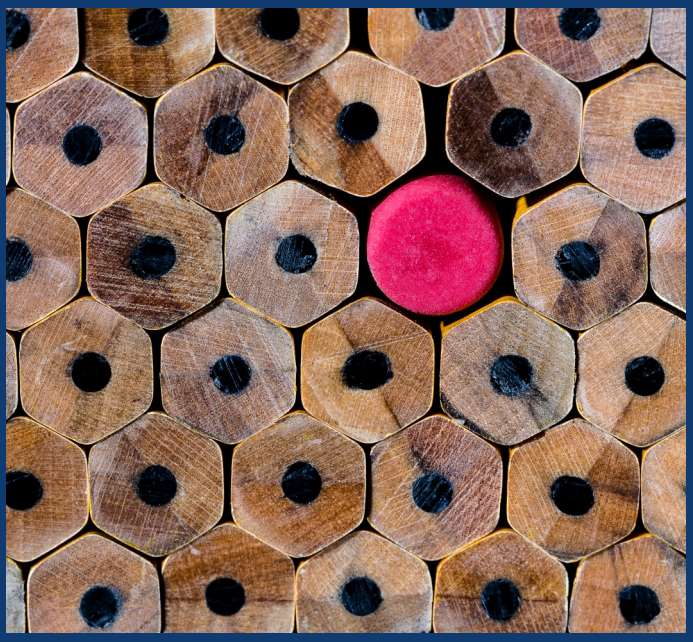
The Journal of the EMDR Association UK & Ireland
Spring 2019 Vol 1 No 1

EMDR THERAPY QUARTERLY



EMDR in the treatment of OCD: the published evidence

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

https://emdr-europe.org/
Eva Muenker-Kramer, EMDR Europe Association Secretary
secretary@emdr-europe.org
Angela Giordano, EMDR Europe Executive Assistant
angela@emdritalia.it

The views expressed in this publication are entirely the views of the authors and do not necessarily represent the views of the Editor or the EMDR Association UK & Ireland

New name and new look to meet changing needs

On behalf of the Board of Trustees of the EMDR Association, it is my pleasure to announce the launch of *EMDR Therapy Quarterly*, and to welcome you to the EMDR Association's new journal.

The EMDR Association UK & Ireland has produced a newsletter for its members since 2009 and appointed Omar Sattaur as Editor in 2010. Around this time, the Association membership was approximately 200.

Today, our membership exceeds 3500 and needs have changed. You will have noticed that we have been experimenting over the past year with producing a publication that addresses these changing needs, and with choosing a name and design to reflect this. This process has resulted in *EMDR Therapy Quarterly*. This journal will continue the reporting of news from EMDR conferences formerly covered in *EMDR Now* but aims to extend the type of coverage significantly. The most important of these new aims is to establish a scientifically robust journal that can report new research findings and their clinical implications and promote innovative practice. In summary, the objectives of *EMDR Therapy Quarterly* are to:

- promote research and innovative practice among members
- provide a forum for contributions from members
- provide a resource for members
- keep members informed of the above

This issue gives the highlights of the Annual Conference held in April 2019 in Birmingham as well as a review of EMDR in the treatment of OCD.

We hope you enjoy reading it and look forward to receiving your contributions whether as letters, case studies or original research articles.

With best wishes,

Lorraine Knibbs.
President, EMDR Association United Kingdom & Ireland

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.

ETQ may publish articles of a controversial nature on occasion. The views expressed are those of the author and not the EMDR Association or the Editor.

International humanitarian of the highest order

Francine Shapiro, 1948 - 2019

NEWS

Personal reflections from Derek Farrell, President of Trauma Aid Europe

I've always considered that the real hero in the development of EMDR Therapy was not Francine Shapiro – but her PhD Supervisor. Imagine the scenario: a student enters her supervisor's office to 'pitch' a potential research proposal. The essence of this, she says, is to bring to mind a trauma memory whilst moving your eyes from side to side. "A new treatment for PTSD - that's your hypothesis?" queries the supervisor. Instead of showing the student the door, the recommendation is "OK, why not?". This was California after all and the rest, as they say, is history.

Today, EMDR Therapy is a remarkable, empirically supported trauma treatment that is practised and researched worldwide. It is endorsed by the World Health Organization, the National Institute for Health and Care Excellence, the US Veterans Association and Department of Defense and the International Society for Trauma Stress Studies - an incredible achievement in just over 30 years.

I am fortunate to have had many one-to-one conversations with Francine, not as many as I would have liked, but enough to appreciate just how inspirational she was. In one such conversation I asked her a personal question: "What's this journey been like for you?" "How do you know a pioneer?", she countered. "They're the ones with holes in their backs, from the countless arrows that people have fired at them". It was a profound and poignant statement but made with humility and a touch of humour. I left that meeting feeling 10 feet tall – she had an astonishing knack of making people feel that way.

My first meeting with her was in 1996, in Chicago, when Paul Keenan and I - the entire British contingent of an otherwise all-American EMDR Training - were learning about 'Cognitive Intertwines', a joke she got, incidentally. She'd picked up on our Liverpudlian accents and shared her love for the Beatles. "Welcome to the EMDR family" she said. I knew she meant it – and we've never left. Now the EMDR Family is truly global.

Francine, from my perspective, presented us all with two crucial challenges: to research and to publish. Virtually every conversation I ever had with her would always feature, at some point, these two challenges – "interesting, but have you published that?" They remain as important now as ever: publish or perish.

Her ultimate passion was in addressing the global burden of psychological trauma. The best accolade I can give her is that she was an international humanitarian of the highest order and her commitment continued to the very end. Her mark is truly etched onto the global stage.

The International EMDR Therapy Community will miss her – I will miss her. The help and support she gave me whilst I was President of Trauma Aid Europe and Programme Director of the University of Worcester MSc Programme was significant, challenging, inspiring and empowering.

Francine celebrated 25 years of EMDR in 2014 at the EMDR Europe Conference in Eidinburgh

I last heard from her several months ago when I received an email 'out of the blue'. She had just read my paper about treating a Hillsborough Survivor. I'd previously mentioned that Hillsborough was a trauma for me and my family, due to personal connection. She wrote that she'd enjoyed the paper but asked me one thing: "make sure all your students read it". Francine read everything anyone published about EMDR.

In 1996, Francine was probably one of the most remarkable individuals I'd ever met; this continues, past, present and future. May her indelible footprints continue for, even in passing – there is still much to do.

Rest in Peace Francine. You literally changed my life and for that I am truly, truly grateful.

Learn how your clients regulate their emotions

Anabel Gonzalez summarises her keynote address to the Association's Birmingham Conference, shining a light on the complexity of working with clients with severe mental illness

Emotional dysregulation is a common feature of trauma-related disorders. The problems of emotional regulation seem to be linked to particular psychological psychiatric conditions, which can influence how EMDR procedures work in different clients and explain divergences in individual responses to bilateral stimulation. Understanding the patterns of emotional dysregulation can guide our decision making during EMDR therapy. Taking into account a client's predominant strategies for emotional regulation can help us to fine tune our interventions to specific post-traumatic disorders.

Some EMDR specialists insist that good emotional regulation is a prerequisite for trauma processing therapy, particularly in complex trauma cases. The Dissociative Disorders Task Force considered good affect tolerance a necessary pre-condition for trauma-oriented work in dissociative clients. However, most concern is directed to those clients with extreme emotional activation. These clients experience their emotions as very arousing and usually feel overwhelmed by them. They can feel out of control.

Emotional regulation has been extensively studied during the past few decades, from the perspectives of cognitive neuroscience, neurobiology and brain-body interaction research. All these new data are yet to be fully integrated into EMDR theory and clinical practice. Some interventions aim to enhance regulatory capacity in dysregulated clients, most proposing the use of hypnotic or mindfulness techniques in the preparation phase (Phase 2) of EMDR therapy. Various techniques for affect management, including containment, grounding and present-orientation strategies, mindfulness or somatic awareness techniques have been proposed. However, emotional regulation is not a simple phenomenon and a more elaborate conceptualization is required.

Gonzalez: We already have too many protocols

The situation may be different for people with good premorbid capacity to regulate their emotions. Emotion-regulation strategies may influence how clients understand and explain their present problems and early experiences (Phase 1 of assessment in EMDR therapy). Depending on these strategies, they may be ready to work on traumatic memories, reluctant to do so, or may consider such work unnecessary as they have overcome those problems. Thus, according to their capacity for emotional regulation, some people can experience their emotions as overwhelming, others face distress adaptively and some feel emotionally disconnected from the experience when trying to access the perceptual, cognitive, emotional and sensory components of a memory (Phase 3).

Similarly, clients' strategies for emotional regulation will also influence memory processing in Phase 4 (desensitization). More specifically, dysfunctional styles of emotional regulation can be activated when information processing systems are unblocked by bilateral stimulation (BLS). It seems that when dysfunctional styles are not pervasive, long-lasting and rigid, EMDR standard procedures may resolve the situation. When a person has a strong tendency to use dysfunctional strategies, and if additional interventions are not introduced, the standard EMDR procedure is not enough for the memory

p5

to be processed and integrated.

When 'go with that' is not enough

There are some important considerations for clinical work with this client group, all of them grounded in an appreciation of the uniqueness of each client. The Adaptive Information Processing model proposes that bilateral stimulation activates the client's innate processing system. But when emotional processing has huge and pervasive dysfunctions, we may be activating a dysfunctional system. 'Go with that' is not enough in many cases. Clinicians must formulate a thoughtful understanding of the specific emotional regulation patterns in each case, which can then guide any modifications in EMDR procedures that may be necessary.

Beyond the window of tolerance

Dissociation can be a problem but it is not the only one that the EMDR therapist must manage. We are at risk, as always, of becoming lazy in our appreciation of the pitfalls of therapy. The window of tolerance, to take one example, is a simplistic concept which can lead to somewhat confusing outcomes. It does not help with the diversity of presentations we must be aware of in order to help severely dysregulated clients access and process their memories. We must therefore do more than be aware of the client's window of tolerance, defences and dissociative patterns; we must understand the complexity of this particular client's emotional processing and use this knowledge to adapt procedures for him or her. Understanding which type of dysfunctional emotion-regulation strategy is being used may help us to select more effective interventions. Clients may under- or over-control their emotions, may tend to employ ruminative strategies, may be avoidant or may disconnect from emotions because they suppress them or dissociate. Each one of these would need a different response from the therapist.

Polyvagal theory

The Polyvagal theory offers a hypothesis about the way in which different clients respond to bilateral stimulation. When the client is presenting a dorsovagal parasympathetic response (tiredness, collapse...), "go with that" will not be enough to overcome it. The parasympathetic effect of bilateral stimulation varies according to the basal autonomic state.

The level of complexity

The level of complexity in emotional regulation is also important. Healthy complexity is good, and many EMDR procedures such as self-care interventions or resource installation include a kind of training of these complex regulation abilities. To identify dysfunctional emotion-regulation tendencies such as self-blame, revenge-focusing and many others, may guide us to select more appropriate and effective preparation interventions and interweaves.

Better understanding, fewer protocols!

EMDR work in these complex cases should not spur the development of more protocols - we already have too many! Instead we need to understand how these dysfunctional patterns developed from early relational interactions. We should identify what was lacking in early caregiving and titrate and modulate our interventions accordingly. We don´t need specific protocols. We need to understand the basics of the Standard Protocol, know the person we are working with, and use our common sense. For example, a person who is very avoidant cannot work directly on the worst memory, even if it is the most relevant. If the client has problems in accessing or processing memories, we need to understand why. When we know 'why', the 'how' becomes easier to find.

Therapeutic alliance

The therapeutic relationship is crucial in emotional regulation and, in individuals with severe dysregulation, an attuned therapist is more relevant than the technique or the specific procedure.

In summary, emotional processing is a critically important and developing area whose careful study will enrich EMDR therapy and help us as clinicians to fine-tune our interventions in a way that maximises their therapeutic efficacy.

Dr Anabel Gonzalez is a board member of the European Society for Trauma and Dissociation and is Vice President of Spain's national EMDR Association. She coordinates the Trauma and Dissociation Program which treats severely traumatized patients at the University Hospital of A Coruña.

EMDR in the treatment of compulsive sexual disorders

by Jan Topley

Hooray now sex and EMDR are on the agenda! Nicola Pinder, a psychosexual therapist and EMDR Practitioner, started the second day of the Conference by describing a small study comparing the perspectives of six psychosexual therapists and six EMDR Consultants. She gave them two clinical vignettes which included sexual dysfunction and asked for their case conceptualisation and plan of treatment. The psychosexual therapists tended to ignore the significance of trauma and the EMDR Consultants focussed much more on trauma as the cause of sexual dysfunction. The EMDR Consultants were less inclined to ask clients routinely about their sexual experience, which may of course be important but unexpressed.

Silva Neves, a psychosexual therapist and trauma therapist trained in EMDR, gave a very useful presentation on treating compulsive sexual disorders with EMDR. He made the point that compulsive sexual behaviours are a sexual health behaviour problem rather than an addiction and these behaviours seek to meet sexual, attachment or emotional needs. He advised that the use of the term Sexual Addiction is unhelpful and shame-inducing and may result in inappropriate treatment using a 'sobriety model'.

The preparation stage he described included psychosexual education, explaining to the client that: compulsive sexual behaviour is not a disease, is not a character defect, and is not an addiction. The treatment is not an addiction treatment and 12-step support groups are not recommended. The treatment is sex-positive and non-shaming; no-one will tell the client what to do with their sex life and sexual abstinence is not necessary. Sex is good, positive, diverse, varied and should be pleasure-centred. The Six Principles of Sexual Health: Consent, Non-exploitation, Protection from STIs and pregnancy, Honesty, Shared Values and Mutual Pleasure are discussed. Sex is different for everybody and there are no rules as to what is 'normal' as long as it is consensual, legal and safe.

Neves reported that EMDR is a good and successful treatment for compulsive sexual behaviours and that he often uses the Flash Technique initially to diminish shame. He recommended taking a Sexual History Timeline and using the Sexual Symptom Assessment Scale (exploring urges), the Hypersexual Behaviour Consequences Scale (assesses severity) and the Adverse Childhood Experiences Score. The erotic mind of the client is explored asking for behaviours and fantasies which cause peak 'turn on' and the characteristics of these. They inform us of possible erotic conflicts in the client's relationship and inform us of what is in conflict with the client's values and integrity.

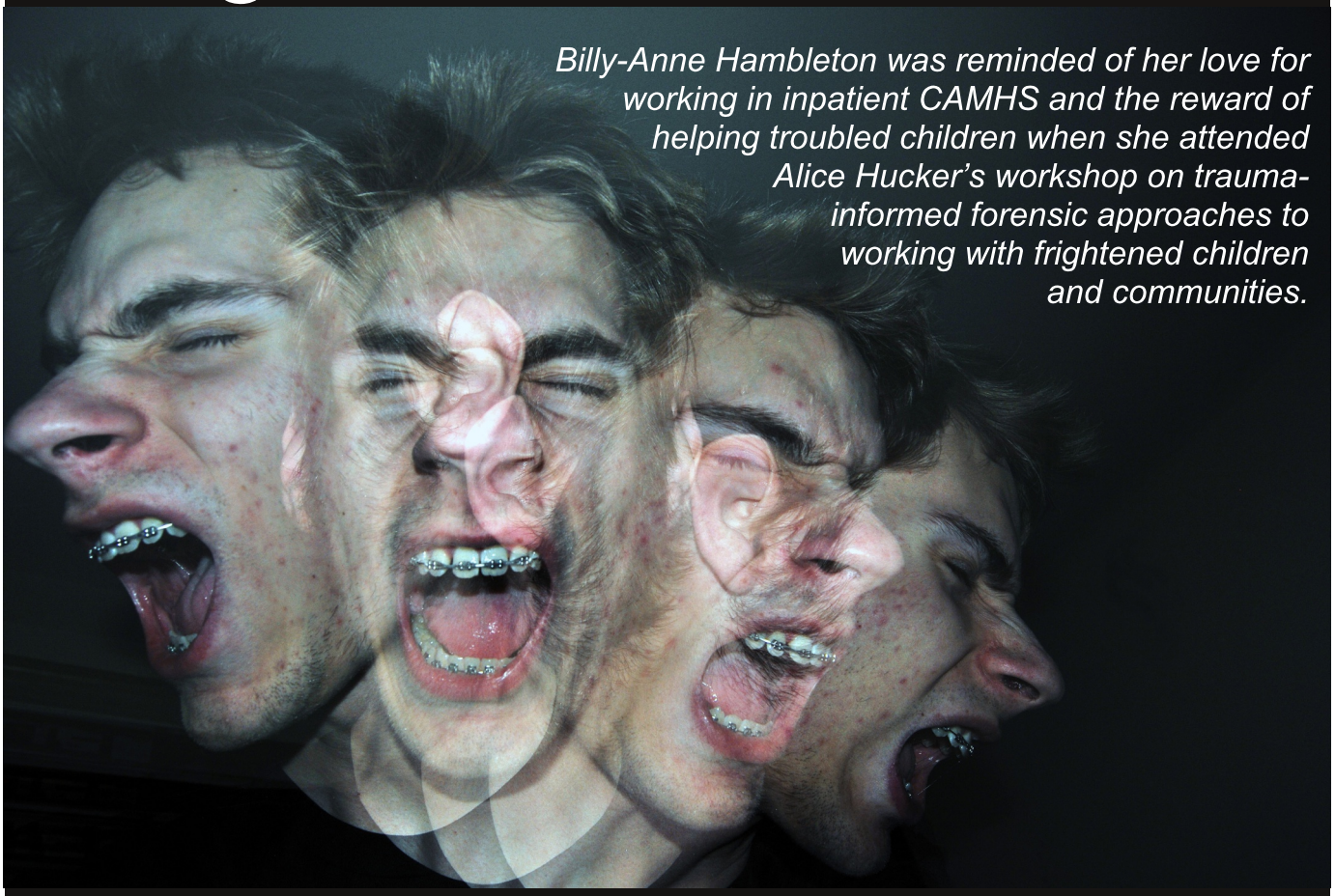
Treatment generally entails EMDR processing of starting-point trauma memories and practise of alternative soothing activities. Starting-point traumas may include sexual trauma, bereavements, physical and emotional traumas, bullying or hostility about sexuality from family. If there is no starting-point trauma memory the DeTUR Protocol focusses on typical sexual content triggers (and not behaviours, which can be shaming) focussing on unwanted urge reduction. When the DeTUR has been completed the client may become aware of the underlying trauma which could not be accessed beforehand. The Feeling State Protocol is also useful in breaking the link between sexual pleasure and behaviours.

He described clients who compulsively engage in masturbation with or without porn, casual sexual encounters outside their relationship, women seeking casual sexual encounters with men and group sex with chem sex. Most clients had resolution of symptoms within 12 sessions.

This presentation was an important learning experience for much of the audience and hopefully we will hear more on the use of EMDR in sexual dysfunction.

Jan Topley is an EMDR Consultant working in private practice in Bristol

Seeing the troubled child underneath



Billy-Anne Hambleton was reminded of her love for working in inpatient CAMHS and the reward of helping troubled children when she attended Alice Hucker's workshop on trauma-informed forensic approaches to working with frightened children and communities.

The workshop began with a reminder that, compared with the general population, there is a significantly higher proportion of young people in forensic services with learning disabilities, communication difficulties, mental health disorders and substance use. Given that those in the Youth Offending Service will have high Adverse Childhood Experience (ACE) scores as well, these young people do not come from a position of advantage. She reminded us of how society often portrays this client group negatively, but – and this was her most important message - "seeing the child underneath" is critical.

Hucker reminded us that good-enough parenting and the development of secure attachments are essential for healthy development. Her description of the types of relationships her young clients have had made it possible for us to indeed see those children, and to imagine their pain.

Hucker went on to describe how the damage sustained in early life often results in disorganized and insecure attachment and how this affects brain physiology. She explained the link between low serotonin and higher impulsivity and aggression. Furthermore, the brain stem becomes larger, in turn compromising the growth of the prefrontal cortex, which impacts on empathy, logic, consequential thinking and reasoning.

She then illustrated behavioural manifestations of disorganized and insecure attachment. One might see a child not asking for or accepting help, presenting as anxious and emotionally sensitive whilst at the same time as threatening and aggressive. The young person is likely to be erratic, impulsive and unpredictable. Behaviours will have a shock element and will be contradictory. She described the origins of such behaviour.

Having set the scene for addressing such presentations in this specialist CAMHS setting, Hucker moved on to describe graphically how what these young people have learned about relationships will be enacted with professionals. The beautifully excruciating depiction made it possible to imagine what it might feel like to be a child in this position (feeling unlovable, uncontained, confused, out of control and worthless), or an adoptive parent, (feeling frightened, a failure and, one would guess, that their hopes for parenting to be

less traumatic had been dashed!).
Hucker told us that the system needed to be stabilized for any healing to take place and referred to Dan Hughes' Dyadic Developmental Psychotherapy. What followed was an ultimately heart-warming story. Hucker had read the narrative of the child's life whilst his mum provided BLS. Hearing his own story being described and understood, together with an explanation of what he couldn't have appreciated before, the child was able to see the enormous progress he and his adoptive mum had made and the new direction his life was now taking. Hucker closed with a quote that the child had agreed she could share with others: "I haven't broken any XBOX controllers for a while now!"

Clearly the impact of this quality of therapy can create hope and potential for children to grow more healthily, reduce the likelihood of further crime, interpersonal damage and generational abuse. The empathy, skill and hard work Hucker clearly puts in to help counterbalance the effects of early adverse experiences on young people was evident.
Hucker's handouts on the Association website evidence just how much she had managed to pack into 30 minutes! It was delivered passionately, professionally, respectfully and in an impressively relaxed manner. Exemplary teaching, in my opinion.

Billy-Anne Hambleton was the manager of an inpatient adolescent unit in the 1980s. She now works with clients of all ages in private practice in the West Midlands

EMDR EYE MOVEMENT DESENSITISATION AND REPROCESSING THERAPY

EMDR Child and Adolescent Committee

Using Stories for Trauma and Attachment Resolution
(6 CPD credits)

The Priory Rooms, Quaker Meeting House 40 Bull Street,
Birmingham, B4 6AF
14 September 2019

Learn how to incorporate storytelling into your EMDR treatment plan. This workshop draws on the work of Joan Lovett and will provide you with a framework for writing stories for your EMDR clients. You will have the chance to practise writing stories and using the framework.
Eligibility: You must have completed EMDR Europe Accredited Training Part 1 and your core profession must qualify you to work with children and adolescents.

The presenters will outline the rationale for using storytelling with EMDR and illustrate this with a range of case studies with clients of different ages and experiences. They will briefly describe the process of incorporating stories into EMDR and provide a framework for you to use in the practicum.

The presenters are: Dr Alexandra Dent, Mike O'Connor, Alison Russell and Dr Robin Logie

Feedback from previous workshops:
"lots of case descriptions brought theory to life"

Please click here for more information and registration

Trauma, attachment and affective behaviour sytems: Implications for EMDR therapy

Why do abused children love their abusers? How does a loving, uncritical mother end up with a domineering and contemptuous son? When might it not be a good idea to begin EMDR therapy at Phase 1? It's all to do with attachment and other affective behaviour systems according to Arun Mansukhani, one of the keynote speakers at this year's Annual Conference in Birmingham

Arun Mansukhani: "Perhaps the most important aspect is the therapist's attunement and sensitivity"

EMDR therapy, developed by Francine Shapiro since the late 1980s, has proven to be very effective and has helped a large number of patients put an end to their suffering. The way that EMDR has reshaped psychotherapy in the past 30 years will remain Shapiro's enduring legacy. But, as any good therapist appreciates, it is not 'one-size fits all'. This is particularly true when the patient is an adult with severe attachment deficits. For this complex group we need to appreciate the interplay between affective behaviour systems and how this influences their interactions with significant others, crucially with the EMDR therapist. The traumatised adult must be able to tolerate dual focus; able to regulate sufficiently to stay with their disturbing material in the session. This is a big ask. Affective behaviour systems assume control below the level of awareness in severely traumatised people. Helping our traumatised clients to keep one foot here with us and the other in contact with the disturbing memories is, probably, our biggest challenge. But first we should agree on what we mean when we talk about trauma and affective behaviour systems.

What do we mean by trauma?

In the context of the AIP model, trauma is related to certain life episodes that have not been processed in the ordinary way and are therefore not integrated into the (mainly cortical) narrative and biographic networks. Instead, they are stored (or maybe remain) in different networks, which we can call traumatic networks. These traumatic networks are mainly subcortical and therefore implicit. It's obvious that we are here using the word memory in its widest sense, meaning not only images but also emotions and/or sensations (Shapiro, 2006); indeed, some authors have suggested that we should use alternative terms to accommodate all internal states (González & Mosquera, 2012).

So, why are certain events not processed and integrated into biographic memory networks? The answer is that integration requires homoeostasis. Abnormal levels of arousal of the nervous system, either hyper- or hypoactivation, prevent integration. Let's use as an example the response to a threat: if someone with an axe enters a room filled with people, we know exactly what's going to happen. Some bystanders will freeze, some will prepare to fight while others will try to escape. These are the three basic hyperactivation responses of the Defence System (DS), mediated by a sympathetic activation of the Autonomic Nervous System (ANS). If none of these are possible, then the ANS will initiate a parasympathetic (or dorsal vagal) response; the entire body will enter into hypoactivation and, in extremis, will enter the state known as feigned death. It's all about survival and damage reduction: if my body can't escape, my mind will.

Norepinephrine levels rise during the hyperactivation response (Masten *et al.*, 2015). At the same time gamma-amino butyric acid (GABA) – a neurotransmitter involved in affect regulation - will decline (Anderson

p10

et al., 2017). The result is that the prefrontal cortex (PFC) starts to shut down and limbic structures, especially the amygdala and hippocampus (Teicher *et al.*, 2017), are hyperactivated. If these measures are still not effective to deal with the threat, then the limbic structures will start shutting down leaving only the sub-limbic structures functioning.

Under any of these circumstances, and due to the shutting down of the PFC, integration of information into the cortical memory networks is impossible. In fact, integration will not take place until optimal levels of arousal/activation are re-established. Until then, recall of any aspect of this memory will again lead to deregulation, preventing post-trauma integration.

The level of arousal associated with the recall of a particular memory gradually reduces in time. When the level is sufficiently low to permit cortical activation during recall once again, the memory of the event is 'transferred' to cortical-biographical memory networks. If, however, the arousal due to the recall of the event doesn't erode with time, the 'transfer of memory' will not happen; in this case the PFC remains hypoactive and the limbic system hyperactive. In this state, the person will have some measure of difficulty distinguishing past from present and inner world from external world.

The Window of Tolerance, coined by Dan Siegel, is a useful metaphor to understand this. For each of the three arousal zones, we can describe how the Central Nervous System (CNS) and the Autonomous Nervous System (ANS) will respond (see Figure 1).

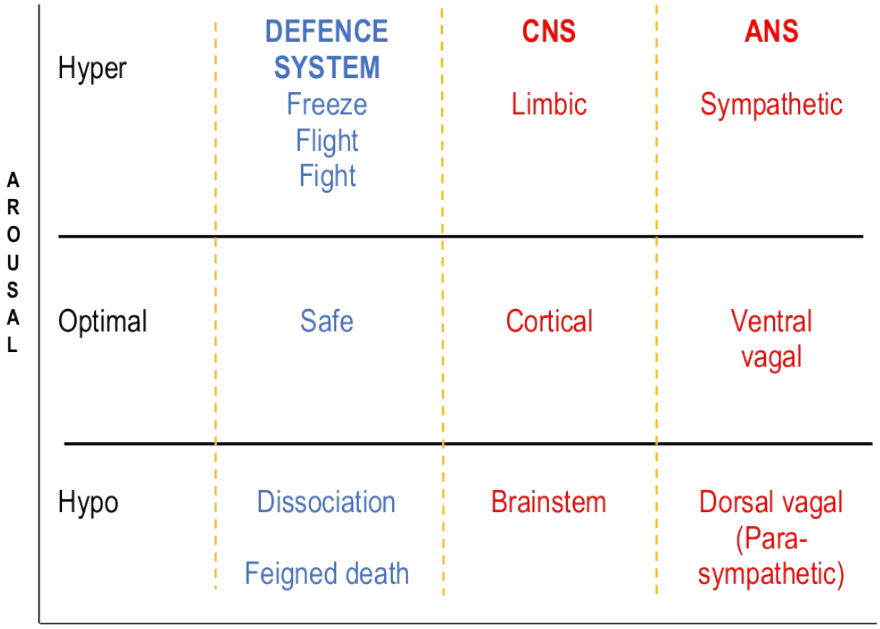


Figure 1: Nervous system response to a threat (Defence System hypo- or hyperactivation)

In threat situations, the whole nervous system gets hyper- or hypoactivated. This is appropriate in response to present, actual threat. But when this occurs as a reaction to past threats – and there is no present threat in the external world - we are talking about a post-traumatic response.

So a post-traumatic response in the context of psychotherapy is a stress reaction produced by the brain and nervous system as a reaction to the activation of dysfunctionally stored memories and internal cues which deregulate one or more of the behaviour control systems (hypo- or hyperactivating them).

Affective behaviour systems

So far, we have just focussed on the Defence System (DS). But the DS is not the only affective system we have. This leads us to our next question. If the DS is not our only system, can the other behaviour or affective systems be sensitized and traumatized in a similar way? Let's try to answer this question.

Affective or Behaviour Systems regulate flexible goal-oriented responses that serve evolutionary functions (survival or reproduction). They are linked to subcortical and sub-limbic structures and the ANS. They are stored in implicit memory networks and have therefore more to do with procedural than declarative memory. They get activated by stress and by external and internal conditioned cues. They tend toward homoeostasis (regulation). These on/off systems are present early on in life but gradually develop in a harmonic way so that, by adulthood, they are more sophisticated, differentiated, integrated and under cortical control.

Although there is not complete agreement about how many systems we have, nearly all authors agree that human beings have the following: Defence, Social Ranking (Social Hierarchy), Attachment/Caregiving (considered by some authors as different systems), Exploration, Pleasure/Seeking and Sexual. Of these, Attach-

p11

ment is considered the most important as it has an "organizing effect on the child" (West & Sheldon-Keller, 1995).

Attachment/caregiving

Although attachment has been studied since the 1950s, it is only recently that we have begun to understand it from a trauma perspective. As for the Defence System, the Attachment System (AS) can be in homoeostasis, hyperactivated or hypoactivated. And the activation pattern within the CNS and the ANS will also be very similar to that seen in defence: cortical for the CNS and Ventral Vagal for the ANS, meaning optimal arousal; Limbic CNS and Sympathetic ANS, for hyperactivation; Sub-limbic CNS and Dorsal Vagal ANS (parasympathetic) in hypoactivation. When the DS is in homoeostasis, the person feels safe; in the same way the person feels connected and secure when the AS is in homoeostasis. This is known as a secure response in attachment. But when a person feels stress or fear (of loss or abandonment, for example) the AS will be hyperactivated, leading to behaviours such as 'attachment cry' and 'seeking behaviour' (proximity to the attachment figure). This hyperactivation of the AS is what we recognize as an anxious ambivalent attachment style (Mikulincer & Shaver, 2008). Just as with defence, if these hyperactivation strategies are not useful, the person will enter into hypoactivation; the behaviours observed now will be avoidance of interpersonal contact and suppression of internal negative feelings. This is what we recognize as avoidant attachment. As in the DS, attachment is hierarchically organized. The first response to threat results in hyperactivation of the system (the anxious-ambivalent response) and the second response results in hypoactivation (the avoidant response). Again, the AS can be traumatized (read 'sensitized') according to life events. As a result of this process the adult develops a main pattern of attachment that is the result either of hyperactivation or hypoactivation of the system.

Disorganized attachment

This, then, is how attachment types are related to arousal. But what about disorganized attachment? Disorganized attachment was initially described by Mary Main through the approach-flight paradox which explains what happens when both defence and attachment systems are activated simultaneously, by the same external stimulus.

Under threat, a child's DS will become activated. However, when the child's attachment figure is present, the child's AS gets activated and this overrides and calms the DS, because the attachment figure makes the child feel secure. But what happens when the same person is the perpetrator of e.g. violence and is also the attachment figure? The same person activates the threat hyper response (flight) and the attachment hyper response (seeking proximity of the attachment figure). This is the paradox described by Main. In human children, the AS is stronger than the DS. So despite being battered or abused by their parents, children will maintain strong ties to them. In a way, the bigger the threat, the more hyperactive the attachment response. In cases where one parent is abusive but very much engaged with the child, and the other is not abusive but emotionally absent, we see that the child will consider the abusive parent as the main attachment figure. This perfectly explains what is happening in disorganized attachment as described by Main at an affective/behavioural level: both Attachment and Defence Systems become enmeshed due to the attachment figure and the perpetrator being one and the same person.

In fact, if attachment were not a major behaviour system in us and we were like most other animals - let's say like crocodiles or octopuses - we would have no dependency problems. If I were being abused or ill-treated in a relationship, such treatment would activate my DS and I would simply run away. But in humans we see the opposite, and not just in children. In gender violence, for example, a woman who has been contemplating leaving her abusive partner was close to doing so, becomes less likely to leave him immediately following a renewed attack.

So attachment/caregiving overrides the DS as the primary protector system in humans, even in adults. Let us revisit the example I gave earlier of the three possible reactions of bystanders confronted by a man armed with an axe. If a bystander was with his/her child they might well sacrifice themselves to save the child; the Attachment System could override the Defence System and a fight-flight-freeze response. And this is not limited to parent-child relations: adults can put themselves at risk to help other adults they are close to or to help unrelated children.

p12

There are other systems, too, that can be deregulated, sensitized and traumatized.

Social ranking

One of these is the Social Ranking System (SRS), often confused with attachment. (Bullying, for example, has more to do with the SRS than with attachment, although they are quite interrelated, as we shall see.) All social animals have a SRS, and we are the most social of all animals. In humans, as in other species, the SRS is mediated by serotonin levels (Peterson, 2017).

Again, as for the Defence and Attachment systems, the SRS can also be in homoeostasis (leading to cooperative behaviour) or be hyperactivated (giving rise to dominance behaviours) or hypoactivated (leading to pleasing and submissive behaviours). The CNS and ANS activation will be very similar to what we have seen in the defence and attachment systems because the 'hardware' - the machinery beneath these various systems - is partly shared.

The AS and SRS evolve closely together. Children's demands outstrip the capacity of their parents to meet them (Trivers, 1974). So, to cope with that demand, and also to control children's behaviour, parents become active social ranking agents. This is particularly true in more developed societies where families tend to be smaller and children spend far less unsupervised time with other children. Because attachment and social ranking systems are partially opposed to each other, certain dysfunctions may arise:

- Children who perceive their parents as weak, tend to hyperactivate their social ranking system, attaining dominating positions and expressing anger at their parents.
- Such children show Higher Reactive and Displaced Agressive behaviour to lower stress levels, what is known as "stress-induced displacement aggression" (Card & Dahl, 2011).
- They learn less self-regulation, tend to be more impulsive and less able to tolerate frustration.
- They also have lower self-esteem (Sapolsky, 2017).

As we saw with the DS, enmeshment between the SRS and AS may occur, leading to dependency problems in adult relationships (Mansukhan,i 2017).

These three systems have evolved to protect and keep us safe when we are under threat. They are, in fact, based on fear, albeit different types of fear: in the case of the DS it is the fear of being harmed or injured by a predator; in the case of the AS it is the fear of being neglected or abandoned and, for the SRS, it is the fear of being humiliated, isolated or harmed by a group member. Thus it is possible for these three systems to become activated simultaneously and repeatedly. Another common aspect is that all three, in their hyperactive mode, can result in angry and aggressive behaviours. A last aspect to take in account is that they can compensate each other, and frequently do so. For example, a person fearing abandonment (AS) may assume either dominating or submissive behaviour (SRS) in order to maintain interpersonal proximity (Mansukhani, 2017).

We frequently see people whose responses have created problems for them in that they are inappropriate, an over-reaction, an under-reaction or a failure to respond. In many cases this results from activation of the wrong system.

Ideally, a child will have good enough attachment figures and consequently their behaviour systems differentiate and then integrate under cortical control so that, as adults, they are able to respond in an appropriate and sophisticated way. When this does not occur and there is repeated activation of different systems at the same time with the same stimulus, it leads to these systems not differentiating and becoming emmeshed with each other; hence the aberrations in behaviour.

We can see this with any of the systems mentioned above. We have already seen how the AS and SRS can become enmeshed. Another example is enmeshment of the sexual system or pleasure/seeking systems. In many cases the sexual system has been sensitized and is either chronically hyper- or hypoactivated. It is often used to compensate other systems. We see clear indications of sexual systems emmeshed with attachment or with social ranking systems. Many sexual offences actually have more to do with dominance than with sexual pleasure, and dominance is related to the SRS. The same is true for the pleasure/seeking system; for example hypoactivated in certain depressions or hyperactivated in various addictions (Hoffman & Hase, 2012). The use of EMDR addiction protocols in adult attachment problems responds to this logic.

It is important for clinicians to distinguish between the AS and the SRS. We can imagine the case of a mother that has a reasonably secure attachment style with her child. But as this

p13

child matures, he starts exhibiting demanding and dominant behaviour towards his mother. If his mother had a very strict and dominating parent she might, in order to avoid being like her parent, avoid exhibiting any corrective behaviour; this mother may well have a tough time dealing with her child's tantrums and plays for dominance. The child can perceive this as submissive behaviour and adopt an even more dominating stance. If this goes on long enough, the attachment relationship between them will start to deteriorate because it is very difficult to treat with love someone who is displaying abusive behaviour towards you. Such parents frequently start exhibiting anxious and/or avoidant behaviour. If at some moment this dyad of mother/son, for example, start therapy, the therapist could well think that the anxious-avoidant traits observed in the attachment figure are the cause of the tantrums in the child. In many cases an EMDR therapist can get lost looking for initial targets of avoidant behaviour and processing them without managing any improvement. In such cases it's much more useful to work on the child's self-regulation and to teach co-regulation to the parent, as well as parenting skills. It can also be very useful to process the mother's childhood memories with the dominant parent.

Healthy attachment

Defence and social ranking (evolved from territoriality) are very old systems, perhaps 300 million years old, or more. Attachment, on the other hand, is much more recent. As far as we know, the AS developed when mammals started flourishing, somewhere in the last 65 million years. And the high levels of attachment exhibited by humans and other hominids are even more recent, perhaps just a few million years old. In spite of that, attachment in humans is more important than the other two affective systems, due to the immaturity of our offspring. In fact, as Jeremy Holmes states (2001): it's "the organizing principle around which psychological development takes place". This is due to various factors:

- The AS protects against ACE (Adverse Childhood Experiences), in terms of both prevention and repair. Statistically, children with parents with secure attachment suffer fewer traumatic experiences, both in and outside of family settings.
- The AS creates implicit knowledge of "how to do things with others" (Lyons-Ruth, 1988). Secure attachment in childhood is related to healthy adult relations.
- The AS sets the base for self-regulation, both coregulation and autoregulation. Regulation is the base of a healthy development.
- The AS contributes to self-esteem, self-image and self-compassion. We treat ourselves as others treated us (Zessin et al., 2015).
- The AS mediates mental health and well-being.

A child that grows up in a healthy emotional environment, who enjoys mainly secure attachment relationships, tends to be regulated most of the time and enjoys healthy mental development. This allows all the affective systems to develop, differentiate and integrate under cortical control, resulting in sophisticated adult behaviours. On the other hand, if the child grows up in an environment in which his/her arousal is frequently hyper- or hypoactivated, the affective system responses will be not differentiated and will not be under cortical control. Repeated hyper- or hypoactivation results in narrow windows of arousal and unsophisticated behaviours ensue.

When this absence of regulation has been especially serious, the development of cortical structures is hindered and incomplete, favouring distinct

p14

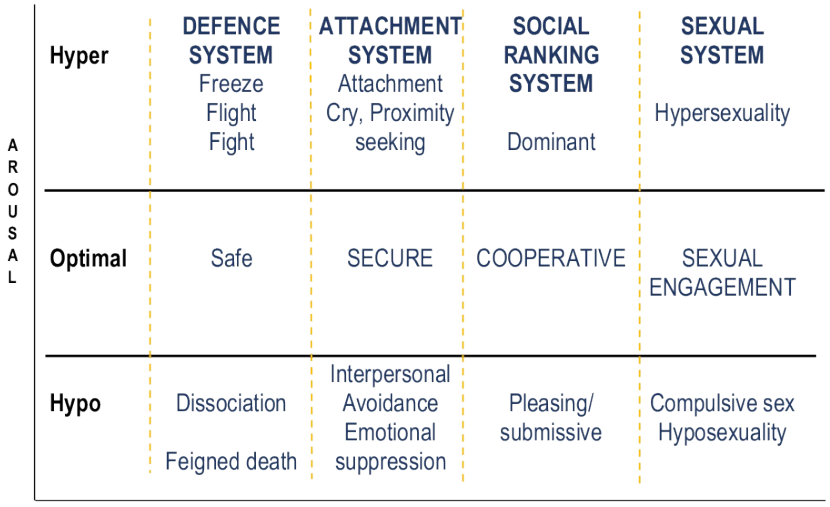


Figure 2: Hyper- or hypoactivation of the various Affective Systems and associated behaviours

ego states and, in extreme cases, dissociative parts (see Figure 2).

EMDR and adult attachment

We should remember some basics about Attachment before considering how to work with it from an EMDR perspective:

• It is an implicit memory system (Amini et al., 1996) which activates under conditions of stress, fear, loss, loneliness, intimacy situations, etc.

• The AS is frequently enmeshed with other Affective Systems. We can see people who tend to respond in intimacy relationships from the Social Ranking System, The Defence System or the Sexual System.

• Some people have an overall attachment pattern, although they frequently exhibit different styles under different circumstances.

• In adults with insecure attachment, we often see people with ambivalent and avoidant features.

• It varies in flexibility-rigidity: people with secure attachment styles find it easier to accommodate to new information than those with insecure attachment styles, who will assimilate all new relational information under old guidelines.

• Except in extreme cases, disorganized attachment is not a fourth category; most adults vary in their level of disorganization.

• In those with insecure styles, the AS activates more frequently and interpersonally. "The insecurely attached project strong negative feelings into their current attachment figures. Unable to view themselves as deserving and the others as welcoming, once these feeling states are projected in current relationships they have a very great likelihood of evoking corresponding feelings in other people [...] in a self-fulfilling way" (Kobak & Sceery, 1988)

• When the patterns are very dysfunctional, they tend to result in repetitive negative relationships that mirror the person's initial attachment problems: "In insecure attachment, the individual's relational strategies are dominated by set, clearly repetitive patterns of attachment" (West and Sheldon-Keller, 1994).

Standard protocol

The Standard EMDR Protocol (8 stages, 3 prongs) is a fabulous tool for intervention. But it requires, as Farrell and Laliotis (2017) have shown, clients who can: access their experience and their response to it, maintain dual attention, tolerate distress without becoming overwhelmed or shutting down, shift from one state to another (distress to calm and vice versa), observe and reflect about the experience instead of being completely absorbed by it, access positive experiences and self-soothe between sessions.

Clients with attachment issues frequently will not meet most of the above criteria, requiring EMDR Phase 2 interventions before we can start processing directly past memories. Plus, these clients have certain problems that make Phase 1 of EMDR difficult, such as:

• They often have no explicit memories of their childhood attachment experience, or these are inaccurate. In fact, the more severe the attachment deficit in childhood, the less aware the adult patient is about it. This is known as "attachment blindness" (Siegel, 2012).

• History taking is deregulating and evocative (Steele *et al.*, 2016). Patients will destabilize when they activate their AS. They enter in either hyper (and get locked out of normal arousal) or hypo (and get shut down).

• They may have a great fear of destabilizing, not allowing themselves to come in contact with any inner or outer stimulus that could connect them with emotion and/or feeling. This is what we call the 'window of control'. It is narrower than the optimal arousal zone and it confines the patient within it. Therapists often confuse this with dissociation-hypoactivation but they are different states and require different therapeutic approaches.

• Problems with recall and connection due to dissociation or partial dissociative features: avoidance, emotional suppression, semantic and/or episodic memory dissociation, BASK dissociation (Braun, 1988), etc.

All the above make it impossible to start our intervention from Phase 1. So, what do we do when we can't start from Phase 1? We do the next best thing and start from Phase 2.

Phase 2: The therapeutic relationship

Phase 2 becomes the first phase in EMDR treatment with complex attachment patients. Attachment has to do with intimacy and therapy is "an in-vitro experiment in intimacy" (Holmes, 2012). We therefore have to be especially careful with the therapeutic relationship. Patients with childhood attachment issues easily activate their (damaged) AS in therapy. We have to remember that they have low self-regula-

p15

tion and/or extreme control (sometimes both). Due to the nature of their problems, they are also very challenging at an interpersonal level. They will show positive and negative transference. In more difficult cases, we could have serious enactments of their past in therapy (Schore, 2015). If therapist and patient manage to develop an adult relationship in therapy this will help the patient develop his 'inner adult', a concept we work on more with each therapy session.

At the same time, therapists too have their Attachment System which can also become activated. Frequently, the worst enactments have to do with issues from the patient's past that somehow drag the therapist into a confrontation that activates scenarios from his/her own past (countertransference). So, the therapist should try to:

- Be sure that the past that is being recreated is not his/her own but the patient's; have developed an inner adult.
- have worked on his/her attachment history and have an Earned Secure Attachment (Main & Goldwyn, 1984; Hess, 2008).
- Ba a Safe Base for the patient to explore his/her insecurity (Johnson, 2016); be able to provide a safe therapeutic setting for the patient that is predictable and has clear limits.
- Be an interactive coregulator, with the capacity of being in relational mindfulness.
- Enter (and therefore validate) the client's worldview before challenging it. This implies understanding (the function) and respecting bonding patterns and 'parts'.
- Understand the importance of enactments: they mirror a patient's attachment problems as a child. Handled correctly, they can be a powerful corrective experience for the patient. Often, they mark the beginning of therapeutic change and the first chance the client has of experiencing a healthy relationship with an adult.

Phase 2: Resourcing

In general terms, we could consider that the objectives of Phase 2 are to achieve:

- Stability (symptom reduction); this is true for all cases except for certain patients with a marked avoidant pattern whose pathology is precisely their extreme stability.
- Security, in the present and in sessions. We have to be sure that the patient's present is safe and that we can keep them connected / bring them back to the present in sessions.
- An understanding of pathology and treatment from an EMDR perspective. Also, how the patient's particular life events and attachment history has led them to their current situation. This frequently is not attainable in this initial stage of therapy and will happen gradually during the second phase (in attachment cases, Phase 1: history taking).
- Being able to connect without overwhelming or numbing (Solomon, 2016).

But these objectives are seldom met completely in complex cases. In some cases, this is because patients are destabilized and highly symptomatic when they arrive. In other cases, they start destabilizing when they start talking about their past. There is yet a third group of patients who are extremely stable and disconnected. Beneath this appearance, there is a great fear of destabilizing so they require a lot of Phase 2 interventions. Not only is Phase 2 the initial phase, in the most complex cases it overlaps with the other phases of therapy.

We can divide the stabilization intervention in three large categories:

- Individual external: self-care habits such as sleeping, eating, resting, sports, etc; energetic level regulation, pleasurable activities (hedonic, eudemonic and achieved goals), reduction of toxic habits and addictions (TV, alcohol, substances, etc) and distinguishing safe from dangerous activities, people or environments.
- Individual internal: Safe/Calm place, Resource installation, Self-soothing techniques, positive future templates, self-understanding and self-compassion, inner child, inner adult, etc.
- Couples: When we are working with couples, the ongoing conflict is one of the main causes of destabilization during therapy. Phase 2 techniques with couples could therefore entail conflict reduction, mutual coregulation, positive activities and positive interaction, healthy limits and all the addiction protocols adjusted to interpersonal dependency (very useful with toxic and dependant relationships).

Phase 1: History taking

Once certain levels of stabilization and security have been attained, we can begin Phase 1. In these patients, it takes the form of a co-creation of life history. Frequently this is done from present to past, starting with present interpersonal conflicts and tracing them back to childhood relationships.

Most of the attachment

p16

trauma memories won't appear until the person activates his/her AS. Before processing these memories, they have to be integrated into a life history. This has usually not happened because the patient has felt overwhelmed when thinking about them and has therefore avoided them, activating all their defence mechanisms. To avoid this, and to facilitate processing, we use various techniques such as staying in dual focus (letting the person feel emotions that are coming up and just being able to stay with them until they start losing intensity), short or slow BS, tactile BS while the person is talking, partial processing (using BS with dual focus on small bits of memory or feeling/emotion) and the CIPOS technique (Knipe, 2009). It is very important to understand that in EMDR, dual focus is just as important, possibly even more important, than BS. Without dual focus, processing of traumatic memories is not possible. And dual focus, from an arousal perspective, occurs at the edges of the window or tolerance, when the patient has one foot here (cortical) and the other in contact with the disturbing memories (hyper- or hypoactivation) (see Figure 3).

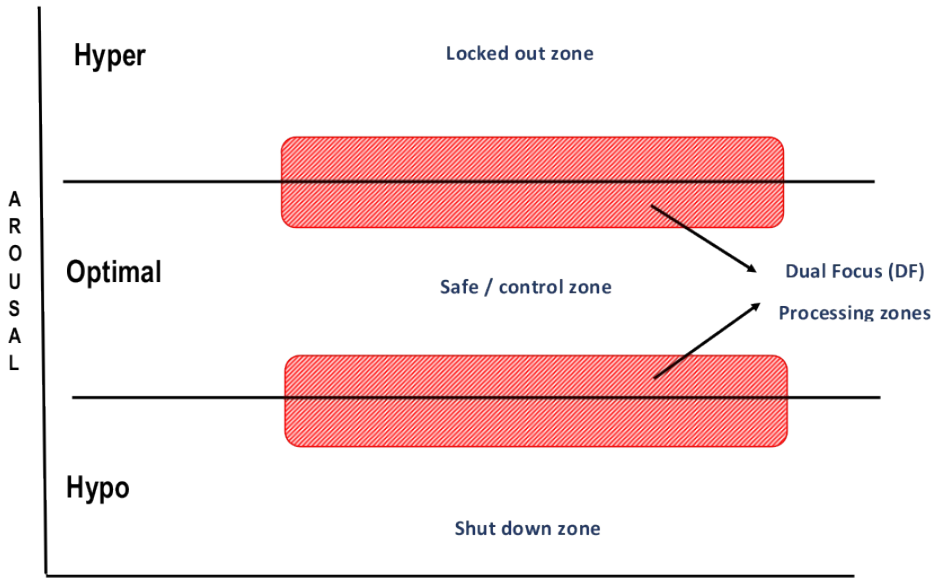


Figure 3: Dual Focus and processing, in relation to level of arousal

The aim is to help the clients stay and cope with the activation that appears when thinking about or remembering traumatic attachment issues. This will widen their Window of Tolerance, help them mentalize (Fonagy 1997, 2007) and enhance their reflective functioning (Bowlby, 1988). All this increases the likelihood that they are able to make the connection between their attachment problems and their current issues. At the same time, it's important that they are able to regulate following exposure to manageable bits of disturbance. This will gradually allow us to come closer to standard processing and understand the rhythm the patient requires. It is very important that patients manage to be regulated and calm at the end of each session, widening their Window of Tolerance, making them confident in the technique and the therapist, helping them achieve insights and feel secure and in overall control.

Phases 3 to 6: Targets

Unlike in simpler cases, targets for this patient group are rarely 'close to the surface'. Targets tend to appear gradually as narration activates the AS. So we have to work towards the emergence of targets. These will normally appear in reverse hierarchical and temporal order, the most recent and less important ones appearing first. Frequently, only after working with present and minor targets, encouraging the Window of Tolerance to gradually widen, will the deeper rooted, older and more pathological situations emerge.

Initially it may be difficult to get complete targets (due to overwhelm or disconnection) so we have to use partial processing: using two modalities (sensory, emotional or cognitive) and short saccades to integrate and desensitize them (Shapiro, 1995, 2001; Gomez, 2013). This is also useful when the patient gets blocked during processing. Sometimes, something as simple as changing the speed of the stimulation can be very helpful. The use of EMD in initial stages is helpful. Also, techniques designed to overtax the working memory have proved to be very useful in these cases.

Phases 3 to 6: Images

We can work with many types of image in attachment. They may be specific images related to particular situations, just as in standard processing, but also:

• Symbolic images: mother's

p17

face, back, etc. Such targets don't represent particular moments but general aspects of the pathological relationship with the attachment figures, etc. They are frequently useful to elicit attachment-related negative cognitions (i.e. "What words come to you as you see the image of your mother's back now?").

• Projections: own or other children, movies, pets, etc.

• Imagine how... (for situations that occurred very early in life). Frequently these situations will have to be processed twice, once from an adult perspective and a second time from a child perspective.

• Scenarios (recurrent situations) and nodal memories (Holmes, 2001), related to more than one memory network (and therefore different cognitions). These types of situations will require the installation of different PCs, related to different systems.

Phases 3 to 6: Cognitions

Due to the nature of intra-familial trauma, the same situation may have provoked activation of different Affective or Behaviour Systems. This will usually result in identification of more than one type of Negative Cognition (NC). So we can install different Positive Cognitions (PC) for the same target (about being safe, then guilt and then about the self, for example).

Responsibility/defectiveness cognitions are the most commonly found in attachment. The cognitions concerning Safety/Vulnerability and Power/Control are more common in DS trauma. The NC can be a useful way to distinguish if we are in attachment or trauma territory. If the same situation is related to both types of NC, we may have to decide on the order of processing. If there is a strong inner adult, normally we would process first the defence trauma. If this is not the case, we have to work first with the inner world and attachment traumas before being able to process acute trauma.

Another difference with this patient group is that PCs are often unavailable at the beginning of the processing (or maybe too unbelievable). In such cases, we can use progressive installation of the PC, starting from PCs that are easier to believe and, as we manage to install them with VOC7, progress to deeper PCs that are more related to the self. For example:

• it's over / it's over and I am safe now / I learnt / I am free of guilt.

• I am learning that everybody makes mistake / Everybody deserves to be loved / I am learning to be loved / I deserve to be loved.

In our experience, it is better to end processing with a VOC of 7 than with a deeper PC that never reaches VOC7.

In the service of dual focus

These suggestions should not be seen as alternatives to the Standard Protocol but as modifications aimed at bringing the client closer to being regulated enough and, at the same time, sufficiently in touch with the events of his/her life history to process them. As I stated previously, DF is as important or more than BS in EMDR processing. In fact, what hinders or prevents processing is the client's difficulty to stay in dual focus. This is even more true, as we have discussed, when attachment is emmeshed with other affective and behavioural systems.

Perhaps the most important aspect is the therapist's sensitivity and attunement, informing them, moment by moment, of what manageable bits of disturbance the client is ready to be exposed to. This gradual approach widens slowly the patients window of tolerance. This, in turn, increases the client's reflective capacity (necessary for integration) and makes the client feel safer with the therapist and more confident with the method. And all this brings the client closer to the possibility of completing processing with the Standard Protocol. Perhaps the most useful skills that EMDR therapists can learn are aimed at helping the client stay in dual focus while processing difficult childhood memories. I hope this article offers some simple steps in that direction.

For a full reference list of references please contact the author at:
arun@arunmansukhani.com

Dr Arun Mansukhani is a Clinical Psychologist and Sexologist. He is an EMDR-Europe Accredited Consultant and Facilitator. He is currently Vice Director at the IASP Centre in Malaga leading a team of psychologists working with trauma and attachment.

EMDR EYE MOVEMENT DESENSITISATION AND REPROCESSING THERAPY

EMDR Central Scotland Regional Group

New Treatment approaches in Complex PTSD

By Professor Ad De Jongh

Date: 7th November (Thursday) 2019
Venue: Citizen Glasgow hotel, 60 Renfrew Street, Glasgow G2 3BW

Standard Rate is £80 with 6 Association CPD points applied for.

Book here

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.

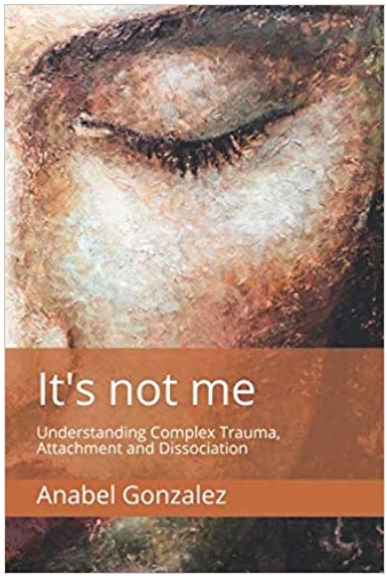
Write to:
editor@emdrassociation.org.uk

BOOK REVIEW

How attachment patterns in childhood become adult defences

It's not me. Understanding complex Trauma, Attachment an Dissociation
By Anabel Gonzalez

Anabel Gonzalez (2018)
ISBN-13: 978-8409066865



Reviewed by Christos Papalekas

This book is an engaging and compassionate guide to the deeper mental structures that affect human behaviour. The first half of the book is about emotional regulation and the second about psychological resilience and how we can 'look at the past from the present'. Anabel Gonzalez explains with warmth how attachment issues in early life influence our later psychological development. She offers templates on how attachment bonds in childhood form defence mechanisms in adulthood.

As a therapist I felt that everything she said rang true. It's a unique book, especially in the way she shows us how we can reframe our understanding of emotional regulation. Gonzalez elegantly describes the positive nature of emotions with apposite illustrations from her clinical practice and through her creative use of metaphor.

The main strength of the book is that it keeps the reader engaged in a thoughtful and reflective mode. Practitioners will find it valuable for the wealth of information it provides in explaining the impact of traumatic experiences and the significance of secure attachment as part of a healing process. It also has value as a psychoeducation guide for clients. Gonzalez normalises the feelings of different parts created in childhood as natural protective mechanisms. She makes particular reference to EMDR in Chapter 20.

Gonzalez explains in a simple way how psychotherapy offers a constructive means of rediscovering our inner healing qualities so that we may live in the present with a more accepting and compassionate stance to our past. She illustrates how the adult self can intervene to resolve inner conflict in younger selves. The main thrust of the book is on the awareness that arises through exploration of the various parts (beliefs, emotions, behaviours) we all have in a way that rationally alters how we see ourselves and our relationships with significant others. Gonzalez is honest about how difficult as well as rewarding the journey of recovery might be.

This profoundly insightful book was a privilege to read.

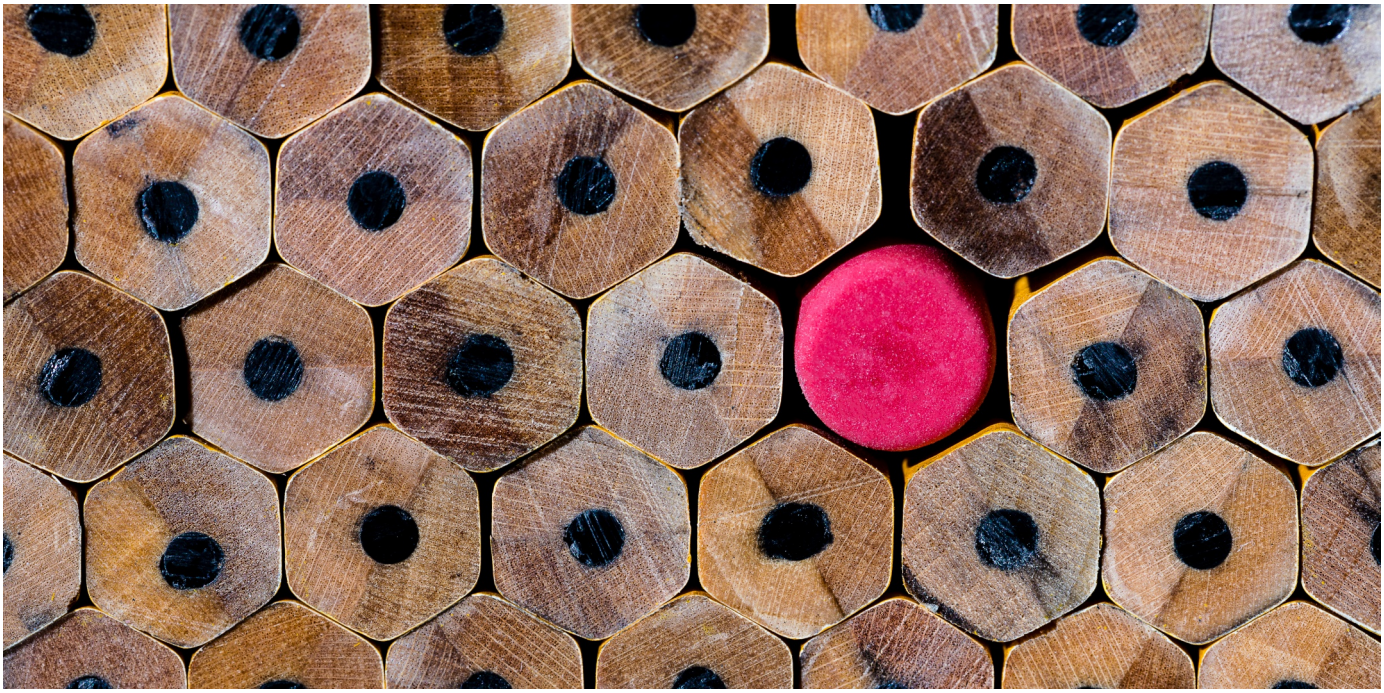
Christos Papalekas is a Registered Counselling Psychologist, CBT and EMDR Psychotherapist

Advertising Policy

Advertisements are the responsibility of the advertiser and do not constitute endorsement by the EMDR Association UK & Ireland of the advertiser, its products or services. The EMDR Association UK & Ireland and Editor reserve the right to refuse, reject or cancel advertisements without notice.

How does the literature inform us regarding the use of EMDR for the treatment of obsessive-compulsive disorder (OCD)?

Robin Logie
Clinical Psychologist, EMDR Consultant & Trainer
info@robinlogie.com



Introduction

Prior to 2006, nothing had been published in relation to the use of EMDR in the treatment of obsessive-compulsive disorder (OCD). Since that time, there have been an increasing number of published case reports, case series and two randomised controlled trials (RCTs) regarding the use of EMDR for OCD. Different protocols have been proposed and tested and specific issues regarding the use of EMDR with this client group have been addressed. It is therefore time to take stock of the literature and summarize what we can learn from it.

Obsessive–compulsive disorder (OCD) is characterized by one or both of the following: 1. Recurrent and persistent intrusive thoughts causing anxiety, which the individual attempts to suppress; 2. Repetitive behaviours (e.g. hand washing or checking) which the individual feels compelled to carry out in order to reduce anxiety. The person recognizes that the obsessions or compulsions are unreasonable although this is not always the case for children with OCD. The symptoms are time consuming and significantly interfere with the person's functioning or relationships (American Psychiatric Association, 2013).

OCD affects 2.3 percent of the population within their lifetime (Goodman, Grice, Lapidus, & Coffey, 2014).

Is the Adaptive Information Processing model relevant for OCD?

I will illustrate the main developments and questions arising from the research on this topic with my own experiences of work with real clients with OCD. Let us begin with Annie.

Annie, aged about 10 suffered from OCD with obsessions and compulsions relating to food and, in particular, eating in public places. This had a very clear onset, the occasion on which she vomited on a long family car journey a few years before. This had been the first time she had vomited in her life as far as her parents could recall. Vomiting on a car journey would not usually be regarded as a trauma or significant adverse life event. However, for a child with an anxious temperament and no prior experience of vomiting, this event, for her, would constitute a trauma.

What is the rationale for using EMDR for the treatment of OCD? EMDR is based upon the Adaptive Information Processing (AIP) model. This model (Shapiro, 2007) describes how new experiences are integrated into existing memory

p24

networks. Normally, memories are processed and assimilated using the individual's past experience and understanding of themselves and the world they live in. However, if the experience is traumatic, the information processing system stores the memory in a 'frozen' form without adequately processing it to an adaptive resolution. Traumatic memories fail to become integrated into the individual's life experience and self-concept. The assumption therefore is that EMDR may be a suitable treatment only for those psychiatric disorders that have their roots in unresolved traumatic or adverse life events.

To what extent is OCD caused by trauma or adverse life events? Miller & Brock (2017) carried out a meta-analysis of the connection between past trauma exposure and current severity of obsessive compulsive symptoms in 24 studies. Four types of interpersonal trauma (violence, emotional abuse, sexual abuse, and neglect) were associated with such symptoms. So, there is clearly a link, but is this the case for all individuals? Cromer, Schmidt and Murphy (2006) found that 54% of individuals with OCD had experienced at least one traumatic life event. More recently (Ozgunduz, Kenar, Tekin, Ozer, & Karamustafalıoğlu, 2016) found that at least 70% of individuals with OCD had suffered a childhood trauma. This indicates however that some individuals (30 to 50% perhaps) with OCD did not experience any identifiable trauma. However, it is important to consider what we define as a 'trauma'. Dykshoorn (2014), writing about OCD and trauma, suggests that if we adopt a more 'liberal' definition to include concepts such as 'adverse experiences' the picture may be different. "Essentially, any event can be considered traumatic if the individual experiences it as such." (Dykshoorn, 2014, p 521.). For example Briggs and Price (2009) found that children, with a tendency to be more anxious and/or depressed before a traumatic experience, are more likely to develop OCD.

Is the use of EMDR appropriate for such individuals? Presumably Annie would be described as such an individual and EMDR would clearly be an appropriate therapy for her as one can see how the AIP model would be relevant to understand her OCD symptoms.

Should EMDR be a "treatment of choice" for OCD?

There appears to be a consensus (American Psychiatric Association, 2010; Franklin & Foa, 2011; NICE, 2006; Ponniah, Magiati, & Hollon, 2013) that the treatment of choice for OCD should be medication alongside Cognitive Behaviour Therapy (CBT). The CBT approach that has been found to be particularly efficacious in the treatment of OCD is Exposure and Response Prevention (ERP). ERP is a behavioural therapy that involves repeated exposure to distressing situations or cues (e.g., objects perceived to be contaminated) while preventing the use of ritualized or repetitive behaviours (e.g., handwashing) that are used to neutralize distress or to relieve obsessive preoccupations (e.g., fear of becoming contaminated and ill) (Meyer, 1966).

Although there is considerable evidence in support of CBT (Olatunji, Davis, Powers, & Smits, 2013) it is often pointed out that exposure tasks can be difficult to tolerate; clients often find it too frightening to face their worst fears and some clients do not complete their treatment (Maher *et al.*, 2010). Estimates indicate that 25 percent of patients drop out of treatment (Aderka et al., 2011). Even in the CBT world therefore, the search continues to find a more effective treatment for OCD (Foa, 2010) and there is good reason for EMDR to be considered as a possibility.

In addition to several case studies and case series (Bekkers, 1999; Böhm & Voderholzer, 2010; Keenan, Farrell, Keenan, & Ingham, 2018; Marsden, 2016; Mazzoni, Pozza, La Mela, & Fernandez, 2017) two RCTs have indicated the effectiveness of EMDR in the treatment of OCD. The first of these, carried out in Iran (Nazari, Momeni, Jariani, & Tarrahi, 2011), compared EMDR with citalopram, both of which produced a significant and comparable reduction in OCD symptoms. However, this study gives no detail of the actual EMDR protocol used. In addition, it has suggested that the dose of citalopram was less than adequate (Ponniah et al., 2013). A more recent study in the UK (Marsden, Lovell, Blore, Ali, & Delgadillo, 2017) compared EMDR with CBT which showed promising results, indicating that both therapies were equally effective in treating OCD.

The current literature indicates therefore that EMDR can be an effective treatment for OCD and is comparable with CBT in its effectiveness.

Should we use the EMDR standard protocol for treating OCD?

The literature appears to indicate three main issues in relation to this question:

p25

• Should target selection be in the usual order of past, present and future?
• Should we use EMDR alone or use it as part of a package?
• Why is flashforwards particularly relevant for treating OCD?

I will address each of these questions in turn.

Should target selection be in the usual order of past, present and future?

Janet, in her 30s, had suddenly developed OCD following a road traffic accident. She always had an obsessional personality, but her OCD became much worse after an RTA in which she was seriously injured, and which appeared to be her own fault. She described an affectionless controlling mother, which could explain the genesis of her OCD. However, I chose to start by tackling the current symptoms first as these seemed very pressing and there was an urgency to tackle the presenting problems. Initially we targeted the mini-trauma of not washing hands twice after putting some rubbish in the bin.

The standard protocol for EMDR teaches us that past events, which have sown the seeds for a client's disorder, should always be processed first, followed by present and then future events (Shapiro, 2018).

However, John Marr hypothesised that this may not apply to individuals with OCD and he offered the following rationale:

"Although OCD may have originated in early experiences, it appears to be a self-maintaining disorder. The author hypothesizes that OCD is best understood as a series of self-perpetuating and interlaced traumatic events, or as a complex multiple event. Each current trigger - each obsession and compulsion - is viewed as a separate recent "traumatic event," which links with other related events, and with past memories, to reinforce and perpetuate multidimensional disturbing patterns of thoughts and behaviors. OCD is not one continuous event, but instead it is a number of interlaced events that both support and reindoctrinate each other.

Consequently, it is recommended that treatment starts by addressing the current events. Therapeutic interventions that begin by addressing past incidents will almost always be undermined by the more recent OCD events. OCD treatment is most successful when it focuses on first reducing the power of present experiences." (Marr, 2012, p.11)

Marr experimented with two protocols in which he used EMDR to process targets in the sequence present-future-past or present-past-future. Using each protocol with two clients he successfully treated four individuals with OCD who had previously been unsuccessful with CBT (Marr, 2012).

Subsequently, Marr's protocol was subjected to a more rigorous analysis when it was used as the basis for an RCT using the present-future-past sequence of processing (Marsden *et al.*, 2017). The protocol was compared with CBT incorporating ERP with 29 participants randomly allocated to the EMDR and 26 allocated to the CBT arm of the experiment. Overall, 61.8% completed treatment and 30.2% attained reliable and clinically significant improvement in OCD symptoms, with no significant differences between groups.

There is therefore now empirical evidence that, for OCD, it may be efficacious to target present behaviour and symptoms first before targeting past events when using EMDR.

Should we use EMDR alone or use it as part of a package?

Eleven-year-old Marc had compulsions about touching certain things. He had to do actions in threes or multiples, for example, switching the light on and off nine times or twirling nine times before descending the stairs. He believed that his family would be murdered if he did not carry out these rituals. He would be awake until 2am worrying that he would die if he did not sleep in a certain way. EMDR therapy targeted an image of switching on the light just once only and, within three sessions, he reported that he was completely symptom free. A few months later, Marc experienced a further relapse and saw another psychologist who used CBT and, in particular, ERP.

I subsequently met with Marc and his mother. They both agreed that, whilst the EMDR had produced a rapid improvement, it had been insufficient on its own to promote a long-term change because it did not equip him with the necessary strategies to prevent further episodes of OCD. Marc said, "Your way was quicker but it didn't last long." He thought the CBT had shown

p26

a longer-term effect because he was given the opportunity to "talk through everything that worries me." Marc's mother agreed that the speed of change had differed in the two therapies. Whilst he reported feeling completely better after just two or three sessions of EMDR, it had taken four sessions of CBT before any change was detected. Both Marc and his mother agreed that a combination of the two therapies would have been best. His mother added that when he saw me his problems were more severe and therefore the fast acting EMDR had been particularly helpful at that stage.

Several published research studies regarding the use of EMDR for OCD indicates that EMDR may be more effective as part of a package that includes CBT, and in particular, ERP.

Böhm and Voderholzer (2010) described three case studies in which EMDR had been combined with ERP. In one case, EMDR was used first, in another it was used second and in the third, EMDR and ERP were used alternately. The rationale for this was provided by evidence from some previous research by Bekkers (1999) who had found that isolated use of EMDR for compulsions, "appears to have little effect" (p. 2 of English translation).

The use of EMDR as part of a package is being explored in more detail by Pozza *et al.* (2014). In the 'Tackling Trauma to Overcome OCD Resistance (The TTOOR Florence trial)' for clients with "resistant" OCD, they are carrying out an RCT to compare 1) ERP alone versus 2) ERP combined with EMDR. It is based on the premise that an extra ingredient needs to be added to the traditional ERP approach in the case of some individuals who are particularly hard to treat. Whilst the findings of the RCT have not yet been presented, the research group has published a preliminary paper regarding the results with three cases studies (Mazzoni *et al.*, 2017). Similar to the Böhm and Voderholzer's study these illustrate the use of EMDR before ERP, after ERP and simultaneously with ERP with all three patients showing a significant reduction in symptoms.

I learnt from my experience of working with Marc that EMDR is not usually effective on its own when working with children. Often EMDR needs to be combined with elements of CBT, although not necessarily using ERP. In particular, I have found that children require preliminary psycho-education regarding OCD. This is commonly used in CBT for children with OCD (for example, Waite & Williams, 2009). In the psycho-education phase, Waite & Williams characterise OCD as a "bully" which the child needs to overcome. This does not appear to sit well with the AIP model. I have, instead, described OCD to children as being like an "unwanted friend" who initially make out they are on your side but starts to be manipulative and nasty and ultimately the friendship needs to be jettisoned.

In conclusion, it appears that, whilst EMDR can be effective in treating OCD, this may only be the case when it is part of a treatment package combined with other therapies such as CBT.

Why is flashforwards particularly relevant for treating OCD?

14-year-old Rosie had a complex bedtime ritual which prevented her settling at night leaving her exhausted and causing increasing frustration for her mother. The only identifiable adverse life event was the death of her grandmother two years previously. The death was expected; Rosie grieved normally and was able to share her feelings with her family. Thus, there were no past events to target and we therefore proceeded straight targeting her worst fear. This was that the bedroom window might be left open and that an intruder would kill her. As a result, "I would be dead" which would be "boring"! After two sessions of processing she was symptom free.

Developing the rationale of John Marr, described above, it appears that OCD differs, for example, from PTSD in that the client is preoccupied by the present ('what might happen') rather than by the past ('what did happen'). Whilst a PTSD client may have symptoms of re-experiencing, arousal and avoidance in relation to some past traumatic event, the OCD client fears what might happen now or in the future and tends to catastrophise about what may occur. For this reason, the Flashforwards procedure appears to be particularly relevant when treating OCD with EMDR.

The Flashforward procedure (Logie & De Jongh, 2014) is identical to the standard EMDR protocol, except that the target relates to a feared catastrophic future event rather than to a past one. For example, a client who still fears driving after the trauma of a road traffic accident (RTA), despite having fully processed the traumatic memory, would be asked what future

p27

catastrophe they fear the most. They might anticipate their own death in an RTA. This image would be used as a target. More details of this procedure can be found elsewhere (Logie & De Jongh, 2014, 2016).

Although not specifically described as Flashforwards, one of the case studies in Böhm & Voderholzer (2010), describes using EMDR to target and successfully process a future scenario in which the client with OCD believes that she will be punished in hell.

The first published articled which has specifically addressed the use of Flashforwards for the treatment of OCD was recently published by Keenan, Farrell, Keenan, & Ingham (2018). Eight clients for whom ERP had previously been unsuccessful, were treated with EMDR. For four of these individuals, it was decided that the Flashforwards procedure would be utilized without targeting any past events as these individuals reported no past traumas. In both groups there was a reduction in symptomatology although there was a greater reduction in the trauma/ standard protocol group than in the 'notrauma'/ flashforwards group. Whilst group sizes are too small for statistical comparison, this difference may reflect that the groups differed because the 'notrauma' individuals may be more treatment resistant as a function of either their obsessional temperament or, perhaps, as yet unidentified traumatic experiences or adverse life events.

Children and Adolescents

Very little attention in the literature has been paid to the use of EMDR for the treatment of children and adolescents with OCD. The only exception to this is the recent article (Cusimano, 2018) describing a case study with a 13-year-old boy. Cusimano utilised the standard protocol, targeting events in the order past-present-future over 16 sessions. An 82 percent reduction in OCD symptoms was achieved. Although, ERP was not utilised, Cusimano incorporated psychoeducation about OCD in the Preparation phase, using a workbook entitled "It's only a false alarm" (Piacentini, Langley, & Roblek, 2007)

My experience of working with children who have OCD is that they tend to be difficult to treat, whatever treatment approach is used (including EMDR) and many children are resistant to any kind of intervention. However, EMDR has been successful in children for whom other approaches, such as CBT, have been unsuccessful. It is therefore well worth including EMDR as a possible intervention for such children although it needs to be incorporated into a treatment package that will include psychoeducation. I have found Flashforwards to be particularly useful when treating children with OCD.

Conclusions

This review of the literature indicates that there is now encouraging published evidence for the use of EMDR when treating OCD. Whilst there is no evidence that EMDR is any more effective than CBT in the treatment of OCD, the research indicates that EMDR should certainly be added to the toolkit for treating OCD. This is because several studies suggest that EMDR can be effective for clients for whom CBT was not successful (Keenan et al., 2018; Marr, 2012; Mazzoni et al., 2017). This is particularly important for a disorder such as OCD for which the dropout rate is particularly high. My own experience of treating clients with OCD is that, even when using EMDR, the dropout rate is still higher than for other disorders. However, if both CBT and EMDR (or a combination of both) are available to the therapist, there is a chance that a greater number of clients will be successfully treated.

In my opinion the research indicates that we need to be flexible about the order in which we target past, present and future, depending on the individual client. Often, processing the present is more effective than processing past events, which would be the case using the standard protocol. In addition, flexibility is required as to the extent that we should combine EMDR with other therapies such as ERP and psychoeducation.

In conclusion it appears that there is no universally recognised protocol for the treatment of OCD with EMDR. And, I would contend, perhaps there never will be such a protocol, as this complex and diverse client group will always require an individual approach to their needs. Individuals with OCD crave order and certainty in their lives and, perhaps, so do we as therapists when we are attempting to help them. If, perhaps, we can learn to live with the uncertainty and model this for our OCD clients, we will better be able to help them.

References

Aderka, I. M., Anholt, G. E., van Balkom, A. J., Smit, J. H., Hermesh, H., Hofmann, S. G., & van Oppen, P. (2011). Differences between early and late drop-outs from treatment for obsessive–compulsive disorder. *Journal of Anxiety Disorders*, 25(7), 918-923.

p28

American Psychiatric Association. (2010). Treatment of Patients With Obsessive-Compulsive Disorder, retrieved 16.07.10. Retrieved from www.psychiatryonline.com/pracGuide/pracguideChapToc_10.aspx

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (DSM-5®): American Psychiatric Pub.

Bekkers, A. (1999). Enige ervaringen met EMDR bij dwang. Ongewoon en anders, 25.

Böhm, K., & Voderholzer, U. (2010). Use of EMDR in the treatment of obsessive-compulsive disorders: a case series. Verhaltenstherapie, 20, 175–181.

Briggs, E. S., & Price, I. R. (2009). The relationship between adverse childhood experience and obsessive-compulsive symptoms and beliefs: the role of anxiety, depression, and experiential avoidance. *Journal of Anxiety Disorders,* 23(8), 1037-1046.

Cromer, K., Schmidt, N., & Murphy, D. (2006). An investigation of traumatic life events and obsessive-compulsive disorder *Behaviour Research and Therapy*, 45, 2581-2592

Cusimano, A. (2018). EMDR in the Treatment of Adolescent Obsessive-Compulsive Disorder: A Case Study. *Journal of EMDR Practice and Research*, 12(4), 242-254.

Dykshoorn, K. L. (2014). Trauma-related obsessive–compulsive disorder: a review. *Health Psychology and Behavioral Medicine: an Open Access Journal,* 2(1), 517-528.

Foa, E. B. (2010). Cognitive behavioral therapy of obsessive-compulsive disorder. *Dialogues in Clinical Neuroscience*, 12(2), 199.

Franklin, M. E., & Foa, E. B. (2011). Treatment of obsessive compulsive disorder. *Annual review of clinical psychology*, 7, 229-243.

Goodman, W. K., Grice, D. E., Lapidus, K. A., & Coffey, B. J. (2014). Obsessive-compulsive disorder. *Psychiatric Clinics*, 37(3), 257-267.

Keenan, P., Farrell, D., Keenan, L., & Ingham, C. (2018). Treating Obsessive Compulsive Disorder (OCD) using Eye Movement Desensitisation and Reprocessing (EMDR) Therapy: An Ethno-Phenomenological Case Series. *International Journal of Psychotherapy*, 22(3), 74-91.

Logie, R., & De Jongh, A. (2014). The "Flashforward procedure": Confronting the catastrophe. *Journal of EMDR Practice and Research*, 8(1), 25-32.

Logie, R., & De Jongh, A. (2016). The Flashforward Procedure. In M. Luber (Ed.), *Eye Movement Desensitization and Reprocessing (EMDR) Therapy Scripted Protocols and Summary Sheets: Treating Anxiety, Obsessive-Compulsive, and Mood-Related Conditions* (pp. 81- 94). New York: Springer.

Maher, M., Huppert, J. D., Chen, H., Duan, N., Foa, E. B., Liebowitz, M. R., & Simpson, H. B. (2010). Moderators and predictors of response to cognitive-behavioral therapy augmentation of pharmacotherapy in obsessive–compulsive disorder. *Psychological medicine*, 40(12), 2013-2023.

Marr, J. (2012). EMDR Treatment of Obsessive-Compulsive Disorder: Preliminary Research. *Journal of EMDR Practice and Research*, 6(1), 2-15.

Marsden, Z. (2016). EMDR treatment of obsessive-compulsive disorder: Three cases. *Journal of EMDR Practice and Research*, 10(2), 91.

Marsden, Z., Lovell, K., Blore, D., Ali, S., & Delgadillo, J. (2017). A randomized controlled trial comparing EMDR and CBT for obsessive–compulsive disorder. *Clinical psychology & psychotherapy*, 25(1), e10-e18.

Mazzoni, G.-P., Pozza, A., La Mela, C., & Fernandez, I. (2017). CBT combined with EMDR for resistant refractory obsessive-compulsive disorder. Report of three cases. *Clinical Neuropsychiatry*(5).

Meyer, V. (1966). Modification of expectations in cases with obsessional rituals. *Behavior Research and Therapy*, 4, 273–280.

Miller, M. L., & Brock, R. L. (2017). The effect of trauma on the severity of obsessive-compulsive spectrum symptoms: a meta-analysis. *Journal of Anxiety Disorders*, 47, 29-44.

National Institute for Health and Clinical Excellence. (2006). Obsessive-compulsive disorder: Core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder.

Nazari, H., Momeni, N., Jariani, M., & Tarrahi, M. (2011). Comparison of eye movement desensitization and reprocessing with citalopram in treatment of obsessive – compulsive disorder. *International Journal of Psychiatry in Clinical Practice*,, 15, 270–274.

Olatunji, B. O., Davis, M. L., Powers, M. B., & Smits, J. A. (2013). Cognitive-behavioral therapy for obsessive-compulsive disorder: a meta-analysis of treatment outcome and moderators. *Journal of psychiatric research*, 47(1), 33-41.

Ozgunduz, C., Kenar, J., Tekin, A., Ozer, O. A., & Karamustafalıoğlu, O. (2016). The frequency of dissociation and childhood trauma among obsessive-compulsive patients by comparing with healthy controls. *European Neuropsychopharmacology*, 2(26), S630.

Piacentini, J., Langley, A., & Roblek, T. (2007). *Cognitive behavioral treatment of childhood OCD: It's only a false alarm therapist guide*: Oxford University Press.

Ponniah, K., Magiati, I., & Hollon, S. D. (2013). An update on the efficacy of psychological treatments for obsessive–compulsive disorder in adults. *Journal of obsessive-compulsive and related disorders*, 2(2), 207-218.

Pozza, A., Mazzoni, G. P., Neri, M. T., Bisciglia, R., La Mela, C., Fernandez, I., & Dèttore, D. (2014). "Tackling Trauma to Overcome OCD Resistance"(The TTOOR Florence trial) Efficacy of EMDR plus CBT versus CBT Alone for Inpatients with Resistant Obsessive Compulsive Disorder. Protocol for a Randomized Comparative Outcome Trial. *American Journal of Applied Psychology*, 2(5), 114-122.

Shapiro, F. (2007). EMDR, Adaptive Information Processing, and Case Conceptualization. *Journal of EMDR Practice and Research*, 1(2), 68-87.

Shapiro, F. (2018). Eye movement desensitization and reprocessing (EMDR) Therapy: Basic principles, protocols, and procedures. In: New York: Guilford Publications.

Waite, P., & Williams, T. (2009). *Obsessive Compulsive Disorder: cognitive behaviour therapy with children and young people*: Routledge.

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:

p30

a. Abstract
b. Learning objectives
c. Introduction
d. Research question
e. Methodology
f. Results
g. Discussion
h. Summary and further reading
i. Required Statements
j. References

3. Preparation of Manuscripts

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

3.1 Structure

1. Title Page: highlights major issues
2. Main manuscript:
   a. Abstract
   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

EMDR Therapy Quarterly is committed to investigating any suspected cases of misconduct. All manuscripts are screened for plagiarism. Reviewers are asked to disclose any conflicts of interest when assigned a manuscript and, where necessary, other reviewers will be sought to maintain a thorough peer review.

5. Required Statements

The following three sections must be included after the references section:

5.1 Ethical Statements

All articles should include 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.

5.2 Conflict of Interest

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

5.3 Financial Support

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

6. Proofs and Copyright

Proofs of accepted articles will be provided to authors for the correction of errors. Authors submitting a manuscript do so on the understanding that if it is accepted for publication, exclusive copyright of the paper shall be assigned to *EMDR Therapy Quarterly*. The publishers will not put any limitation on the personal freedom of the author to use material contained in the paper in other works.

Any queries should be addressed to: editor@emdrasssociation.org.uk