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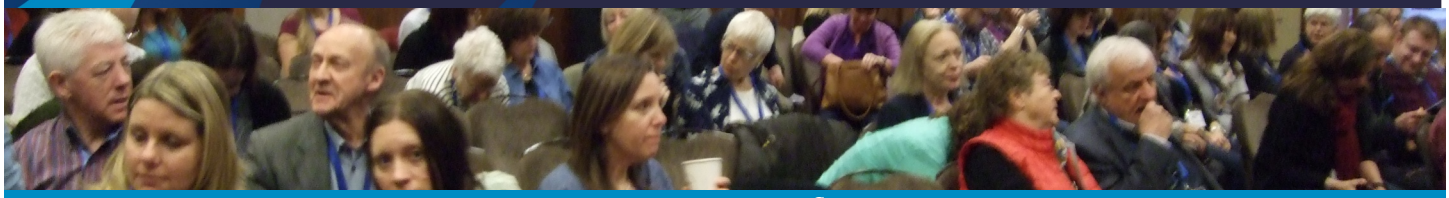

Liverpool 2016: Annual Conference Highlights

Trauma, mental health and the role of EMDR

Omar Sattaur reports on the Keynote Address by Isabel Fernandez, President of EMDR Europe

The Liverpool conference got off to a good start when Isabel Fernandez, President of EMDR Europe Association, gave her comprehensive Keynote Speech on advances in our understanding of the role of trauma in mental health and the growing evidence for the relevance of EMDR in treatment.

She drew attention to the fact that DSM5 recognises big and small T traumas; in all, 52 disorders related to trauma and stress. Fernandez reminded us how neurobiology and psychological research are providing growing evidence for the physical impacts of trauma on neural structures. At the same time, research is uncovering more information about the physical changes to neural structures that occur during and after EMDR treatment.

Derek Farrell and Isabel Fernandez enjoy a coffee break

Non-verbal abuse

One of the most surprising and important pieces of new evidence to come out of this type of research concerns the contribution of non-verbal abuse to the later development of psychological conditions, including depression. Omissions of care, the psychological problems faced by important attachment figures play an important role in fashioning the capacity for emotional regulation in children.

Fernandez talked of the critical contribution that EMDR can make in the current global refugee crisis. This was neatly captured by a quote she recalled from an Afghan refugee with whom she had worked: "Accept your past, live your present, be ready for the future".

EMDR in childhood OCD

Nick Carroll found Robin Logie's presentation on The Use of EMDR with children with OCD informative and engaging

There was a good mix of theory and practice in this presentation, which included a 20-minute video showing some sessions with one of the two case examples, that of a 12-year-old boy with OCD in a case of complex trauma.

Having first defined the difference between obsession - persistent and intrusive recurring thoughts, urges and images - and compulsion - repetitive behaviour or mental acts aimed at reducing the anxiety and distress of a dreaded event - Logie gave an overview of OCD in children. It affects two to four per cent of children. Most children will develop OCD between the ages of 7.5 and 12.5 years and it is often accompanied by other disorders (only seven per cent of those affected have 'pure' OCD).

Robin Logie: psychoeducation and homework is important

Causes of OCD include genetic factors, an adverse life event (ALE), a traumatic event (54 per cent of individuals with OCD had experienced at least one traumatic event) as well as having a pre-existing 'OCD temperament'.

Evidence from studies with adults being treated for OCD indicate that 'pure' EMDR on its own is not sufficient. Logie recounted a clear illustration of this from his personal experience. He had successfully treated a child suffering with OCD using the standard protocol, bringing the SUDs down to zero in one session. But at follow-up,

nine months later the client disclosed a relapse. The relapse had been successfully treated with CBT therapy, following which there had been no further known relapse. The lesson from this, confirmed by other clinicians, was that EMDR cannot be used alone in cases of OCD, that psycho-education was important as well as homework, or, according to one paper, that it should be combined with Exposure and Response Prevention (ERP). In the case example described by Logie, a narrative of the child's life story and his experiences from when he was conceived was found to be very helpful.

Logie suggested a variation on the sequence of the protocol, first targeting the present, followed by either future and then past or, alternatively, past and then future events. In both cases it was advised to first use Flashforward (a feared but unlikely future catastrophe) and then the Future Template (a feared but predictable future event).

Watching the video, it was instructive to see how much time, skill and patience is often needed to establish a clear and relevant NC, and how helpful it is to use the list Good Thoughts and Bad Thoughts for Children (for adults - Examples of Cognitive Belief Clusters), both available from HAP UK & Ireland.

As always it was a pleasure to meet friends and colleagues from other parts of the country and share the conference experience with them.

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Where the hurt is: EMDR and the pandemic of Gender-Based Violence

Omar Sattaur reports on Derek Farrell's moving and inspiring presentation on gender-based violence

Gender-based violence (GBV) has no boundaries. It is not limited geographically or politically. The perpetrators of GBV are not of a particular social class, religion, age or ethnicity. And as such, it is our duty as therapists to make no assumptions about the context in which it takes place; to do so we risk perpetuating the stifling silence in which so many of the victims of GBV suffer.

Farrell provided shocking statistics which grabbed our attention. Pakistan, 98 per cent Muslim, has a huge GBV problem. But so does the Philippines, which is 95 per cent Roman Catholic. One in four men interviewed in a UN study admitted to using violence against women. One in 10 admitted to having raped a woman or girl, half of them as teenagers. All had themselves witnessed or experienced violence to women as children. The message was clear; boys learn how to control and subjugate, intimidate and abuse from the men who were around them when they were growing up. The so-called Islamic State has targeted the Yezidi people of Northern Iraq, massacring their menfolk and subjugating their young women to a life of sex slavery and serial abuse. A former head of a UN Peacekeeping Force summed up the severity of the problem when he said "It has probably become more dangerous to be a woman than a soldier in armed conflict".

So if we are to tackle this global problem, it is futile to focus solely on maladapted neural networks. Victims live in daily, ongoing threat to their persons. We must attend to the roots of the problem, Farrell said; we must open our eyes to the cultural, structural, direct and natural types of violence. And whilst we are all familiar with the victims of GBV, and can likely bring to mind several clients who would fit the description, we should remember that we probably also know as many perpetrators. How many of our male clients, though, would raise our suspicions in this way?

Well-founded hope

If part one of Farrell's presentation left participants rather shell-shocked, part two brought us back in touch with the well-founded hope that EMDR engenders. He began with the controversial question about the importance of stabilisation. There are two broad schools; the German says it is critically important, the Dutch says it may not be as important as we think. Using a case example with which he opened the presentation, Farrell said clients may often be high-functioning. Workaholism often accompanies complex trauma. In such cases, beginning with current trauma may be exactly the wrong thing to do

Working with shame and complex trauma

Mary Burns found plenty of food for thought in Helga Mattheß' presentation on Complex PTSD and Shame

This Workshop was delivered by Helga Mattheß, a psychotherapist with a special interest in trauma. It was an impressive and interesting workshop, given that she had less than 24 hours' notice to prepare it due to the cancellation of the scheduled workshop on EMDR with Children and Adolescents at Risk. Mattheß offered an extensive background knowledge on shame and trauma to an attentive and interested audience in the space of 75 minutes. Mattheß argued the importance of this background. She opened her talk with an image of a cat walking through a puddle - an unusual sight, you will agree, as cats do not normally like water. The blue background then fades to reveal the wider picture - a pack of German Shepherd dogs behind the cat. Mattheß' point is that we must always look at the background in every situation.

This is exactly what Mattheß went on to do. In helping us to understand the background of complex PTSD and Shame, Mattheß spoke about the evolutionary context of shame. She quoted Darwin who, in 1872, identified shame and its counterpart pride as paralleling the signals for dominance and submission.

Pride and shame are self-conscious emotions that serve a social function in communicating information about social status. Studies have indicated that individuals automatically attribute pride to status. Shame has an important role in shaping conformity and is used to organise human groups.

Humiliation and guilt

Mattheß spoke of the difference between shame, humiliation and guilt. Shame is about self blame, humiliation is viewed as damage unjustly inflicted upon us by others and guilt is about doing something wrong with the implication

as the client is likely to be destabilised. He said that it was often unlikely, however desirable, that such a client would do the 'right thing' and, for example, leave the violent partner and find a safe haven; the reality is that they will be returning home daily to continuing violence.

Farrell gave the example of one of his clients, whose story we were able to follow through his presentation. He talked about collaboratively constructing an action plan. Examining the possible targets they arrived at the conclusion that his client was not able, nor ready, to tackle the present problem. She chose instead to look at her first experience of abuse. This involved utilising EMDr, where the small *r* denotes restricted processing. Here, the past trauma was processed up to the point that the client's feedback began to relate to her present problems. Instead of continuing the reprocessing, Farrell chose to go back to the initial target as they had agreed that she was not ready, nor did she feel able, to begin to tackle her current predicament.

It may make sense for some clients to begin to process the risk assessment factors. For example, if a client reports a SUD of 10 when merely thinking about disclosing their true current situation to a loved one or close friend, in the safety of the therapist's office, it is very unlikely that they are going to disclose such sensitive and dangerous information in real life. So processing the fears associated with such an action may begin to make this more possible.

Farrell went on to talk about the use of the Blind to Therapist Protocol. He made the interesting observation that, in many cases, where he has no idea about the 'image' or material being processed, the SUD falls to such an extent that the client ends up disclosing the material anyway. In this case, he says, the Dutch-German dichotomy would seem to disappear; at one and the same time the client is being resourced by way of processing.

There was much more in this stimulating and inspiring presentation, plenty of food for thought and plenty to spur us on to more creative EMDR therapy.

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that eventually we can make reparation. Mattheß explained in detail the difference between guilt and shame. In shame, the focus is on the self being wrong; it is a passive emotion where the person imagines himself in the eyes of others and she describes it as an acutely painful and disorganising emotion.

Shame is linked to anger and hostility. It is associated with avoidant and less empathic behaviour, with suicidality, poor quality of life and low self-esteem. It correlates positively with psychopathology. On the other hand, a person experiencing guilt focuses on the behaviour they have exhibited and desires to undo the events. Guilt may be experienced without intense affect and leads to adaptive and empathic behaviour. Guilt is unrelated to psychopathology.

Mattheß expanded further on the background associated with shame and complex trauma in turning our attention towards attachment, explaining the process of attachment, the internal working model, the synthesis of experiences in order to create a pattern of behaviour and a style of relating to others. She spoke about how disorganised attachment is one of the main features in clients who experience dissociation and highlighted that dissociation is often not related to violence but to shaming events. Maternal disrupted communications which are hostile, withdrawn, or fearful are likely to produce chronic shame states (criticism and ridicule).

Shame

Finally, Mattheß spoke of shame in psychotherapy. She quoted a study from 2000 by Andrews et al. who found that shame was the only independent predictor of PTSD symptoms. It was found that greater proneness to shame was associated with higher levels of dissociation, especially among females who experienced sexual trauma early in their development. Where there was no proneness to shame the dissociation scores were found to be within normal range.

Feeling trap

In looking at the role of shame within the therapeutic alliance, Mattheß talked about shame being a normal reaction to disrupted social bonds. She says that the therapist can allow the client to emerge from this 'feeling trap' in which they feel ashamed of being ashamed. The therapist should have awareness of the client's body posture, the power imbalance between client and therapist, and the client's defences. Shame should be addressed directly and shared laughter should be brought into therapy sessions when possible. Mattheß advises that shared laughter helps when feelings of shame become too strong. Working with shame demands listening and responding, showing empathy with the client's experience and with the client's disconnection that may have been part of their survival strategy. The therapist also needs to be fully present and engaged in the therapeutic relationship, to be aware of their own innate shame responses.

Mattheß gave a very interesting presentation at very short notice which, though bordering on information overload, was very engaging. However, there was little mention of EMDR bar a reference to how the 'blind to therapist' protocol may be helpful where shame is an issue. Nonetheless, it struck me that

Mattheß' presentation would be of interest to all therapists working with trauma, regardless of their therapeutic approach.

Whilst this is most likely due to stepping in at the last moment, Helga Mattheß likely has much to offer EMDR therapists. It would have been interesting to hear about case examples that illustrate how she works with shame in the context of EMDR.

Mattheß closed with a slide that was just as attention-grabbing as her opening one. This was a quote from Brene Brown: "If you could put shame in a petri dish it needs three things to grow exponentially: secrecy, silence and judgement".

Mary Burns is a consultant clinical psychologist and an accredited EMDR practitioner who specialises in child and adolescent trauma and works mostly with Looked After Children. She is employed by Central Manchester University Hospitals NHS Foundation Trust.

Keeping the train on the tracks: The Therapeutic Interweave

John Henry reports on Gus Murray's imaginative take on interweaves

The therapeutic interweave is one of the hardest parts of the EMDR method for beginners to learn; at the same time, for the advanced EMDR clinician, it is one of the most creative and imaginative parts of the EMDR method. Gus Murray gave an overview of the types of interweaves and their uses, after reminding us of the Adaptive Information Processing model and the importance of understanding the client's window of affect tolerance. He then went on to explain how PTSD develops when the natural information processing of the brain breaks down. Murray explained how the eight-phase EMDR protocol works without a hitch, in the absence of significant psychological defences or dissociation.

Murray explained that there is a continuum of complexity, beginning with a single incident and strong resources. Next on the continuum is the single incident where there is some previous trauma but the client has strong resources. Then comes complex trauma with strong resources; single incident, complex trauma history and poor resources; multiple traumas, poor resources with some attachments and, at the more severe end, multiple traumas, poor resources with poor attachments.

We use the interweave to jump-start blocked processing by introducing certain material rather than depending on the client to provide all of it. We are more likely to need to use interweaves (cognitive interweaves or therapeutic interweaves) with complex populations, however these should be used selectively so that the client's own processing system can do the work necessary for full integration of information.

Beware over-use

Murray cautioned against sliding away from EMDR by over-use of interweaves. The challenge is to incorporate interweave strategies in a way that maintains the integrity of the EMDR/AIP model without departing into a parallel therapeutic approach. He used the metaphor of a train to illustrate this: he said that the train is on its tracks as it moves from one stop (therapeutically adaptive plateau) to another, dropping things off and taking things on. When this is happening our message is 'keep going' or 'go with that'. However, the train may at times become unsteady on the tracks, get stuck on the tracks, come off the tracks or run out of tracks. And it is here that the interweave gets the train moving again.

Murray categorised interweaves around the eight-phase protocol as Regulation/Modulation Interweaves, Somatic Interweaves, Relational Interweaves, Mindfulness Interweaves, Informational Interweaves and Ego-State Interweaves.

Regulation and modulation are at the centre of everything. Murray quotes Alan Schore: 'The therapist must act as an auxiliary cortex and affect regulator of the patient's dysregulated states in order to provide a growth-facilitating environment for the patient's immature affect- regulating structures. He then went on to say that some clients need help with dual attention: "we are helping them to become like a fly on their own wall". Mindful attention that is essential during the therapeutic process is achieved through engagement of the prefrontal cortex, awareness of being in the here and now. The ability to be mindful is essential to the successful working through of traumatic material.

Murray cited Peter Levine's assertion that sensory awareness is enhanced by supporting initial exploration and acceptance of sensation – helping clients to find their way home to their bodily sensations and their capacity to self soothe and to learn to access, tolerate and utilize their inner sensations.

Relationship rules

The therapeutic relationship is crucial to the successful outcome of therapy. The therapeutic alliance is most difficult with clients who have experienced early complex trauma. Murray argued that by using the relational matrix (projective identification) we are able to create an empathic bridge. This will help with creation of relational interweaves that will help the client to move on when stuck.

Murray's explanation of ego-state interweaves entailed his playing a fascinating video of his own work in this area. With the continuum of dissociation illustrated by the structural model of dissociation, we can see that by using interweaves as a preparation to help with stabilisation it may become possible to process old memories with EMDR. We all have ego states but they are co-conscious. With the structural model of dissociation, we have Apparently Normal Parts and Emotional Parts. Murray's video showed how he worked with a target. The client was working

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Earth-shaking work with Turkish quake victims

Mike O'Connor was moved by Ümran Korkmazlar's and Billur Kurt's account of their work with traumatised children and families in Turkey

Professor Ümran Korkmazlar and Billur Kurt are both clinical psychologists working primarily with children in Turkey. Speaking from their personal experiences of implementing and adapting the EMDR Group Protocol for Children (EMDR-GPC) Ümran and Billur provided an outstanding, fascinating and moving account of their work with children and families following the earthquakes in Turkey during 1999, the Soma Mining disaster in 2014 and more recently with Syrian refugees.

The 1999 earthquakes resulted in such a huge loss of life, injury and homelessness that local services, including mental health services, were overwhelmed. As Ümran recalled one of the positive outcomes of the disaster was the introduction of EMDR to the mental health services. This came about via the EMDR-Institute and EMDR Europe HAP intervention. For Ümran, this provided the opportunity to include EMDR in their psychological support model for children affected by the earthquakes. Many years later Ümran and Billur were then able to apply their learning and experience to help the children and families affected by the Soma Mining Disaster in which over 300 miners lost their lives. Their research reveals that the EMDR-GPC is working very effectively with earthquake survivors, children who lost fathers in the mining disaster, Syrian refugee children and with groups of children experiencing other types of trauma and loss.

During the workshop they illustrated how the group protocol follows the standard EMDR eight phase treatment model and how it can be adapted to take into account the age and developmental stage of children.

Imaginative adaptations

These adaptations and their imaginative integration of other therapeutic modalities into the treatment (e.g. drawing and storytelling) will be familiar to EMDR clinicians who work with children. Ümran and Billur also described how the EMDR-GPC protocol can be used at different time periods. Their research has revealed that when the protocol was used with children in the acute phase following trauma eighty per cent of the group recorded a reduction in their SUDS score to between 0-3, fewer individual EMDR sessions were needed and generally the children did not develop PTSD. They also report positive outcomes when it is used after PTSD symptoms have developed.

Much of the workshop was taken up by a detailed discussion of the methodology they use to implement the protocol in the field. Key elements of the procedure in the Assessment phase are the use of drawing of the 'Safe Place' by each child on an A4 sheet followed by the children being asked to draw the 'worst image' (NC, emotions, body sensations, SUDS level all recorded on the same page as the drawing). This 'worst image' is deliberately made on half an A4 sheet to make it seem

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on a complex trauma but was compromised by ego states. Murray showed how by being sensitive to younger parts who were not agreeable to present-day reality, he could gently coax them to come out of their hiding place and present themselves to be helped.

In another video Murray explained that he was not wanting to get rid of this part "lying in the long grass"; on the contrary, its place and contribution was assured. He asked this part whether it was available, and what assurances it needed to take the uncharacteristic step of coming out into the open. He said "Okay, you can pull the plug at any point". After some more relational questioning he asked: "Would you be prepared to meet the present day person". Murray presented the possibility of joining up with the present-day adult for the continuing journey. He asked what contribution the younger part could make? It answered, "tenacity". He then handed them back to each other so they could work to figure out their journey. Murray then facilitated this integration process with BLS.

I was left with the impression that Gus has made a significant contribution to working with complex clients using this gentle interweave process as a part of the preparation for processing, but also as an effective way of working with clients whose younger ego states may interrupt processing due to their mistrust of other parts. Murray showed how ego state interweaves can be used to earn the trust of these parts as they emerge and so make them available for eventual integration.

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How EMDR can reduce the global burden of trauma

Omar Sattaur reports on Rolf Carriere's inspiring Keynote Address

Rolf Carriere received a standing ovation for his Keynote Speech on the role of EMDR in Confronting the Global Burden of Trauma. In a visionary address, founded on the best of available data, Carriere demonstrated his gift for strategic thinking and diplomacy born of 34 years in the service of the UN system to map out a plan to harness the power of EMDR by bringing it into the international system. To achieve this, Carriere said, "would be a global and historic contribution".

The World Bank estimates that one in five people live in countries affected by violent civil conflict. The United Nations High Commissioner for Refugees estimates that 60 million people worldwide have been displaced as a result of conflict, violence and human rights abuses. One-third of women in the world have suffered sexual and/or physical abuse in their lifetimes. One million people are killed every year in road traffic accidents. In 1998, for the first time in history, more UN aid workers were killed than UN Peacekeeping Forces. Thus a significant amount of the world's trauma is a result of direct violence alone.

When we consider the quarter of a billion people affected by natural disasters and the additional contributions of structural and cultural violences, Carriere said, there could be 500 million people in the world with PTSD. But this is based on incomplete data, and extrapolations for countries that underestimate, define trauma differently, or simply have no data of this kind. Bearing this in mind, Carriere concluded that "The dominant psychological state of the world is traumatised". Yet the recognition of this trauma, and possible ways to treat it, does not feature much in the deliberations and publications of the UN system. For example, trauma is not mentioned in the UN's Sustainable Development agenda.

A standing ovation for Rolf Carriere

EMDR's advantages

Carriere listed the advantages of EMDR in tackling this global problem. It is comparatively quick, can be adapted to treat groups of traumatised people, can be used effectively as an early intervention, works far beyond trauma and is easily accepted both by the

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less 'powerful' than the 'Safe Place' with the instruction that there be as little discussion and sharing between group members to prevent further traumatisation. The Desensitisation phase involves using the 'butterfly hug' (BLS) as developed by Jarero, Artigas et al (2008) as the children look at their drawing.

The children then continue to process with BLS with a second, third and fourth drawing (each drawing on a different paper to prevent previous images interfering with the processing). At the end of the fourth drawing children are then asked again to give SUDS levels. Further drawing and processing can continue if required but mostly this is not required and the group then have a break (a metaphor for 'life goes on') before continuing with the Installation phase. A crucial part of this phase is the development by the therapist (s) of a 'healing story' written especially for that specific traumatic event. This narrative is based on the flow of the Standard Protocol and is used to help the group make sense of their experience. Ümran and Billur provided participants with two outstanding examples of healing narratives they developed in their work; 'Hero Ants' (Soma Mining disaster, 2014) and 'Migratory Birds' (EMDR with Syrian refugees, 2016).

They also provided examples of the exercises they use in the Closure phase of EMDR treatment and emphasised the importance of providing children with 'powerful' closure exercises particularly when children are living in an ongoing trauma situation. Participants had the opportunity to experience these first hand!

As is often the case with traumatised children working with a parent/caregiver is an essential part of the treatment. Ümran and Billur acknowledged this and discussed the process involved in deciding whether the parent/caregiver should be directly involved in the group process. For a more detailed account of their work see the references below.

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Stochastic resonance as a mechanism for EMDR

Art O'Malley on Paul Millar's foray into the workings of the brain in EMDR

stochastic
1. involving or containing a random variable or variables
2, Involving chance or probability

The American Heritage Science Dictionary

The key conclusion of Paul Millar's presentation was that the effective component of EMDR therapy is thalamocortical binding. It is known that this can be achieved by allowing the brain to resonate at the gamma band frequency of 40 Hertz. What is less well known is the origin of this binding. Millar proposed in his talk to explain the phenomenon of stochastic resonance. This can be described as the outcome in a mammalian auditory system effected when intrinsic noise is added to a sub-threshold signal; not only can the resulting noisy signal be detected, but also the information carried by the signal can be completely recovered.

Those keenly following the research on the mechanism of action of EMDR will be interested in Millar's reference to the article by Uri Bergmann in the Journal of EMDR Research and Practice. Robert Stickold from Harvard University has published articles relating EMDR therapy to a REM-like brain state. The reprocessing is aided by a slowing in thinking during the psychotherapeutic exchange. The threshold for synaptic transmission is held to be due to helpful randomness otherwise known as stochastic resonance. Millar illustrated this with three images. In the first there was a weak signal, in the second there was random noise and in the third there was a signal plus a high noise level. The middle picture with a random noise input delivered the clearest image. This was likened to how talking in a crowded room can facilitate two individuals who are focussing on their own conversation.

Triune brain

Millar described the triune model of the brain first proposed by Paul McLean in the 1960s. In this model the amygdala is like a metal detector and the thalamus is like the security guard at an airport check-in terminal. If, for example, the airport has lost the current list of terrorist subjects then everyone is stopped and searched. This is how a traumatised brain reacts until bilateral stimulation and dual attention components of EMDR restore normal brain functioning.

Millar described the research of Ruth Lanius published in the American Journal of Psychiatry in 2003. This described how a husband and wife reacted to hearing a narrative of their road traffic accident being read out while their brains were being scanned by an MRI machine. While the husband was processing the material in Broca's area of the left cerebral hemisphere, his wife was processing the image in her visual cortex. This shows that the husband had reprocessed the visual traumatic images and made sense of them at a level of language comprehension whereas his wife was still re-living the event. According to Millar, such a dysfunctional memory network leads to negative self-belief and consequently negative cognitions related to the incident.

These are key targets for EMDR therapy. Often the person experiencing the trauma puts on a mask to cope with their feelings but this is not adequately dealing with the problem. Masking leads to what Millar described as a 'psychic abscess', affecting the patient's attitudes and how the traumatic memories are stored in the body at a physiological level.

Thalamic level

Millar went on to discuss the case of Paddy Hill who was one of the Birmingham Six. He served almost 17 years behind bars for a crime he did not commit. During that time he had little contact with his family. When he was released, he

traumatised and treatment professionals. After acknowledging the general prevailing belief that no solution is available to partially explain why there has been no concerted effort to bring psychological expertise into the international system, Carriere sketched out a plan of action.

First, there is a shortage of health professionals. To address this with the urgency required, we cannot afford to train up sufficient EMDR therapists. It would simply take too long. Instead Carriere proposes a three-tier system comprising Psychological First Aid as first responders. This has already proven useful and the UN already has guidance about this. The second tier would comprise paraprofessionals offering what Carriere calls "psychological second aid". These paraprofessionals may be trained to offer, for example, the group protocol. Carriere acknowledges the resistance to this kind of proposal from professionals but compares it to the resistance from the medical profession when the UN similarly proposed large-scale inoculation against smallpox by non-medical staff, which proved instrumental in its eradication. Finally, "Psychological Third Aid", which is where EMDR therapists enter the strategy.

Achieving this would require organisational partnerships to engage stakeholders, to mobilise resources and to influence this type of thinking worldwide. If we are serious about tackling the global burden of trauma, Carriere said, we must achieve a "global alliance for trauma therapy".

The creative therapist

The Editor's personal highlights from Joany Spierings' Encyclopaedia of Interweaves in EMDR therapy

Joany Spierings will be familiar to those who have attended EMDR conferences in recent years. Her breadth of experience, creativity and engaging sense of humour all make attending her presentations a lively and absorbing experience. She was given the title An Encyclopaedia of Interweaves in EMDR Therapy by the organisers and characteristically made it her own: no one reads a whole encyclopaedia in one sitting, so don't expect comprehensive coverage; but, like an encyclopaedia, use it strategically to provide the missing information you may need. I am going to follow her example in this brief write up of her presentation and give you three things that I have taken from her encyclopaedia and am looking forward to trying out in my practice.

First the boundary role play for those clients who are inexperienced in setting and enforcing boundaries. Like many of her interventions, this seems to borrow from Dramatherapy principles and practice. Give your client a piece of cord (a long scarf worked just as well in this session) and ask them to lay it down on the floor to create a boundary:

Joany Spierings informed us and made us laugh

behind it constitutes the client's space, anything in front is the therapist's space. Beginning 4-5 paces away from the cord, turn to face the client and inform the client that you will, very, very, slowly approach the boundary. The client must use all their resources to prevent you from crossing into their territory. If at any time the client feels overwhelmed, it is agreed that they will make a T sign with their hands and the role play stops immediately.

As in so many role plays, acting quickly transforms into real and deep interaction. As you, the therapist, move towards the boundary, pay careful attention to body language, posture, facial expression and, if there is verbal expression, the tone and pitch and volume of voice as well as the words that are being uttered. All this should be offered in feedback to the client after the role play.

In our trial – there was a brave volunteer from the delegation – this role play was very rich. There was at first a mimicking of the therapist's actions, step for step. Then both hands gently attempted to swish the therapist back. Then the word 'No', at first gentle and tentative and growing fiercer with each iteration. The therapist eventually crosses the boundary in the absence of the T signal from the client. Did the client use all their resources to repel this intruder? The fruits of this exercise lies in the thoroughness of the debrief, really using it to explore the client's feelings, worst fears, perception of the strength of their resistance.

Universal USB

Second is Spierings' stone of good ending for clients who lose track of the fact that they are now out of danger, that they did, indeed survive. I like this one for its versatility. The idea is simply to offer the client a pebble and help them imbue it with a sense of safety. It serves as a physical, tangible reminder to the client that he or she is present in the here and now, the 'Apparently Normal Part' rather than the 'Emotional Part', the healthy, functioning client rather than the traumatised client, the adult rather than the child. Spierings calls this the universal USB which can be 'uploaded with anything' you (or the client) think might be useful. Spierings has the client holding, and squeezing, this stone when the processing is marked by abreaction or potentially overwhelming affect.

Finally, for the client whose traumatic experience left them feeling dirty and worthless, there is the banknote interweave. There

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said he felt "cold and numb" and was unable to relate to his children forever more. Albert Einstein said, "You cannot solve a problem at the same level at which it was created". Millar suggests that you need to go to the thalamic level to bring in a different level of thinking that can help to solve the problem. This thalamocortical binding approach is believed to be the essential effective component of EMDR therapy.

Millar reviewed a lot of research from the past 20 years in his fascinating talk. This included MacCulloch from 2006, Denny, 1995 (Orienting reflex) and 1996 (Extinction model of the orienting reflex). In 1997, the vividness of the visuospatial sketchpad was outlined. All these researchers primarily applied their theories to CBT. However, in 2002, Frank Corrigan, an adult psychiatrist working in Scotland, published an article on reciprocal inhibition of the anterior cingulate cortex. Millar simplified this to illustrate a model of metacognitive functioning that he applied to EMDR. As fear memories are decreased with EMDR therapy there is reduced emotional reactivity, which is reflected by decreased limbic system activity.

In conclusion, Millar quoted Herkt who found that, in EMDR, bilateral stimulation produced a better result than simultaneous stimulation, which produced a better result than no stimulation at all. This talk shows how research is increasing our understanding of how EMDR works at a brain level and lends greater weight to calls for more widespread training and provision of EMDR therapy.

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John Spector's In Practice

EMDR in the treatment of functional neurological symptoms, submitted by Abrar Hussain

Within my role as a liaison psychiatrist working in the community, I regularly see patients with medically unexplained symptoms (MUS). Patients with MUS form a heterogeneous group with overlapping symptom clusters and syndromes usually defined by the particular organ system involved. The term 'functional neurological symptoms' broadly captures unexplained symptoms in the neurological system such as weakness, numbness, pain, tremors, gait difficulties and seizures.

Working with patients presenting primarily with functional neurological symptoms can be challenging as often they, understandbly, seek a 'medical' cure for their physical symptoms. Exploring psychological factors and making links between traumatic events and the onset of their physical symptoms is helpful. EMDR offers these patients an avenue to process traumatic experiences, taking into account the somatic expressions of trauma.

In my experience, EMDR seems to work well in patients when other therapies, particularly CBT, has not worked well. The reason for this may be that other therapies rely heavily on verbal accounts from patients. By allowing therapeutic work to start and progress without depending on the patient's vocabulary, EMDR brings an added advantage to the therapist.

Another way of thinking about MUS is that these patients are expressing distress somatically, which may mean that they are not able to express distress verbally. Early life experiences (and trauma) may predispose to this as well; for instance, it is well established that MUS in the father is a strong risk factor. EMDR allows patients to work with their preferred mode of expression. The EMDR assessment serves to validate the link between physical and psychological factors as the somatic experience is explored and documented along with psychological parameters such as NC, PC and SUDs.

At the outset, I take a full psychiatric history and complete an EMDR assessment. I provide written information and explain about EMDR and if the patient consents, arrange an initial six sessions of hourly therapy on a weekly basis. We create a time line focussing on the first, worst and most recent traumas in relation to the onset of the MUS, but also make a note of other traumas. I then install the safe place and resource(s) before starting to reprocess.

As the trauma is processed, both physical and psychological symptoms are monitored. I use outcome measures such as PHQ-9, GAD-7, PHQ-15 and IESR-R on a weekly basis. I will present a case scenario below to illustrate the use of EMDR in functional neurological symptoms.

A Case scenario

Miss D, 18 years old, was referred by her GP with functional neurological symptoms. She presented with unexplained collapses/fainting spells and emerging personality traits with intermittent self harm (superficial cutting). She was a frequent attender at the surgery. Objectively, she was almost always well-presented and appeared to have a normal mood with a reactive affect. Her GP felt there was a mismatch between her subjective psychological distress and her observed appearance and behaviour. This caused some breakdown in their doctor-patient relationship. A referral to neurology did not reveal any physical reason for her collapses and a diagnosis of functional neurological symptom was made.

She was initially referred to the IAPT service where she had four sessions of CBT without any noticeable improvement. She disengaged from the service.

During our first meeting, I took a detailed history of her physical symptoms. In addition to fainting spells, she also experienced lower abdominal pain which was so far medically undiagnosed. She reported that her symptoms started soon after a traumatic experience. She had been on a trip with her friends when she had experienced a single episode of sexual assault. She experienced shame and humiliation in relation to the trauma and held herself responsible for the attack. She also reported intermittent flashbacks of the event.

There was no history of other childhood traumas and her premorbid personality (before the assault) was 'normal'.

Her negative cognition was "I cannot protect myself" and her positive cognition "I am safe now" had a VOC of 1. The predominant emotion was fear. The SUDS were 10 and the physical location was in her chest.

We processed the memory of the assault using bilateral stimulation with tactile buzzers. After the second session,

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is some preparation required here as you will need a large banknote – Spierings uses a €50, but in the UK a £50 would work well – in your wallet. Spierings takes it out and shows it to the client and asks them how much it is worth. The answer is of course €50. She then acts out (she will be awarded a dramatherapy equivalent of an Oscar one day) spitting on it, blowing her nose into it, peeing on it, wiping her bottom on it, crumpling it and stamping on it. She then smooths it out, holds it out to the client and asks again, how much is it worth?

I hope this brief accounthas whetted your appetite to dip into the Spierings encyclopaedia the next time she and you are at the same conference, it is a great read.

there was some increase in her suicidal thoughts but she kept herself safe and managed to engage. We completed six sessions of EMDR.

After the fifth session, she noticed considerable improvement in her psychological and physical symptoms. She felt that her mood was more stable and she no longer felt suicidal. Her intermittent self harm completely stopped. Her family also reported a change in her personality as her old self emerged. The psychological improvement corresponded to a reduction in her abdominal pain and she experienced no further blackouts. The SUDs dropped to zero and the VOC for "I am safe now" improved to seven.

I reviewed her after three months and her improvement was sustained. She had been able to re-start work and reported that her personality was almost back to normal.

In her patient feedback, she wrote "Now having had my final session, I cannot believe that only six one-hour sessions have helped me so dramatically. It is wonderful to begin to see myself changing. My family have also noticed the change in me and said they are pleased that I am getting back to how I used to be".

On reflection, the above case example probably represents the milder end of the spectrum. She was psychologically resilient and able to make good progress with EMDR. There was no evidence of co-morbid mental illness, personality disorder or substance use which contributed to a favourable prognosis.

In more complex patients, there may be layers of trauma including sustained childhood abuse which usually needs longer treatment. Complex patients need longer preparation times and other techniques to manage difficulties such as multiple ego states, dissociative experiences and other barriers to trauma work.

Dr Abrar Hussain is a Consultant Liaison Psychiatrist working within the community psychological medicine service in Berkshire. His area of interest is medically unexplained symptoms.
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John Spector comments:

Abrar's work using EMDR with clients with functional neurological symptoms including NEAD (non-epileptic attack disorder or psychogenic seizures) is a useful reminder of the potential value of EMDR with this under-reported group. I am aware of only two published works in this area (Kelly et al. 2007, and Chemali & Meadows 2004).

Clients with medically unexplained symptoms (MUS) frequently have experienced co-morbid trauma, sometimes amounting to PTSD. These are the clients for whom Abrar is proposing EMDR and, further, implicitly, that trauma should always be explored with MUS clients. Not untypically, Miss D's GP and IAPT had not explored her sexual assault (two years previously) and associated lower abdominal pain as a possible contributor to her MUS symptoms, but Miss D may not have disclosed this. Abrar, experienced in trauma work and EMDR, was able to recognise the significance, and target the assault with EMDR. This led to rapid improvement in mood and symptoms over six sessions of EMDR, whereas previous CBT for her MUS symptoms had been ineffective.

This demonstrates the importance of forensic trauma enquiry in such presentations, and the huge value of EMDR where an a priori link between trauma and MUS symptoms can be made. The same reasoning might be applied to other "medical" conditions such as CFS.

John Spector, EMDR trainer, pioneered EMDR in the UK and has trained thousands of therapists in a career spanning 20 years

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Give us your questions, share your clinical experience! Tell us about an interesting paper or book you read or an engaging meeting that you attended. Write for EMDR Now and reach your colleagues.

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