might impose themselves. The space in which we work holds no limitation or constraint on the creativity of our imaginations that we can use when working with children and adolescents. As a therapist I believe you can be as creative as you want through your own imagination, which often gives permission for the most traumatised children to create a space that works for them.

Sara Young is an Integrative Child Psychotherapist and Adolescent Psychotherapist

EMDR Association UK & Ireland
PO Box 3356
Swindon SN2 9EE
info@emdrassociation.org.uk

http://www.emdr-europe.org/.
Dafna Kalkstein, EMDR Europe Association Administrator
dafna@emdr-europe.org
Katja Gasperini, EMDR Europe Executive Assistant
katja@emdritalia.it

severity. The review also identified that treatments lasting more than 60 minutes per session was a major factor in improving symptoms of depression and anxiety. Studies were carried out in a wide range of countries

Gemma Wilson's study explored the efficacy of EMDR in treating PTSD

demonstrating the effective delivery of EMDR therapy to different cultures. Low dropout rates across all studies indicate EMDR therapy is well tolerated by clients. Limitations of the review included: not considering non-RCT studies, lack of homogeneity between studies, low sample sizes within some RCTs, ignoring economic factors, and including only those studies on PTSD which cited EMDR as the main focus. However, Wilson pointed out it is clear from this extensive, robust evidence that EMDR is an effective treatment for PTSD.

The CMHT setting

Jonathan Hutchins compared outcomes for clients with severe and enduring mental health problems in a Community Mental Health Team setting treated with CBT or combined CBT and EMDR. In this rapid-fire presentation Hutchins' enthusiasm for EMDR therapy and research was clear. We are used to combining treatment models, particularly when clients don't fit neatly into a diagnostic category. However, there is a dearth of research into combined treatments, perhaps because reviewers for peer-reviewed journals will often question which approach created the observed improvement. The findings of this study showed first that there was no significant difference in the length of therapy (around 10 sessions) between CBT and CBT plus EMDR. This dispels an often-heard myth that the introduction of EMDR will lengthen therapy. The study considered not just PTSD but also mood disorders, anxieties, personality disorders and psychoses. Finally, it showed similar outcomes for single and combined treatments, with CBT plus EMDR proving slightly more effective.

Matt Kiernan then gave a status update of the EMDR UK & Ireland Research Strategy. We heard about further research being supported by academic institutions. It was encouraging to hear that the EMDR Association is partnering with Northumberland University to fund a PhD into EMDR and is looking for suitable applicants. Also that our national association funded the systematic review presented by Gemma Wilson earlier in the morning. There was a call for standardising our clinical data collection amongst the membership of the Association, particularly from those clinicians working in the NHS. We could be sitting on large amounts of positive outcome data for EMDR Therapy, which could be utilised in published research, proving its efficacy, but this cannot be done if we are all using different clinical measures. There was also a call for volunteers for a NICE working group to promote EMDR during the review of national guidelines into PTSD. Derek Farrell began the conference with a reference to the film Gladiator, with a call for us all to 'Stand Together'. As EMDR increasingly seems to come under threat from other models, particularly CBT, debates in our community about which approach works best might only leave us more vulnerable to a bigger danger. Maybe we don't just have 'Stand Together' as Derek advised but also need to 'Step Up'. This could be by offering our time, skills and enthusiasm within the new EMDR NICE Working Group or writing up papers for peer reviewed journals including this one. Otherwise, EMDR could lose its footing in the competitive market of evidence-based approaches for PTSD. Any takers?

Matt Wesson is an EMDR Europe Accredited Trainer and Consultant for The EMDR Academy

Stabilisation as treatment intervention

by Omar Sattaur

Conventional wisdom advocates stabilisation prior to processing of traumatic material. Babette Rothschild, in her excellent book Trauma Essentials, emphasises the primacy of the traumatised client's safety and reminds us that "safe trauma therapy aims to improve a client's quality of life. Stability and ability to function normally in a secure environment are essential to accomplishing all other goals". Recent research by Cordula Eichfeld during a humanitarian project by Trauma Aid in Cambodia, now provides compelling research evidence that stabilisation not only provides a safe foundation from which to treat trauma but is a treatment intervention in its own right.

Eichfeld's study looked at a population of adults, adolescents and children all meeting both DSM and ICD criteria for PTSD. They were offered psychoeducation and taught a range of stabilisation techniques including distancing, how to manage flashbacks, framing, grounding exercises amongst others. The results showed a dramatic improvement in the PTSD diagnostic criteria among the treatment group. The findings are particularly important in that stabilisation for this treatment group appeared to be sufficient, requiring no further intervention. Since stabilisation techniques are safe, flexible and adaptable to the cultural and spiritual context, Eichfeld said it had important implications in reducing psychological trauma worldwide. Particularly in countries stricken by violent conflict and where there is a dearth of trained therapists, stabilisation techniques can readily be taught to paraprofessionals.

Davy Hutton continued the stabilisation theme in his presentation which focused on the installation of symbolic resources to treat traumatised clients. Hutton, whose work has focused for the past 16 years on the treatment of victims of violence in Northern Ireland, spoke of the need for therapists to consider the varied learning styles that we and our clients have. Sometimes words can say far more than pictures, or music can evoke feeling states that would otherwise elude the traumatised client. He showed a very moving picture to illustrate his point, drawn by an orphan in Iraq. The little girl who had lost her mother, had drawn in chalk an outline of her mother. She made sure that the torso was large enough that she could curl up, in a fetal position, within the outline of her mother's torso, not to say, womb. A poignant picture and one that brought home Hutton's point; the child could not have described her loss any more powerfully.

Hutton's presentation focused on the use of an image chosen by one of his clients to represent strength and invulnerability. The client had been traumatised as a child by the appearance outside her front-room window of a masked figure. Since that time she had experienced a terror of masks and masked figures which had later generalised such that she could not even look at the statues representing saints in churches as she so abhorred the incongruity – the statues were not people, just stone pretending to be people.

During Phase 3, Hutton asked the client for an image representing strength. She chose the red bull, a computer-generated image from a drinks advert on TV a few years previously. He was able to use the image of the bull to protect the client from the figure at the window, and talk the client through a scenario in which the red bull led the masked figure out of sight and so no longer a danger.

Hutton gave many examples of creative use of drawings, photographs, natural objects and the imagination to help clients reframe their experiences and transform traumatic memories into adaptive responses.

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

EMDR effective in treating clients in an acute mental health crisis

Simon Proudlock works with people referred to a Crisis Resolution and Home Treatment Team (CRHTT). Proudlock's starting point in his presentation was that trauma has often played a key role in the lives of people referred to CRHTTs, in which case there is likely to be a role for EMDR in their recovery. So far, so good, but there are considerable obstacles to overcome in offering this client group any sort of therapy much less EMDR therapy.

This client group are often at active risk of suicide, self-harm and, occasionally at risk of harm to others. Conventional wisdom is that they are unsuitable for therapy, too volatile emotionally and unable to engage. Typical management would be containment and stabilisation through medication and discharge back to GP, Community Mental Health Team or the community. Proudlock's presentation showed further evidence (he has an impressive track record in this field) that EMDR therapy, in a very few sessions, can not only save the lives of high-risk clients, but considerably reduce their suicidality, anxiety, depression and PTSD symptoms, reduce their re-presentation to crisis services and so result in significant financial savings for the NHS.

The Berkshire Healthcare NHS Foundation Trust has adopted a model of suicide developed by American psychologist, Thomas Joiner which, amongst other things, 'helps clinicians take positive risks while continuing to work therapeutically with clients'. Joiner's model holds that perceived burdensomeness and thwarted belongingness both contribute to a desire for suicide. When this desire coincides with an acquired capacity to implement suicide, the person is at a high risk of successfully completing suicide or making a serious attempt. Yet, Proudlock reminded us, many also have a higher than normal motivation to solve their problems.

The RCP library

Proudlock's presentation centred on a joint project of The Health Foundation and Berkshire Healthcare NHS Foundation Trust exploring the use of EMDR with patients in an acute mental health crisis. The results from treating 70 patients were extremely positive. Rather than the feared worsening of clinical risk, the treated individuals showed clinically significant reductions in suicidality and symptoms of anxiety, depression and PTSD. More than 40 of the patients treated needed fewer than 12 sessions, a handful required between 12 and 20 sessions and fewer than five patients needed more than 20 sessions. Most were discharged from mental health services and Proudlock estimates that the Project resulted in savings of at least £100,000 by reducing the need for inpatient beds, CRHHT support and further psychological therapy. Proudlock cites six major factors in the success of the Project:

- clients were seen within one week of referral and, for most, treatment started immediately;
- clients were seen 2-3 times per week;
- causes rather than symptoms were the focus of treatment;
- joined up working between the Project, ward, CRHTT and community;
- containment of the ward and CRHTT
- clients' increased motivation at time of crisis.

Omar Sattaur

Adverse Childhood Experiences, Attachment Trauma and Personality Development

Gus Murray reports on Dolores Mosquera's keynote address in which she explored the developmental foundations of personality disorder and complex trauma as well as conceptualising their treatment through the lens of the AIP model.

Dolores Mosquera began her keynote presentation by reminding us of the interrelated roles of nature and nurture in the development of personality and, therefore, in the development of personality disorder. Biological factors (people's genetic make-up and temperament) as well as environmental factors (their life experiences, particularly early childhood experiences) both have critical roles to play in the development of personality disorder. Mosquera stressed that "although it is simpler to discuss these two factors separately, many experts believe they cannot be understood independently from one another" but instead work together such that "each of us has a personality style that is unique, almost like a fingerprint." Mosquera further proposed that "a particular collision of genes and temperament with a suboptimal or hostile environment may explain the development of some personality disorders, especially Borderline Personality Disorder" (BPD).

Attachment and other developmental trauma

Early childhood attachment experiences contribute further to this complex picture. Mosquera observed that while "overt abuse can be targeted and resolved, through working with traumatic experiences in a pretty straightforward manner when there is secure attachment, insecure and disorganized attachment can interfere with trauma work in many different ways."

Reflecting on her clinical experience, she drew attention to the importance of recognising the coexistence of both overt and covert developmental trauma. Without detracting from the importance of overt trauma such as physical and

Mosquera: a person's personality style is "unique, almost like a fingerprint"

sexual abuse, severe neglect or humiliation and bullying, Mosquera held that covert and hidden trauma can be more challenging to access and treat. Such trauma can range from subtle maltreatment and abuse (emotional neglect, variable neglect inconsistency and lack of predictability) to covert maltreatment and abuse (lack of healthy boundaries, enmeshment, role reversal and overprotection). These kinds of experiences can give rise to a range of problems in later life including: emotional dysregulation, poor self-care, identity issues and fragmentation. Mosquera identified key symptoms that may ensue, such as problematic relationships, self-harm, risk behaviours, impulsivity, violence, alexithymia, eating disorders, sleep disorders, depersonalisation and derealisation, detachment, addictions and auditory verbal hallucinations. Referencing preliminary data from her Family in Childhood Experiences Scale Study (2013) she de-

Contd. p7

Planned Dream Intervention, REM sleep and EMDR

Veterans suffering chronic insomnia due to dreaming past traumatic events can make dramatic improvements using planned dream intervention. Jessica Wooliscroft was intrigued enough to try it in her own practice

Justin Havens had the challenge of presenting Planned Dream Intervention (PDI) in a 25-minute slot sandwiched tightly between two other swift and excellent presentations on the morning of the second day of conference. His background in the military, as a project manager and a business consultant was apparent from the start, as he seemed very much at ease with the audience, the power point technology and his subject matter – as he should, given that it forms the basis of his PhD.

Havens described how healthy sleep patterns typically include three phases of REM sleep per night, during which we all dream whether we remember our dreams or not. The dream's function is to process the day's information and prepare the body for a period of deep restful sleep in which repair and rejuvenation takes place. Traumatised clients who wake frequently from horrific nightmares keep missing out on deep sleep with profoundly damaging effects on their health. Sleep disturbance can slow trauma recovery.

Havens says REM is like 'free EMDR'

Havens described REM sleep as equivalent to "Three free sessions of EMDR every night!" (a phrase I will certainly borrow, thank you Justin). But if a dream is too horrific and the client wakes, then REM processing is interrupted. The aim of PDI is to alter the dream so the client stays asleep throughout the REM stage. This means

Contd. p8

scribed the high incidence of the above experiences and symptoms in a BPD sample.

All of this has significant implications for the AIP model and EMDR processing. According to Mosquera, for a person with a reasonably healthy history, reprocessing a memory of a single traumatic experience will generally result in the spontaneous linking of dysfunctionally-stored information with adaptive information contained in other memory networks. However, it is her view that "this natural process of spontaneous adaptive linking can be severely impaired in dissociative disorders. The linking with adaptive information might not happen spontaneously because defensive barriers can be strong, the capacity for dual attention is limited, or there is a lack of adaptive information".

Dysfunctional storage

To address this challenge, Mosquera references her collaborative work in which "the AIP model is extended to explain issues related to the effects of chronic, early neglect and traumatization". Specifically, this involves expanding the traditional AIP concept of dysfunctionally-stored memories and introducing the more inclusive concept of dysfunctionally-stored information (DSI) which "is used to include both autobiographical memories as well as those dysfunctional elements that are generated in the client's intrapsychic experience". Applying this to the clinical setting, Mosquera points out that "a number of EMDR protocols already implicitly address DSI in a larger context other than the autobiographical memories of traditional EMDR targets. Examples include work on defences, affect tolerance, dissociative phobias and dysfunctional positive affect"

Clinical Application

Mosquera highlighted the importance of integrative work, not only with "symptoms related to overt traumatic memories" but also working to improve the attachment and social engagement systems, "unlearning old patterns and learning new ones". Therapists should help clients to learn self-care as well as to recognise emotions and needs. . Mosquera went on to review further concepts, too numerous to list in this review, to guide therapeutic work with attachment-related issues. She touched on some useful interventions for working with personality disorders and finished with Bruce Perry's (2017) three-phase model for promoting integrative capacity and functioning: Regulate, Relate and Reason.

Mosquera emphasised the importance of attunement as a key resource for therapists in responding to and working with the above presentations. Indeed, she illustrated her own exquisite use of attunement, as well as several of the clinical skills and methods outlined, in a variety of clinical video segments that she generously shared throughout her presentation.

Gus Murray is an EMDR Europe Accredited Trainer and Consultant. He represents the Republic of Ireland on the boards of EMDR UK & Ireland and EMDR Europe. Gus was awarded the Carl Berkeley Memorial Award (2017) from the Irish Association for Counselling and Psychotherapy in recognition of his outstanding contribution to the profession.

they can process their experiences and move onto deep sleep. Properly rested clients are also better able to engage in EMDR. Havens proposes that PDI be utilised as an imaginative interweave for stabilisation and symptom management in the beginning stages of EMDR therapy at Phase 2, but also whenever it is apparent the client's sleep is being disturbed by nightmares. So, PDI promises to be an extremely relevant and useful tool for any trauma therapist.

For a fuller description of his presentation and research study please go to the EMDR UK & Ireland website conference page for a download. Here I shall describe in brief his approach as he presents it to clients. Dreams are healthy. We all need to dream and bad dreams help us process difficult events. A repetitive nightmare from which one wakes signals that the processing during the REM phase gets stuck. Havens uses the example of a washing machine…a "dream machine" ….that has developed a malfunction. PDI gets it going again.
Select a client's typical nightmare, paying attention to the part of the dream just before the client wakes;
Together with the client create a different scenario by altering features of the dream just before waking;
The new scenario must "feel good" at a gut level;
The new scenario must confront the issue in the dream. Running away, escaping or avoiding the issue does not work;
Keep things simple, work on one or two dreams is enough as the effect will generalise;
Warn the client that practice improves the outcome.
Havens gave the following example: A client has nightmares of being chased by soldiers with guns shooting at him. The PDI replaces the guns with cameras with long lenses and the soldiers are running around taking photographs. This client was really into photography so he had a good gut feeling about this new scenario.

Havens maintains that PDI differs from 'dream image rescripting' as it does not pathologise the nightmare. I am a little puzzled by this as my own understanding of dream rescripting is that it works in a very similar way to PDI. I have not come across the idea of it pathologising nightmares, rather simply helping clients to move on, but I am willing to be convinced. Havens also noted that interpreting the meaning of a dream is not necessary; PDI works even if the client does not understand the deeper significance of the dream. My own thoughts on this are that dream interpretation only works therapeutically if it is well timed and leads to an active change in attitude towards the problem. There are many instances when dream interpretation is poorly timed and more meaningful to the therapist than the client, hence has little or no effect. I think the guidance to make the new scenario confront the issue rather than avoid it is essential because it offers what good dream interpretation offers - seeing the problem in a new light and understanding that it cannot be avoided.

Havens gave data from a small pilot study he conducted with seven clients, all military veterans suffering severe sleep disturbance and recurrent nightmares. Three had a good outcome, two had moderate outcome and two did not complete the study. He is keen for others to try the approach and conduct their own research. Their average Impact of Events scores were well above 50 at the start of treatment, and after PDI their scores were all below 35 or less. See the Association website for more details of this study.

I was enthusiastic about trying the approach myself and had the opportunity three days after the conference. I was able to contact Havens who gave feedback on my attempt and we also shared our thoughts on dream work generally.

My (relatively new) client had suffered waking nightmares for decades and would wake most nights screaming and covered in sweat with dreams involving planes crashing in flames, suffocating to death, attacks from strangers. Horrible. I described the PDI approach to the client and we looked at five typical dreams creating new scenarios for each (this was probably overkill as Havens explained to me only one dream scenario is necessary as it generalises with practice). The following day the client emailed me to say he had woken up but the dream was less violent, and none of the scenarios we had worked on had arisen. I encouraged the client to keep a note and keep practising each night. The following week the client reported no recurrence at all of the typical nightmares, but did have a dream that seemed to evoke difficult feelings but which did not wake him up. In conversation with Havens, this is the key to the success of PDI - the REM sleep enables difficult material to be processed only if the client sleeps through. Given I had only followed the instructions from Havens' slide presentation, this felt like a pretty impressive result to me.

I am so impressed by the rapid positive result with my own client that I would encourage others to use this approach as part of their EMDR resource and also to record the outcomes and find out from EMDR UK and Ireland how to contribute to the collection of useful research data. Thank you, Justin, for a lively and helpful presentation.

Jessica Wooliscroft is an EMDR Europe Accredited Consultant, psychotherapist, trauma therapist, supervisor and trainer based at the Hope Street Centre in Sandbach, Cheshire

Working with the dissociative client

Dolores Mosquera illustrated her innovative clinical work with dissociative clients with ample use of recorded clinical material. Gus Murray reviews her workshop

Dolores Mosquera kicked off her workshop by emphasising the importance of assisting clients in experiencing an internal sense of safety. Clients with dissociative disorders need to know and realize that the danger is over, they need the ability to differentiate between past and present.

Progressive Approach

She went on to introduce the Progressive Approach, which is her substantive model for guiding the treatment of dissociation. The kernel of this approach is to facilitate such clients in a gradual approach to their traumatic internal states and experiences. This involves the gradual use of bilateral stimulation to process dissociative phobias, defences and fragments of trauma as well as to reinforce adaptive capacities and resources. The goal is the development of emotion regulation and dual attention.

According to Mosquera, the progressive approach rests upon the twin pillars of the Adaptive Information Processing (AIP) model and the standard EMDR eight-phase protocol. Mosquera sums up the clinical application of the progressive approach as follows: "Processing of dysfunctional elements is introduced from the very early stages of therapy. BLS is dynamically applied, using procedures characterised by a gradual approach to the traumatic contents". Mosquera contrasts the progressive approach with what she calls the "all or nothing" perspective whereby "trauma processing is understood as a discrete intervention that happens in a specific session". With the "all or nothing" perspective, BLS is used in two discrete sets of circumstances, to install positive elements and for "desensitisation" or "reprocessing" of traumatic memories. According to Mosquera, there are two main problems with the all or nothing perspective. Firstly, "EMDR is underused, applying it only in highly-functioning clients, or after many years of other therapeutic interventions. Secondly, the risk of "re-traumatisation when clients lack adaptive information or resources to regulate after the sessions".

Working with the inner world

Mosquera went on to explore the internal world of the dissociative client, describing the lack of integration and internal conflict they experience. Mosquera proposed that "many of our clients live in a constant battle with themselves and their inner experience is not easily understood. When clients experience intolerable thoughts, feelings, memories and impulses, their inner system tends to organise itself into dissociated parts. Working with dissociative disorders requires an understanding of their internal structure on the part of both therapist and client. Learning to understand these parts of the self and their function is a crucial aspect of treatment".

Mosquera stressed the importance of maintaining the client's adult perspective in working with the internal system, suggesting that "if the adult part can be present most of the time while being aware of and compassionate toward other parts, there can be better integration and less switching in the more dissociative cases". When this can be achieved, "one of the simpler ways to explore the internal system of parts is asking questions through the Adult Self. Exploring whatever comes up for the client, regardless of how they refer to their parts or voices, is a good way to begin".

Mosquera went on to describe several clinical strategies to assist clients in exploring their internal system including exploratory questions, listening for and identifying internal conflict, use of drawing and other creative media as well as accessing and getting to know the different parts and their roles in the system. She concluded this section by setting out three important principles:

1. "When we explore the internal system of parts, make sure we include all parts and voices, even the ones that cannot show themselves
2. Do not ignore any parts, especially the hostile ones. Clients tend to avoid them and want to get rid of them. Therapists should not do the same.
3. Accept how the client experiences what happens without necessarily agreeing with it. Validating while offering other options."

Mosquera then demonstrated her clinical work with dissociative clients using an extensive collection of excellent video segments illustrating her use of several of the methods and skills she had described. She also very helpfully interspersed the video segments with comments, insights and some questions to highlight and reinforce some of the key learning points.

Dissociative phobias

Drawing on the theory of structural dissociation, Mosquera proposed that while "dissociation and lack of integration start during early traumatising events, what maintains this type of structure is dissociative phobias, lack of social support and lack of realisation". She highlighted the phobia of *Contd. p10*

traumatic memories but also included others such as the phobia of attachment and the phobia of trauma-derived mental actions. She summarised the relevance of the concept of dissociative phobias in EMDR therapy: "If we try to reprocess core trauma, without realising the presence of these "protective layers", we will probably encounter diverse problems. These layers should be carefully removed (and eventually reprocessed) in a step by step procedure, approaching the extreme pain that the client is feeling in a gradual, safe and careful way".

Mosquera then described how dissociative phobias can be processed and desensitised using the progressive approach. "The target will be the dysfunctional emotion (fear, rage, shame, disgust) and the somatic sensation that one part experiences towards another", she said.

The Tip of the Finger and the Freckle

The workshop concluded with a review and demonstration of two further techniques that can be used when working with dissociation. These were the Tip of the Finger Strategy (TFS) and the Freckle Strategy. "In TFS, the target is not the traumatic memory, but a small part of a disturbing sensation or emotion that may be considered a peripheral consequence of the memory", she explained. With this strategy a tolerable portion of the memory is deliberately targeted and processed in a manageable way.
The freckle strategy is similar in that it also uses a fractionated approach to target a manageable portion of the memory for processing. However, it is different in that it does not do this deliberately but rather in response to the emergence of traumatic material that arises and which may be destabilising.

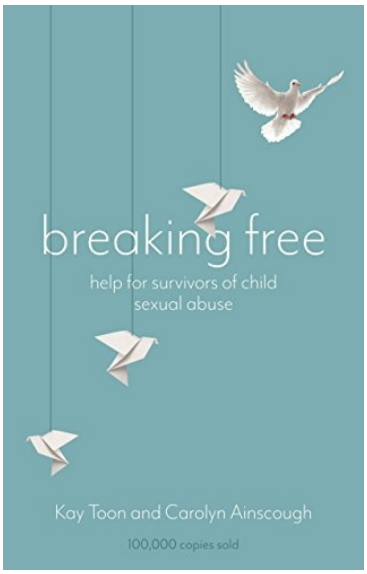
ooks books books books books books books

Help for Survivors

Breaking Free
Help for survivors of child sexual abuse

Kay Toon and Carolyn Ainscough
Sheldon Press, 2018, 348 pp
ISBN 978-1-84709-465-0
Paperback, £14.99

Reviewed by Omar Sattaur



In this latest edition of Breaking Free, Kay Toon enhances our understanding of how the impact of childhood sexual abuse is rooted in trauma. So much more of this distressing story has been uncovered and publicised since the first edition, with co-author and colleague Carolyn Ainscough, was published in 1993, permitting Toon the opportunity to update the language used but also making the book – essentially a self-help book for survivors – ever more relevant today. With it's explanation of trauma and the relevance of EMDR, Breaking Free would be a helpful companion to survivor clients undergoing EMDR therapy.

The language is compassionate and clear, two qualities conspicuously missing from the inner dialogues of those crippled with the confusion, blame and shame that often follows childhood sexual abuse. A box in the second chapter helpfully lists no fewer than 63 effects of sexual abuse that survivors might experience, from anxiety and suicidality to the inability to love or show affection to children and feeling unconfident and overly dependent on others (p18). Dissociation is a common coping strategy for abused children and it is often hearing about others' abuse experiences as adults that will unlock traumatic memories laid down in childhood and signal the beginning of recovery.

Toon's & Ainscough's down-to-earth language will be validating and healing for many survivors. It is helped by their adoption of American researcher David Finkelhor's four-step model of abuse: 1. There must be a person who wants to abuse; 2. The person overcomes inhibition about abusing; 3. The abuser gets the child alone or in a position where he or she can be abused; and 4. The abuser overcomes the child's resistance. The first of these steps concludes that : "The abuser's desire to abuse is not created by the child – it is there before the child appears on the scene". Clear and printed in bold, the authors do all they can to break through the bars of guilt behind which survivors often imprison themselves. There are many more examples of this throughout the book.

The book is laid out logically, beginning with helping survivors to understand the impact of abuse and how to begin to keep themselves safe. The second part explores in depth the feelings of guilt and shame that assail survivors, and the reasons they feel such feelings. Part 3 of the book helps them tackle these feelings and symptoms – indeed, practical self-help exercises pepper the chapters and help to consolidate learning. Part 4 encourages survivors to explore their feelings towards others including children, mothers and abusers.

Usefully, very practical advice on how to tackle anxiety and panic is set aside in the first appendix for quick reference. Appendix 2 recounts the stories of six survivors whose real life experiences and reflections are captured in their quotes throughout the book. Useful, again, to separate these accounts – it helps those readers who do not wish to read potentially distressing material to avoid it.